Resource-oriented therapeutic models in psychiatry: conceptual review
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Background
Like other medical specialties, psychiatry has traditionally sought to develop treatments targeted at ameliorating a deficit of the patient. However, there are different therapeutic models that focus on utilising patients’ personal and social resources instead of ameliorating presumed deficits. A synopsis of such models might help to guide further research and improve therapeutic interventions.

Aims
To conduct a conceptual review of resource-oriented therapeutic models in psychiatry, in order to identify their shared characteristics.

Method
The literature was searched to identify a range of resource-oriented therapeutic models, particularly for patients with severe mental illness. Key texts for each model were analysed using a narrative approach to synthesise the concepts and their characteristics.

Results
Ten models were included: befriending, client-centred therapy, creative music therapy, open dialogue, peer support workers, positive psychotherapy, self-help groups, solution-focused therapy, systemic family therapy and therapeutic communities. Six types of resources were utilised: social relationships, patients’ decision-making ability, experiential knowledge, patients’ individual strengths, recreational activities and self-actualising tendencies. Social relationships are a key resource in all the models, including relationships with professionals, peers, friends and family. Two relationship dimensions – reciprocity and expertise – differed across the models.

Conclusions
The review suggests that a range of different therapeutic models in psychiatry address resources rather than deficits. In various ways, they all utilise social relationships to induce therapeutic change. A better understanding of how social relationships affect mental health may inform the development and application of resource-oriented approaches.

Declaration of interest
None.

Medical diseases are commonly characterised by a deficit, and treatments are designed to target – directly or indirectly – that deficit, so that the patient is cured or at least not hindered by the deficit any more. The history of psychiatry has been dominated by a similar deficit focus.1,2 Treatments have been developed to remove or ameliorate the presumed deficit, even if assumptions on the specific nature of the deficits may often have been rather speculative. Such a deficit focus applies to models of pharmacological treatments as well as psychotherapeutic ones, such as psychoanalysis or cognitive–behavioural therapy, that aim to solve an underlying conflict or to change maladaptive thinking and behaviours. This focus on deficits has a number of limitations3–4 for example, it may strengthen a negative image of patients4 and reduce their sense of control, leaving them passive recipients of expert care.2 Arguably more important is that the deficit focus in psychiatric research has produced, at best, limited therapeutic change. A better understanding of how social relationships affect mental health may inform the development and application of resource-oriented therapeutic models for patients with severe mental illness, as the traditional core group of patients in psychiatry, without using diagnostic categories. Conventional diagnostic categories, sometimes linked to the idea of disorder-specific treatments, may suggest a more deficit-oriented understanding of disease which would have been inconsistent with the aim of the review. Our specific objectives were to compile a non-exhaustive list of distinct therapeutic models in psychiatry that can be seen as resource-oriented and to identify their key characteristics.

Method
A systematic search with fixed search terms was of limited use as the resource orientation of such models has not necessarily been explicitly addressed in the literature, and the sources of such information are often disparate. Instead, we followed the recommendations for conceptual reviews by Lilford et al to gain a diverse understanding of resource-oriented models.7 This included:

(a) searching widely using disparate databases and sources, i.e. journal articles, textbooks and internet-based sources within a variety of disciplines, without attempting an exhaustive review of all the literature;

(b) making sure that the review is informed by different perspectives;
In the first stage an initial framework of criteria was developed with which to analyse and the focus of the review decided accordingly. These characteristics were continuously discussed among the research team in an iterative process.

### Results

**Resource-oriented models of therapeutic intervention**

We identified ten distinct resource-oriented therapeutic models to be included in the further analysis.

**Befriending**

Befriending schemes involve the regular provision of a supportive relationship through one-to-one companionship, by matching volunteers with patients who engage in shared social and recreational activities.9–12

**Client-centred therapy**

Client-centred therapy assumes that all people have a self-actualising tendency. It facilitates this self-determination towards optimal functioning through helpful therapist behaviour with empathy, congruence and unconditional regard.13–17

**Creative music therapy**

The Nordoff–Robbins model of music therapy uses music creation and the meaningful interactions within it to encourage patients’ personal growth, expressive skills and ability to relate to others.18–22

**Open dialogue**

Open dialogue treats patients within their own personal support systems. This is achieved by involving patients, their social network and healthcare professionals in joint treatment meetings and promoting a dialogue to help them understand the patients’ experiences.23–25

**Peer support workers**

Peer support workers are individuals with a history of mental illness who are employed in the provision of care of others with similar problems.26,27

**Positive psychotherapy**

Positive psychotherapy uses a number of exercises to build happiness by encouraging positive attitudes, cognitions and behaviours.28

**Self-help groups**

In self-help groups or mutual support groups, people with shared problems meet regularly to support one another.29–31

**Solution-focused therapy**

Solution-focused therapy helps patients identify exceptions to the problem and then find possible solutions that work independently of the cause of the problem.32–34

**Systemic family therapy**

Systemic family therapy can include different structural and strategic models.35–38 They all treat patients within the context of the family, focusing on interactions or boundaries to mobilise the family’s resources.

**Therapeutic communities**

Therapeutic communities aim to create a community within an institution. They provide a ‘living–learning’ situation, in which
everything that occurs between staff and patients can be applied to life outside.28–42

Resource-oriented themes

The two-stage synthesis identified six themes describing different types of resources that are explicitly utilised and developed in the models. The themes have some overlap, but still represent different criteria to characterise the models. Table 1 summarises their distribution across the different models.

Social relationships

All ten models utilise the patients’ social relationships in one way or another. As a result, this later became the focus of further analyses in the review.

Patients’ decision-making abilities

Several models rely on the patient’s decision-making ability. In client-centred therapy the therapist takes a non-directive approach, allowing patients to make their own decisions.13–17 Similarly, in solution-focused therapy the patient is seen as the expert who knows which solutions would work best. The therapist asks the right questions to guide the patient in identifying these solutions.28–34 Creative music therapy also allows patients to have a high level of freedom in deciding where to go next with the session and in what way they wish to contribute to the session.18–22 In the open dialogue model the patient’s opinion on treatment decisions is important, even if this means holding back on medication or hospitalisation.24,25 Finally, in therapeutic communities, shared decision-making among both patients and staff is an important principle.39–41 These models all show confidence that the patients know best and utilise their ability to make decisions.

Experiential knowledge

Some of these models utilise the experience and knowledge of the patient. In solution-focused therapy the therapist helps patients to explore the things that could be drawn upon both to achieve the aims of an intervention and to guide the intervention itself. For example, in structural family therapy the therapist might challenge the balance of the system, allowing it to correct itself favourably.35 Experiential knowledge is, therefore, a resource that can be drawn upon either to help the individual directly or to help others who share the problem.

Patients’ individual strengths

Some of these models also use the individual strengths of patients, i.e. what it is that they are good at. In positive psychotherapy this is achieved through the ‘signature strengths’ exercise in which patients write down their top five strengths and think of ways that they could use these within everyday life.28 In solution-focused therapy the therapist helps patients to explore the things that work. This may involve the identification of strengths that could be drawn upon as a solution.32–34 Finally, in creative music therapy the patients’ strengths are used to structure the intervention itself. For example, if patients are good at singing, writing music or playing an instrument, then this should be utilised in the session.18–22 The patients’ individual strengths are a key resource that can be drawn upon both to achieve the aims of an intervention and to guide the intervention itself.

Recreational activities

Three of the models use recreational activities. Many self-help groups provide an opportunity for patients to engage in recreational and social activities together.29 In creative music therapy patients are given the opportunity to play instruments, write music or sing.18–22 A key aspect of befriending involves the befrienders’ using their strengths to help others who are going through a similar situation.26,27,29,31

Table 1 Resources explicitly utilised in the therapeutic models

<table>
<thead>
<tr>
<th></th>
<th>Social relationships</th>
<th>Patient’s decision-making ability</th>
<th>Experiential knowledge</th>
<th>Patient’s individual strengths</th>
<th>Recreational activities</th>
<th>Self-actualising/self-correcting tendencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Befriending</td>
<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>Client-centred therapy</td>
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<tr>
<td>Creative music therapy</td>
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<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>Open dialogue</td>
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<td></td>
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<td>Yes</td>
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<tr>
<td>Peer support workers</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Positive psychotherapy</td>
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<td>Self-help groups</td>
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<td>Solution-focused therapy</td>
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<td>Yes</td>
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<tr>
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<td></td>
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<td>Yes</td>
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<tr>
<td>Therapeutic communities</td>
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<td>Yes</td>
<td></td>
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</table>
confidence in these natural positive tendencies and use them as a resource.

**Types of relationships**

As all ten resource-oriented models utilise relationships, we conducted further analyses to identify the types (with whom) and nature (how) of the relationships used. Four types of relationships are used: with professionals, peers, friends and family. Table 2 shows which types of relationships are used in the different models.

**Professionals**

Relationships between professionals and patients are a component explicitly used across the models. In client-centred therapy the patient’s perception of empathy and unconditional positive regard from the therapist and the genuine contact between two individuals are central principles. Although an empathic therapeutic relationship can be seen as important in any psychological intervention, the client-centred model explicitly details it as the core element. Similarly, the therapeutic alliance and use of a solution-focused conversation between therapist and patient have been identified as specific active ingredients in solution-focused therapy. The professional–patient relationship is also central in therapeutic communities, where patients and staff are encouraged to take part in various shared everyday activities as learning experiences. Creative music therapy uses musical activities to engage patients in meaningful contact with a therapist, using non-verbal means for patients who might otherwise find it difficult to engage in such relationships. Open dialogue also facilitates reciprocal empathy and understanding which a professional without such experience cannot. Finally, creative music therapy can provide meaningful contact with peers through non-verbal interactions in group sessions, which may benefit patients who are unable to engage in social relationships through other means.

**Friends**

The models also use friendships. In positive psychotherapy there are several therapeutic exercises that can improve a patient’s friendships. ‘Gratitude visits’ stipulate that the patient should thank somebody to whom they are grateful. ‘Active–constructive responding’ involves reacting in a visibly positive and enthusiastic way to good news from someone else once a day. Such exercises encourage patients to appreciate their friendships and may strengthen them. Befriending schemes provide patients with new friendships, offering additional support and fostering their social skills. Finally, open dialogue mobilises a patient’s wider social network from the start of their treatment. It attempts to create a dialogue to help significant members of the patient’s social network, including friends, to have a better understanding of the patient’s experiences.

**Family**

The models also make use of the patient’s family relationships. Systemic family therapy aims to improve the interactions and clarify the boundaries in the family system. This can mobilise the resources of the family to support a patient and build up resilience. Similarly, solution-focused therapy originally grew from family therapy to mobilise the resources of the family. Positive psychotherapy may utilise the family in the same way as it utilises friendships, through ‘gratitude visits’ and ‘active-constructive responding’. The open dialogue approach can also utilise the family in the same way as it does friendships, through creating a dialogue between the patient and family members.

**Nature of relationships**

Whereas all the models utilise social relationships, their nature may vary in terms of the reciprocity of the helping relationship and the reliance of expertise.

**Reciprocity**

Some of the models suggest a reciprocal helping relationship between a therapeutic provider and the patient. In therapeutic communities both patients and staff should be seen as equal in the community, learning from one another and making decisions together. Similarly, self-help groups are usually run by the members of the groups themselves with everyone bringing their own support for one another. Befriending can also be seen as a reciprocal relationship in that both patient and befriender are there to create and maintain a friendship, not a therapeutic relationship. Open dialogue also facilitates reciprocal

| Table 2 Types of social relationships explicitly utilised in the therapeutic models |
|----------------------------------|----------|--------|--------|
|                                  | Professionals | Peers | Friends | Family |
| Befriending                      | Yes       |        |        |        |
| Client-centred therapy           | Yes       |        |        |        |
| Creative music therapy           | Yes       | Yes    |        |        |
| Open dialogue                    | Yes       |        | Yes    | Yes    |
| Peer support workers             |           | Yes    |        | Yes    |
| Positive psychotherapy           |           |        | Yes    |        |
| Self-help groups                 |           | Yes    |        |        |
| Solution-focused therapy         | Yes       |        |        |        |
| Systemic family therapy          |           |        | Yes    |        |
| Therapeutic communities          | Yes       |        |        | Yes    |
relationships by promoting a dialogue to facilitate change in the whole family,23–25 and viewing patients as partners in therapy rather than objects of therapy.24 On the other hand, client-centred therapy, systemic family therapy, solution-focused therapy, creative music therapy, positive psychotherapy and peer support workers all suggest a unidirectional relationship with a therapeutic provider from whom a patient receives help. Peer support workers, however, may suggest a more reciprocal relationship than the others.26

Expertise
There are some differences between the models in terms of who is seen as the expert. In client-centred therapy,13–17 solution-focused therapy,32–34 positive psychotherapy28 and open dialogue,23–25 the patient can be seen as the expert who knows best. The therapist taps into this expertise by asking relevant questions or providing necessary exercises. For self-help groups and peer support workers,26,27,29–31 it is the peers who have at least some of the relevant expertise. Their experience is relied on in supporting the patient. In therapeutic communities everyone can be seen as an expert and everyone is there to learn from each other.39–42 Patients are commonly seen as the experts, whether it be the patients themselves or peers. The only arguable exception to this is systemic family therapy, where the therapist can be seen as the expert who is there to influence the family system.35–38

Discussion
Using a narrative approach we synthesised conceptual characteristics of distinct resource-oriented therapeutic models for patients with severe mental illness and identified six resources that are utilised in such models: social relationships, patients’ decision-making abilities, experiential knowledge, patients’ individual strengths, recreational activities and self-actualising/correcting tendencies. Social relationships especially appear to be central in all the models. Further analysis identified four types of social relationships that may be used, i.e. with professionals, peers, friends and family. The nature of the relationships suggests a unidirectional helping relationship for most of the models, although some appear to be more reciprocal. Finally, the majority of the models suggest the expertise lies with the patients, either the patient in question or peers who have had similar experiences.

Social relationships
Although the review included very different models, all of them share one core characteristic – the idea of utilising social relationships to bring about change and help the patient. Relationships are also seen as important in other therapeutic models that do not primarily focus on resources,44,45 and have been suggested as crucial for the recovery process.46–49 However, people with severe mental illness have few close relationships to utilise.50–54 The therapeutic context may therefore be an approach to help the patient learn to establish and maintain beneficial relationships. Nevertheless, it has been suggested that some relationships may have a negative impact on a patient’s recovery.47,48,55,56 Thus, the therapeutic task is not only to increase the number of social relationships, but also to help the patient to shape them so that they are beneficial. The models in this review vary in their explicit assumptions about how exactly relationships are to be used and benefit the patient, but two potentially important aspects were identified. Some, but not all, of the models provide a sense of reciprocity and expertise within the relationships. This may strengthen a person’s sense of personal agency and efficacy, with a positive impact on their recovery.47,48,53,57

This importance of social relationships in psychiatric therapeutic models parallels similar trends towards emphasising relationships in other fields, including teacher–student relationships in education,20 caregiver–child relationships in healthy child development,19 and helping relationships in social work and physical health.16,61

Strengths and limitations
Although we searched widely and included different perspectives, the reliance on expertise within the research team may have made the review and analysis selective. The findings represent the interpretation of the research team, may be influenced by their belief in the importance of a social dimension of mental healthcare,6 and do not constitute an exhaustive understanding of resource-oriented models in psychiatry. The characterisation of some models may also be seen as simplified and debatable. Finally, we focused only on resource orientation without exploring how such an approach may be integrated with a deficit orientation. However, the flexible and dynamic approach enabled us to gain a diverse understanding of the disparate literature, to conceptualise resource-oriented therapeutic models and to arrive at criteria for characterising key aspects.

Implications of the study
A number of therapeutic models in psychiatry do not target a deficit of the patient, but focus on the patient’s positive resources. They vary, and are often rather vague, in the extent to which they specify which resources are used, how exactly they are mobilised and what precisely their beneficial effect is. More conceptual work on this might benefit from considering several models rather than analysing each one in isolation. All the models utilise social relationships, although the type and nature of the relationships vary. A better understanding of how social relationships affect patients’ mental health might help to advance such models and, possibly, to develop new ones. This might require more specific theories about the helpful factors across social relationships and how they can be used in different therapeutic contexts.47,62 The identification of overarching aspects of relationships – such as reciprocity and expertise – might provide a framework for evaluating how different forms of relationships facilitate change and reduce mental distress.

In treatment studies, relationships and interactions should be assessed more systematically to provide evidence on helpful processes, and underpin the advancement of existing models and the development of novel ones. Further empirical research on social relationships is badly needed in psychiatry, and may inform the development of new therapeutic models in the future.

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