

The therapeutic relationship in psychiatric settings

Priebe S, McCabe R. The therapeutic relationship in psychiatric settings. *Acta Psychiatr Scand* 2006; 113 (Suppl. 429): 69–72. © 2006 Blackwell Munksgaard.

Objective: To discuss the current climate of research on the therapeutic relationship (TR) in mainstream psychiatric settings.

Method: Consideration of theoretical frameworks, quantitative and qualitative research methods, along with potentials for interventions.

Results: Most of the concepts and methods used to investigate the TR in conventional psychiatric settings have been imported from psychotherapy and, despite significant differences between the two, there is little specific research. A distinction is suggested between therapeutic relationships and patient–clinician interactions.

Relationships predict outcome and may be assessed with operationalized methods. Specific communicative skills may be helpful in the treatment of particular illnesses. The feasibility and effectiveness of potential interventions in the TR have rarely been studied.

Conclusion: Specific conceptual and methodological work is required to develop a better understanding of TRs in psychiatric settings.

Further research should include intervention studies and might support a stronger emphasis on TRs in training and supervision.

S. Priebe, R. McCabe

Unit for Social & Community Psychiatry, Academic Unit, Newham Centre for Mental Health, London, UK

Key words: professional–patient relations; psychotherapeutic processes; research; psychiatry

Stefan Priebe, Unit for Social & Community Psychiatry, Academic Unit, Newham Centre for Mental Health, London E13 8SP, UK.

E-mail: s.priebe@qmul.ac.uk

This paper was read in a preliminary version at the 3rd International Zurich Conference on Clinical and Social Psychiatry, Zurich, 25–27 September 2003. The conference and publication of this supplement were exclusively sponsored by Eli Lilly, Suisse.

Introduction

Mental health care revolves around relationships between clinicians and patients. The clinician participates in the relationship in a professional role with formal status, and represents a service, although the service can be as small as an office-based practice. Whether self-administered interventions, e.g. with instructions downloaded from the Internet, are an exception to this rule is debatable. Yet, in conventional psychiatric settings the therapeutic relationship is the central element of care through which diagnoses are made, treatment plans are negotiated and most interventions are delivered. In a recent study, patients identified the quality of the therapeutic relationship as the most crucial factor in psychiatric care (1). Indeed, the relationship itself may be a curative factor in its own right. Such relationships can last for seconds or decades, be amicable or hostile, and have a positive or detrimental effect. Thus, the term ‘therapeutic relationship’ (TR) is used descriptively and does not necessarily assume that all relationships are necessarily therapeutic or helpful.

Aims of the study

This paper presents an overview of the current climate of research on the TR in mainstream psychiatric settings. It will consider theoretical frameworks for understanding the TR, the differences between conventional psychotherapy and psychiatric treatment, the use of qualitative and quantitative methods to explore and assess the TR, and experimental interventions to improve the TR.

Material and methods

Based on the literature and our own research, we discuss key conceptual and empirical issues that reflect the current state of the art in research on the TR in psychiatric settings.

Results

Psychotherapy and psychiatric settings

Freud called the TR the ‘vehicle of success in psychoanalysis exactly as in any other method of treatment’ (2). Subsequently, there has been a vast

amount of literature on the quality and the role of the TR in psychoanalysis and other forms of psychotherapy. Empirical research in this area has used a range of terms (e.g. working alliance, helping alliance), concepts (e.g. psychoanalytic, cognitive behavioural, Rogerian) and methods of assessment (self, clinician and expert ratings) to study the TR. A better relationship has been found to predict a more favourable outcome across different forms of psychotherapy (3). Hence, the TR is widely regarded as the most important non-specific treatment component.

Psychiatric settings, particularly those for the treatment of patients with severe mental illness, are considerably different from traditional psychotherapy settings. In psychiatric settings, professionals often have a statutory role and may – at least potentially – subject their patients to involuntary treatment. In many cases, it is the professional (or service), not the patient, who initiates the treatment relationship. The treatment is rarely a one-to-one meeting in a psychotherapy office for a fixed period of time. Professionals meet their patients in different locations, for varying periods of time and often with other professionals and carers present. The timescale for treatment is rarely fixed and may last for several years or decades. Treatment goals may change over time, and often treatment aims more at stability than change. Typically, there is more of a focus on medical intervention and hands-on support (e.g. assistance with housing, finances, employment) than on the patient's cognitive and emotional processes. Professionals in psychiatric settings often work in multi-disciplinary teams, and patients have relationships with other professionals, often from the same service, at the same time. Finally, care in psychiatric settings rarely follows only one theoretical model and therapy school, but is usually eclectic and may include interventions on a physical, psychological and social level. Thus, the differences between psychotherapy and psychiatric settings are substantial, and models and findings of psychotherapy research may not be wholly transferable to psychiatric settings.

Theoretical models for research

Jaspers stated that ‘...the ultimate thing in the doctor–patient relationship is *existential communication*, which goes far beyond anything that can be planned or methodically staged. The whole treatment is...defined within a community of two selves who live out the possibilities of Existence itself, as reasonable beings.’ (4). To understand and research such a fundamental, complex process, a

reductionistic approach is required which may be situated within a specific theoretical model. Several frameworks have been suggested to understand the therapeutic relationship, each of which has a different focus with different implications for research (5). Examples of such frameworks are role theory, psychoanalysis, social constructionism, systems theory, social psychology and cognitive behaviourism. Role theory looks at separate and mutually validating roles and focuses on consistent aspects of the therapeutic relationship in a given situation. Psychoanalysis assumes that the individual history of the participants informs their present behaviour and focuses on consistent aspects in the participating individuals. Social constructionism regards the therapeutic relationship as a socially constructed institution and a mutually constructed reality. It emphasizes constructs determined by the given context. Systems theory considers the dyadic as related to other systems, e.g. the patient's family and the clinician's institution. It focuses on differences and relationships within systems. Social psychology regards the therapeutic relationship as defined by social exchange and determined by social influence and expectations with a subsequent focus on situational and contextual factors. Cognitive behaviourism understands the therapeutic relationship in terms of mutual conditioning and reinforcement related to previous learning history of the participants. Its focus is on learning principles and underlying cognitions. To a varying degree, all these models have been applied in research on the therapeutic relationship. Which model provides the most appropriate guidance to research, may depend on the context and purpose of the research.

Terminology

Research on the therapeutic relationship shares a problem with other fields of social sciences, i.e. often unclear terminology. Numerous terms may be used to describe identical or overlapping concepts. However, a minimum degree of terminological clarity is essential for useful communication and progress in research. In order to clarify the focus of research, a distinction between ‘relationship’ and ‘interaction’ is helpful. An interaction may be defined as the behavioural exchange between patient and clinician that is observable and that can be described in objective terms. A relationship is the psychological construct held by individuals participating in the therapeutic relationship on each other and their interaction. Interaction and relationship may or may not be linked. The relationship can obviously be

influenced by the interaction that has been going on between patient and clinician and, vice versa, inform the behaviour of the participants in further interactions. Yet, as subjects of research, relationships and interactions are distinct.

Quantitative and qualitative methods

Both quantitative and qualitative methods may be used to investigate relationships and interactions in psychiatric settings (6). Like in psychotherapy, assessments of the TR have been found to predict short-term and long-term outcome of psychiatric treatment (7–9). For example, patients in community mental health care who felt better after talking with their key worker had significantly fewer re-hospitalizations within a 20 month follow-up period, than patients who felt unchanged or worse (10). The association between a positive therapeutic relationship and better outcome remains poorly understood. It seems to not be fully explained by patients' psychopathology and not mediated only through compliance with the prescribed interventions (10, 11).

Research in this area has been hindered by the absence of a specifically designed and validated scale to assess the TR. Scales used have either been adopted from psychotherapy research or are *ad hoc* instruments. In the main, their psychometric properties have not been adequately demonstrated in psychiatric samples. Recently, a new instrument (STAR: Scale for the Assessment of Therapeutic Relationships in community mental health care) has been specifically developed to assess the TR with patients with severe mental illness in community mental health care, (R. McGuire-Snieckus, unpublished data). It is based on qualitative and quantitative work and has a clinician and a patient version with 12 items each. The scale captures three distinct factors: first, positive collaboration reflecting how well patient and clinician get on with each other and how well the 'chemistry' between them functions; second, positive clinician input in the form of support and commitment; and third, non-supportive input of the clinician (in the patient's version) or the clinician's emotional difficulties in dealing with the patient (in the clinician's version). The scale has good psychometric properties demonstrating that the TR can indeed be assessed and measured by operationalized methods.

A wide range of qualitative methods (e.g. semi-structured interviews, ethnography, participant observation) may be used to explore therapeutic processes and interactions. An example is conver-

sation analysis, which studies what participants do rather than what they say they do, and involves micro-analysing naturally occurring communication. When medical consultations with psychotic patients were investigated, psychiatrists were found to explore psychotic experience only when checking medication effects, but otherwise not to go into the contents of patients' hallucinations and delusions (13). Hence, patients used many strategies in an attempt to raise the content of their psychotic experience, along with the emotional consequences, including asking questions in the preclosing phase of the consultation. Psychiatrists (and carers when present) responded with smiling and other avoiding behaviour, which made patients markedly uncomfortable. Given the difficulties engaging psychotic patients in mental-health services, there may be an opportunity to improve clinician–patient communication in routine consultations. Although one might argue about the most appropriate way to elicit and respond to patient's psychotic experiences, such research highlights the need to put more emphasis on the communication skills of psychiatrists in research and training, and to develop specific models for relationships and interactions in psychiatric settings. It may be that specific skills are required to communicate effectively with different diagnostic groups of patients. For example, research on expressed emotion has shown that emotionally neutral communication on the part of both formal and informal carers is a significant factor in ameliorating the outcome of schizophrenic patients. Communicative behaviours found to discriminate outcome were how staff/carers responded to negative feelings of the patient and whether they criticized aspects of the patient's personality (14, 15).

Interventions in therapeutic relationships

What are the practical implications of identifying positive or negative TRs? One might allocate patients to different clinicians, although there are as yet no valid criteria for such a scenario. In the case of a poor therapeutic relationship, a change of clinician may be considered. Although this may be a plausible intervention in theory, it may be difficult to pursue in practice because it might be a humiliating experience for the clinician whose relationship with the patient is regarded as too poor, and there is no guarantee that the next clinician would establish a better one. In general, the competence of clinicians to establish and maintain positive therapeutic relationships may be improved through training and supervision

(16, 17). A certain degree of flexibility in dealing with patients may be helpful for the clinician. Specific approaches and/or interventions depending on the therapeutic relationship may be developed in the future (18). For the time being, only general interventions are being tested. An example is the MECCA study, which is a randomized controlled trial in six European countries comparing standard care with a new intervention in community mental health care (19). In the experimental group, patients' views of their quality of life, treatment satisfaction and needs for care are regularly assessed by clinicians and intended to inform the therapeutic exchange. The hypothesis is that regular assessment of the patient's views as part of a therapeutic session improves both the TR and outcome.

Discussion

A stronger research focus on the therapeutic relationship may help to develop a specific theory and influence the therapeutic culture in psychiatric settings. It might also make psychiatry more attractive, possibly affecting recruitment and retention of staff. This could be achieved through a focus on relationship aspects in undergraduate and postgraduate teaching (16), a stronger emphasis on conventional and new elements of psychotherapy (20), and on-going supervision. Future research needs conceptual work that is specific to psychiatric settings and not just adopted from psychotherapy. It will probably require innovative qualitative and quantitative studies along with experimental studies testing specific interventions to improve the TR in psychiatric settings. The challenge is to assess TRs in intervention studies as an outcome criterion in its own right and as a mediating factor explaining variance in outcome due to non-specific effects. Dedicated research on the TR, the centrepiece of psychiatric practice, is just at the beginning.

References

1. JOHANSSON H, EKLUND M. Patients' opinion on what constitutes good psychiatric care. *Scand J Caring Sci* 2003;**17**:339–346.

2. FREUD S. On beginning the treatment. In: STRACHEY J, ed. The standard edition of the complete psychological works of Sigmund Freud. London: Hogarth Press, 1913.
3. MARTIN DJ, GARSKE JP, DAVIC MK. Relation of the therapeutic alliance to outcome and other variables: a meta-analytic review. *J Consult Clin Psychol* 2000;**68**:438–450.
4. JASPERS K. General psychopathology, Vol. II. XXXX: XXXX, 1959. (Translated by J. Hoenig and M.W. Hamilton, 1997)
5. MCGUIRE R, MCCABE R, PRIEBE S. Theoretical frameworks for understanding and investigating the therapeutic relationship in psychiatry. *Soc Psychiatry Psychiatr Epidemiol* 2001;**36**:557–564.
6. CRUZ M, PINCUS HA. Research on the influence that communication in psychiatric encounters has on treatment. *Psychiatr Serv* 2002;**53**:1253–1265.
7. FRANK AF, GUNDERSON JG. The role of the therapeutic alliance in the treatment of schizophrenia: relationship to course and outcome. *Arch Gen Psychiatry* 1990;**45**: 228–236.
8. WEISS M, GASTON L, PROPST A, WISEBORD S, ZICHERMAN V. The role of the alliance in the pharmacologic treatment of depression. *J Clin Psychiatry* 1997;**58**:196–204.
9. MCCABE R, PRIEBE S. The therapeutic relationship in the treatment of severe mental illness: a review of methods and findings. *Int J Soc Psychiatry* 2004;**50**:115–128.
10. PRIEBE S, GRUYTERS T. The role of helping alliance in psychiatric community care – a prospective study. *J Nerv Ment Dis* 1993;**181**:552–557.
11. MCCABE R, PRIEBE S. Are therapeutic relationships in psychiatry explained by patients' symptoms? Factors influencing patient ratings. *Eur Psychiatry* 2003;**18**: 220–225.
12. MCCABE R, HEATH C, BURNS T, PRIEBE S. Engagement of patients with psychosis in the medical consultation: a conversation analytic study. *Br Med J* 2002;**325**:1148–1151.
13. MOORE E, KUIPERS L, BALL R. Staff–patient relationships in the care of the long-term adult mentally ill. *Soc Psychiatry Psychiatr Epidemiol* 1992;**27**:28–34.
14. KAVANAGH DJ. Recent developments in expressed emotion and schizophrenia. *Br J Psychiatry* 1992;**160**:601–620.
15. HARRISON J, GOLDBERG G. Improving the interviewing skills of psychiatric trainees. *Eur J Psychiatry* 1993; 31–34.
16. GASK L, DOWRICK C, DIXON, C et al. A pragmatic cluster randomised controlled trial of an educational intervention for the assessment and management of depression. *Psychol Med* 2004;**34**:63–72.
17. PRIEBE S. Ensuring and improving quality in community mental health care. *Int Rev Psychiatry* 2000;**12**:226–232.
18. PRIEBE S, BULLENKAMP R, MCCABE R et al. The impact of routine outcome measurement on treatment processes in community mental health care: approach and methods of the MECCA study. *Epidemiol Psychiatr Soc* 2002;**3**: 198–205.
19. SUDAK DM, BECK JS, WRIGHT J. Cognitive behavioral therapy: a blueprint for attaining and assessing psychiatry resident competency. *Acad Psychiatry* 2003;**27**:154–159.