ORIGINAL PAPER

R. McGuire · R. McCabe · S. Priebe

Theoretical frameworks for understanding and investigating the therapeutic relationship in psychiatry

■ **Abstract** *Background:* Mental health care is delivered through a relationship between a clinician and a patient. Although this therapeutic relationship is of central importance for mental health care, it appears to be relatively neglected in psychiatric research. Empirical research has for the most part adopted concepts and methods developed in psychotherapy and general medical practice. Hence, unpacking the presuppositions that have informed research on the therapeutic relationship to date may be a useful first step in developing this field. *Method:* A review of the literature was carried out. *Results:* Six central theories are identified as framing the definitions and methods on this topic: role theory, psychoanalysis, social constructionism, systems theory, social psychology and cognitive behaviourism. To date, role theory, psychoanalysis and systems theory appear to be the frameworks most often applied in research in this field. Each perspective offers a unique emphasis in the analysis of the therapeutic relationship, which is reflected in the empirical work from each perspective discussed herein. *Conclusions:* None of the theories identified have been fully specified and comprehensively investigated in psychiatric settings. However, more than one approach may be used for thinking about relationships, depending on the treatment situation. Further specification and testing of the theories in psychiatric practice – taking account of the specific context – is warranted to underpin more pragmatic research. A stronger link between fundamental psychological and sociological research and applied health care research would advance our understanding of which elements of positive therapeutic relationships are instrumental in improving patient outcome and ultimately contribute to improving mental health care.

R. McGuire (✉) · R. McCabe · S. Priebe
Unit for Social & Community Psychiatry
East Ham Memorial Hospital
London E7 8QR, UK
E-Mail: r.a.mcguire@mds.qmw.ac.uk

Introduction

The therapeutic relationship is a fundamental component of mental health care. It is the means by which a professional hopes to engage with, and effect change in, a patient, and has been found to predict treatment adherence and outcome across a range of patient diagnoses and treatment settings (Olivier-Martin 1986; Frank and Gunderson 1990; Legeron 1991; Priebe and Gruyters 1993; Broker et al. 1995; Gaston et al. 1998) and may become central to the quality of life of long term care patients (McCabe et al. 1999). Although the alliance construct has proven to be a valid one in psychiatry, the field has taken on board conceptual frameworks and measures developed for psychotherapy and general medical practice without examining their applicability to psychiatric settings.

An explicit analysis of research on the therapeutic relationship is therefore required with a view to 'unpacking' the theoretical presuppositions that have framed the definitions and methods on this concept to date. Each definition of the professional-patient relationship is necessarily framed by a theoretical model, which, in turn, informs the methods used to assess it. Six central theories have been selected on the basis that they have been used in research examining the therapeutic relationship: role theory, psychoanalysis, social constructionism, systems theory, social psychology and cognitive behaviourism. The emphasis in this paper is on a review of the theories with reference to the therapeutic relationship rather than a review of the theories *per se*. While some approaches may complement one another, and there may exist some conceptual overlap, each is sufficiently distinct to warrant separate consideration. Although each approach may suggest a particular method for assessing the therapeutic relationship, the methods are not exclusive to any one approach. A brief description of each theoretical model is made, definitions of the therapeutic relationship from each theory are described, and an account of methods and research

results from each approach are discussed. Much research on the therapeutic relationship has been conducted in psychotherapy and general medical practice settings; however, particular emphasis will be made regarding research conducted in psychiatric settings.

Role theory

The first approach, role theory, focuses upon identities that define a commonly recognised set of persons by designed functions or patterns of behaviour with regard to a particular social context within a social system (Biddle 1956). From this perspective, the therapeutic relationship is defined by the separate and mutually validating roles occupied by the professional and patient, who are each expected to exhibit different behaviour patterns within a socially defined context. Three central styles of communicative behaviour have been identified to describe different therapeutic role relationship patterns: paternalistic, consumer based and collaborative.

The paternalistic relationship emphasises the authority of the physician and the relative passivity of the patient. In this model, the professional is dominant in the interviewing process, principally asking closed-ended questions, providing most information, and making most decisions on behalf of the patient (Buijs et al. 1984; Emanual and Emanual 1992; Ong et al. 1995; Benbassat et al. 1998; Shelton 1998; Coulter 1999; Goodare and Lockwood 1999). Some patient variables may predict preference for this model of interaction, including: increased severity of illness, older age, lower income, lower education, and male gender (Geller et al. 1976; Benbassat et al. 1998; Shelton 1998; Coulter 1999). Physician variables identified as predicting preference for this model include younger age and male gender (Benbassat et al. 1998). The second, consumer-based, model emphasises the authority of the patient and the relative passivity of the professional. The communicative interaction is dominated by the patient, who asks most of the questions during the interviewing process, and makes most of the decisions (Eisenthal et al. 1979; Buijs et al. 1984; Ong et al. 1995; Roter et al. 1997; Shelton 1998). The third, collaborative or partnership, model is characterised by a non-hierarchical mode of communicative interaction, in which the patient and professional combine resources, contribute information equally, and share in the decision-making process to work together toward a common goal (Eisenthal et al. 1979; Roter et al. 1997; Shelton 1998; Coulter 1999). Patient psychological factors, such as internal locus of control and high self-efficacy, are cited as possible factors relating to preference for this model (Docherty and Fiester 1985).

Methods from this perspective aim to investigate repeating patterns across persons, situations and time, explained by the roles and each participant's understanding of them, and have been predominately assessed using conversation analysis in general medical practice

(Byrne and Long 1976; Buijs et al. 1984; Peräkylä 1995; Heath 1997; Roter et al. 1997); however, quantitative rating scales have also been used in psychiatry (Geller et al. 1976).

Patient passivity (characteristic of the paternalistic model) and professional passivity (characteristic of the consumer model) have been found to lead to negative patient outcome, such as non-compliance, and a high early drop out rate in both general medical practice and psychiatric settings (Geller et al. 1976; Docherty and Fiester 1985; Mohl et al. 1991; Britten et al. 2000). In general medicine, particular attention is increasingly paid to the collaborative model, evidenced by various journal editorials promoting this approach (Austoker 1999; Cleary 1999; Coulter 1999; Goodare and Lockwood 1999; Sculpher et al. 1999; Williamson 1999). A collaborative approach has been linked to better patient outcome in a variety of psychiatric settings, from increased treatment adherence (Eisenthal et al. 1979; Fenton et al. 1997) to patient satisfaction with care received from psychiatrists in acute settings (Barker et al. 1996), to positive assessments of treatment and favourable changes in patients' self-rated condition in a day hospital setting (Priebe and Gruyters 1999). Thus, beyond the 'political correctness' of emphasising a partnership approach to the therapeutic relationship, there exists empirical evidence linking it to better patient outcome.

Psychoanalysis

The second approach is psychoanalytic theory, where difficulties experienced by a person are regarded as the result of disturbances in early life experience which are retained in expectations, crystallised attitudes, and unknown fears that are brought to newly encountered relationships in the perpetuation of relationship patterns (Wolstein 1995; Lane et al. 1998). Three relationship types are identified under the psychoanalytic model: the transference, the developmentally reparative relationship, and the real relationship.

The transference relationship represents the patient's unconscious transposition of habitual patterns, unresolved problems, and expectations onto the professional, and the professional's transference distortions that are projected onto the patient (Luborsky 1976; Horowitz and Marmar 1985; Clarkson 1993; Hanly 1994; Wolstein 1995; Lane et al. 1998; Meissner 1999; Horvath 2000). The developmentally reparative relationship refers to the secure base that a professional may provide for patients to recover from maladaptive attachment patterns resulting from failed or pathological attachment in childhood (Gerhardt 2001; Clarkson 1990; Adshead 1998; Lewis 1998; Arnkoff 2000). The real relationship reflects the ability of the patient and professional to appropriately and reasonably respond to one another in an undistorted and realistic manner (Hartley and Strupp 1983; Clarkson 1990; Horvath and Luborsky 1993; Horvath 2000).

Transference patterns have been investigated using Kelly grid and rating scale methods in psychotherapy (Piper et al. 1991) and psychiatric (Hentschel et al. 1997) settings. Patient attachment styles have been assessed using the Relationship Questionnaire to predict treatment adherence (Satterfield and Lyddon 1998; Ciechanowski et al. 2001). The extent to which the patient is engaged in an ego-reality based 'real relationship' with the professional has been measured by scales such as the Psychotherapy Status Report (Frank and Gunderson 1990), the Scale to Assess the Therapeutic Alliance (Allen et al. 1984) and the California Psychotherapy Alliance Scales (unpublished manuscript Gaston and Marmar 1991).

In psychotherapy settings, the quality of patient object relations, characterised by lifelong relationship patterns, predicted therapeutic alliance ratings (Piper et al. 1991). Among a severely mentally ill sample in psychotherapy, the comparability of internalised mother and father images to the image of the therapist determined alliance ratings (Hentschel et al. 1997). Here, patients with an introjected image of a strong mother type, for instance, made use of the softer character traits of the therapist. In a university-based counseling clinic, securely attached individuals were found to form strong bonds with counselors, whereas fearfully attached individuals were not (Satterfield and Lyddon 1998). Finally, the extent to which the patient is engaged in an ego-reality based real relationship with the professional has been related to better patient outcome in both psychotherapy and psychiatric settings (Allen et al. 1988; Frank and Gunderson 1990; Gaston et al. 1994; Gaston et al. 1998).

Social constructionism

Social constructionism focuses upon the process by which individuals interpret, organise, and ascribe meaning to their experience through communication with others (Hoffman 1993; Lax 1993; Dwivedi and Gardner 1997; Doan 1998). From this perspective, human knowledge is developed, transmitted and maintained in social situations, constructing the basis for shared 'reality' (Berger and Luckmann 1991). In contrast to role theory and psychoanalysis, which emphasise role expectations and perpetuated transference distortions brought to the therapeutic interaction, social constructionism places more of an emphasis on how identities are co-constructed by the parties involved. This theory regards knowledge as an event that is constructed within relationships and mediated through language (Penn and Frankfurt 1994). From this perspective, each patient's presenting problems are examined within their sociocultural-political context in view of the fact that each person produces the meaning of his or her own life within a particular social, cultural and political context (Hoyt 1996; Monk et al. 1997). Through the therapeutic relationship, old problematic truths may be deconstructed and new ones re-authored through the co-construction of a new narrative (Gottlieb and Gottlieb 1996; Summers and Tudor 2000). With the aim to explore each patient's understanding of his or her experiences and the rejection of the hierarchical and objectifying tendencies of more traditional therapeutic models, social constructionism has been considered a 'post-modern' approach to therapeutic interactions (Gottlieb and Gottlieb 1996; Dean 1998).

Research on the therapeutic relationship from this perspective focuses on the way in which patients and professionals construct their identities in relation to one another (e.g. Cecchin 1993). The Narrative Process Model provides a coding system to identify and evaluate the process by which patients and professionals organise and represent the patient's sense of self and others into a meaningful story (Angus et al. 1999). A narrative approach to the deconstruction of the voices of schizophrenic patients has also been used in a therapeutic context (Holma and Aaltonen 1995, 1997, 1998; Davies et al. 1999). Participant text, such as letter writing and journal entries between therapy sessions, have been used to analyse the therapeutic dialogue that exists between patients and professionals (Berkery 1998; Epston et al. 1993; Penn and Frankfurt 1994). The analysis of general medical practice consultations using conversation analysis (Heath 1997; Elwyn and Gwyn 1999) has revealed asymmetries in the doctor-patient relationship, which may be aligned to the 'paternalistic relationship' from the perspective of role theory. In contrast to role theory, however, which emphasises the role expectations that the patient and professional each bring into consultation, social constructionism focuses on the process by which asymmetry is accomplished in and through the here-and-now interaction between both parties in consultation.

Systems theory

In systems theory, relationships are seen as part of a more or less complex system of relations (and, in theory, the entire cosmos) that may be described in relational terms. The structure and function of long-lasting relationships, from this perspective, tend toward a state of equilibrium by establishing norms that delimit and reinforce patterns of behaviour through a homeostatic mechanism (Watzlawick and Weakland 1977; Clarkson 1993; Caldwell 1994). Two therapeutic systems have been considered from this approach, the key relative-patient-professional system, and the inpatient ward system.

The patient's key relative is considered relevant to the therapeutic system, in view of the fact that patients' presenting problems are often developed and maintained in a system of interaction within the family (Bloch et al. 1991; Priebe and Pommerien 1992; Caldwell 1994). Indeed, the level of emotion expressed by relatives of individuals with schizophrenia within a few weeks after a hospital admission is strongly associated with patient

relapse during the first 9 months following discharge (Vaughn and Leff 1976). Members of the therapeutic system are not considered in absolute terms, but rather in a relational way, by comparison within the system, whereby only differences are relevant (Priebe 1989; Priebe and Pommerien 1992; Rait 2000). In the inpatient ward system, professional staff and patients are said to establish and reinforce patterns of behaviour in relation to one another to maintain the equilibrium of their evolved system (Caldwell 1994).

Methods that examine the structural and functional differences between members of a therapeutic system include: a two-part question assessing the relational attitude differences toward patient illness (Priebe 1989; Priebe and Pommerien 1992; Priebe and Gruyters 1994) and descriptive clinical case studies (Hahn et al. 1988). Differences in attitude toward patient illness between key relatives and professionals predicted better outcome among depressive inpatients (Priebe 1989; Priebe and Pommerien 1992), and in psychiatric community care (Priebe and Gruyters 1994).

In general medical practice, clinical case study descriptions reveal that many patients seek to form a 'compensatory alliance' with the physician for deficits in the family system (Hahn et al. 1988).

Social psychology

Social psychology emphasises the interpersonal context of human interaction. Two models are offered from this approach: the therapeutic relationship defined by social exchange, and the therapeutic relationship defined by social influence.

Social exchange theory specifies the exchange of tangible or intangible resources that the patient and professional may give and receive in the therapeutic context. According to this theory, six classes of 'resources' may be exchanged within an interpersonal context: love, status, information, money, goods and services (Foa and Foa 1974, 1980; Schaap et al. 1996). In the therapeutic context, the professional may provide the patient with 'love' (warmth, comfort), 'status' (regard), 'goods' (medication), 'information' (interpretation, insight, feedback) and/or services (form-filling for access to social services or accommodation) in exchange for 'money' (income) and 'status' (prestige or esteem). Social influence theory emphasises the capability of the professional to influence the patient on the basis of his/her access to particular resources or perceived social power (Schaap et al. 1996). From this perspective, the professional may also influence the patient on the basis of his or her social attractiveness by exhibiting positive personal qualities, such as warmth and empathy (Safran and Segal 1998).

Rating scales developed from this approach have been used to assess the relationship between patient perception of therapist use of social influence strategies and the quality of their therapy: the use of some personal reward influence strategies was positively related to patients' perceptions of therapy quality, while the use of some coercive influence strategies and certain types of expert influence strategies were negatively associated with patients' perceptions of therapy quality (McCarthy and Frieze 1999).

Cognitive behaviourism

Finally, the cognitive behaviour model focuses upon the link between belief systems and behaviour. Difficulties experienced by a person are regarded as the consequence of dysfunctional patterns of thinking and behaviour (Enright 1997). The therapeutic relationship has been investigated from this approach using two concepts: the self-concept and causal schemata. Behaviourism focuses on reinforcing patterns of behaviour that may facilitate or impede the development of a good working relationship.

The self-concept is described as a structural representation that makes up one's sense of 'self', and once established, individuals are said to be motivated to maintain and verify their self-conceptions (Fiske and Taylor 1991). The 'self' may be best understood as a social concept that is derived from interactions with others (Muran et al. 2001). This concept is continually revised both socially and self reflexively through the oscillation of the subjective, observing 'I' and the objective, observed 'me' (Muran et al. 2001). A patient who is unwillingly engaged in psychiatric services may resist incorporating mental illness into their self-concept on the basis that they do not regard themselves as ill. Here, therapeutic resistance may reflect the patient's need to preserve meaning in the face of new information presented by mental health professionals with the aim of holding onto old constructs that maintain the organisation of their cognitive system (Safran and Segal 1998). Resistance to incorporating mental illness into the self-concept may also be motivated by the fear of social stigmatisation. Indeed, denial of illness and social stigma were identified by community mental health care nurses in South Wales as key barriers to effective care (Fung and Fry 1999). Furthermore, research conducted for the Department of Health in the United Kingdom revealed that 80% of young people believe that having a mental health problem will lead to discrimination (Department of Health 2001).

Causal schemas, which represent an individual's beliefs and assumptions regarding cause and effect (Kelly 1971, 1972; Berley and Jacobson 1984; Fiske and Taylor 1991), have been used to analyse professional approaches to patients on the basis of attributions of patient responsibility for their illness (Brewin 1988). In psychiatry, medical students tended to be more willing to prescribe drugs to patients viewed as victims of uncontrollable life stress than to patients whose problems were viewed as 'of their own making' (Brewin 1988). Hospital staff may provide more or less help for different categories of patient: Brewin (1988) found that suicide

victims, drug addicts and prostitutes were pronounced dead more quickly than patients regarded as 'respectable citizens' by staff, and resources were allocated according to moral conceptions of 'deservingness'. Thus, a professional's response to a patient may be influenced, in part, by their causal schemas about illness and their perception of a patient's responsibility for their illness. It has been suggested that efficient mental functioning depends upon the selection of relevant material – and the exclusion of unwanted material from entering consciousness – by flexible excitatory and inhibitory mechanisms (Brewin and Andrews 2000).

Meanwhile, behaviourism focuses on reinforcing patterns of behaviour that may facilitate or impede the development of a good working relationship through the process of conditioning (Schaap et al. 1996; Horvath 2000). From this perspective, 'techniques' have been developed to identify positively and negatively reinforcing behaviours in therapeutic interactions. The moment-to-moment effects of therapist verbal statements and therapist verbal consequences on client verbal responses have been analysed to identify potential therapist variables that may be systematically altered to produce patient change, namely: positive antecedent stimulus control and generalised reinforcement variables (Procaccino 1998). A 'coached client' method has also been developed where clients rate interactions with their counselor from 'very low rapport' to 'very high rapport', and has been successfully used in professional training programmes for counseling (Sharpley and Ridgway 1992).

Discussion

Each approach may offer a unique emphasis in the analysis of the therapeutic relationship in practice. A role theory approach may be useful to assess patient and professional alignment to different role relationship patterns. Psychoanalysis may offer insight into 'difficult' behaviour, where transference distortions are brought into play in the relationship (Hentschel et al. 1997). A social constructionist approach may provide insight into the possible tension between the narrative that patients bring into the consultation and the professional's understanding of illness (Launer 1999). A systemic approach emphasises the professional's awareness of his/her structural and functional relationship with the patient in relation to the patient's significant others. A social psychological approach may emphasise the tangible and intangible goods exchanged in the therapeutic context and the social influence strategies employed (Schaap et al. 1996). A cognitive-behaviour approach may provide insight into the link between belief systems and behaviour contributing to, or detracting from, the development of a good working relationship.

In comparison to psychotherapy, psychiatry is an area that is complicated by heterogeneous treatment goals and components (e. g. treatment adherence, reha-bilitation, stability rather than change, public safety, prevention of relapse, accessing services), a variable setting (inpatient hospitals, outpatient wards, day hospitals, supported housing and home and office visits with community mental health care professionals) and the formal statutory role of professionals. The professionals, who attempt to engage with mentally ill patients whose clinical diagnoses and symptom severity vary, come from different training backgrounds (psychiatrists, psychologists, community psychiatric nurses, social workers, occupational therapists, support workers). The relative applicability of the various theoretical approaches will probably depend on the therapeutic actions and aims of the professional within a relationship at different points of time over the course of any one relationship. Moreover, the fact that any individual may have relationships with a number of different professionals at any one time, which are interdependent, will also be important. The extent to which the theoretical models can accommodate the flexibility of the diverse settings and situations that inevitably occur in psychiatry has yet to be investigated. Supervision and training in psychiatry is often eclectic or atheoretical; however, the complexity of the settings and the high number of confounding factors may be precisely the reason why a clearer and consistent theoretical focus is needed to understand the processes that predict different outcomes and also facilitate practical interventions. An explicit theory – perhaps different theories for different psychiatric contexts – would make it possible to link training and supervision to a full background of specific theoretical and empirical work. While an integration of the theoretical models would be ideal, it would probably prove difficult to achieve because each model not only requires very different methodological approaches in research, but also may imply different views of outcome. At a later stage of research, when methods on this topic are advanced, it may be clearer which elements of a positive therapeutic relationship may be particularly applicable to each particular setting and which elements are generic across all settings.

In order to advance this neglected field, where relationships may be fragile and unrewarding for both clinicians and patients, the theories and their implications need to be further specified and empirically tested in research to determine their value in clinical practice. In naturalistic studies, assessments of the relationship may be tested for their prognostic value with respect to established outcome criteria, an approach adapted by most research in this field to date (e. g. Frank and Gunderson 1990; Neale and Rosenheck 1995). In controlled studies, models of the therapeutic relationship may be used to design specific interventions targeted at both a more positive relationship and a better outcome (e. g. Priebe and Gruyters 1999). In other intervention studies, including randomised controlled trials of new drugs, psychological treatments and health service configuration, it may be useful to determine the extent to which the therapeutic relationship is a mediating factor in im-

proving outcome. Indeed, in a randomised controlled trial testing the efficacy of pharmacotherapy for depression (Weiss et al. 1997), it was found that the therapeutic alliance accounted for between 21 and 56% of the variance in outcome. It may therefore be useful to specifically assess and analyse the therapeutic relationship as a potentially mediating – or confounding – factor in existing trials.

Conclusions

Given the conceptual and pragmatic differences between the therapeutic relationship in psychotherapy or general medical practice and mental health care, the unpacking of the presuppositions that have informed research on the therapeutic relationship to date is a useful first step in determining what concepts are more or less applicable in this field. It appears that role theory, psychoanalysis and systems theory have been applied more often in research on the therapeutic relationship in psychiatry than social constructionism, social psychology or cognitive behaviourism. While no theory is more right or wrong – some may lend themselves more readily to operationalisation (e. g. social constructionism may be more difficult to operationalise and assess than role theory). Further specification and empirical testing of the theories in psychiatric practice will usefully inform more pragmatic research and advance specific concepts for the delivery of effective mental health care. The end product may be that patients are allocated according to their 'fit' to what different programmes may offer in a therapeutic relationship. Alternatively, existing therapeutic programmes may be generally improved – perhaps through staff training – so that patients are engaged in a more positive way. Finally, specific internal or external staff supervision may be employed with a focus on the patient-professional relationship. While the prognostic value of different interventions may be established, knowledge of the theory that informs such differences is needed. Finally, a stronger link between fundamental psychological and sociological research and applied health care research seems to be required.

References

Adshead G (1998) Psychiatric staff as attachment figures: Understanding management problems in psychiatric services in the light of attachment theory. Br J Psychiatry 172: 64–69

Allen JG, Newsom GE, Gabbard GO (1984) Scale to assess the therapeutic alliance from a psychoanalytic perspective. Bull Menninger Clin 48: 383–400

Allen JG, Deering D, Buskirk JR, Coyne L (1988) Assessment of therapeutic alliances in the psychiatric hospital milieu. Psychiatry 51: 291–299

Anderson H, Goolishian H (1993) The client is expert: a not-knowing approach to therapy. In: McNamee S, Gergen KJ (eds) Therapy as social construction. Sage, London

Angus L, Levitt H, Hardtke K (1999) The narrative process coding system: research applications and implications for psychotherapy practice. J Clin Psychol 55: 1255–1270

Arnkoff DB (2000) Two example strains in the therapeutic alliance in an integrative cognitive therapy. J Clin Psychol 56: 187–200

Austoker J (1999) Gaining informed consent for screening. B M J 7212: 721–722

Barker DA, Sukhwinder S, Shergill S, Higginson I, Orrell M (1996) Patients' views towards care received from psychiatrists. Br J Psychiatry 168: 641–646

Benbassat J, Pilpel D, Tidhar M (1998) Patients' preferences for participation in clinical decision making. Behav Med 24: 81–89

Berger P, Luckmann T (1991) The social construction of reality: a treatise in the sociology of knowledge. Penguin, London

Berkery AC (1998) What it means to be in a therapeutic relationship: a hermeneutic interpretation of the practice of nurse psychotherapists. Dissertation Abstracts International: Section B. The Sciences and Engineering 58: 4718

Berley RA, Jacobson NS (1984) Causal attributions in intimate relationships: toward a model of cognitive-behavioral marital therapy. In: Kendall PC (ed) Advances in cognitive-behavioral research and therapy. Academic Press, Orlando

Biddle BJ (1956) Role theory: expectations, identities and behaviour. Academic Press, New York

Bloch S, Sharpe M, Allman P (1991) Systemic family therapy in adult psychiatry. Br J Psychiatry 159: 357–364

Brewin CR (1988) Cognitive foundations of clinical psychology. Lawrence Erlbaum Associates, Hove

Brewin CR, Andrews B (2000) Psychological defence mechanisms: the example of repression. Psychologist 13: 615–617

Britten N, Stevenson FA, Barry CA, Barber N, Bradley CP (2000) Misunderstandings in prescribing decisions in general practice: a qualitative study. B M J 320: 484–488

Broker M, Röhricht F, Priebe S (1995) Initial assessment of hospital treatment by patients with paranoid schizophrenia: a predictor of outcome. Psychiatry Res 58: 77–81

Buijs R, Sluijs EM, Verhaak PFM (1984) Byrne and Long: a classification for rating the interview style of doctors. Soc Sci Med 19: 683–690

Byrne PS, Long BEL (1976) Doctors talking to patients: a study of the verbal behaviour of general practitioners consulting in their surgeries. Department of Health and Social Security, London

Caldwell MF (1994) Applying social constructionism in the treatment of patients who are intractably aggressive. Hosp Community Psychiatry 45: 597–600

Cameron R (1978) Behaviour change techniques. In: Foreyt JP, Rathjen DP (eds) Cognitive behavior therapy: research and application. Plenum Press, New York

Cecchin G (1993) Constructing therapeutic relationships. In: McNamee S, Gergen KJ (eds) Therapy as social construction. Sage, London

Ciechanowski PS, Katon WJ, Russo JE, Walker EA (2001) The patient-provider relationship: attachment theory and adherence to treatment in diabetes. Am J Psychiatry 158: 29–35

Clarkson P (1990) A multiplicity of psychotherapeutic relationships. B J Psychotherapy 7: 148–163

Clarkson P (1993) On psychotherapy. Whurr, London

Cleary PD (1999) The increasing importance of patient surveys. B M J 7212: 720–721

Coulter A (1999) Paternalism or partnership: patients have grown up – and there's no going back. B M J 7212: 719–720

Davies P, Thomas P, Leudar I (1999) Dialogical engagement with voices: a single case study. Br J Med Psychol 72: 179–187

Dean RG (1998) Postmodernism and brief treatment: a more inclusive model. Crisis intervention and time limited treatment 4: 101–112

Department of Health (2001) Ignorance and fear breeds mental health discrimination. Department of Health Web Site, United Kingdom

Doan RE (1998) The king is dead; long live the king: narrative therapy and practicing what we preach. Fam Proc 37: 379–385

Docherty JP, Fiester SJ (1985) The therapeutic alliance and compliance with psychopharmacology. In: Hales RE, Frances AJ (eds) Psychiatry update. American Psychiatric Association Annual Review, 4. American Psychiatric Press, Washington

Dwivedi KN, Gardner D (1997) Theoretical perspectives and clinical approaches. In: Dwivedi KN (ed) Therapeutic use of stories. Routledge, London

Eisenthal S, Emery R, Lazare A, Udin H (1979) Adherence and the negotiated approach to patienthood. Arch Gen Psychiatry 36: 393–398

Elwyn G, Gwyn R (1999) Stories we hear and stories we tell: analysing talk in clinical practice. B M J 318: 186–188

Emanuel EJ, Emanuel LL (1992) Four models of the physician-patient relationship. JAMA 267: 2221–2226

Enright SJ (1997) Cognitive behaviour therapy – clinical applications. B M J 314: 1811–1816

Epston D, White M, Murray K (1993) A proposal for a re-authoring of therapy: Rose's revisioning of her life and a commentary. In: McNamee S, Gergen KJ (eds) Therapy as social construction. Sage, London

Fenton WS, Blyer CR, Heinssen RK (1997) Determinants of medication compliance in schizophrenia: empirical and clinical findings. Schizophr Bull 23: 637–651

Fiske ST, Taylor SE (1991) Social cognition. McGraw-Hill, New York

Foa UG, Foa EB (1974) Societal structures of the mind. Charles C Thomas, Springfield, Illinois

Foa EB, Foa UG (1980) Resource theory: interpersonal behaviour as exchange. In: Gergen KG, Greenberg MS, Willis RH (eds) Social exchange: advances in theory and research. Plenum Press, New York

Frank AF, Gunderson JG (1990) The role of the therapeutic alliance in the treatment of schizophrenia: relationship to course and outcome. Arch Gen Psychiatry 47: 228–236

Fung C, Fry A (1999) The role of community mental health nurses in educating clients and families about schizophrenia. Aust N Z J Ment Health Nurs 8: 162–175

Gaston L, Piper WE, Debbane EG, Grant J (1994) Alliance and technique for predicting outcome in short- and long-term analytic psychotherapy. Psychother Res 4: 121–135

Gaston L, Thompson L, Gallagher D, Cournoyer LG, Gagnon R (1998) Alliance, technique, and their interactions in predicting outcome of behavioural, cognitive, and brief dynamic therapy. Psychother Res 8: 190–209

Geller JD, Astrachan BM, Flynn H (1976) The development and validation of a measure of the psychiatrist's authoritative domain. J Nerv Ment Dis 162: 410–422

Gerhardt S (2000) The myth of self creation. Br J Psychother 17: 329–343

Goodare H, Lockwood S (1999) Involving patients in clinical research. B M J 7212: 724–725

Gottlieb DT, Gottlieb CD (1996) The narrative/collaborative process in couples therapy: a postmodern perspective. In: Hill M, Rothblum ED (eds) Couples therapy: feminist perspectives. Harrington Park Press, New York, pp 37–47

Hahn SR, Feiner JS, Bellin EH (1988) The doctor-patient-family relationship: a compensatory alliance. Ann Intern Med 109: 884–889

Hanly C (1994) Reflections on the place of the therapeutic alliance in psychoanalysis. Int J Psychoanal 75: 457–467

Hartley DE, Strupp HH (1983) The therapeutic alliance: its relationship to outcome in brief psychotherapy. Empirical Studies of Psychoanalytic Theories, 1. Erlbaum, Hillsdale, New Jersey

Heath C (1997) The delivery and reception of diagnosis in the general-practice consultation. In: Drew P, Heritage J (eds) Talk at work: interaction in institutional settings. Cambridge University Press, Cambridge

Hentschel U, Kiessling M, Rudolf G (1997) Therapeutic alliance and transference: an exploratory study of their empirical relationship. J Nerv Ment Dis 185: 254–262

Hoffman L (1993) A reflexive stance for family therapy. In: McNamee S, Gergen KJ (eds) Therapy as social construction. Sage, London

Holma J, Asltonen J (1995) The self narrative and acute psychosis. Contemp Fam Ther 17: 307–316

Holma J, Asltonen J (1997) The sense of agency and the search for a narrative in acute psychosis. Contemp Fam Ther 19: 463–477

Holma J, Asltonen J (1998) Narrative understanding in acute psychosis. Contemp Fam Ther 20: 253–263

Horowitz M, Marmar C (1985) The therapeutic alliance with difficult patients. In: Hales RE, Frances AJ (eds) Psychiatry update. American Psychiatric Association Annual Review, 4. American Psychiatric Press, Washington

Horvath AO (2000) The therapeutic relationship: from transference to alliance. J Clin Psychol 56: 163–173

Horvath AO, Luborsky L (1993) The role of the therapeutic alliance in psychotherapy. J Consult Clin Psychol 61: 561–573

Hoyt M (1996) Cognitive-behavioural treatment of posttraumatic stress disorder from a narrative constructivist perspective: a conversation with Donald Meichenbaum. Guilford Press, New York

Kelly HH (1971) Attribution in social interaction. General Learning Press, Morristown, New Jersey

Kelly HH (1972) Causal schemata and the attribution process. General Learning Press, Morristown, New Jersey

Lane RC, Quintar B, Goeltz WB (1998) Directions in psychoanalysis. Clin Psychol Rev 18: 857–883

Launer J (1999) A narrative approach to mental health in general practice. B M J 9: 117–119

Lax WD (1993) Postmodern thinking in clinical practice. In: McNamee S, Gergen KJ (eds) Therapy as social construction. Sage, London

Legeron P (1991) Facteurs predictifs d'une bonne response aux therapies cognitives dans la depression. Encephale 17: 405–409

Lewis J (1998) For better or worse: interpersonal relationships and individual outcome. Am J Psychiatry 155: 582–589

Luborsky L (1976) Helping alliances in psychotherapy. In: Claghorn JL (ed) Successful psychotherapy. Brunner-Mazel, New York

McCabe R, Röder-Wanner UU, Hoffmann K, Priebe S (1999) Therapeutic relationships and quality of life: association of two subjective constructs in schizophrenia patients. Int J Psychiatry 45: 276–283

McCabe R, Quayle E, Beirne A, Duane M (2000) Is there a role for compliance in the assessment of insight in chronic schizophrenia? Psychol Health Med 5: 173–178

McCarthy WC, Frieze IH (1999) Negative aspects of therapy: client perceptions of therapists' social influence, burnout, and quality of care. J Soc Issues 55: 33–50

Meissner SJ (1999) Notes on the therapeutic role of the alliance. Psychoanal Rev 86: 1–27

Mohl PC, Martinez D, Ticknor C, Huang M, Cordell L (1991) Early dropouts from psychotherapy. J Nerv Ment Dis 179: 478–481

Monk G, Winslade J, Crocket K, Epston D (1997) Narrative therapy in practice: the archaeology of hope. Jossey-Bass, San Francisco

Muran JC, Samstag LW, Ventur ED, Segal ZV, Winston A (2001) A cognitive-interpersonal case study of a self. J Clin Psychol 57: 307–330

Neale MS, Rosenheck RA (1995) Therapeutic alliance and outcome in a VA intensive case management programme. Psychiatr Serv 46: 719–721

Olivier-Martin R (1986) Facteurs psychologiques, observance et resistance aux traitments antidepresseurs. Encephale 7: 197–203

Ong LML, De Hales JCJM, Hoos AM, Lammes FB (1995) Doctor-patient communication. Soc Sci Med 40: 903–918

Penn P, Frankfurt M (1994) Creating a participant text: writing, multiple voices, narrative multiplicity. Fam Proc 33: 217–231

Peräkylä A (1995) Conversation analysis: a new model of research in doctor-patient communication. J R Soc Med 90: 205–208

Piper WE, Azim HFA, Joyce AS, McCallum M, Nixon GWH, Segal PH (1991) Quality of object relations versus interpersonal functioning as predictors of therapeutic alliance and psychotherapy outcome. J Nerv Ment Dis 179: 432–438

Priebe S (1989) Can patients views of a therapeutic system predict outcome? An empirical study with depressive patients. Fam Proc 28: 349–355

564

Priebe S, Gruyters T (1993) The role of the helping alliance in psychiatric community care: a prospective study. J Nerv Ment Dis 181: 552–557

Priebe S, Gruyters T (1994) The patient-relative and the patient-therapist relationships: empirical findings in psychiatric community care. In: Borgo S, Sibilia L (eds) The patient-therapist relationship: its many dimensions. Consiglio Nazionale delle Ricerche, Rome

Priebe S, Gruyters T (1999) A pilot trial of treatment changes according to schizophrenic patients' wishes. J Nerv Ment Dis 187: 441–443

Priebe S, Pommerien W (1992) The therapeutic system as viewed by depressive inpatients and outcome: an expanded study. Fam Proc 31: 433–439

Procaccino AT (1998) The effects of therapist verbal consequences on client verbal responses in therapy: a study of verbal interaction. Dissertation Abstracts International: Section B. The Sciences and Engineering 58: 5701

Rait DS (2000) The therapeutic alliance in couples and family therapy. J Clin Psychol 56: 211–224

Reda MA, Mahoney MJ (1984) Cognitive psychotherapies: recent developments in theory, research, and practice. Ballinger, Cambridge, Massachusetts

Roter DL, Stewart M, Putnam SM, Lipkin M, Stiles W, Inui TS (1997) Communication patterns of primary care physicians. JAMA 277: 350–356

Safran JD, Segal ZV (1998) Interpersonal processes in cognitive therapy. Basic Books, New York

Satterfield WA, Lyddon WJ (1998) Client attachment and the working alliance. Counsel Psychol Q 11: 407–415

Schaap C, Bennun I, Schindler L, Hoogduin K (1996) The therapeutic relationship in behavioural psychotherapy. Wiley, New York

Sculpher MJ, Watt I, Gafi A (1999) Shared decision making in a publicly funded health care system. B M J 7212: 725–727

Sharpley CF, Ridgway IR (1992) Development and field-testing of a procedure for coached clients to assess rapport during trainees' counseling interviews. Couns Psychol Q 5: 149–160

Shelton SB (1998) The doctor-patient relationship. In: Studemire A (ed) Human behaviour. Lippencott-Raven, Philadelphia

Summers G, Tudor K (2000) Cocreative transactional analysis. Int Transact Anal J 30: 23–40

Vaughn C, Leff J (1976) The measurement of expressed emotion in the families of psychiatric patients. Br J Soc Clin Psychol 15: 157–165

Watzlawick P, Weakland JH (1977) The interactional view: studies at the MRI Palo Alto, 1965–1974. WW Norton, New York

Weiss M, Gaston L, Propst A, Wisebord S, Zicherman V (1997) The role of the alliance in the pharmacologic treatment of depression. J Clin Psychiatry 58: 196–204

Williamson C (1999) The challenge of lay partnership. B M J 7212: 721–722

Wolstein B (1995) Transference: its structure and function in psychoanalytic theory. Jason Aronson, London