

THE THERAPEUTIC RELATIONSHIP IN THE TREATMENT OF SEVERE MENTAL ILLNESS: A REVIEW OF METHODS AND FINDINGS

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ABSTRACT

Aims: To review the methods and findings from studies of the therapeutic relationship (TR) in the treatment of severe mental illness.

Method: A literature search was conducted to identify all studies that used an operationalised measurement of the TR in the treatment of severe mental illness.

Results: Fifteen scales – the majority of which were developed for psychotherapy – and the expressed emotion index have been used. Most scales have acceptable internal, inter-rater and test–retest reliability. As none of the scales has been used in more than five studies, no single scale is widely established in psychiatric research. A more positive relationship consistently predicts a better short- and long-term outcome. It appears that a large global factor accounts for the greatest proportion of the variance in the therapeutic relationship.

Conclusions: The therapeutic relationship is a reliable predictor of patient outcome in mainstream psychiatric care. Valid assessments may need to take account of different, specific aspects of the relationship in psychiatric settings such as greater heterogeneity of treatment components and goals, increased variability of setting and the statutory responsibility of the clinician. Methodological progress may require conceptual work to ensure valid assessments of this central element of treatment.

INTRODUCTION

The relationship between patient and therapist, variously referred to as the *therapeutic relationship* (Alexander & Coffey, 1997), *helping relationship* (Goering & Stylianos, 1988), *working alliance* (Gehrs & Goering, 1994), *helping alliance* (Luborsky *et al.*, 1983; Priebe & Gruyters, 1993; Klinkenberg *et al.*, 1998) or *therapeutic alliance* (Clarkin *et al.*, 1987) has been extensively studied in psychotherapy ever since the special relationship that exists between the patient and therapist was highlighted by Freud (1913). This relationship is also central to the practice of psychiatry being used as a means to engage patients – who may not agree that they need treatment – and to deliver complex treatment programmes. The TR is difficult to define with each definition at least partly determined by the presuppositions within the given theoretical framework. However, there is consensus that ‘therapeutic’ implies that the relationship between the therapist and patient should have some curative

properties. For the present purposes, it refers to the relationship between health professionals trained to provide treatment to people ostensibly in need of such treatment, setting aside claims as to whether or not the relationship is deemed to be curative.

This paper focuses primarily on empirical studies of the patient-clinician relationship in the treatment of severe mental illness to date with a particular focus on the methods used to assess the relationship. A search of electronic databases – Medline, PsychLIT, CINAHL and the Cochrane Library – in addition to a manual search of peer-reviewed journals for the past five years was conducted. For inclusion in this review, studies were required to meet three criteria, i.e. involve the treatment of severe mental illness, professional-patient interpersonal relationship/processes and an operationalised measurement of the relationship. Although the term *severe mental illness* is widely used operationally (e.g. Kessler *et al.*, 1998; Tyrer *et al.*, 2000), there is no universally agreed definition. The UK National Service Framework (Department of Health, 1999) definition was used to identify studies for inclusion in this review. However, because the definitions are somewhat variable and precise information to determine patient diagnostic and clinical status was not always published, this review was over-inclusive with respect to definitions of severe mental illness. This paper will present first the methods that have been used to assess the relationship, second the findings using these methods and conclude with a discussion of conceptual issues pertaining to therapist-patient relationships in these settings.

THERAPEUTIC RELATIONSHIP SCALES

Fifteen operationalisations of the therapeutic relationship were employed in studies involving severe mental illness and all but four of these measures were developed in psychotherapy. Most were not derived explicitly from a single theoretical formulation of the alliance but are based on a generic concept of the TR, with the precise definition of the TR remaining elusive in most cases. However, most scales assess the bond between the patient and therapist along with their collaboration. For each of the scales, Table 1 provides information on the structure, number of items, rater, rating form, time to complete, the number of studies which have used the scale, psychometric properties and main emphasis in the scale.

The two most widely used measures in psychiatric research, i.e. the California Psychotherapy Alliance Scale (Marmar & Gaston, 1988)¹ and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), have parallel versions for client, therapist and independent observer. The key conceptualisation of the alliance in the CALPAS is of a dynamic process influenced by both parties which may either progress collaboratively or develop into a conflict between client and therapist. The WAI is based on Bordin's (1979) tripartite conceptualisation of the alliance, assessing the attachment between patient and therapist (bonds), collaboration on specific therapeutic activities (tasks) and the agreement between therapist and client on the global objectives of therapy (goals).

Three of the measures used have parallel client and therapist versions. The Therapist Client Relationship Scale (Bennun *et al.*, 1986) was developed to assess the client's and therapist's perception of each other in behaviour therapy: the client assesses the therapist's positive regard/interest, competency/experience and activity/direct guidance while the therapist

assesses the client's positive regard, self-disclosure/engagement and co-operation/goal orientation. As the name suggests, the Therapist-Patient Relationship Scale for Schizophrenic Patients (TPRS; Stark *et al.*, 1992) was developed for use with schizophrenia patients: the therapist rates how they perceive themselves within the relationship (their therapeutic competence and feeling of personal and professional acceptance) while the patient rates how the therapist relates to them along with their therapeutic skills (Stark, 1994). Finally, the Therapeutic Working Alliance scale (TWA; Hentschel *et al.*, 1997), developed specifically from a psychoanalytic perspective, assesses both positive and negative aspects of the relationship and the collaboration from therapist and client perspectives.

Scales rated solely by the client include the pioneering alliance measure in psychotherapy, the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962), the Helping Alliance Scale (HAS; Priebe & Gruyters, 1993) and the Helping Alliance Measure (HAM; Klinkenberg *et al.*, 1998). The BLRI is based explicitly on the Rogerian proposition that therapeutic change occurs in proportion to the therapist's creation of 'facilitative conditions' in therapy. The HAS is a short questionnaire that was developed specifically for use in psychiatric community care while the HAM was adapted from a longer scale originally constructed to assess client expectancies in counselling. All three scales emphasise the perceived characteristics of the therapist/keyworker (e.g. honesty, warmth, trust, understanding, criticism, dependability).

Only one scale is exclusively rated by the therapist, i.e. the Psychotherapy Status Report (PSR; Stanton *et al.*, 1984), which assesses the patient's ability to work purposefully in therapy with a minor emphasis on the therapist's own involvement. Meanwhile, four scales are completed exclusively by an expert rater. Luborsky *et al.* (1983, 1985) developed two closely related measures (Helping Alliance counting signs and Helping Alliance rating) both of which were derived from Freud's view of the transference process and seek to assess the non-neurotic, friendly feelings between the patient and therapist. The Scale to Assess the Therapeutic Alliance (SATA; Allen *et al.*, 1984, 1985) attempts to distinguish the therapeutic alliance as distinct from the transference by referring exclusively to the patient's collaborative work and not the patient's experience of the relationship with the therapist. The Therapeutic Alliance rating (TA; Clarkin *et al.*, 1987) was devised explicitly for use with psychiatric in-patients and focuses wholly on the patient's perceived insight, need for and involvement in treatment. Finally, the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983) – partly based on the work of Luborsky and Bordin – assesses both therapist and patient individual contributions along with the extent of collaboration between them.

A different framework is offered by the Expressed Emotion (EE) index (Vaughn & Leff, 1976; Doane *et al.*, 1981), where a trained rater counts the critical and hostile attitudes expressed during an interview/speech sample along with the degree of emotional involvement between the parties (Magaña *et al.*, 1986). Although concerned with rating interactions, it is of interest as it was developed specifically to rate interactions between people with schizophrenia and their carers and, similar to research on the relationship *per se*, has linked the findings to patient outcome and relapse.

Psychometric properties of scales

Although most of the scales have reported acceptable internal, inter-rater and test retest reliability (see Table 1), the validity of the 'therapeutic relationship' in the treatment of

Table 1
Measures of the therapeutic relationship used in psychiatric settings

Measure	Structure/components	Items	Rater	Rating form	Time to rate	Studies	Psychometric properties	Emphasis
BLRI	Empathic understanding, Congruence: Positive regard, Unconditional regard	64	Client	Questionnaire	20 mins	2	High internal consistency; Subscales highly inter-correlated Highly correlated with the WAI	Therapist contribution
CALPAS	Patient commitment: Patient working capacity Therapist understanding & involvement: Working strategy consensus	1, 24 2, 30 3, 24	1. Client 2. Therapist 3. Expert	1. Questionnaire 2. Questionnaire 3. Videotapes	1. 15 mins 2. 15 mins 3. Lengthy	3	Adequate test re-test reliability and high inter-rater reliability FA 2 factors: alliance, therapist influence; CALPAS-P highly correlated with the WAI-P and VTAS	Client contribution
CFI	Emotional involvement, hostility & criticism	Coding system	Rater	Transcripts	Lengthy	2	Adequate inter-rater reliability	Staff emotional involvement
HACS HAR	Helping alliance type 1 & 2	Manual	Rater	Transcripts	Lengthy	2 1	Moderate inter-rater reliability High internal consistency	
HAM	Case manager's honesty, warmth, trust, attentiveness, dependability & support	15	Client	Questionnaire	5 mins	1	Internal reliability $\alpha = 0.97$ at two points of assessment (months 2 and 14)	Case manager contribution
HAS	Therapist commitment, understanding & criticism View of treatment Feeling after session	5	Client	Questionnaire	5 mins	2	All items weakly to moderately positively inter-correlated with the exception of case manager criticism which was negatively correlated with other items	Case manager contribution
PSR	Patient working capacity; Patient resistance; Therapist optimism, involvement; Adherence to treatment parameters	15	Clinician	Questionnaire	10 mins	2	None detailed	Patient contribution
SATA	1. Collaboration 2. Mediating variables: trust in therapist, acceptance, optimism & expression of affect	1, 1 2, 4	Expert rater or trained therapist	Rating scale (Transcripts)	Lengthy	2	Good inter-rater reliability All subscales highly inter-correlated except expression of affect	Patient contribution; collaboration
TAS ↓ TARS	Patient & Therapist positive contribution Patient & Therapist negative contribution	41	1. Client 2. Therapist 3. Expert	1. Questionnaire 2. Questionnaire 3. Audio/video	1. 15 mins 2. 15 mins 3. Lengthy	3	Adequate inter-rater reliability PCA → 6 factors: therapist positive and negative factor, 2 patient positive and 2 patient negative factors	Patient contribution

TA	Perceived need of treatment; Treatment involvement; Insight	6	Expert rater	Questionnaire (chart material)	30 mins	2	High inter-rater reliability	Patient contribution
ICRS	1. Positive regard, competency, activity; direct guidance 2. Positive regard, self-disclosure, co-operation	29	1. Client 2. Therapist	Questionnaire	20 mins	1	Good internal consistency Predictive validity for patient's positive and negative contributions and less for therapist's positive contributions	Common contribution
TPRS	1. Therapist relationship & competence; skills 2. Self-perception in relationship, acceptance of client	1, 30 2, 16	1. Client 2. Therapist	Questionnaire	10 mins	2	C.A. of therapist: 4 factors: rejection/ inadequacy, insecurity, detachment, personal acceptance, professional acceptance C.A. of patient: 4 factors relating to therapist behaviour High test retest reliability	Therapist contribution
TWA	Positive & negative aspects of relationship Positive & negative aspects of co-operation	20	1. Client 2. Therapist	Questionnaire	20 mins	1	High inter-rater reliability and internal consistency; Highly correlated with CAPLAS and WAI.	Client contribution
VIAS	Contribution of: Therapist; Patient; Treatment situation	44	Expert rater	Questionnaire (Audiotapes)	Lengthy	1	High inter-rater reliability and internal consistency; Highly correlated with CAPLAS and WAI. PCA 6 factors: positive climate; therapist intrusiveness; patient resistance, motivation, responsibility and anxiety	Client contribution
WAI	3 components: Bonds, Tasks & Goals	36	1. Client 2. Therapist 3. Rater	1. Questionnaire 2. Questionnaire 3. Videotapes	1. 20 mins 2. 20 mins 3. Lengthy	5	High inter-rater reliability and internal consistency Highly correlated with CAPLAS and VIAS Subscales highly inter-correlated	Common and Therapist contribution

Abbreviations: BLRI: Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962); CAI-PAS: California Psychotherapy Scales (Gaston & Marmar, 1991); CFI: Cambewell Family Interview (Vaughn & I.E.H., 1976); HAes and HA-r: Helping Alliance counting signs and rating (Luborsky *et al.*, 1983); HAM: Helping Alliance Measure (Klinkenberg *et al.*, 1998); IAS: Helping Alliance Scale (Pribe & Grutiers, 1993); PSR: Psychotherapy Status Report (Stanton *et al.*, 1984); SAJA: Scale to Assess the Therapeutic Alliance (Allen *et al.*, 1984); TA: Therapeutic Alliance Scale (Clarkin *et al.*, 1987); TARS: Therapeutic Alliance Rating System (Marmar *et al.*, 1986); TAS: Therapeutic Alliance Scale (Marziab, 1984); TCRS: Therapist Client Relationship Scale (Bennun *et al.*, 1986); TPRS: Therapist - Patient Relationship Scales for Schizophrenic Patients (Stark *et al.*, 1992); TWA: Therapeutic Working Alliance (Hentschel *et al.*, 1997); VTAS: Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983); WAI: Working Alliance Inventory (Horvath & Greenberg, 1989)
CA: Cluster Analysis; FA: Factor Analysis; PCA: Principal Components Analysis

severe mental illness has not been widely investigated. A cluster analysis of the therapist version of the TPRS (Stark *et al.*, 1992) revealed four factors relating to personal and professional acceptance within the relationship while the client version yielded four factors relating to therapist behaviour. Salvio *et al.* (1992) factor analysed the BLRI and WAI rated by patients with depression and found that all subscales loaded substantially on one general factor labelled 'strength of the therapeutic alliance'. Similarly, Hatcher and Barends (1996) found that a single factor accounted for over two-thirds of the variance in patient ratings of the alliance. Different operationalisations of the alliance are moderately to highly inter-correlated (Tichenor & Hill, 1989; Bachelor, 1991; Salvio *et al.*, 1992) indicating that they assess the same underlying construct.

This 'global' factor has been further analysed from patient and therapist perspectives using the WAI, CALPAS-P and Penn scales (i.e. HA: Luborsky *et al.*, 1983) in psychodynamic therapy. Although a single factor accounted for a significant part of the variance in both patient and therapist ratings of the alliance, Hatcher *et al.* (1995) found that patients and therapists have different ideas about the nature of the alliance. They reported that patients' ratings of collaboration and helpfulness in treatment diverged from their ratings of agreement on goals and tasks. On the other hand, therapists' views of the extent of collaboration and agreement on goals/tasks were more closely linked. Interestingly, Allen *et al.* (1984) also found that an expert's ratings of the collaboration and relationship aspects of the alliance corresponded highly with each other.

FINDINGS USING THESE SCALES

Influential factors

Factors found to influence a more positive therapeutic relationship include older age (Draine & Solomon, 1996) more service contacts (Klinkenberg *et al.*, 1998) and less severe symptoms (Clarkin *et al.*, 1987; Frank & Gunderson, 1990; Neale & Rosenheck, 1995), in particular hostility (Klinkenberg *et al.*, 1998), but not the type of therapy (Salvio *et al.*, 1992). The sex of the therapist appears to be an influential factor in how therapists respond emotionally to patients with schizophrenia. Stark *et al.* (1992) found that high emotional response was manifested as rejection in male therapists and emotional commitment in female therapists, both of which were associated with higher relapse rates at two-year follow-up. Factors associated with positive patient ratings of the alliance in cognitive therapy were encouragement and awareness in the initial phase, personal insight and talking to someone who understands in the working phase and self-understanding and problem solution in the discharge phase (Svensson & Hansson, 1999a). Meanwhile, therapist strategies found to differentiate improved alliances (and outcome) and unimproved alliances (and poor outcome) were addressing the patients' defences and their problematic feelings in relation to the therapist rather than avoiding them (Foreman & Marmar, 1985).

Predictive value

The predictive value of the TR has been the subject of most research in this area. Studies that linked the relationship to outcome are listed in Table 2 with information pertaining to the

study sample, alliance measure used, rater of the alliance, the nature of the treatment, follow-up period and findings. An association between a better therapeutic relationship and improved outcome has been found in the treatment of people with depression (Krupnick *et al.*, 1996; Weiss *et al.*, 1997; Gaston *et al.*, 1998), addictive disorder (Luborsky *et al.*, 1985) psychosis (Frank & Gunderson, 1990; Priebe & Gruyters, 1995; Tattan & Tarrier, 2000), post-traumatic stress disorder (Marmar *et al.*, 1986) and in mixed diagnostic groups (Hansson & Berglund, 1992; Neale & Rosenheck, 1995; Solomon *et al.*, 1995; Klinkenberg *et al.*, 1998). This finding holds across different settings, i.e. in-patient (Clarkin *et al.*, 1987; Frank & Gunderson, 1990; Hansson & Berglund, 1992; Svensson & Hansson, 1999b) and out-patient treatment (e.g. Gehrs & Goering, 1994; Neale & Rosenheck, 1995; Solomon *et al.*, 1995; Krupnick *et al.*, 1996; Gaston *et al.*, 1998; Klinkenberg *et al.*, 1998).

Outcome criteria assessed in these studies ranged from symptom severity (Clarkin *et al.*, 1987; Tattan & Tarrier, 2000) and quality of life (Solomon *et al.*, 1995; McCabe *et al.*, 1999) to social functioning (Neale & Rosenheck, 1995) and time spent in hospital over a 20-month follow-up period (Priebe & Gruyters, 1995). With respect to hospital treatment the strength of the alliance was found to be correlated with a better outcome at discharge (Hansson & Berglund, 1992), three months follow-up (Gehrs & Goering, 1994) and two-year follow-up (Solomon *et al.*, 1995). A poorer alliance at admission to hospital was also found to predict violent behaviour during the first week of hospitalisation (Beauford *et al.*, 1997). Contrary to research in psychotherapy where patient ratings of the alliance have greater predictive validity than therapist ratings (Horvath & Symonds, 1991), a stronger association has been found between therapist rather than patient ratings and outcome in the treatment of depression (Weiss *et al.*, 1997) and schizophrenia, psychosis or major affective disorder (Gehrs & Goering, 1994; Neale & Rosenheck, 1995).

Given that high EE among family members appears to be a consistent predictor of poorer patient outcome in schizophrenia and other disorders (Kuipers & Bebbington, 1988; Kavanagh, 1992; Moore & Kuipers, 1992), the concept has since been applied to staff-patient interactions (e.g. Moore *et al.*, 1992; Kuipers & Moore, 1995; Tattan & Tarrier, 2000). Staff in high EE relationships were found to leave negative feelings of the patient unchallenged (Moore *et al.*, 1992) and were more likely to criticise aspects of the patient's personality (Kavanagh, 1992). Interestingly, low criticism was associated with the belief that the patient's problems were a result of their illness and high criticism with attributing problems to the person's personality. In a recent study however, Tattan and Tarrier (2000) found that high EE among case managers was not associated with clinical outcome, although a global assessment of a positive case manager-patient relationship was.

DISCUSSION

Research on the alliance in the treatment of severe mental illness has adopted conceptual frameworks and measures developed for psychotherapy. These measures appear to have acceptable psychometric properties, in particular reliability, when used in mainstream psychiatric treatment. With respect to the validity of the construct assessed, the few relevant studies suggest the existence of one general factor accounting for approximately two-thirds

Table 2
Studies of the therapeutic relationship and outcome

Study	Sample	Measure	Rater	Treatment & follow-up	Findings
Marziali <i>et al.</i> (1981)	N = 10 out-patients with PTSD symptoms	TAS	Independent observer	12 sessions psychotherapy	Patient contribution to alliance discriminated outcome but therapist contribution did not
Luborsky <i>et al.</i> (1983)	N = 20 non-psychotic psychiatric out-patients	HACs	Observer (transcripts)	≥ 25 sessions psychotherapy	Early positive signs of alliance moderately correlated with rated gains
Marziali (1984)	N = 42 neurotic out-patients	TAS	Therapist, client and observer	Outcome at 3 months after 20 sessions psychotherapy	1. Patient & therapist ratings of their own & others' positive contributions predict therapeutic change 2. Increased symptoms associated with a less positive contribution
Allen <i>et al.</i> (1985)	N = 37 mixed in-patients	SATA	Clinician	Admission to discharge: mean stay 10.6 months	Alliance strongly positively correlated with better functioning at discharge
Marmar <i>et al.</i> (1986)	1. N = 10 PTSD 2. N = 52 PTSD/severe adjustment disorder	TARS	Independent observer	'Time-limited' psychotherapy	1. Positive patient contribution to alliance predictive of good outcome but not therapist 2. Negative patient contribution correlated with increased pathology
Clarkin <i>et al.</i> (1987)	N = 96 mixed in-patients	TA Rating Scale	Expert raters on basis of chart material	Admission to discharge	Alliance at admission was a significant predictor of GRAS score at discharge
Luborsky <i>et al.</i> (1985)	N = 110 drug use disorder	HA Manual (Luborsky <i>et al.</i> , 1983)	Observer (transcripts)	Outcome 7 months after 12-16 sessions psychotherapy or counselling	Strength of alliance strongly correlated with outcome
Frank & Gunderson (1990)	N = 122 SZ in-patients	PSR	Therapist	2 years psychotherapy initiated before discharge from hospital	A better alliance formed in first 6 months associated with greater treatment acceptance & better outcome
Hansson & Berglund (1992)	N = 106 MMI mixed in-patients	2 items	Clients	Admission to discharge	A better alliance related to a better outcome at discharge from hospital
Stark <i>et al.</i> (1992)	N = 34 ICD-9 SZ out-patients	TPRS	Therapist and client	Outcome after 2 years & alliance rated at end of 12 sessions (weekly)	Higher relapse rates when therapist rated high on emotional response (i.e. rejection/commitment)
Priebe & Gruyters (1993)	N = 72 chronic psychotic out-patients	HAS	Client	20 months of routine community care	A more positive view of the alliance was correlated with less time in hospital over follow-up

Gehrs & Goering (1994)	N = 22 DSM-III-R SZ/SA out-patients	WAI	Therapist and client	Outcome after 3 months of active rehabilitation	Significant correlation between alliance & outcome early in therapy & at 3 months
Neale & Rosenheck (1995)	N = 143 DSM-III-R MMI mixed out-patients	WAI	Therapist and client	Alliance & outcome rated after 2 years intensive case management	Case manager rating of alliance correlated with 5 of 6 outcome measures (not client rating)
Solomon <i>et al.</i> (1995)	N = 96 DSM-III-R MMI mixed out-patients	WAI	Therapist and client	Alliance & outcome rated after 2 years intensive case management	At 2 years, significant correlation between alliance & outcome (more so with subjective measures)
Krupnick <i>et al.</i> (1996)	N = 225 major depression	VTAS - modified version	Independent observer	16-20 sessions psychotherapy; pharmacotherapy over 16 weeks	Patient contribution accounted for 21% of the outcome variance
Beauford <i>et al.</i> (1997)	N = 328 major mental illness	TA Rating Scale	Expert rater	First week of admission	Patients with a poor alliance were more likely to display violent behaviour
Weiss <i>et al.</i> (1997)	N = 31 DSM-III-R major depression	CALPAS	Therapist and client	11.5 months (1 session per month) of pharmacotherapy	Therapist perceptions of alliance predicted 41% of variance in outcome measures while patient perceptions predicted 25%
Gaston <i>et al.</i> (1998)	N = 120 out-patients with major depression	CALPAS	Independent observer	16-20 sessions psychotherapy over 12 weeks	Stronger alliances (in particular working strategy consensus) were associated with a better outcome
Klinkenberg <i>et al.</i> (1998)	N = 105 MMI mixed out-patients	HAM	Client	14 months of intensive case management	3 significant baseline predictors of the alliance at 2 months (race, hostility & needs) & 1 (consumer satisfaction) at 14 months
McCabe <i>et al.</i> (1999)	N = 90 SZ first-admitted patients & 176 in- & out-patients	HAS	Client	First-admitted followed up after 9 months & long-term after 1.5 years of routine care	A significant relationship between therapeutic relationship & quality of life in long-term but not first-admitted patients at baseline & follow-up
Svensson & Hansson (1999b)	N = 26 mixed in-patients	PSR	Therapist and client	Twice weekly sessions cognitive therapy over on average 62 weeks	Therapist ratings of initial alliance were significantly positively related to outcome at discharge
Taitan & Tarrier (2000)	N = 158 severe psychosis	Five Minute Speech Sample	Case manager	6-9 months case management	A positive relationship was associated with a better outcome - less positive & negative symptoms & social disability

Notes: MMI: major mental illness; PTSD: post-traumatic stress disorder; SZ: schizophrenic disorder; SA: schizoaffective disorder

of the relationship variance (i.e. Salvio *et al.*, 1992; Stark *et al.*, 1992; Hatcher *et al.*, 1995; Hatcher & Barends, 1996). In addition to a large general factor, there may be specific features of the therapeutic relationship in these settings that need to be considered.

The setting and role of the therapist in the treatment of severe mental illness are less clearly defined than in psychotherapy. The therapist practices in a variable organisational setting including in-patient wards, out-patient clinics, community mental health centres and the patient's home. In psychiatry there is rarely a fixed duration of treatment, which can often last a lifetime. The professional tasks in caring for a patient with long-term mental illness are heterogeneous, spanning treatment, rehabilitation, prevention of relapse and accessing services (Thorncroft, 1991). The statutory responsibilities for care and the requirement to monitor patients in the community (i.e. outside of the places where 'treatment' traditionally takes place) mean that many 'therapeutic relationships' are initiated and maintained not by the patient but by the mental health professional, a feature of assertive outreach models of care and all forms of 'compulsory treatment'. In this situation, there is often a conflict between the client's and therapist's perspective of what treatment is required. In psychotherapy, while the client's and therapist's perspectives may not coincide early in treatment, they are increasingly likely to agree as therapy proceeds and are particularly likely to agree during the later stages of therapy (Horvath, 1994). However, Svensson and Hansson (1999a) found that concordance between patient and therapist ratings did not increase over time in psychiatric treatment.

As the therapeutic relationship is a subjective construct, it may overlap with other subjective outcome evaluation criteria (e.g. Fakhoury *et al.*, 2002). Both conceptually and methodologically, the therapeutic relationship is intertwined with treatment satisfaction, which is typically viewed as a central outcome criterion. Treatment (whatever the components may be) is delivered through the relationship and the relationship itself is an integral element of treatment. Indeed, some therapeutic relationship scales explicitly assess satisfaction with treatment (e.g. CALPAS, HAS) and some satisfaction scales assess the therapeutic relationship (e.g. Druss *et al.*, 1999). Such items seem to have acceptable internal consistency with other therapeutic relationship items and empirical studies consistently show that the two constructs are positively inter-related (Solomon & Draine, 1994; Neale & Rosenheck, 1995; Solomon *et al.*, 1995; Klinkenberg *et al.*, 1998; Tattan & Tarrier, 2000).

Another construct of relevance to the therapeutic relationship in the treatment of severe mental illness is insight. Indeed, insight, perceived need of treatment and treatment involvement comprise the three dimensions assessed by the Therapeutic Alliance scale (Clarkin *et al.*, 1987). While insight may be measured in different ways depending on the underlying theoretical framework (Markova & Berrios, 1995), how the person makes sense of their experiences is fundamental to therapeutic interaction (McCabe & Quayle, 2002). Not surprisingly, if there is a mismatch between the patient and clinician in their assessment of the problem, patients are less satisfied with their care (Barker *et al.*, 1996). There is increasing interest in explanatory models of illness, i.e. the patient's view of their illness and its meaning to them, in promoting positive collaboration and communication between clinician and patient (e.g. Callan & Littlewood, 1998; Bhui & Bhugra, 2002). We found in a UK study that a biological explanatory model was related to enhanced treatment satisfaction and TRs (McCabe & Priebe, in press). Given that the predominant treatment model (being medication based) is biological, this suggests that concordance between patients and professionals contributes to an enhanced

TR. As a means of assessing patients' potential for forming a therapeutic alliance, Rosenberg and Kesselman (1993) asked the patient about the nature of their illness in the psychiatric emergency room and found that the question itself (along with others) was relationship building. In a similar vein, Frank and Gunderson (1990) found that a better therapeutic relationship after six months of treatment was associated with less denial of illness.

CONCLUSIONS

All measures of the TR identified in this review assess the bond between the client and therapist along with their collaboration, although in slightly different ways. As in psychotherapy, the therapeutic relationship has repeatedly been shown to have predictive power in relation to treatment outcome. Whether all of the scales developed for psychotherapy are equally applicable to the treatment of severe mental illness is questionable. However, there may be no such thing as the ideal assessment of the therapeutic relationship. The most appropriate method may rather depend on the purpose of the assessment. For example, studies investigating how therapeutic relationships are influenced by service structure or training interventions may warrant different assessments than studies identifying which relationships are helpful and effective with which patients and in which situation.

In mental health research, the relevance of the therapeutic relationship lies in its role first as an independent predictor of treatment outcome, second as a mediating factor that captures significant variance in the outcome of treatment interventions (Frank, 2000; Priebe, 2000), such as pharmacological therapies and finally as an outcome criterion in its own right (Priebe & Gruyters, 1999). Valid assessments may need to take account of the differences from conventional psychotherapy outlined herein. Specific research may be crucial to advance our understanding of the patient-clinician relationship in the treatment of severe mental illness and ensure a valid assessment of this central component of treatment.

NOTE

1. The CALPAS was preceded by the TAS (Marziali *et al.*, 1981) which, in turn, was preceded by the TARS (Marmar *et al.*, 1986).

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