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The Role of the Helping Alliance in Psychiatric Community Care

A Prospective Study

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In this study, we assessed the quality of the helping alliance between patients and clinical case managers in psychiatric community care and examined its value as a predictor of treatment outcome. Patients were interviewed about five different aspects of the helping alliance using simple questions and visual analogue scales. The duration and degree of hospitalization and changes in the patients' working and accommodation situations during a 20-month follow-up period were obtained as outcome criteria for 72 patients with mostly psychotic disorders receiving long-term treatment. The patients' general view of the helping alliance was quite positive. Some aspects of the helping alliance were significantly correlated with hospitalization and changes in working situation during the follow-up period, which indicated a better outcome for patients who experienced the helping alliance more positively. The findings suggest that the helping alliance may be a relevant therapeutic factor not only in psychotherapy, but also in complex psychiatric treatment settings.

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In psychotherapy, intensive research has focused on nonspecific therapeutic components that may be similarly effective in all therapies (Frank, 1989; Strupp, 1986), and in particular in the patient-therapist relationship. Different scales have been used to assess qualities of the helping, working, or therapeutic alliance between patient and therapist (Luborsky et al., 1983; Tichenor and Hill, 1989). Most of the scales are rated by an observer of a therapeutic session, some directly by the patient or the therapist. Among other aspects, they reflect the degree to which the patient experiences therapist and therapy as positive and helpful. While the agreement among the patient, therapist, and observer perspectives of the helping alliance has been found to be low or nonexistent, some studies have shown that the helping alliance can to some extent predict the eventual outcome of psychotherapy (Horvath and Symonds, 1991; Luborsky et al., 1985; Marziali et al., 1981; Rudolf et al., 1988). Where a so-called treatment alliance has been examined in psychiatric inpatient treatment and also been found to be related to outcome (Clarkin et al., 1987), this alliance has indicated only a general motivation and therapeutic compliance of the patient and not a specific quality of the interaction or interpersonal relationship with the therapist.

In complex psychiatric treatment settings such as community care, the dyadic relationship between patient and therapist is supposed to be less central than in conventional psychotherapy. Patients do not have contact with their individual therapists alone; therapeutic interactions can also take place with nurses, occupational therapists, social workers, other members of a usually multiprofessional therapeutic team, and fellow patients. Nevertheless, in some community systems, clinical case managers follow the patient's path through the institutional network, retain the responsibility for all decisions regarding treatment, and have a long-lasting relationship with the patient (Bachrach, 1989, 1992; Thornicroft, 1990). Depending on the nature and extent of their training, they may integrate elements of different psychotherapies in the sessions. Thus, their role as a case manager includes that of a therapist.

In this study, we assessed patients' views of the helping alliance between themselves and clinical case managers in a community care setting using simple questions, and tested whether these views predicted outcome over a follow-up period of 20 months. The duration of full and partial hospitalizations and changes in work and accommodation situation during that time were taken as outcome criteria. These criteria were chosen because they are operationalized and quantitative, and reflect success of long-term treatment in objective terms. A more positive helping alliance as viewed by the patients was hypothesized to be associated with shorter periods of hospitalization and with an improvement in both the work and accommodation situations.

Method

The study was carried out in a community care system serving an inner-city district (Charlottenburg) of Berlin, Germany. The care system is oriented toward

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providing long-term treatment for patients with severe and chronic mental illnesses. It includes three partial hospitalization programs (day hospital, printing workshop, night clinic), various outpatient facilities, and community based services such as a day-care center, drop-in center, and supervised living apartments. The institutions within the system cooperate as a network so that patients can be easily transferred from one institution to a different one according to their current condition and needs.

Continuity of care is guaranteed by clinical case managers who are psychiatrists, social workers, or nurses with a clinical background and some psychotherapeutic training of different orientation. Each patient has one case manager, and each case manager approximately 25 patients. Patients have regular meetings and sessions with their clinical case manager, irrespective of the institution in which they are currently being treated. During the sessions, psychotherapeutic techniques may be administered when thought appropriate. Thus, case managers are individual therapists and responsible for all treatment modalities such as medication throughout the entire period of treatment in the care system. Inpatient treatment is provided by collaborating psychiatric hospitals.

At the time of the study, approximately 210 patients were undergoing long-term treatment in the care system (excluding the drop-in center). A sample of 100 patients seen consecutively by their case managers within a period of 4 weeks took part in the study. An interviewer not otherwise involved in treatment asked the patients five questions concerning the helping alliance: a) Do you feel understood by your case manager? b) Do you feel criticized by your case manager? c) How much is your case manager committed to and actively involved in the treatment? d) Is the treatment you are currently receiving right for you? e) How do you feel immediately after a session with your case manager? Answers to the first four questions were self-rated on 100-mm long visual analogue scales (Bond and Lader, 1974; Luria, 1975), with the extreme points "not at all" (=0) and "entirely" (=100). Each 10-mm interval was marked, so that the scales also had the characteristics of an 11-point rating scale (Guyatt et al., 1987). There were only two possible answers to the fifth question: immediately after a session with the case manager, patients could answer either that they felt better or that they felt unchanged or worse than before. By using this simple method to assess the patients' views of the helping alliance, we tried to avoid excluding any patients who might be unable or unwilling to answer more complicated questions or extensive questionnaires. The questions were intended to be similarly applicable to and easily understandable for all patients. The scales were used as a means both of quantifying and of operationalizing the views of the patients.

The number of days of full and partial hospitalization during a period of 20 months after the interview was recorded. A hospitalization index (HI) was also calculated for this period (Lavik, 1983; Steinhart and Priebe, 1992; Tansella et al., 1986). The HI reflects the degree (full or partial) and duration of hospitalization (total number of days of full hospitalization multiplied by three, plus days of partial hospitalization multiplied by two and the sum divided by the number of all days within the observation period). Changes in the accommodation and work situations were assessed on two axes according to a method described by Steinhart and Bosch (1990)—a modification of similar axes suggested by Ciompi et al. (1977). The accommodation axis distinguishes five levels ranging from full hospitalization to independent living; the work axis distinguishes four levels, ranging from inability to do any kind of occupational work to a regular full-time job.

Results

Sample

By the end of the 20-month period, 28 patients had either terminated treatment or for different reasons been transferred to other therapeutic institutions and thus were no longer in the care system. These 28 patients were younger (36.6 *vs.* 44.3 years, $p < .01$) and had shorter durations of illness (4.9 *vs.* 10.9 years, $p < .01$) and treatment in the care system (2.2 *vs.* 5.3 years, $p < .01$) than the 72 patients who were still receiving treatment in the care system at the end of the follow-up period. The two groups did not differ significantly in regard to any of the other sociodemographic (age, gender, and marital and occupational status) or clinical (diagnosis and frequency of previous hospitalizations) variables recorded in the study, or in regard to their views of the helping alliance as assessed in the interview.

The ages of the 72 patients (37 women and 35 men) for whom the relationship between view of helping alliance and treatment outcome was calculated ranged from 23 to 69 years ($\bar{X} \pm$ SD, 44.3 $\pm$ 11.5). Eight of the patients had attended school for less than 9 years, 30 for 9 and 19 for 10 years; fifteen had completed higher-level education. Thirty had no occupational training. Thirty-five had completed an apprenticeship; seven held university degrees. At the time of the interview, 22 were retired, three were housewives, and four were in occupational training. Nineteen were unemployed, four had a part-time job, six had a sheltered full-time job, and 14 had an unsheltered one. Thirty-six patients were living independently either alone or on a flat-sharing basis, 18 with a partner, and six in a family with

their own children; five were living with parents, five were in psychiatric institutions, and two were in a protected group living apartment.

The duration of illness varied between 6 months and 31 years (10.9 ± 8.5 years). At the time of the study, patients had been continuously treated in the care system between 6 months and 15 years (5.3 ± 4.3 years). The psychiatric diagnoses according to the DSM-III-R (American Psychiatric Association, 1987) were schizophrenia (34 patients), schizoaffective disorder (14), psychotic disorder not otherwise specified (2), bipolar disorder (10), major depression (2), dysthymia (4), depressive disorder not otherwise specified (2), panic disorder with agoraphobia (1), and personality disorders (3). Thus, two thirds of patients were diagnosed as having schizophrenia or schizoaffective psychosis.

Helping Alliance

On the average, the patients' views of the helping alliance were positive. They rated their case managers relatively high on understanding (73.5 ± 27.4), found them quite highly committed to and involved in treatment (79.5 ± 22.9), and not very critical (30.2 ± 29.1). Treatment was rated rather as right (73.8 ± 24.7). Forty-six patients (64%) stated that they felt better immediately after a session with their case manager, while 26 patients (36%) reported that they felt unchanged or worse than before.

Intercorrelations between different aspects of the helping alliance as viewed by the patients and as assessed in the study are shown in Table 1.

While case manager's criticism is negatively correlated with the other items, the remaining four aspects are all positively and significantly intercorrelated, with moderately high coefficients of between .20 and .56.

Prediction of Hospitalizations

The number of days of full hospitalization within the 20-month period varied between 0 and 403 (28.2 ± 62.2 days), and that of days of partial hospitalization between 0 and 598 (62.1 ± 116.7). The HI for this period ranged from 0 to 2.08, and the mean score was 0.34.

Patients' views of case managers' understanding, criticism, and involvement were not significantly correlated to the number of days of full hospitalization, nor to that of days of partial hospitalization. Subsequently, correlations between the patients' views and the HI for the 20-month follow-up period were not significant. Patients' assessments of the extent to which they were receiving the right treatment were not correlated to the number of days of full hospitalization; however, they were correlated to the number of days of partial hospitalization (Pearson's $r = -.40$, $p < .001$) and consequently also to the HI ($r = -.27$, $p < .05$). How the patients felt immediately after sessions with their case managers predicted both the number of days of full hospitalization (point biserial $r = -.21$, $p < .05$) and the extent of partial hospitalization ($r = -.27$, $p < .05$). The correlation between how the patients felt and the HI during the 20-month period was $r = -.30$ ($p < .01$). When the predictive relationship between the way the patients felt after a session and the number of days of hospitalization was assessed on the basis of group differences alone instead of correlation coefficients, clear differences emerged for each variable (Figure 1).

The number of days of full hospitalization, the number of days of partial hospitalizations, and the HI were more than twice as high for the patients who felt unchanged or worse after a session with their case managers than for the patients who felt better.

Multiple regression analysis with the HI as dependent variable showed the way patients felt after a session to be the sole best predictor. Stepwise inclusion of other aspects of the helping alliance did not significantly increase the amount of explained variance.

Prediction of Changes in Housing and Working Situation

During the 20-month follow-up period, nine patients improved and five deteriorated on the housing axis. Thus, only 14 patients (19%) showed some positive or negative change. Because there was so little variation on this outcome, criterion correlations (Spearman's

TABLE 1
Intercorrelations of Different Aspects of the Helping Alliance as Viewed by the Patients (N = 72)

	Case manager understanding	Case manager criticism	Case manager involvement	Adequacy of treatment
Case manager's understanding[a]	—			
Case manager's criticism[a]	−.41***	—		
Case manager's involvement in treatment[a]	+.56***	−.07	—	
Adequacy of treatment[a]	+.35**	−.24*	+.43***	—
Better feeling after session[b]	+.26*	−.07	+.28**	+.20*

[a]Pearson's *r*.
[b]Point biserial r.
*$p < .05$; **$p < .01$; ***$p < .001$.

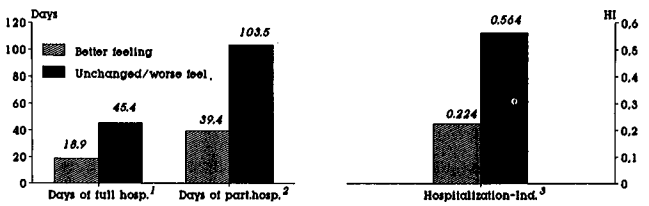

FIG. 1. Days of full and partial hospitalization and HI in patients feeling better and in those feeling unchanged or worse immediately after a session with their case manager ($N = 72$). $^1t = 1.74$, $p < .05$; $^2t = 2.28$, $p < .05$; $^3t = 2.57$, $p < .01$.

rank correlation) with patients' views of the helping alliance were all low and statistically insignificant.

Since 29 patients (40%) were retired, housewives, or in some sort of training at the time of the study, the work axis applied only to the remaining 43 patients (60%). Of those 43 patients, eight improved and nine deteriorated one level or more on the work axis during follow-up. These changes were significantly correlated with case managers' understanding ($r = .40$, $p < .01$) and criticism ($r = -.35$, $p < .05$) as rated by the patients at the interview. Correlations with the three other aspects of the helping alliance failed to reach statistical significance. In a stepwise multiple regression analysis, the degree of variance that was explained by case managers' understanding alone could not be significantly increased by including other aspects of the helping alliance as predictors.

Sum Score for the Helping Alliance

In a final step, we calculated the sum score of all five aspects of the helping alliance. The dichotomous variable how the patients felt after a session with the case manager was therefore transformed into scores of 0 (unchanged/worse) and 50 (better than before), and scores on the criticism by case manager scale were reversed. The correlation between this sum score and changes on the accommodation axis was not significant, but correlations with the HI during the follow-up period (Pearson's $r = -.20$, $p < .05$) and the changes on the work axis (Spearman's $r = .29$, $p < .05$) reached significance. All the correlations between the five aspects of the helping alliance and the sum score on the one hand and the HI and the changes on the work axis on the other are summarized in Table 2.

Discussion

On the average, the patients expressed a positive view of the helping alliance with case managers in community care. This result is in line with the literature, since most studies examining patients' satisfaction with treatment in community care or with other forms of psychiatric treatment have found a fairly high degree of satisfaction in the majority of patients (Conte et al., 1989; Kalman, 1983; Lebow, 1982; LeVois et al., 1981; Weinstein, 1979). However, some patients assessed the helping alliance more positively than others, and it was this variation that was tested for its value as a predictor of outcome during the following 20 months.

TABLE 2
Correlations between Aspects of the Helping Alliance as Viewed by the Patients (Including the Sum Score), HI, and Changes on the Work Axis During the Follow-Up Period

	HI ($N = 72$)	Changes on working axis ($N = 43$)
Case manager's understanding[a]	−.03	.40**
Case manager's criticism[a]	.02	−.35*
Case manager's involvement[a]	−.07	.22
Adequacy of treatment[a]	−.27*	.16
Better feeling after session[b]	−.30**	.18
Helping alliance sum score[a]	−.20*	.29*

[a]Pearson's r/Spearman's r.
[b]Point biserial r/biserial rank r.
*$p < .05$; **$p < .01$.

Three outcome criteria—hospitalization, accommodation situation, and work situation—were considered. Prevention and shortening of the time spent in hospital and improvement, as well as prevention of deterioration, in the patients' accommodation and work situations are definitely central goals of treatment in community care. However, they are not the only ones. A comprehensive assessment of treatment success including other and more detailed criteria, such as quality of life and attainment of individual goals, was not undertaken in this study. Moreover, since 60 patients (83%) were living independently (= highest level of accommodation axis) at the beginning of the study and too few changes therefore occurred on the accommodation axis, only two criteria—hospitalization and changes in work situation—could be used to test the hypothesis. The length of the follow-up period was chosen for reasons of practicality. It is rather short given the long-term nature of rehabilitation processes. Within longer periods, psychosocial interventions should be more likely to lead to more stability in the patient's condition and to substantial changes in his or her living situation (Steinhart and Priebe, 1992). Thus, the criteria for outcome and prediction were limited, and it remains an open question whether even clearer results would have been obtained had different criteria or different follow-up periods been considered.

When all five aspects of the helping alliance and the sum score were taken as predictors, and the HI and changes on the work axis as criteria for prediction, six out of 12 correlations were statistically significant. All of these significant correlations were consistent with the hypothesis. Patients who felt more understood and less criticized by their case managers, who felt better immediately after a session with them, and who viewed their treatment as statistically more right than wrong had a better outcome. Although they were significant, the correlation coefficients were only low to moderately high.

It is important to take some methodological problems of the study into account in the interpretation of the findings. The sample was highly heterogeneous, *e.g.*, in regard to age and psychiatric diagnoses. The treatments also varied. Treatment in community care

may be a combination of various approaches, such as the principles of the therapeutic community and milieu therapy, medication, unspecific emotional support, and eclectic psychotherapy. Even the treatment received by a single patient over a period of 20 months is not consistent: certain essential elements and goals may change. Therefore, the role of helping alliance was studied in a heterogeneous sample receiving heterogeneous treatment within a consistent setting.

The methods used to assess the helping alliance were not as elaborate as those employed in psychotherapy research. The questions and scales were simple and tentatively applied. We investigated only the patients' views of the helping alliance. The perspectives of the therapists or observers were not taken into consideration. However, in spite of the heterogeneity of the sample and the simplicity of methods, the study yielded significant results that are consistent with the hypothesis. A more positive helping alliance predicted a more positive outcome in those 72 patients who were still in the care system by the end of the follow-up period. Patients' views of the helping alliance did not predict leaving the care system during the 20 months. However, those 28 patients who did not complete the study had been treated in the care system for a significantly shorter period of time. Within this time, they might not have been able to form a helping alliance that was similarly stable and influential as that of the other 72 patients whose relationship with their case manager had lasted, on the average, for 3 years longer already.

The finding that the aspects of the helping alliance that predicted hospitalization (HI) were different from those that predicted changes in the work situation should be carefully interpreted before an attempt is made to replicate them in a similar setting. Considering the complex nature of therapeutic processes in community care, specific distinguishable aspects of the helping alliance are unlikely to account for completely different outcome criteria. Rather, we assume that there is considerable overlap between aspects regarding predictive validity.

Although both patient's view of the helping alliance and outcome criteria might be influenced by a third variable, such as worsening of the psychotic process, the results suggest that the helping alliance may be a relevant therapeutic factor in treatment in psychiatric community care. Theoretical constructs of the helping alliance as developed in psychotherapy may be partly applicable to psychiatric settings (Bordin, 1979; Freebury, 1989; Saltzman et al., 1976), although there are obvious differences between psychotherapeutic and psychiatric treatment: both the therapeutic tools and the goals and duration of treatment may be different.

As regards community care, it has not yet been established which interactional or cognitive processes lead to a more positive view of the helping alliance and to which other characteristics of the patient, therapist, or treatment it may be related (Gruyters and Priebe, 1992). It is also unclear how the helping alliance works and which mediating variables are involved in its influence on outcome (Priebe, 1992). One of the possible mediating variables might be the patients' compliance with medication. This compliance could be promoted by a positive patient-case manager relationship and would then enable patients to attain a positive outcome. The therapeutic effect of the helping alliance may vary depending on other treatment variables, current problems, and conditions of the therapeutic situation.

Conclusions

As a nonspecific therapeutic element, the helping alliance is, in principle, associated with a more favorable outcome in community care. It would therefore seem profitable to examine the quality of the dyadic patient-therapist relationship as a factor potentially influencing outcome even in complex psychiatric settings. Simple questions and scales similar to those used in this study may prove a suitable method for empirical investigation of the helping alliance in the treatment of the severely mentally ill.

For community care, it may be concluded that clinical case managers should have obtained some kind of therapeutic training and experience and also receive adequate supervision to equip them to form a positive helping alliance with severely disturbed and often difficult chronic patients. The findings could support the case for a clinical case management system rather than a mere brokerage model of case management.

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