

## **Therapeutic relationships in psychiatry: The basis of therapy or therapy in itself?**

STEFAN PRIEBE & ROSEMARIE MCCABE

*Barts and the London School of Medicine and Dentistry, Queen Mary University of London, London, UK*

### **Abstract**

All healthcare is delivered in relationships between professionals and patients, and this relationship is particularly central to mental healthcare. Although fewer studies have been conducted in community psychiatry than in psychological treatments, there is increasing evidence that the therapeutic relationship predicts outcome across various psychiatric settings. The clinician-patient relationship and communication may indirectly improve outcome, e.g. mediated through better treatment adherence. Yet, evidence suggests that these interpersonal processes also have a direct therapeutic effect. Thus, depending on the conceptual model of therapeutic processes they may be seen as therapy in itself. Clinicians receive little specific instruction and supervision in communication skills, and research on the issue is scarce. Whilst there are conceptual and methodological challenges to such research, the aim should be to identify therapeutically effective elements of relationships and communication that can be tested in experimental studies. Although still rare, interventions to improve clinician-patient communication in routine mental healthcare show favourable results. A further step may be adapting established psychological treatment models, such as cognitive behaviour or solution focused therapy, to make routine clinical interactions more therapeutic and evidence based. This would be in the interest of clinicians, in optimizing their therapeutic potential, and patients alike.

### **Introduction**

According to the Oxford dictionary, social is ‘concerned with the mutual relations of human beings’. Thus, all healthcare may be seen as a social affair because it is delivered in relationships between healthcare professionals and patients. The relationships can take various forms, and may last between a few seconds and several decades. They do not necessarily involve face-to-face contact, and may also be established via the telephone, the web or other means of communication. Yet, there practically always is some form of communication and a direct or indirect exchange of material or immaterial goods, behaviour, information and/or emotions. Whilst this in principle applies to all types of healthcare, it is particularly relevant in mental healthcare. One may argue that studying and improving therapeutic relationships in psychiatry is a core task for social psychiatry. Whilst we use the broad term therapeutic relationship in this paper, it may be variously referred to and construed as, for example, the ‘therapeutic alliance’, ‘helping alliance’ or ‘working alliance’ (e.g. Catty, 2004).

### **The therapeutic relationship and outcome**

Numerous studies have shown that the quality of the relationship between therapist and patient is a consistent and strong predictor of outcome across various forms of psychotherapy (Martin, Garske, & Davic, 2000). However, the setting in mainstream psychiatric services differs from conventional psychotherapy in important aspects. These include the actual or potential use of coercive treatment measures, the often open-ended nature of treatment, and the higher variability of the frequency, length and aims of meetings. Fewer studies have investigated the therapeutic relationship as a predictor of outcome in psychiatric settings (McCabe & Priebe, 2004). Yet, there is increasing evidence that a more positive therapeutic relationship also leads to better adherence to treatment and more favourable outcomes across a range of diagnoses and treatment settings (e.g. Castonguay & Beutler, 2006; Frank & Gunderson, 1990; Hansson & Berglund, 1992; Klinkenberg, Calsyn, & Morse, 1998; Krupnick et al., 1996; Priebe & Gruyters, 1995; Tattan & Tarrier, 2000; Weiss, Gaston, Propst,

Wisebord, & Zicherman, 1997). In their meta-analysis, Martin et al. (2000) found an effect size of 0.22-0.26 and about one quarter of the 77 studies included focused on severe mental illness.

In qualitative research, the nature of the therapeutic relationship has been identified as a major factor in engaging patients in care (e.g. Kirsch & Tate, 2006). For instance, in-depth interviews with 'difficult to engage' patients in assertive outreach teams in London showed that poor therapeutic relationships were the reason for patients disengaging from mainstream services initially, whilst a partnership type of relationship and shared decision-making helped patients to re-engage with specialized services later (Priebe, Watts, Chase, & Matanov, 2005). In patient surveys, the therapeutic relationship has repeatedly and in different settings been reported as the most important component of care (e.g. Johansson & Eklund, 2003). The methodological quality of research in this area varies, and there is still a need for methodologically rigorous observational and experimental studies on the role of the therapeutic relationship in psychiatric treatment. Nevertheless, the existing evidence clearly suggests that the quality of the therapeutic relationship is of major importance across different kinds of psychiatric settings and treatments.

### Assessing the therapeutic relationship

If the therapeutic relationship is important for research in community mental healthcare, there should be a method to assess it with sufficient reliability and validity. Most methods used for this purpose were either developed in psychotherapy or designed *ad hoc* without a systematic development process. The Scale to Assess Therapeutic Relationships in Community Mental Healthcare (STAR) (McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007), however, was specifically developed and designed to be used in community psychiatric settings. It was guided by psychometric principles and is based on qualitative work and quantitative testing of newly developed items and appropriate items of existing scales. STAR exists in a version for patients and clinicians. Each version has twelve items which capture three distinct factors. The first and most important factor is 'positive collaboration' which reflects the general way the clinician and patient get on with each other. This factor might be difficult to influence through specific clinician behaviour as it may have more to do with the 'chemistry' between two personalities in a given context. Yet, there are two other factors which are more directly behaviour related. In each version, there is a positive and a more negative factor.

The positive one reflects 'positive clinician input' whilst the negative one describes 'non-supportive clinician input' in the patient's view and 'emotional difficulties' in the perspective of the clinician. At least the first of these two factors assess aspects of the direct communication between clinician and patient.

The therapeutic relationship and communication are related terms but describe distinct phenomena. Whilst communication or interaction signifies the behavioural exchange between patient and clinician that is observable and may be described in objective terms by an independent observer, the relationship is a psychological construct held by the participating individuals on each other and their interaction. The way patient and clinician relate to each other influences how they communicate, and their communication influences how they think and feel about each other, i.e. their relationship. Thus, the two aspects are intertwined, and identifying whether a clinician and patient communicate effectively because they have a positive relationship, or whether they have a positive relationship because they communicate effectively, or both, is an area for future research.

### Communication and clinical practice

The main way for a clinician to influence the relationship and communication with a patient in a given clinical setting is through the way he or she behaves towards the patient. Clinicians in psychiatry should therefore be competent to communicate with patients in a way that helps establish good therapeutic relationships and is effective in achieving clinical aims. Are psychiatrists and other mental healthcare professionals specifically trained in communicating with patients, including those with severe disorders and high symptom levels? Do they receive regular supervision on how they communicate with patients in everyday practice? Is the quality of therapeutic relationships assessed in routine care? And, finally, is there extensive research on therapeutic relationships in psychiatry? The answer to all of these questions arguably is no. A study of communication in routine outpatient psychiatric consultations in the UK showed that psychiatrists tended to address psychotic experiences of patients only in a general way to check current symptom severity (McCabe, Heath, Burns, & Priebe, 2002). When patients raised their concerns linked to the content and emotional consequences of psychotic experiences, e.g. 'doctor, why don't people believe me when I say I'm God', psychiatrists tended to avoid a discussion on this. There may be many reasons for such avoidance, one of which may be lack of specific training on how to respond to such concerns.

Many medical students and psychiatric trainees do receive some training in communication with patients. In the UK, this is assessed in Objective Structured Clinical Examinations, in which an actor has a well-defined role of a patient with specific symptoms and problems and is interviewed by the examinee. The examinee is expected to introduce him or herself, explain the nature of the interview, get informed consent, and behave 'professionally' throughout the interview. At the end of the interview an observer and the actor rate the empathy of the examinee. There is a real challenge in achieving a balance between 'professional' and, at the same time, personal communication. What may get lost in such a learning process is the confidence to show and utilize personal characteristics and specific skills to engage with a patient. More intensive training on good communication might therefore have to be more individualized and require new teaching concepts.

Why is there not more research in psychiatry on such a central issue as the therapeutic relationship? Such research is certainly not driven by the financial interest of major stakeholders such as drug companies. It may also be more difficult to meet the requirements of evidence-based medicine in this complex area of research than with more straightforward forms of treatment techniques, which in turn make it more difficult to pass peer review processes for funding and publication of research. However, one might also argue that systematic research on the issue is a contradiction in itself. Jaspers (1959) suggested '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'. Can systematic research with mostly reductionistic methods ever reflect the complexity of a relationship between two people? Probably not, but this does not mean that research is necessarily impossible or useless (Cruz & Pincus, 2002). It should still be feasible to identify elements of relationships that are important for health and social outcomes that can be influenced through general or individualized interventions (Hassan, McCabe, & Priebe, 2007; McCabe & Priebe, in press).

### Theoretical concepts and models

There are at least three distinct aims of good communication and positive relationships. The first one is engagement. There needs to be a minimal threshold in the therapeutic relationship to motivate the patient to engage with a clinician and his or

her service. If the relationship is too poor, the patient may not turn up for another appointment and refuse all further contact. If engagement is achieved, the next aim is adherence to treatment suggestions and decisions. This applies not only to medication, but to all actions a patient is supposed to take as a result of the discussion with the clinician. A relationship may be good enough to ensure engagement, but still not strong enough to motivate the patient sufficiently to adhere to treatment. These two aims appear relatively uncontroversial, and there is some research evidence demonstrating that a positive therapeutic relationship is more likely to lead to engagement and treatment adherence. However, there may be less consensus on a third aim, which is therapeutic change of symptoms and behaviour. Can a good therapeutic relationship on its own lead to symptom improvement? In other words, is the therapeutic relationship only the basis of therapy or is it therapy in and of itself?

Therapeutic relationships are often seen as non-specific factors. Yet, whether a treatment factor is regarded as specific or non-specific depends only on our understanding of the underlying concept. A factor is only non-specific as long as there is no specific theory for its effect. As soon as a theoretical concept has been specified the formerly non-specific factor becomes specific. Since the effects of positive relationships and good communication have been studied and considered, one might argue that the first steps have already been taken to develop a specific theoretical model for their impact in treatment.

### Improving communication and therapeutic relationships

As already outlined, therapeutic relationships are expressed in and influenced by the way patients and clinicians communicate. Might it be possible to improve routine clinical communication? In research, we need to identify the active communication mechanisms in psychiatric settings and how they can be enhanced to maximize their impact on outcome. In addition, many practising psychiatrists have undergone psychotherapeutic training. They may try to apply some of their skills in psychiatric settings. However, this is not based on specific evidence for how to use those elements in a form of 'poor man's' psychotherapy in frequently brief meetings across varying settings. There is very little literature on how to adapt established models such as psychodynamic or cognitive behavioural methods so they can be utilized in a very short meeting with a patient in the community. Rather than adjusting complex and disorder-specific psychological treatment models, it may be easier to take more generic approaches that

can be flexibly applied and are not linked to an aetiological theory of a specific disorder. Some psychological treatment models arguably meet these requirements. Examples include client centred therapy and solution focused therapy, which originated from very different theoretical and practical positions, but are both applicable across settings and disorders. Other models are applicable across settings and disorders, but are more specific with respect to the task of the intervention. For instance, motivational interviewing requires an intentional ambivalence on which to work. It is a challenge for specialists in defined psychological treatment models to define generic components or adjust central elements so that they can be widely used in psychiatric settings in institutions and the community.

### Intervening in clinical interactions

A European multi-centre trial tested a simple intervention i.e., DIALOG to make patient-clinician interaction in community mental healthcare more effective and improve outcomes in patients with psychotic disorders (Priebe et al., 2007). In the experimental group, the DIALOG intervention was applied in routine meetings between key workers and patients about every two months. Key workers asked patients about their satisfaction with 8 life domains and 3 treatment aspects and their wishes for additional or different help in each area. If patients expressed a wish for different or additional help, its nature was recorded. The ratings were graphically displayed on hand-held computers and compared with previous ratings. In the randomized controlled trial, patients in the experimental group had more favourable quality of life, higher treatment satisfaction and fewer unmet needs after one year. Whilst the overall effect size was rather small, a medium effect size was achieved in patients with more problematic baseline scores.

Even if such an intervention on average achieves only a small effect for each individual patient, there are two aspects that would make the wide rolling out of such an intervention highly relevant and important. Firstly, intervening in therapeutic relationships across psychiatric settings is not a specialist programme for a limited number of patients, but a generic method that can be utilized in routine care throughout different types of services. In England alone, there are about 300,000 patients on the Care Programme Approach, i.e. in ongoing care of mental health teams in the community. Most of those patients suffer from severe mental illnesses, and may potentially benefit from more effective interaction with their clinicians. Thus, even small health and social gains for individual patients will add up to substantial effects on a public health

level. This also applies to potential cost savings. Secondly, interventions such as DIALOG can be implemented in existing routine care, and do not require setting up new services or organizational restructuring. They can be implemented at relatively low costs and require only limited training of clinical staff. Because of its generic nature, this and similar interventions would not compete with other existing treatment methods. They could be administered in combination with all other evidence-based treatment methods so that positive effects could accumulate or – for example in case of improved treatment adherence – even enhance each other.

Why was the DIALOG intervention effective, and how could the effect be enhanced? Whilst the intervention defined the assessment of the patient's perspective of pre-defined domains and presentation of the patient's ratings, it did not specify how clinicians should respond to the information provided by patients. Clinicians could, in a client centred manner, focus on the patients' feelings and emotions associated with their ratings. They also could, in a cognitive-behavioural approach, address the thoughts and assumptions behind the ratings as well as patients' expectations of further interventions and actions. In a solution-focused approach, clinicians could adopt a more forward looking style emphasizing patients' resources and options for change. The DIALOG intervention may be seen as a first step towards simple generic interventions for improving communication and subsequently long-term outcomes. The challenge for research is now to equip clinicians with therapeutic skills to optimize the effect. This will have to draw on existing theory on psychological interventions and finally involve a defined programme of training and on-going supervision. If widely implemented, such interventions may have important effects beyond improving individual treatment outcomes. The confidence of using psychological treatment elements in everyday psychiatric practice may increase the therapeutic aspiration throughout community mental health services so that clinicians aim to provide therapy rather than merely manage a case. The availability of an evidence-based method throughout community mental healthcare may also improve its reputation, reduce negative attitudes towards services and their patients, and make working in community mental healthcare more attractive to talented and qualified staff.

### Evaluating and improving complex interventions

The general challenges for research on therapeutic relationships reflect the difficult task of evaluating and improving complex interventions



in general (MRC, 2000). In qualitative and quantitative research, complex processes need to be disentangled, and methods need to be developed to evaluate distinctive steps and assess intermediary outcomes. Such research will need to model, optimize and test further interventions. Future interventions may have to be individualized and specified depending on patient characteristics and the therapeutic situation. For instance, some patients (those who are younger and have had more negative experiences of treatment) prefer partnership models of relationships, but this does not apply to all patients (Hamann, Cohen, Leucht, Busch, & Kissling, 2005). Some are in favour of a more paternalistic approach. A 'one size fits all' approach may not achieve the best possible outcome for every patient. Thus, modelling interventions to enhance therapeutic relationships may require specification for different patients and situations.

Individualizing interventions may also have to take into account the personal strengths and the potential for flexibility of the given clinician. Perhaps, clinicians may use different methods depending on their strengths and skills, or future research may identify how patients and clinicians can best be matched to facilitate positive relationships and the use of effective intervention methods.

### The wider social context

So far, the therapeutic relationship has been addressed as a phenomenon between two people, i.e. patient and clinician, as if they would both act in isolation from their respective contexts. The patient lives within a family and/or in a community, and the nature of the various relationships with family members and other social contacts is likely to influence how a patient engages with and benefits from a therapeutic relationship with a healthcare professional. The clinician acts in a professional role and his/her behaviour will be closely associated with his/her role in the service along with the context of the healthcare institution and wider social system. Exploring how these relationships are interlinked and how interventions at different parts of the interactional network influence patients' behaviour, may be a major and promising research agenda in social psychiatry.

### Conclusion

If the therapeutic relationship in mental healthcare is indeed therapy in its own right, the challenge for psychiatry as a speciality is to enhance therapeutic relationships to optimize their therapeutic effect. The qualification of a psychiatrist should include specific skills to communicate and engage with patients with

different mental health disorders in different settings. This will require better training, ongoing supervision and proper evaluation. Finally, in psychiatry, specific conceptual models of therapeutic relationships and related interventions are needed to systematically improve engagement, adherence and patient outcome.

### Acknowledgements

This manuscript was presented, in part, at the Symposium Wulf Rössler in Zurich.

**Declaration of interest:** The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

### References

- Castonguay, L. G., & Beutler, L. E. (2006). *Principles of therapeutic change that work*. New York: Oxford University Press.
- Catty, J. (2004). 'The vehicle of success' Theoretical and empirical perspectives on the therapeutic alliance in psychotherapy and psychiatry. *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 255–272.
- Cruz, M., & Pincus, H. A. (2002). Research on the influence that communication in psychiatric encounters has on treatment. *Psychiatric Services*, 53, 1253–1265.
- Frank, A. F., & Gunderson, J. G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia. *Archives of General Psychiatry*, 47, 228–236.
- Hamann, J., Cohen, R., Leucht, S., Busch, R., & Kissling, W. (2005). Do patients with schizophrenia wish to be involved in decisions about their medical treatment? *American Journal of Psychiatry*, 162, 2382–2384.
- Hansson, L., & Berglund, M. (1992). Stability of therapeutic alliance and its relationship to outcome in short-term inpatient psychiatric care. *Scandinavian Journal of Social Medicine*, 20, 45–50.
- Hassan, I., McCabe, R., & Priebe, S. (2007). Professional-patient communication in the treatment of mental illness: A review. *Communication and Medicine*, 4, 141–152.
- Jaspers, K. (1959). *General psychopathology*, Vol II. (Translated by J. Hoening and M. W. Hamilton 1997).
- Johansson, H., & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Science*, 17(4), 339–346.
- Kirsch, B., & Tate, E. (2006). Developing a comprehensive understanding of the working alliance in community mental health. *Qualitative Health Research*, 16, 1054–1074.
- Klinkenberg, W. D., Calsyn, R. J., & Morse, G. A. (1998). The helping alliance in case management for homeless persons with severe mental illness. *Community Mental Health Journal*, 34, 569–578.
- Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., et al. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the national programme. *Journal of Consulting and Clinical Psychology*, 64, 532–539.
- Martin, D. J., Garske, J. P., & Davic, M. K. (2000). Relation of the therapeutic alliance to outcome and other variables: A meta-analytic review. *Journal of Consulting & Clinical Psychology*, 68, 438–450.

- McCabe, R., Heath, C., Burns, T., & Priebe, S. (2002). Engagement of patients with psychosis in the medical consultation: A conversation analytic study. *British Medical Journal*, *325*, 1148–1151.
- McCabe, R. & Priebe, S. (2008). Communication and psychosis: It's good to talk, but how? *British Journal of Psychiatry*, *192*, 404–405.
- McCabe, R., & Priebe, S. (2004). The therapeutic relationship in the treatment of severe mental illness: A review of methods and findings. *International Journal of Social Psychiatry*, *50*, 115–128.
- McCabe, R. & Priebe, S. (in press). Communication and psychosis: It's good to talk, but how? *British Journal of Psychiatry*.
- McGuire-Snieckus, R., McCabe, R., Catty, J., Hansson, L., & Priebe, S. (2007). A new scale to assess the therapeutic relationship in community mental health care: STAR. *Psychological Medicine*, *37*, 85–96.
- MRC (Medical Research Council) (2000). A framework for development and evaluation of RCTs for complex interventions to improve health. Medical Research Council.
- Priebe, S., & Gruyters, T. (1995). Patients' assessment of treatment predicting outcome. *Schizophrenia Bulletin*, *21*, 87–94.
- Priebe, S., Watts, J., Chase, M., & Matanov, A. (2005). Processes of disengagement and engagement in assertive outreach patients: Qualitative study. *British Journal of Psychiatry*, *187*, 438–443.
- Priebe, S., McCabe, R., Bullenkamp, J., Hansson, L., Lauber, C., Martinez-Leal, R., et al. (2007). Structured patient-clinician communication and 1-year outcome in community mental healthcare. Cluster randomised controlled trial. *British Journal of Psychiatry*, *191*, 420–426.
- Tattan, T., & Tarrier, N. (2000). The expressed emotion of case managers of the seriously mentally ill: The influence of expressed emotion on clinical outcomes. *Psychological Medicine*, *30*, 195–204.
- Weiss, M., Gaston, L., Propst, A., Wisebord, S., & Zicherman, V. (1997). The role of the alliance in the pharmacologic treatment of depression. *Journal of Clinical Psychiatry*, *58*, 196–204.