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The therapeutic relationship and patients' experience of interpersonal bonds – research conducted in outpatient mental health care

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Summary

Aim. To study the therapeutic relationship in community mental health care, in terms of patients' socioeconomic status and their experience of interpersonal bonds.
Method. Research study included patients treated in community mental health care (N=64) who met the criteria for psychosis, and the professionals who managed their treatment. Patients' psychotic symptoms were measured with the use of the PANSS scale, whereas the STAR scale was used to assess the therapeutic relationship, in separate models for evaluating patients and clinicians. The patients' socioeconomic data was collected, as was information about the therapists.
Results. Patients' experience of bonds, understood as a current or past marriage or parenthood, correlated positively with their views on the therapeutic relationship. Patients assessed therapeutic relationships more favourably than their therapists. Therapists assessed the therapeutic relationship in the "positive clinician input" dimension more favourably than did financially independent patients.
Conclusions. Patients' experience of interpersonal bonds enhances their chances of establishing a successful therapeutic relationship and it also contributes to establishing a good therapeutic relationship in the opinion of therapists.

therapeutic relationship / schizophrenia / outpatient mental health care

INTRODUCTION

The therapeutic relationship is the key element responsible for the efficiency and success of help given to mentally ill patients. Research into the factors which affect the therapeutic relationship may help in recognizing the areas which require the provision of support, training and supervision to professionals in order to raise their working standards. Mental health care cannot even exist without the concept of the therapeutic relationship. In fact, the quality of the connection between patient and therapist correlates with the course and results of treatment, and predicts the formation of a therapeutic attachment [1, 2]. In social psychiatry there is a discussion about the central role of the relationship between a patient and therapist in the treatment process, as the ties established between the two in the course of treatment are an integral element of community care and are crucial, to a large extent, to its efficiency and the progress of treatment. Cechnicki, quoting Bleuler, says that a stable relationship with another person is an essential ingredient of treatment targeting the essence of schizophrenia [3]. In this study, we shall discuss the therapeutic relationship in McGuire's understanding of the term [1], where it is thought of as the evaluation by the patient and the therapist of the extent to which their cooperation is positive, where the patients evaluate both positive

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input by therapists and interventions that fail to provide support and the therapists talk of emotional difficulties in their work with patients. This approach has been especially prepared for the needs of the evaluation of community mental health, with its unique role of accompanying patients with persistent psychotic symptoms in their everyday lives.

In mental health care, especially in the community care approach, a therapist faces the task of establishing a relationship with his patient, predicated on long-term, mutual cooperation. It is believed that such a therapist should be able to inspire trust in his patients, consider their authority and maintain safe boundaries around their relationship [4]. A therapist should ensure autonomy and independence in the relationship between himself and the institution he represents on the one hand, and a patient who would have been using various healthcare institutions for years on the other. A therapist should recognize and try to understand his patient's experience, being at the same time tolerant of psychopathology and optimistic as far as the prospects of recovery are concerned. In the literature on the subject there are some opinions to the effect that it is hard to establish a good therapeutic relationship with psychotic patients because of their illness and past experiences [5]. A good example of such difficulty can be mistrust displayed by patients or the delusionary character of some of their beliefs. In such situations therapists may find it difficult to respond empathetically to the delusionary experiences of their patients.

Patients indicate that the psychotherapy process is helped by the feeling of being understood by a therapist, supported in arriving at insights, supported in a more general sense, confronted in all honesty, and also being shown a certain level of care and interest [2]. A relationship understood in this way can be practically applied not only in community treatment but in all forms of psychiatric care, both institutional and ambulatory.

Unfortunately, the Polish system is still dominated by the hospital-oriented model, with psychiatric hospitals being the main place of treatment. It is, after all, impossible to carry out so-called "active care" [6] in outpatient clinics. Additionally, there has been an increase in the number of beds in long-term psychiatric care, e.g. in various care and treatment centres [7]. Załuska emphasises that this trend points towards the presence of a trans-institutionalisation mechanism, and indicates that it is necessary to study the reasons behind it.

One of the attempts to reform this situation is the idea that family doctors or general practitioners take responsibility for the early detection and preliminary treatment of non-psychotic disorders, such as neurosis, adjustment disorders or depression [8]. Psychiatric consultants and psychologists who work in regional mental health centres may assist this process. According to this concept the diagnosis, treatment and rehabilitation should be carried out by mental health clinics, in cooperation with community health care teams. Such a model of care is becoming an alternative to institutional treatment in psychiatric hospitals. Defining the level of the therapeutic relationship may also be an expression of one of the efforts to evaluate the efficiency of community health care [6] and treatment in outpatient clinics.

In this research, it has been accepted that in order to understand the quality of the therapeutic relationship between psychotic patients and their therapists, it is important to consider both their experience of other relationships and the socio-economic context they live in. The therapeutic relationship is more than anything a relationship with another person, and it seems that the ability to have relationships with others may be indicative of the patient's overall capacity to form attachments. It seems that a simple division into psychotic/non-psychotic may be insufficient here to evaluate the patient's receptivity to therapy, and so other parameters which may play a role in the therapeutic process should be studied.

Mentally ill patients still meet with social exclusion, which leads to their lowered social-economic status. Giving consideration to socio-economic context is the result of thinking which presupposes that there might be other factors significant in the process of entering into the therapeutic relationship than the dimension of experiencing interpersonal bonds. Besides, by considering a broader context we can understand the therapists' complex relationships with their patients more fully. The introduction of socio-demographic variables into the research is

an attempt to show the significance of the entire context of the therapeutic relationship, which is particularly important in the forms of community care that consider it to be significant information.

The following research hypotheses were put forward:

1. Patients' experience of close interpersonal relationships (bonds) correlates favorably with the way they enter a therapeutic relationship.
2. Professionals evaluate their therapeutic relationship with patients who have had the experience of interpersonal bonds higher than with those that have not.
3. Therapists' and patients' evaluations of therapeutic relationship are similar.

The following research question was proposed:

Does the level at which patients function correlate with their evaluation of therapeutic relationship and with the evaluation of the relationship by the professionals in charge of their treatment?

METHOD

The PANSS scale was used to evaluate the patients' mental condition and the STARR scale to measure the therapeutic relationship in the version for patients and therapists. The questionnaire, described in detail elsewhere [9], was designed to investigate the relationship in the community context of the dimension of positive cooperation, the therapist's positive input and interventions which are seen by patients as non-supportive, as well as therapist's emotional difficulties.

The researched group comprised the patients who remained under the supervision of a community care team that offered active ambulatory care and home visits. The patients' therapists were also in the researched groups i.e. psychiatrists, psychologists, nurses and other therapists.

All 10 therapists selected for the research agreed to participate in it, among them 9 women. The average age of therapists was 39 with an average length of professional career of 13 years, including 6 years in the researched centre. 7 of the therapists had a first degree specialism in clinical psychology.

As far as the patient group is concerned, 64 took part in the research, including 39 women and 23 men; 2 participants failed to provide the information about their sex. The average age in the group of patients was 37. It included 8 people with a vocational education, the greatest number i.e. 31 with a secondary or incomplete higher education and 24 with higher education. 40 out of the 63[1] researched patients declared themselves to be financially independent. 35 of the patients were unmarried, 15 in a relationship and 13 were divorced or widowed. 36 people declared that they supported young children. 43 patients were certified disabled, among them 6 with a grade[2] 1 disability, 25 with grade 2 and 5 with grade 3.16 people worked professionally for a living or studied, 11 were retired, 36 were unemployed or received benefits. The average size of their accommodation was approximately 29 m^2 per family member (Tab. 1 – *next page*).

37 people were diagnosed with schizophrenia, 8 with bipolar affective disorder or unipolar depression; 10 people were diagnosed with schizoaffective disorder (Tab. 2 – *next page*).

RESULTS

1. Results of the research on the therapeutic relationshis.

In community care, the mean general score in the STAR-P scale was M=39.49 (SD=00.97); in the dimension of positive cooperation with a therapist the mean score was M=19.79 (SD=0.53); in the aspect of the therapist's positive input M=8.99 (SD=0.33), and in non-supportive interventions M=10.69 (SD=0.27). The general mean score on the STAR-C scale was M=34.81 (SD=0.58). In the positive cooperation scale the mean score was M16.80 (SD=0.35), in the scale of the therapist's

[1] One person did not declare the financial status.

[2] Disability grades in Poland: Grade 1 – advanced disability (incapacity to work or live independently), Grade 2 – moderate disability (e.g. need for temporary or partial help from others in order to function properly), Grade 3 – low level disability (lower capacity for work which can be compensated for with special aid)

Table 1. Socio-demographic data for the researched group

Characteristics		N (n=63)	% (n=63)
Men		23	36
Women		40	64
Age (M)		37	58
Education	Vocational	8	13
	Secondary	31	49
	Higher	24	38
Financial independence		40	63
Marital status	Single	35	55
	In a relationship	15	24
	Divorced/widowed	13	21
Dependent children		36	57
Disability certificate		43	68
In professional employment/education		16	25
Retired		11	17
Disability benefit/unemployed		36	57

Table 2. Diagnoses in the research group

Diagnosis	N	% (n=63)
Schizophrenia	37	58.7
Bipolar affective disorder or unipolar depression	8	12.6
Schizo-affective disorder	10	15.8

Table 3. Mean values, values of standard deviations, minimum and maximum of therapeutic relationship according to patient and according to therapist

Therapeutic relationship	Mean M (N=63)	SD
Patient's evaluation (general)	39.4	0.97
Positive cooperation according to patient	19.7	0.53
Positive input according to patient	8.9	0.33
Non-supportive input according to patient	10.6	0.27
Therapist evaluation (general)	34.8	0.58
Positive cooperation according to therapist	16.8	0.35
Emotional difficulties according to therapist	9.1	0.17
Positive input according to therapist	8.8	0.14

emotional difficulties in his cooperation with a patient M=9.13 (SD=0.17), and in the scale of the therapist's positive input M=8.87 (SD=0.14) (Tab. 3).

2. Results of the research on correlation between the therapeutic relationship and the patient's experience of interpersonal bonds.

In order to investigate a relationship between the therapeutic relationship and the patient's experience of bonds the Kruskall-Wallis test (χ^2) was used. The experience of the patient of a close interpersonal relationship is understood here as a current or past marriage, having grown up or dependent children.

In community care, a crucial correlation between marital status and the evaluation by patients of their therapist's positive input (χ^2 =8.00, df=2, $p<0.05$) was observed; married patients evaluated their therapist's input higher than the unmarried patients.

An essential link between having children and the evaluation of a therapist's positive input was also indicated (χ^2 =6.46, df=2, $p<0.05$); patients who had two children noticed more positive interventions of therapists than patients who had no children.

A statistically significant correlation was also found between the number of dependent children and the evaluation of positive cooperation by therapists (χ^2 =5.10, df=1, $p<0.05$); therapists evaluated cooperation with patients who had dependent children as better than with patients who did not have any children.

A significant correlation was noted between the patients who have children and the therapist's evaluation of emotional difficulties (χ^2 =8.96, df=2, $p<0.05$); therapists experienced more emotional difficulties with patients who had no children than with patients that had two children. Similarly, therapists experienced more emotional difficulties with patients who had one child than with the patients who had two children (Tab. 4 – *next page*).

3. Results of the research on a comparison of the patients' and therapists' evaluations of the therapeutic relationship.

The Wilcoxon rank-sum test (with Mann-Whitney continuity correction) was applied to answer the question about the differences in the evaluation of the therapeutic relationship by patients and therapists.

Table 4. Values of the level of therapeutic relationship in terms of the variables of patient's experience of close interpersonal bonds

Therapeutic relationship	grouping variables	χ^2	Df	p value
STAR-P (patient's evaluation)				
Positive input	Marital status	8.0	2	0.05
	Number of children	6.4	2	0.05
STAR-C (therapist's evaluation)				
Positive cooperation	Number of dependent children	5.1	1	0.05
Emotional difficulties	Having children	8.9	2	0.05

In community care, patients' opinions differed significantly from the opinions of the professionals. A statistically significant difference was observed in the evaluations of the general therapeutic relationship by patients and therapists (W=2522, p<0.001), where patients judged it to be better than therapists. However, no significant differences were observed between the patient's and therapist's evaluation of positive inputs by therapists. (W=21435.5, p=0.13). There were, however, significant differences between the patients' evaluation of non-supportive interventions and the therapists' evaluation of experiencing emotional difficulties (W=2944, p<0.001), where patients observed more non-supportive interventions than therapists did emotional difficulties (Tab. 5).

Table 5. Comparison of patient's and clinician's therapeutic relationship

STAR P/ STAR C	W (Wilcoxon)	p value
theraputic relationship (overall)	2522	0.001
positive cooperation	2721.5	0.001
positive input	2143.5	0.13
non-supportive input/emotional difficulties	2944	0.001

4. Result of the research on a correlation between the therapeutic relationship and the degree to which a patient functions well.

The relationship between a patient's age, sex and the therapeutic relationship was investigated with the use of the Kruskal-Wallis test (χ^2). A significant correlation was observed between a patient's sex and his or her evaluation of non-supportive interventions (χ^2 =4.69, df=1, p<0.05), where women felt that there were more non-supportive interventions than men. We also observed a correlation between a patient's sex and the evaluation of the therapeutic relationship by therapists (overall score) (χ^2 =4.18, df=1, p<0.05). Therapists valued the relationship with women higher than with men (Tab.6).

The Kruskal-Wallis test (χ^2) was also used to investigate the relationship between a patient's socio-economic status and the therapeutic relationship. Lower socio-economic status was understood as lower education, smaller flat, lack of employment or being on benefits, lower income and being financially dependent on others.

Table 6. Values of the level of therapeutic relationship in terms of patient's sex (*p<0.05)

Therapeutic relationship	grouping variable	χ^2	Df	p value
therapeutic relationship (patient's evaluation)	patient's sex	1.22	1	0.26
positive cooperation (patient's evaluation)		1.42	1	0.23
positive input (patient's evaluation)		0.24	1	0.62
non-supportive input (patient's evaluation)		4.69	1	0.03*
therapeutic relationship (therapist's evaluation)		4.18	1	0.04*
positive cooperation (therapist's evaluation)		3.38	1	0,06
emotional difficulties (therapist's evaluation)		3.77	1	0.06
positive input (therapist's evaluation)		0.95	1	0.32

A significant correlation was observed between a patient's financial independence and a therapists' evaluation of their positive input (χ^2 =4.10, df=1, p<0.05); therapists evaluated their positive input higher in cases of patients who were financially independent than in cases of those who were financially dependent on others (Tab. 7 – *next page*).

Table 7. Values of the level of therapeutic relationship in terms of patient's financial independence (*p<0.05).

Therapeutic relationship	grouping variable	χ^2	Df	p value
therapeutic relationship (patient's evaluation)	patient's financial independence	0.05	1	0.81
positive cooperation (patient's evaluation)		0.40	1	0.52
positive input (patient's evaluation)		0.14	1	0.70
non-supportive input (patient's evaluation)		0.67	1	0.41
therapeutic relationship (therapist's evaluation)		3.64	1	0.05
positive cooperation (therapist's evaluation)		3.79	1	0.05
emotional difficulties (therapist's evaluation)		0.57	1	0.45
positive input (therapist's evaluation)		4.10	1	0.04*

DISCUSSION OF RESULTS

Patients' experience of close interpersonal bonds, understood as being or having been married and having children, correlated with a patient's evaluation of the therapeutic relationship. A correlation was observed between a patient's having had an experience of interpersonal attachments and entering into a therapeutic relationship. Patients who have had an experience of a relationship, whether it is a current or past relationship, or are widowed, and patients who have children evaluated the positive input from their therapists more highly. A relationship with another person, a grown up or a child creates an attachment and, through it, the interpersonal experiences which later positively contribute to entering into and maintaining a therapeutic relationship. The assumption is that they also contribute to a more realistic evaluation of a therapist's interventions and being more prepared to evaluate a therapist's intervention subjectively and positively [4]. McCabe et al. [10] presume that a therapeutic relationship may develop in a way similar to other relationships, for example relationships with friends. It is possible that similar patterns of behaviour are characteristic of various relationships developed by a person. New relationships are after all formed on the basis of prior experiences of relationships with others.

Therapists of the patients who have a dependent child evaluated the cooperation with them as better. Besides, therapists experienced more emotional difficulties with the patients with no children, as compared to those who have two dependent children. It is not only that the patients who have had the experience of attachment see their therapeutic relationship as better than those without such experience, but also that the therapists find it easier to work with such patients.

Patients, when compared with therapists, valued their therapeutic relationship and positive cooperation more highly (overall score), but they were harsher in evaluating the non-supportive interventions of their therapists. Generally speaking, patients might have a tendency to place a high value – perhaps even too high a value – on their cooperation with therapists, and see it as better than their therapists do; but the important observation here is that these patients were also sensitive to the symptoms of the therapist's impatience, e.g. making demands on them or being insincere, and evaluated it more strictly than the therapists themselves. These differences in evaluation by patients and therapists may have important practical implications; for example they may call for a need of therapists to pay more attention to their own impatience, tiredness or judgement of a patient.

The analysis of correlations between the therapeutic relationships and socio-demograph-

ic parameters has revealed that they are linked with the patients' sex and socio-economic status, which may have additional implications for clinical practice.

Some interesting observations were made about the correlations of patient's sex and age with the therapeutic relationship. Women, in comparison to men, were stricter in evaluating their therapists' non-supportive interventions. It is also the case that they more frequently thought that their therapists concealed the truth from them, or were too demanding when they talked about the matters that were important to them and their overall situation. Women also felt more frequently that their therapist was impatient with them. Perhaps the issues relating to sincerity, understanding and patience are especially important to women in their relationships with therapists. Therapists also evaluated their therapeutic relationship (overall score) with female patients better than with men. Psychoanalytical research has revealed that women who are in psychotherapy appreciate relational values more, and that standards of cooperation and reliability are important to them [11]. Men choose non-personal issues in psychotherapy, express their struggle for domination and autonomy, and openly display confrontational and aggressive content. This means that the interest in relationships and forming attachments are specifically female characteristics. Other research has shown that men find it more difficult to express emotions and find it harder to reach for professional help in relation to their problems [5]. In the course of socialization and upbringing and the creation of the patterns of emotional attachments and relations, men are taught not to discuss their weaknesses, not to express and not share their experiences but instead to solve problems.

As one of the dimensions of the therapeutic relationship, therapists see their positive input as more effective with financially independent patients. Financial independence indicates the level at which patients function socially. Unemployed patients and those who do not work for health reasons function worst. Other research shows the beneficial impact of social adjustment on the quality of the therapeutic relationship [12], and financial independence is one of the signs of good social adjustment. The literature on the subject also indicates that people who earn more money have better skills for finding the services available in the system and reach out for the help they need [13, 14]. People who are coping better financially and in the area of mental health have opportunities to reach for the necessary sources of social support [15], a successful relationship with a therapist being one of them.

CONCLUSIONS

1. The experience of interpersonal bonds makes it easier for patients to establish a successful relationship with a therapist.
2. Patient's experience of interpersonal bonds also makes it easier for therapists to establish cooperation with them.
3. Therapists describe their therapeutic relationship with patients who function better socially, i.e. financially independent patients, as better.
4. It is possible that patients overestimate their evaluation of the therapeutic relationship with a therapist in charge.

LIMITATIONS OF THE RESEARCH

One of the limitations of the research discussed here is the small research sample, which makes it difficult to fully generalize the results to the population of patients treated in outpatient mental health care. Further research should investigate a group balanced as far as the children, marital status and socio-economic status are concerned, in order to review the results indicating the correlation between the experience of interpersonal bonds and social functioning on the one hand and the therapeutic relationship on the other.

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