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THERAPEUTIC RELATIONSHIPS AND QUALITY OF LIFE: ASSOCIATION OF TWO SUBJECTIVE CONSTRUCTS IN SCHIZOPHRENIA PATIENTS

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SUMMARY

Subjective quality of life is an important criterion in outcome evaluation that has been well-researched in psychiatry. By comparison, the therapeutic relationship which may also be subjectively assessed has been relatively neglected as an outcome criterion although it has predictive power in relation to outcome. This exploratory study investigated subjective quality of life and therapeutic relationships in first-admission ($N = 90$) and long-term ($N = 168$) schizophrenia patients, each at two points of time. The follow-up period was 9 months for the first-admission sample and 1.5 years for the long-term sample. A significant relationship was found between global assessments of quality of life and therapeutic relationships in long-term, but not in first-admission patients. This finding was consistent at both assessments, suggesting that therapeutic relationships may become more central to quality of life in long-term care situations and that patients' views of this relationship are increasingly embedded in their overall appraisal of life.

INTRODUCTION

Quality of Life (QoL) has become a popular construct in the field of psychiatry and an important outcome criterion in evaluative research. This is in line with policy which states that improvement in QoL is one of the major aims of mental health care. Although objective indicators of QoL are reported, subjective indicators are central to its assessment. The construct has been well-researched in psychiatry over the past two decades. During this time, various instruments have been developed for measuring QoL, most of which address satisfaction with life in general and with various life domains (e.g., Lehman, 1983; Oliver, 1991; Lower, 1999; Hansson, 1999).

By contrast, the 'therapeutic relationship' appears to be neglected in psychiatric research even though it is central to the practice of psychiatry. In Freud's terms, it is "the vehicle of success in therapy" and it has been extensively studied in psychotherapy ever since Freud highlighted the special relationship between the client and therapist. A positive therapeutic relationship has been consistently found to predict increased treatment adherence and a better outcome across different forms of psychotherapy (Horvath & Symonds, 1991; Horvath & Greenberg, 1994; Alexander & Coffey, 1997). Numerous papers have been published which

attest to the significance of the therapeutic relationship as a principal predictor and *the* central non-specific element in psychotherapy (for a review see Horvath & Luborsky, 1993).

In psychiatric care, a similar finding has been replicated among adults with severe mental illness across a number of different settings: in complex hospital treatment (Bröker *et al.* 1995), in day hospital treatment (Priebe & Gruyters, 1994) and in a community care setting (Frank & Gunderson, 1990; Priebe & Gruyters, 1993; Gehrs & Goering, 1994; Solomon *et al.* 1995; Gaston *et al.* 1998). As in psychotherapy, the therapeutic relationship displays predictive validity in a psychiatric context and appears to be a very effective element of treatment which is most likely used as a means of delivering other treatment components (e.g., pharmacotherapy, see Weiss *et al.* 1997).

However, there are no established methods for assessing the therapeutic relationship in psychiatric settings. Psychiatry has, for the most part, employed measures developed for psychotherapy, but models of psychotherapy do not apply to dyadic relationships in psychiatry which are different from, and more complex than, those in conventional psychotherapy settings. Measures that have been constructed explicitly for use in a psychiatric context (i.e., four) are extremely reductionistic and short, without any real validation (Clarkin *et al.* 1987; Stark *et al.* 1992; Priebe & Gruyters, 1993; Klinkenberg, 1998). Despite these methodological limitations, global assessments of the therapeutic relationship have demonstrated predictive validity among those with severe mental illness. While research thus far on the role of the therapeutic relationship has been conducted more from the perspective of the health professional (particularly its utility in predicting individual outcome), the therapeutic relationship is also of considerable importance on an individual level, i.e., as subjectively assessed by the patient.

As far as we are aware, the therapeutic relationship has not been systematically studied in relation to QoL. Whereas quality of life has been employed primarily as an outcome variable, the therapeutic relationship is viewed more as a mediating factor rather than an outcome criterion in its own right. Thus, the questions that led to the present study were:

I. how are the therapeutic relationship and QoL related in schizophrenia patients?
II. is the relationship different in short-term and long-term treatment situations because the therapeutic relationship is supposed to be different (i.e., in relation to goals and pace of treatment, adoption of a short or long-term perspective)?

The present study was an exploratory one that investigated one's perception of the therapeutic relationship and whether it was associated with satisfaction with other relationships in one's life and overall satisfaction with life.

Sample

Two groups of subjects meeting ICD-10 criteria for a diagnosis of schizophrenia were compared. The first-admission sample was a group of 90 schizophrenia patients admitted to a psychiatric hospital for the first time in their life, 51 of whom were followed up 9 months after discharge (Röder-Wanner & Priebe, 1998a & b). The long-term sample was a subgroup of the Berlin Deinstitutionalisation Study (Priebe *et al.* 1996; Hoffmann *et al.* 1997; Kaiser *et al.* 1998): the key inclusion criterion for this group was a continuous hospitalisation of at least 6 months. The average cumulative duration of hospitalisations of this sample was 9.8 (±10.3) years. 176 patients in the long-term group were assessed at baseline while in hospital. Of these 176 patients who were assessed, 168 gave clear, unequivocal answers to all questions

of interest here (i.e., in relation to QoL and therapeutic relationships). 113 of this long-term group were followed up on average one-and-a-half years later, 98 of whom gave unequivocal answers to all questions of interest and were in some form of treatment so that the questions about the therapeutic relationship applied. 41 of these had been discharged by the follow-up assessment.

METHOD

Subjective quality of life was assessed using the German version of the Lancashire Quality of Life Profile which was developed by Oliver (Oliver, 1991; Oliver *et al.* 1997; Priebe *et al.* 1995). The questionnaire permits an evaluation of the patients' objective circumstances, their subjective satisfaction with nine specific life domains and their general life satisfaction. Subjective ratings are taken on 7-point scales for satisfaction with life as a whole and with eight life domains (1 = couldn't be worse; 7 = couldn't be better). The means of satisfaction with life as a whole and the eight domains were taken as indicators for subjective quality of life.

A modified version of the Helping Alliance Scale (HAS: Priebe & Gruyters, 1993) was used which focussed on the therapeutic relationship(s) pertinent in one's treatment situation. Three items which pertain to therapeutic relationships ("Do you believe you are receiving the right treatment/care for you?", "Does your therapist/case manager/keyworker understand you and is he/she engaged in your treatment/care?" and "Do you feel respected and well regarded?") were summed to yield an indicator of one's relationship with one's primary therapist, typically a keyworker. Each item was rated on an 11-point visual analogue scale, where 0 = not at all and 10 = yes entirely.

Psychopathology was observer rated using the 18-item version of the Brief Psychiatric Rating Scale (BPRS: Overall & Gorham, 1962).

RESULTS

Demographic data for the two samples was collated (see Table 1). The long-term sample was significantly older than the first-admission sample ($t = 10.7$, $p < 0.001$) while there were significantly more females in the first-admission sample ($\chi^2 = 10.0$, $p < 0.002$). Mean BPRS total score at initial assessment was comparable across the two groups but was significantly lower in the first-admission group at follow-up ($t = 6.6$, $p < 0.001$). Mean subjective quality of life scores were also compared across the two groups: there was no significant difference between the groups at either point of time.

Pearson correlations were calculated to examine the relationship between the therapeutic relationship and the relevant life domains (satisfaction with friends and life as a whole) and overall satisfaction score of the LQLP. Following recommendations by Kaiser *et al.* (1997) and Priebe *et al.* (1999), partial correlations were obtained to control for the influence of psychopathology.

In the first-admitted group, as may be seen from Table 2, only one correlation was significant: that between life as a whole and the therapeutic relationship at baseline. If we

Table 1
Characteristics of the first-admission and long-term sample

	First-admission sample (N = 90)	Long-term sample (N = 168)	Statistics (df)	p
Age (years)	30.3 (±10.0)	48.9 (±14.7)	t (246) = 10.7	<0.001
Sex: female	67%	45%	χ^2 (1) = 10.0	<0.002
Cumulative hosp. (years)	–	9.8 (±10.3)	–	
BPRS sum score:				
baseline	48.1 (±10.4)	47.5 (±16.7)	ns	
follow-up	32.4 (±7.7)	48.0 (±14.5)	t (91) = 6.6	<0.001
Mean satisfaction score:				
baseline	4.5 (±0.8)	4.7 (±0.9)	ns	
follow-up	4.6 (±0.8)	4.7 (±1.0)	ns	

focus on the QoL sum score, it may be seen that there was no significant association between the therapeutic relationship and QoL in this sample at either assessment.

In the long-term group, quite a different pattern emerged. As may be seen from Table 3, there were significant correlations between therapeutic relationships and the 2 domains and the overall score at baseline. At follow-up, all of the correlations remained substantial and statistically significant. Turning our attention to the QoL sum score, the relationship between the therapeutic relationship and overall satisfaction showed an increase from the initial to the follow-up assessment (the follow-up period was one and a half years). Partial correlations controlling for psychopathology are shown in brackets in Table 3. The correlations either remained the same or were slightly lower but remained statistically significant.

A factor analysis was also conducted using the QoL domain scores and the sum score of therapeutic relationships. While the therapeutic relationship was a separate factor at two points in the first-admission group, this was not a consistent result in the long-term group.

DISCUSSION

The main finding of this study was a significant association between global assessments of quality of life and the therapeutic relationship in long-term schizophrenia patients, indicating that there are generalised factors influencing appraisals of both constructs. This was an exploratory study and it is not known to what extent these findings can be generalised to other samples. It is perhaps useful to keep in mind some methodological limitations of this

Table 2
Correlations between therapeutic relationships and satisfaction with friends, life as a whole and overall satisfaction in first-admitted patients

	Friends	Life as a whole	Sum score
1st Assessment	0.13	0.30**	0.10
9 months later	0.09	0.04	0.12

**p < 0.01

Table 3
Correlations between therapeutic relationships and satisfaction with friends, life as a whole and overall satisfaction in long-term patients and (in brackets) after controlling for psychopathology

	Friends	Life	Sum score
1st Assessment	0.40** (0.33**)	0.33** (0.33**)	0.44** (0.38**)
$1\frac{1}{2}$ years later	0.41** (0.27*)	0.48** (0.38**)	0.61** (0.55**)

**p < 0.001

study. Firstly, as this was a cross-sectional study with repeated measures, there was no control over events that occurred in between the two assessments. However, the results seem substantial taking into account that the correlations were consistently different at two points of time in the two samples.

Secondly, the method used to assess the therapeutic relationship was not as elaborate as that employed to assess QoL. Although the number of items was similar in both assessments, they were more tentatively applied with respect to the therapeutic relationship. In addition, only the patients' appraisal of QoL and the therapeutic relationship were assessed and not the therapist/observer perspectives. Interestingly, in psychotherapy research the perspective of the patient has the strongest predictive power, followed by the observer and lastly the therapist. It is not known whether this finding also holds in therapeutic interactions in psychiatry.

From the findings reported herein, it would appear that the therapeutic relationship, after a while, is embedded in an overall appraisal of one's whole life situation. This was, however, only the case in the long-term and not in the first-admission sample. It is conceivable that the therapeutic relationship becomes an important part of day-to-day life for those in long-term care situations and is not separate any more as it appears it is in a first-admission sample. It is plausible that the therapeutic relationship moves into the quality of life arena and that it is viewed by the same global tendencies as one's life generally. On the other hand, it might be argued that long-term schizophrenia patients lose the ability to discriminate between different domains in their appraisal of life circumstances due to cognitive rigidity, an argument that is not supported by the QoL ratings obtained in this study which do differentiate between life domains.

Alternatively, cognitive dissonance theory may account for the differences in how one perceives the therapeutic relationship and one's QoL depending on stage of illness. According to this theory, people do not tend to hold inconsistent feelings, beliefs or attitudes for very long. Rather, they tend to harmonise their views about the world so that they are consistent. In the present context, we would expect that a negative assessment of the therapeutic relationship would not exist alongside a positive appraisal of one's life and *vice versa*. Hence, when the therapeutic relationship becomes more important or features more in one's life (either positively or negatively), it will not be possible to make very different appraisals for the two areas. However, this dissonance between appraisals would be more likely if the events in question are only relevant in the short-term as with the first-admission sample

because, according to this theory, it is less problematic to have dissonance between attitudes in the short-term than in the long-term.

Finally, one could speculate that the therapeutic relationship develops in a similar way to other relationships in one's life (e.g., with friends). Underlying this explanation is the notion that similar patterns of behaviour characterise different relationships that one has, an idea that has its roots in psychodynamic theory. Although there may be some divergence from one's typical position in a relationship when a new relationship is formed, it may be that these relationships are subsequently subject to the same patterns as previous other relationships. Empirical research from a systemic perspective (Priebe, 1989; Priebe & Haug, 1992; Priebe & Pommerien, 1992) provides some support for the idea that therapeutic potential may be assessed, in part, by exploring how the therapeutic relationship is similar to or differs from relationships with significant others, an area of research that warrants further attention.

In conclusion, both quality of life and the therapeutic relationship are important constructs which may overlap depending on the sample and the treatment situation, an association that is not attributable to the influence of psychopathology. With reference to possible practical implications of these findings, it is possible that, in long-term samples, interventions in QoL or changes in the therapeutic relationship will have an influence on each other. Moreover, it may be that neither will be as flexible after years of illness and treatment as they were earlier in the illness trajectory. Conceivably, if interventions to improve the therapeutic relationship are introduced, one's perception of the therapeutic relationship might not change if it is viewed predominantly in the context of one's life overall.

The therapeutic relationship is probably linked to how mental health services are perceived. On a speculative note, if it is more flexible early on in treatment (when a patient first presents), this would be the time to influence it in a positive direction. If it is viewed negatively and this perception remains for many years, it may be much more difficult to change which clearly will affect therapeutic effectiveness. However, these are naturalistic studies and the ways in which the therapeutic relationship can be influenced are not yet known.

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