Understanding and Assessing the Therapeutic Relationship in Community Mental Health Care

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Abstract

The clinician-patient relationship is at the core of community mental health care and impacts on outcome, but no instrument has been specifically developed for its assessment. Existing scales have either unproven psychometric properties in community mental health care settings, or have been designed for other therapeutic settings, or both. My aim in this thesis is to develop a scale to assess the therapeutic relationship in community mental health care (STAR) that has both clinician and patient versions. In part one, understanding the therapeutic relationship in community care, I considered the rationale for mental health care in the community and explore theoretical presuppositions, pre-existing measures, and influences on the therapeutic relationship. In part two, assessing the therapeutic relationship in community care, I developed an assessment tool in four stages. In stage one I generated an item pool using semi-structured interviews and existing scales. In stage two I administered this item pool to 133 community care patients and their 26 clinicians. I constructed subscales based on principal components analyses. In stage three, for final item selection, I assessed retest-reliability. In stage four the scales were administered to a new sample of 180 patients and their 84 clinicians. The factorial structure of the scale was confirmed with a good fit. The end result is both a patient and clinician version of STAR which has 12 items comprising 3 subscales: positive collaboration (6 items) and positive clinician input (3 items) in both versions, non-supportive clinician input in the patient version and emotional difficulties in the clinician version (3 items each). Psychometric properties are satisfactory. STAR is a specifically developed, brief scale to assess therapeutic relationships in

community care. The two versions cover three similar factors each, and may be used in research and routine care.

Chapter 1

From asylums to community care

In the 1860s Union Poor Law infirmaries were built to accommodate a rapidly growing population of sick and disabled people in urban areas of England (Freeman, 1999). Most infirmaries had a 'mental block' or observation unit where mentally ill people were admitted and then discharged or transferred to an asylum. In 1924, a number of reforms were proposed by the Royal Commission on Mental Illness that were embodied in the 1930 Mental Treatment Act (Freeman, 1999). This permitted voluntary admission to mental hospitals and the establishment of outpatient hospitals. The concept of public health services began during the Second World War when the coalition government accepted the principle of a free health service for the whole population (Freeman, 1999).

In 1948 the NHS came into being, taking over care in mental hospitals. Most staff at these hospitals consisted of a superintendent, a deputy and some assistant medical officers – few of whom had training, apart from informal apprenticeship. The post-war years saw a flooding of voluntary patients into mental hospitals. To accommodate for the problems of overcrowding and understaffing mental nursing was introduced (Freeman, 1999).

The 1959 Mental Health Act recommended a reorientation from institutional care and the expansion of community accommodation and social work. It was further recommended that National Assistance grants be made available to people either in the hospital or in the community and that the Medical Officer of Health should be responsible for directing local authority community services (Freeman, 1999). Recommendations were also made that extra powers were granted for local authorities in the care of the mentally ill in the community.

The 1960s are described as a ‘critical decade’ in psychiatry – beginning with Enoch Powell’s arrival at the Ministry of Health. In his ‘Watertower speech’ Powell threatened to bring ‘fire and brimstone’ on the asylums. The 1962 National Hospital Plan introduced the concept of the District General Hospital, with the aim to incorporate psychiatry as one of the core specialties, thereby reducing the number of mental hospitals (Freeman, 1999). This aim was further developed with the introduction of the 1963 Health and Welfare Plan for Local Authority Services – but it was limited by the fact that the Ministry of Health could not influence local level activity (Freeman, 1999).

The expansion of local services, the local relocation of facilities, and increased staffing were declared objectives of the 1975 White Paper: Better Services for the Mentally Ill, whereby mental hospitals were to be replaced by alternative services before they were closed (Freeman, 1999). There was an 11% growth in the number of staff and attendees of outpatients, a 55% growth in the number of day-patients and a 10% decrease in first admissions to inpatient care between 1970 and 1975. The word ‘community’ became increasingly used to describe what was being attempted (Freeman, 1999).

The intention to specifically promote the discharge of long-stay hospital patients was initiated by the 1981 Care in the Community Initiative, which enabled the transfer of funds to local authorities and voluntary agencies from district health authorities in order to support ex-patients in the community (Walker, 1999). The role of the Approved Social Worker was created by the 1983 Mental Health Act and gave rise to intense in-home treatment for acute mental illness with the aim to improve certain aspects of social functioning and to decrease bed usage for patients cared for in the community (Dunn, 2001).

To provide better care and treatment than traditional specialist hospitals, the 1989 White Paper: Caring for People promoted the use of community health services and locally based hospitals - co-ordinated with services provided by social service authorities, voluntary and private sectors, and carers (Department of Health, 1995). In practice however, community services were seen to be losing contact with patients to meet their complex psychiatric and social needs, so patients did not always receive satisfactory care (Marshall and Lockwood, 1998; Department of Health, 1995).

Community mental health centres were developed to provide the base from which multidisciplinary teams can deliver the bulk of mental health services for a particular community (White et al., 1997). Located in the locality they serve, community mental health centres provide assessments, crisis intervention, and case management (White et al., 1997). The Care Programme Approach for people with a mental illness referred to the specialist psychiatric services was introduced to minimise the possibility of patients losing contact with services and to maximise the effect of any therapeutic intervention by providing continued support for mentally ill people in the community (Department of Health, 1994).

The key elements of this approach include: a systematic assessment of patients' health and social care requirements; a care plan that is agreed between the relevant clinician staff, the patients, and his or her carer(s); the allocation of a clinician who is required to maintain close contact with the patient, to ensure that the agreed programme is delivered, and to take immediate action if it is not; and regular reviews of the patient's progress and his or her health and social care needs (Department of Health, 1994).

The rationale for care in the community is to enable individuals with mental illness to live as 'normally' and independently as possible (Rossler, 1998; Tyrer et al., 1998). It is thought that by sharing in the normal rhythms of daily life, with the opportunity to work and to enjoy privacy in their own homes, patients in the community may have the opportunity to live to their full potential (Rossler, 1998; Tyrer et al., 1998).

To date, the principal co-ordinating mechanism for mental health care in the community is the clinician (or 'key worker' or 'care co-ordinator'): one named person who is responsible to keep in close contact with the patient to ensure that agreed health and social care is given (Department of Health, 1995). The clinician is required to maintain sufficient contact with the patient to advise clinician colleagues of changes in the patient's circumstances that might require review and subsequent modification of the care programme (Department of Health, 1995). Clinicians provide frontline support to patients with severe mental illness in the community.

Community psychiatry is an area that is complicated by heterogeneous treatment goals and components (treatment adherence, rehabilitation, stability rather than change, public safety, prevention of relapse, accessing services), a complex setting (in-patient hospitals, out-patient wards, day hospitals, supported housing and home and office visits with community mental health professionals) and the formal statutory responsibility of the clinicians from different training backgrounds (psychiatrists, community psychiatric nurses, social workers, occupational therapists, psychologists, support workers) who attempt to engage with mentally ill patients who vary according to their clinical diagnoses and symptom severity.

Patients in community care typically have long-term mental health problems, with persistent and severe disturbances of thought, feelings and behaviour as the result of psychotic illness (Repper et al., 1994). This patient population often has a wide range of social, medical and personal needs, and they frequently find it difficult to accept services that may help them to reach and maintain a sufficient level of independence (Repper et al., 1994). It is a unique challenge for frontline community care staff to effectively engage and maintain a good relationship with patients to ensure that adequate care is being given.

While community care may not necessarily result in better clinical outcome compared to hospital-based care, it has been associated with other outcome measures. Trauer et al. (2001) revealed that patients transferred to community care units from long-stay psychiatric hospital changed little in terms of symptoms and disabilities, but showed improved quality of life. In a two-year study by Gater et al. (1997) patients were randomly assigned to a community team that provided case management (n = 52) or hospital-based team management (n = 56). Outcomes for the former were better, in that they had more met needs, fewer unmet needs and greater levels of satisfaction (Gater et al., 1997). In a randomised controlled trial patients were randomly assigned to a community based (n = 82) or hospital based (n = 73) team and followed up one year later (Tyrer et al., 1998a). A range of outcomes (clinical psychopathology, depression, anxiety and social functioning) and costs to providing institutions were considered. The community-based approach was found to be more effective than the hospital-based approach. In review of studies comparing community mental health team (CMHT) management and standard care by Tyrer et al. (1998b) found that the former is associated with fewer deaths by suicide and in suspicious circumstances and less dissatisfaction. However no clear difference was found in admission rates, overall clinical outcomes and duration of in-patient hospital treatment (Tyrer et al., 1998b). A comprehensive search of literature on community mental health team management by Simmonds et al. (2001) found that this type of management is superior to standard care in that it is associated with shorter duration of in-patient psychiatric treatment, lower costs, less dissatisfaction with care and fewer deaths by suicide and in suspicious circumstances. Again, no gains in clinical symptomology or social functioning were found for this type of care (Simmonds et al. 2001). The patient-professional relationship in community mental health care has been shown to predict treatment adherence and outcome Priebe and Gruyters (1993) and quality of life of long-term patients (McCabe et al., 1999). The success of care in the community is contingent on the accumulation of good individual working relationships between patients and clinicians.

Patients with mental disorders who disengage with services tend to have an increased risk of social isolation, suicide, homelessness and number of inpatient days (Musuer et al., 1998). Of those people with mental illness who commit suicide, one-third missed their last appointment with health professionals (Department of Health, 2001). The ability of mental health care professionals to effectively engage and maintain relationships with patients is critical to ensure they do not fall through the net.

Chapter 2

The therapeutic relationship

The therapeutic relationship, also called the helping alliance (Luborsky et al., 1983), the therapeutic alliance (Allen et al., 1988) and the working alliance (Horvath and Greenberg, 1986) – is at the heart of the delivery of mental health care. It is the means by which a clinician hopes to engage with, and effect change in, a patient. While much early work on this subject was generated from a psychodynamic perspective, researchers from other orientations have since investigated this area. Research on the power of the therapeutic relationship now reflects more than 1,000 findings (Orlinsky et al., 1994). A meta-analysis of 24 studies by Horvath and Symonds (1991) revealed a moderate effect size value of .26 (r). An update of this meta-analysis by Martin, Garske and Davis (2000) suggests that the therapeutic relationship is related to outcome (r = .23) across 58 studies. A smaller, but nevertheless notable effect size (r = .11) was revealed in a meta-analysis by Stevens et al. (2000). Horvath and Bedi (2002) presented a summary of research on the alliance outcome relationship, taking into account mediators, moderators or interactions with other variables. The data is in part based on the studies by Horvath and Symonds (1991) and Martin et al. (2000) in addition to 10 studies published between 1997 and 2000 and one prior to 1997. The review suggests that the effect of the alliance on outcome in most treatments is between ES .21 to .25. A meta-analysis of 28 studies published between 1990 and 2000 by Beutler et al. (2004) revealed an effect size of (r) .17. As Beutler et al. (2004) note, the exact contribution of the therapeutic relationship to outcome may be dependent on how it is measured, suggesting that the construct of the therapeutic alliance is in further need of definition and refinement. It may therefore be useful to consider the theoretical presuppositions that have informed this concept to date.

Psychoanalysis

Traditional psychoanalytic thought regards human behaviour as influenced unconsciously by specific life experiences, psychic needs and history (Laine et al., 1998; Clarkin and Levy, 2004). Present difficulties experienced by a person, whatever the symptomology, are regarded as the result of disturbances in early life experience, relationships, or developmental history (Laine et al., 1998; Clarkin and Levy, 2004). These disturbances are retained in expectations, crystallised attitudes, and unknown fears that are brought to newly encountered relationships in the perpetuation of relationship patterns (Wolstein, 1995). The 'transference relationship' consists of the patient and the professional onto whom the patient unconsciously transposes these habitual patterns, unresolved problems, developmental issues, and expectations (through 'transference distortions') (Meissner, 1999; Laine et al., 1998; Wolstein, 1995; Hanly, 1994; Clarkson, 1993; Horowitz and Marmar, 1985; Luborsky, 1976). Counter-transference, transference distortions projected onto the patient by the professional, may also occur, often evoked by the patient's transference symbolisations (Clarkson, 1993).

Sullivan (1953) suggested that personality formation is a function of one's history of key interpersonal relations and their internalisation. Here both the gross and subtle interactions between a child and significant others in the environment reflect personality formation along a continuum between pathological and optimally functioning (Sullivan, 1953). For Sullivan (1953), the opportunity to be in a therapeutic relationship is an opportunity to internalise new experience that may counter the effects of older and more troubled familial interaction.

The quality of a patient's relating in interpersonal relationships (their interpersonal relatedness) has been considered in a number of ways – from examining the history of the patient's interpersonal relationships, to their functioning in current relationships, to their perceptions, beliefs and hopes for relationships, to how they relate to the professional during treatment (Clarkin and Levy, 2004). Interpersonal relatedness has also been framed in terms of the quality of object relations - the characteristic way a person interprets social information based on their lifelong pattern of relationships. This is conceptualised along a continuum from immature to mature relatedness (Clarkin and Levy, 2004).

Attachment theory similarly looks at the influence of the quality of central relationships in childhood on interpersonal functioning in adulthood. According to this theory, infants develop a primary attachment relationship around seven months with the primary purpose of protection from predation (Bowlby, 1987). This attachment forms a secure base for the infant and child to explore his or her environment (Bowlby, 1987). Separation from the attachment figure results in separation protest with efforts towards reunion (Bowlby, 1987). Based on the relationship with his or her attachment figure, an internal working model is developed that provides a cognitive structure for subsequent relationships (Bowlby, 1987). This attachment dynamic is not restricted to childhood, but continues throughout the lifespan (Bowlby, 1987). Ainsworth (1969) developed the strange situation test, a reliable instrument for rating the security of a one-year olds' attachment to his parent. Depending on the primary caregiver's responsiveness, four typical patterns have been identified: secure, insecure-avoidant, insecure-ambivalent and insecure-disorganised (Ainsworth, 1969).

Ainsworth's finding that responsiveness is a crucial determinant of attachment raises the possibility that similar responsiveness can be found in therapy (Holmes, 1993). Like responsive mothers who pick up their babies sooner than unresponsive ones, responsive therapists pick up unconscious or hinted at emotional cues in therapy by patients (Holmes, 1993). Stern's (1985) observations of maternal attunement in successful mother-child conversations (for example, a mother patting a child's back rhythmically in time with his vocal utterances) could also be compared to therapist attunement (for example, the capacity to highlight the metaphorical aspects of the patient's apparently concrete utterances) (Holmes, 1993).

Winnicott (1960) introduced the concept of the holding environment where the patient undergoes regression and the dissolution of a false self with the therapist. From this perspective "the analyst is holding the patient, and this often takes the form of conveying in words at the appropriate moment something that shows the analyst knows and understands the deepest anxiety that is being experienced" (as cited by Meissner, 1999). The patient can facilitate or distort the holding environment – however holding is only possible when the patient allows it (Meissner, 1999).

A related concept is the Kleinian metaphor of containment (Klein, 1974). The metaphor of the container refers to the process by which a parental figure accepts projected distress from the child, contains it, modulates and alters it, and gives the transformed affect back to the child in the form of meaningful comment or holding behaviour (Meissner, 1999; Hamilton, 1989). The therapeutic relationship may similarly provide containment for the patient, who may eventually identify with the containing process itself, and learn to contain his/ her own distressing affect (Hamilton, 1989; Gunderson, 1978). Here, primitive emotions are aroused in therapy via the transference, which, by the modulating attunement of the therapist, become manageable for the patient, rather than split off and projected (Holmes, 1993).

From the perspective of attachment theory, the therapeutic relationship may ideally provide the patient with a reparative/ developmentally needed relationship or may provide the basis for a corrective attachment experience for the patient by providing a specific relationship ingredient that is needed (Lewis, 1998; Clarkson, 1990). To redress old patterns of attachment behaviour, the clinician may modulate patient anxiety and arousal by acting as an affective container by providing information and consistent input, thereby providing a secure base for the patient to recover and eventually move on (Adshead, 1998).

Some psychoanalytic methods focus upon transference processes within the therapeutic relationship, such as the Core Conflictual Relationship Theme (CCRT) (Luborsky et al., 1994); Configurational Analysis (Horowitz, 1994); Structural Analysis of Social Behaviour-Cyclic Maladaptive Pattern (SASB-CMP) (Schacht and Henry, 1994); and Psychodynamic Formulation (Horowitz and Rosenberg, 1994). These measures have been derived from therapist-patient interactions, focus upon the operationalization of transference interactions, are evaluated by clinical judges using qualitative content analysis systems, and have preliminary reliability data to support them and may be useful in clinical practice to assess subconscious patterns that impede the development of an alliance with the therapist (Luborsky et al., 1994; Horowitz and Rosenberg, 1994; Horowitz and Marmar, 1985).

In a study of six patients in time-limited dynamic psychotherapy Foreman and Marmar (1985) found that therapist actions that address initially poor therapeutic alliances and outcome include: addressing the patient's defences, addressing the patient's guilt and expectations of punishment, addressing the patient's problematic feelings in relation to the therapist, and linking the problematic feelings in relation to the therapist with the patient's defences.

A significant inverse relationship was found between the proportion of transference interpretations provided by therapists in short-term psychotherapy and measures of the therapeutic alliance and outcome (Piper et al., 1991a). The authors suggest that this may be due to either the patient feeling criticised by the therapist, and thus withdrawing; or to the therapist's response to his/ her perception of a weak alliance, resistance, negative transference, or other signs of poor outcome (Piper et al., 1991a).

Other studies have examined the effect of transference and counter transference relationships determined by individual history on the therapeutic relationship. Using a Kelly grid with 10 pre-formulated constructs and 10 roles, Hentschel et al. (1997) compared the patient's introjected image of his/ her parents with the image of the therapist to examine the effect of similarity-dissimilarity patterns on the therapeutic alliance revealing that the strength of the alliance depends upon the comparability between the projective helper image and the mother or father image. Patients with an introjected image of a timid-depressive mother, for instance, make use of the therapist's stronger, active, dominant qualities; whereas an introjected image of a non-threatening, depressive father evokes a promising evaluation from the therapist who perceives the patient's need of a strong helper.

Research suggests that the patient's quality of object relations is related to whether the patient remains in and benefits from treatment. From this perspective the quality of past relationships determine interpersonal expectations in the present. Research by Meyer et al. (2001) indicates that there is a relationship between a patient's expectations and their elicitation of helpful versus harmful behaviours from their therapist. Piper et al. assessed the effects of a patient's enduring tendency to establish certain kinds of relations with others using a

Quality of Object Relations scale on the therapeutic alliance using a 6 item Likert-type scale revealing that a stronger 'quality of object relations' rating led to a stronger alliance (1991b). A later study by Piper et al. (2004) found that for high Quality of Object Relations (QOR), an increasing level of alliance was related to benefit, whereas for low-QOR patients, a decreasing level of alliance was related to benefit. These findings emphasise the importance of patients repeating their typical pattern of maladaptive interpersonal behaviour in therapy sessions in the context of the professional working with the transference (Piper et al., 2004).

Psychoanalysis offers clinicians insight into possible causes of difficult patient behaviour that may impede the formation of a therapeutic bond, or a good working relationship, by suggesting that a patient's individual history may inform transference distortions that are brought into play in the patient-professional relationship. In cases of patients with a history of failed or pathological attachment, particular care may be taken to provide a secure base to contain and modulate anxiety experienced by the patient (Adshead, 1998). By regarding challenging patient behaviour as an expression of severe arousal and anxiety, or an inability to seek help in more appropriate ways, mental health care professionals may better tolerate negative feelings elicited by the patient (Hinshelwood, 1999; Adshead, 1998; Watts and Morgan, 1994). It is suggested that negative feelings held by professionals toward patients may be acknowledged openly at staff meetings or support groups to put feelings of counter transference into perspective (Watts and Morgan, 1994); or professionals themselves may recognise instances in which they react to difficult patients by depersonalising or morally judging them, cloaked in a 'scientific attitude' (Hinshelwood, 1999).

The Adult Attachment Interview (AAI) was developed by Main (1990) to study adult attachment. This semi-structured interview aims to reveal feelings about current and past attachments and separations and emotional responses to loss and difficulty (Main, 1990). Secure individuals can give a coherent account of their lives and the capacity to not describe painful events in childhood in a detached way. The insecure-dismissive group tend to be unable to remember much about the past, offering brief comments. Those described as insecure-enmeshed give incoherent and often tearful accounts of painful events in the past.

A secure attachment style appears to facilitate a good alliance. Those characterised by secure attachment perceive themselves to be competent in relationships and expect a positive response from others (Bartholomew, 1997; Griffin and Bartholomew, 1994). By contrast, dismissing patients are often resistant to treatment and have difficulty in asking for and accepting help (Dozier, 1990). Preoccupied attachment has been related to low alliance at the beginning of treatment and higher alliance at the end (Eames and Ross, 2000). Satterfield et al. (1998) found that positive scores on the goals subscale of the Working Alliance Inventory were related to security of attachment.

A study by Kanninen et al. (2000) as cited by Meyer and Pilkonis (2002) found that among Palestinian ex-prisoners, differences in attachment style was related to alliance stability. Where securely attached patients formed relatively stable alliances throughout treatment, patients with dismissing attachment reported deteriorating alliances towards the end of treatment. Those with preoccupied attachment had poor alliance in the middle and strong alliances in the latter stages of treatment.

Whilst the therapeutic relationship may be informed by patterns of transference distortions according to psychoanalytic theory, the patient requires the ego capacity to relate to the professional rationally to effect therapeutic change (Gaston et al., 1994; Hovarth and Luborsky, 1993; Hartley and Strupp, 1983). Freud spoke of the unobjectionable, conscious ("unanstössige") part of the positive transference as the "vehicle of success in psychoanalysis" (1958/1912).

Sterba (1934) introduced the alliance concept to psychotherapeutic literature by referring to the alliance between the therapist and the rational parts of the patient's ego. He used the term "ego alliance" to describe the patient's capacity to oscillate between experiencing and observing in therapy (Gaston and Marmar, 1991; Gaston, 1990).

Zetzel (1970) first used the term "therapeutic alliance" in a discussion of divergent viewpoints regarding transference. Here it was suggested that modifications to the classical psychoanalytic technique are necessary for more difficult patients where the therapist should adopt a more positive attitude and accentuate their real, personal qualities (Hougaard, 1994).

By extension, Greenson (1965) emphasises the relatively non-neurotic, rational relationship that exists between a patient and professional as key to the development of a positive therapeutic relationship. Here, the onus is on the patient to determine the quality of the relationship, namely: the patient's day-to-day motivation; and their capacity to perform therapeutic work in a non-distorted, friendly way. From this perspective, these conditions are necessary for the development of a good working relationship – and may facilitate the therapeutic process - however, they are not sufficient to promote therapeutic change.

In the treatment context, the 'real relationship' that exists between the patient and professional is dependent upon, and reflects the ability of both parties to appropriately and reasonably respond to one another within the limits of a generally accepted social interaction (Clarkson, 1990; Hartley and Strupp, 1983). Greenson (1967) warns against the contamination of the working alliance by defensive elements, or resistance: "not only can the transference neurosis invade the working alliance, but the working alliance itself can be misused defensively to ward off the more regressive transference phenomena." Thus the 'real relationship' may be regarded as undistorted, realistic, authentic and genuine, which conceptually contrasts the unconscious projections of transference distortions in the 'transference relationship' (Hovarth and Luborsky, 1993; Clarkson, 1990; Hartley and Strupp, 1983).

Several scales have been developed to assess the 'real relationship' that exists between the patient and the mental health care professional. Two of the four subscales of the California Psychotherapy Alliance Scales, 'patient working capacity' and 'patient commitment' are based on Greenson's concept of the 'reality based' relationship (Gaston and Marmar, 1991). This scale has been used to predict outcome among depressed patients in behavioural, cognitive and brief dynamic therapy (Gaston et al., 1998), among depressed outpatients treated with antidepressants (Weiss et al., 1997), and among neurotic and personality disordered patients in short and long-term analytic psychotherapy (Gaston et al., 1994). A full description of this scale and its use in psychiatric settings will be offered later in this thesis.

Also using Greenson's 'reality based' relationship concept, Clarkin's six-point Therapeutic Alliance (TA) scale to assess the therapeutic alliance measures the patient's motivation in therapy within the context of having the capacity to perform work in a realistic way, from the "Patient is actively involved in therapy – explores problems, makes realistic plans for discharge, and so forth" to the "Patient sees no need for hospitalisation and is constantly demanding discharge; sees no need for aftercare or therapy; totally denies emotional problems; actively refuses treatment" (Clarkin et al., 1987). Using this scale, therapeutic alliance was correlated with improvement at discharge among patients treated in a psychiatric hospital (Clarkin et al., 1987). Beauford et al. (1997) used this scale and found that a weaker therapeutic alliance during the initial evaluation of the patient was related to greater risk of aggressive patient behaviour during the first week of hospitalisation. A more complete description of this scale and its use in the context of psychiatry will be offered later in this thesis.

The Psychotherapy Status Report (PSR) measures the extent to which the patient is engaged in an ego-reality based 'real relationship' with the professional (i.e., 'Patient has clear and realistic perceptions of the therapist, including how the therapist feels about him/ her, and is able to maintain this view for the most part') versus transference distorted perceptions of the professional (i.e., 'Patient has grossly distorted or transference-dominated perceptions of the therapist that override realistic perceptions almost continuously and are immune to realistic criticism or interpretation') (Frank and Gunderson, 1990). Studies using the PSR have predicted positive outcome for schizophrenic and other long-term mentally ill patients in cognitive therapy (Svensson and Hansson, 1999) and in the pharmocological treatment of schizophrenic in-patients (Frank and Gunderson, 1990). A more complete description of the scale and its use in psychiatric settings will be described later this thesis.

The Scale to Assess the Therapeutic Alliance (SATA) similarly investigates the extent to which the patient is engaged in a 'real' versus a 'transference distortion' relationship: from the patient participating in actively identifying, discussing and exploring 'resistances'; to the 'minor acting out of his/ her psychological conflicts'; to engaging in 'repeated destructive acting out [so] that all therapeutic effort becomes directed at containment' (Allen et al., 1984). Using this scale, patient collaboration has been related to positive patient outcome in long-term in-patient hospital treatment settings (Allen et al., 1988; Allen et al., 1985). Again, a more detailed description of this measure and its use will be offered later in this thesis.

A departure from the traditional psychoanalytic approach came with a client-centred focus developed by Rogers in 1942 (Orlinsky et al., 2004). Rogers (1957) asserted that the therapist's ability to be empathetic and congruent and to unconditionally accept the patient was not only an essential but a sufficient condition for therapeutic gain. This perspective further suggested that, regardless of the theoretical framework, the conditions offered by the professional are responsible for change (Horvath, 2000). Rogers (1957) theoretical paper on the effective conditions of personality change spawned a great deal of research. Many investigations explored the effects of Roger's Therapist Offering Conditions (TOC). Initial findings strongly supported the hypothesis: professionals who provided high levels of TOCs were more successful than those who provided less of these conditions (Horvath and Luborsky, (1993). Between 1958 and 1984, 39 studies related professional empathy to outcome (Orlinsky et al. 2004). Between 1985 and 1992, the number of studies on this topic reduced to 14 – and between 1993 and 2001 there were only 7 studies on this topic (Orlinsky et al. 2004). Orlinsky et al. (2004) suggest that this could be due to a decline in interest on client-centred therapy and a general acceptance of empathy as a factor on outcome (Orlinsky et al. 2004). Rogers (1957) emphasis on the therapist's regard for the patient has been supported by 154 studies that show a positive relationship between affirmative professional behaviour and patient outcome (Orlinsky et al. 2004). Some later reviews of the research results suggested that it is the patient's perceptions of professional empathy – rather than actual therapist behaviour – that was most associated with outcome (Horvath and Luborsky, 1993). Specifically, it has been found that it was not the objectively measured level of the therapist's empathy, congruence or unconditional regard that had the most powerful impact on outcome, but the client's perception of these qualities (Horvath, 2000).

The Barrett-Lennard Relationship Inventory (BLRI) derives from Rogers' conception of the necessary and sufficient conditions of therapeutic personality change (Barrett-Lennard, 1962). From this perspective, "the client's experience of his therapist's response is the primary locus of therapeutic influence in the relationship" (Barrett-Lennard, 1962). To this end, the scale measures the patient's perception of (patient version) and the professional's experience of (professional version): professional empathetic understanding; professional level of regard; professional unconditionality of regard; and congruence within the therapeutic relationship (Barrett-Lennard, 1962). This scale has been used to predict outcome among depressed patients in psychotherapy (Elkin et al., 1999) and in couples therapy (Wells et al., 1975). A more complete description of this scale and its use in the context of psychiatry will be provided later in this thesis.

Role theory

Role theory focuses upon identities that define a commonly recognised set of persons by designed functions or patterns of behaviour with regard to a particular social context within a social system (Biddle, 1956). From this perspective, the therapeutic relationship is defined by the separate and mutually validating roles occupied by the clinician and patient who are each expected to exhibit different behaviour patterns within a socially defined context. The titles 'doctor', 'psychiatrist', 'social worker', 'community psychiatric nurse', 'psychologist', and 'occupational therapist' reflect social positions of persons expected to possess specialist expertise enabling them to carry out particular functions within a therapeutic context. Parsons argues that individuals learn the patterns of expectations, attitudes and values associated with this role of 'doctor' long before they enter medical school, although they are said to be crystallised during their studies (Hauser, 1981). From this same perspective, the individual who becomes a medical 'patient' similarly internalises the cultural rules governing this role during early childhood and adulthood by observing various relatives moving in and out of this status, thereby preparing them for this new, and usually temporary, role (Hauser, 1981). This role is said to continue to be learned even after one has become a patient, through various 'cues' within the hospital and through interactions with staff regarding appropriate patient role behaviour (Hauser, 1981). Three central styles of communicative behaviour have been identified to describe different therapeutic role relationship patterns: paternalistic, consumer, and collaborative.

The paternalistic relationship emphasises the authority of the clinician and the relative passivity of the patient. In this model, the clinician is characterised as being dominant in the interviewing process, principally asking closed-ended questions, providing most information, and making most decisions on behalf of the patient (Benbassat et al., 1998; Coulter, 1999; Goodare and Lockwood, 1999; Shelton, 1998; Ong et al., 1995; Emanual and Emanual, 1992; Buijs, 1984). In this context, the clinician directs the patient, who is expected to 'obey' or follow prescribed 'orders' (Hauser, 1981). Some patient variables have been identified as predicting preference for this model of interaction, including: greater severity of illness, older age, lower income, lower education, and male gender (Benbassat et al., 1998; Coulter, 1999; Geller et al., 1976; Shelton, 1998). Clinician variables identified as predicting preference for this model include: younger age and male gender (Benbassat et al., 1998).

The consumer-based or 'patient-centred' model of the therapeutic relationship emphasises the authority of the patient and the relative passivity of the clinician. This approach is characterised by a mode of communicative action dominated by the patient, who asks most of the questions during the interviewing process, and makes most of the decisions (Roter et al., 1997; Shelton, 1998; Buijs, 1984; Eisenthal et al., 1979). The clinician's role in this context may be aligned to that of a 'consultant' who provides information on the basis of the patient's questions (Roter et al., 1997; Shelton, 1998). The clinician's goal, from this perspective, is to follow the patient's lead, to understand the patient's experience from their perspective, and to respond in ways that enable them to express their symptoms, expectations, and feelings (Ong et al., 1995).

The collaborative or 'partnership' model of the therapeutic relationship is characterised by a non-hierarchical mode of communicative interaction in which the patient and clinician combine resources, contribute information equally, and share in the decision-making process to work together toward a common goal (Coulter, 1999; Eisenthal et al., 1979; Roter et al., 1997; Shelton, 1998). This model may be aligned to that of a 'partnership' where the patient and clinician are regarded as equal partners in the diagnostic and treatment decision-making process, the tacit assumption being the patient and clinician have equally valuable resources to contribute. In the collaborative relationship both the clinician and patient may achieve common goals by working together - while the clinician should be informed about diagnostic, prognostic, prevention, and treatment details - the patient may lead in the domain in which they are expert, namely in describing their symptoms, habits and behaviour, social circumstance, preferences, values, concerns, and attitude towards risk (Coulter, 1999; Ong et al., 1995). Patient psychological factors such as locus of control and feelings of self-efficacy are cited as possible factors relating to preference for this model (Docherty and Fiester, 1985).

The assessment of roles ascribed to, or occupied by, patients or clinicians within a therapeutic context may be obtained using audiotape analysis, quantitative rating scales, and questionnaire methods. Methods derived from the role theory theoretical framework include: the Psychiatrists' Sphere of Influence Scale (PSIS), which measures roles ascribed to psychiatrists by patients (Geller et al., 1976); Byrne and Long's Classification System, Conversation Analysis, which assesses physicians' verbal behaviour in consultation to summarise their interview style (Peräkylä, 1995; Buijs et al., 1984); and the Roter Interactional Analysis System, which describes routine patient-clinician communication patterns and relates them to ideal relationship types using audiotape analysis and patient and physician exit questionnaires (Roter et al., 1997). Sharkey (2002) used a hermeneutic-phenomenological approach to explore collaboration from the perspective of a person diagnosis of schizophrenia. Questionnaires assessing patient preferences of the clinician's terms of address, and dress, may also suggest an alignment to a symmetrical or an unsymmetrical relationship, characterised by preferences of authority versus familiarity (McGuire-Snieckus et al., 2003; Swift, 2000).

The extent to which patients participate in their treatment has shown to have significant patient outcome effects, both in general medical practice, and in psychiatry. Patient participation in the therapeutic process may be graded according to each role relationship model: patients being relatively passive and professionals being relatively dominant in the authoritative relationship; patients being relatively dominant and professionals being relatively passive in the consumer relationship; and the patient and professional being relatively equal participants in the collaborative relationship.

Both patient passivity, characteristic of the authoritative model, and professional passivity, characteristic of the consumer-based model, may have negative consequences in terms of patient outcome. A study investigating misunderstandings in prescribing decisions in general medical practice revealed that the patient's lack of participation in the consultation, particularly in terms of voicing preferences and expectations or responses to the physician's actions or decisions often leads to potential or actual problems, such as non-compliance to treatment (Britten et al., 2000). Furthermore, patients who ascribe to a paternalistic model are more likely to drop out of psychiatric treatment than those who do not (Geller et al., 1976). Professional passivity, characteristic of a consumer-based relationship, may lead to similarly negative outcome, including a high early dropout rate in psychotherapy settings (Mohl, 1991) and greater patient non-compliance in psychiatry (Docherty and Fiester, 1985).

Characteristics of the collaborative model, namely, the amount of information provided to patients and the extent to which they can participate in treatment, appears to be related a better patient-professional alliance and to lead to better outcome. In an inpatient psychiatric unit, it was revealed that by simply providing inpatients with access to their medical records led patients to feel more involved in their treatment, while staff reported becoming more thoughtful about their notes in the chart (Stein et al., 1979). A study comparing patients' and physicians' opinions regarding important elements of outpatient care revealed that patients place greater value on effective communication of health-related information than physicians, and that patient satisfaction significantly correlated with the amount of information that they received from their physicians (Laine et al., 1998). A case study by Sharkey (2002) exploring collaboration in a mental health in-patient setting revealed that rather than describing good examples of collaboration, attention was drawn to episodes of non-collaboration, and difficulties in joint decision making. Indeed, most complaints made of physicians by patients are because of communication problems, where patients feel that they have not been provided with sufficient information about their problem and outcome, side-effects of treatment, relief from pain and emotional distress, and advice on what they can do for themselves (Kent, 1998; Meryn, 1998; Tattersal and Ellis, 1998).

It has been suggested that the active participation on the part of both parties (reflective of the collaborative relationship) may be necessary to improve patient outcome (Ong et al., 1995). Increased patient participation and degree of negotiation are cited as resulting in greater patient treatment adherence and outcome in general medical practice (Docherty and Fiester, 1985). In a psychiatric emergency setting, it was revealed that simply asking patients about the nature of their illness and the services that they felt would be helpful served to build a relationship, even among some very hostile and negativistic patients (Rosenberg and Kesselman, 1993). Changes to treatment in response to patient requests in a psychiatric setting were found to predict positive patient assessments of treatment, which may be reflective of an increased agency experienced by the patients who may have regarded themselves as ‘active participants’ rather than ‘passive objects of treatment’ (Priebe and Gruyters, 1999).

The present government in the United Kingdom has taken patient-professional partnership ideology into public policy by emphasising “shared information, shared evaluation, shared decision-making, and shared responsibilities” (Coulter, 1999). To this end, a revised Patient’s Charter has been promised, the patient partnership strategy has been relaunched, NHS Direct Online has been established (providing information via an internet site), and a strategy for healthy citizens has been included in the public health White Paper so that citizens are better informed about treatment options, outcomes, and medical care limitations (Coulter, 1999). A study of the perceptions of 3703 patients and doctors in six countries revealed that only a minority of patients defined the doctor-patient relationship as authoritarian or paternalistic, and that patients felt “more confident and more empowered than they did 10 years ago in dealing with the medical profession” (Pincock, 2003).

A survey that was conducted with community care patients regarding their preferences of dress and address of six different mental health professionals indicates a preference for a more paternalistic-type relationship with GPs and Psychiatrists, evidenced by a preference to be addressed by their first name, to address the clinician by title (i.e. 'Dr.') and for the clinician to be 'smartly', rather than 'casually' dressed (McGuire-Snieckus et al., 2003). By contrast, a preference for a more collaborative-type relationship with social workers, community psychiatric nurses, occupational therapists and psychologists may be inferred by the fact that, with these clinicians, patients prefer a mutual form of address on a first-name basis, and the clinician to be 'casually', rather than 'smartly' dressed, which may suggest different role expectations of familiarity versus authority (McGuire-Snieckus et al., 2003). While this survey may suggest personal preference differences of dress and address according to different professional roles, these preferences might also result from exposure to, and hence expectations of, different forms of dress and address by different professional groups (McGuire-Snieckus et al., 2003). For instance, if people are typically referred to as 'clients' by social workers, they may associate the term with that professional group as opposed to others (McGuire-Snieckus et al., 2003).

Thus beyond the 'political correctness' of emphasising a collaborative or partnership approach to the therapeutic relationship, there exists empirically sound research supporting the view that patient opinions regarding their treatment should be elicited and used meaningfully in clinical practice. The professional's ability to identify patient preference for a particular pattern of interaction in clinical practice may provide insight into an individual patient's desire to participate in the decision-making process (Benbassat et al., 1998). However, patients must first be offered the choice of participating in the decision-making process before they decide whether or not they wish to so (Ong et al., 1995). Whilst it has been suggested that features of patients' communicative styles and characteristics may influence the amount of information offered by physicians, where patients who ask more questions and express more concerns receive more information by doctors, the frequency with which patients ask questions of their physicians is strongly related to the prevalence of the latter's information-giving behaviours (Ong, 1995).

Social Constructionism

Social Constructionism focuses upon the process by which individuals interpret, organise, and ascribe meaning to their experience through communication with others (Hoffman 1993; Lax 1993; Dwivedi and Gardner 1997; Doan 1998). According to this perspective, human knowledge is developed, transmitted and maintained in social situations, constructing the basis for shared reality (Berger and Luckmann 1991). In contrast to role theory and psychoanalysis, which emphasise role expectations and perpetuated transference distortions brought to interpersonal relationships, social constructionism places more of an emphasis on how identities are co-constructed by the parties involved than on what people bring to the interaction. Indeed, "social constructionism views knowledge as an event constructed within relationships and mediated through language" (Penn and Frankfurt 1994).

Within a social constructionist framework, psychiatry may be regarded as a socially-developed, transmitted and maintained institution supporting a body of knowledge that includes theories of deviance, diagnostic apparatuses, and conceptual systems of treatment (Berger and Luckman, 1991). This theory may be aligned to Foucault's conceptual definition of disciplinary power, whereby various operations are utilised to delimit the normal from the abnormal: individual action is referred to the whole (which serves as a field of comparison and a principle rule to be followed); individuals are differentiated from one another in terms of this overall rule; values of the nature of individuals are accordingly measured in quantitative terms and hierarchies; this 'value giving measure' establishes a constraint of conformity that must be achieved; and, finally, the limit that may define differences in relation to all other differences is traced (1991).This evolutionary, socially constructed process of delimiting the normal from the abnormal is evidenced by the increase in classifications from 180 categories in the second edition of the Diagnostic and Statistical Manual to 350 categories in the third, which also marked a distinct transition from an alignment to psychoanalytic theory to neo-Kraeplinean thought (Healy, 1997). This transition may reflect the process by which individuals and groups may compete to promote, protect and legitimise definitions of 'reality' (Hoffman, 1993; Hoskings and Morley, 1991). Once a therapeutic paradigm is recognised as an adequate interpretation of reality, it may realise itself in the phenomena it purports to interpret (Berger and Luckman, 1991).

From this perspective, the patient-professional relationship may be regarded as a forum that legitimises the therapeutic paradigm by participating in the therapeutic rituals that delimit the pathological from the normal (the process of diagnosing the patient according to paradigmatically-driven classifications) and by delivering conceptually-driven treatments. The professional's application of this conceptual machinery may be further viewed as an attempt to ensure that actual or potential deviants (the patients) stay within the institutionalised definitions of reality, thereby legitimising the psychological paradigm (Berger and Luckman, 1991).

The therapeutic relationship thus introduces a dialectic exchange between psychological theory and those elements of subjective reality it purports to define and explain (Berger and Luckman, 1991). Within the therapeutic context, the professional is both participant observer and participant actor in the process of communication and discourse with the patient, as both parties live in and through the narrative identities that they develop in communication and discourse with each other (Anderson and Goolishian, 1993; Ceccin, 1993). This school of thought suggests that individuals structure their lives according to narratives, which enable them to make sense of their experiences and to communicate them with others (Dwivedi and Gardner, 1997; Lax, 1993).

The realities that inform the lives of people within specific cultural groups are reflected by the language systems in which they are generated (Doan, 1998). That there exists no corresponding term for the English word 'depression' in the

Bengali lexicon reflects the 'psychologised' reality in which native English speakers participate. Some social constructionists aim to privilege the patient's voice rather than any academic or formal domain of knowledge held by the professional (Doan, 1998). Here, rather than viewing the patient-professional relationship as the legitimisation of the psychological paradigm of reality guided by the professional 'expert', the latter asks questions from the position of 'not knowing' to facilitate the patient's re-presentation and re-description of their experiences in the re-construction of a new narrative: one that is meaningful, coherent, and adaptive to the self-concept of the client (Dwivedi and Gardener, 1997; Anderson and Goolishian, 1993; Cecchin, 1993; Fruggeri, 1993; Lax, 1993).

Research on the therapeutic relationship from this perspective focuses on the way in which patients and professionals construct their identities in relation to one another (e.g., Cecchin, 1993). The Narrative Process Model provides a coding system to identify and evaluate the process by which patients and professionals organise and represent the patient's sense of self and others into a meaningful story (Angus et al 1999). Conversation analysis, a micro-analysis of conversation that deconstructs text, tone, pauses, interruptions, and non-verbal communication (Elwyn and Gwyn, 1999) may be of particular use to this framework. Conversation analysis is a method that unpacks the process by which social action reflects institutional practice. The way in which physicians attempt to promote, protect and legitimise their authority in general medical practice consultations by using particular communication strategies was investigated using this method (Heath, 1997). It was revealed that by providing only a limited amount of diagnostic information to the patient some professionals establish the basis for divergent realities known by each: where the doctor is privileged as expert, and the patient relatively ignorant to his/ her medical condition, and thus an asymmetrical relationship may be constructed with the patient (Heath, 1997). Here 'role theory' research overlaps significantly with social constructionist research in that it explores the process by which this asymmetry is accomplished in and through the interaction between both parties in consultation.

The content analysis of participant text, including writing in journals, letters, ‘notes’ between sessions, personal biographies, and diaries may also reveal the way in which reality is dialectically constructed between discourse generated within the therapeutic relationship and the patient’s experience outside of it (Berkery 1998; Kogan and Gale, 1997; Penn and Frankfurt, 1994; Epston et al., 1993). It is suggested that the recursive activity of writing may locate new voices both inside and outside the therapeutic relationship, and that new knowledge and narratives are evoked through the development of different readings of their experience (Penn and Frankfurt, 1994). Process research methodology derived from social constructionism emphasises the therapeutic dialogue that exists in the mutual construction of the professional-patient relationship.

Much attention has been paid to narrative approaches to mental health care and general medical practice. It has been argued that the tension that may exist between the complex narrative that patients bring to consultation and the professional’s understanding of formulated diagnoses or ideas regarding pathology may be resolved using a narrative approach by integrating the patient’s biographical knowledge with the professional's professional knowledge by exploring, creating and testing different interpretations that emerge from the therapeutic dialogue (Launer, 1999). In general medical practice, this approach may be particularly relevant, in view of the fact that many patients tend to express their mental problems in terms of physical symptoms (Van der Pasch and Verhaak, 1998) - thus, a narrative approach may serve to 'unpack' a patient's presenting symptomology.

One's culture often determines the dimensions that organise people's experience by providing the backdrop against which experiences are interpreted (Zimmerman and Dickson, 1994). An American study revealed that patients rate visits with race-concordant physicians as more participatory than patients in race-discordant relationships (Cooper-Patrick et al., 1999). This may reflect the divergent phenomenological baselines that inform the lives of patients and physicians from different cultural backgrounds who may lack shared sociocultural understandings regarding health and illness that are embedded in each culture. McCabe and Priebe (in press) illustrated how patients' explanatory models of illness may differ between ethnic groups and influence treatment satisfaction and compliance. A narrative approach may bridge this cultural gap by privileging the patient's voice in describing their experience and understanding of their illness.

As patients often view ill health in this phenomenological form, a narrative approach to the diagnostic encounter in general medical practice may supply useful clues and categories for analysis (Greenhalgh and Hurwitz, 1999).

Narratives also produce a temporal model of the experience of schizophrenia over time (Barker et al., 2001). It has been further suggested that narratives may facilitate the development of medical ethics by providing insight into the different perspectives that may exist in patient's moral choices embedded in the form, content and meaning of their illness stories (Jones, 1999). Finally, narratives may be of use in the education of patients and health care professionals in view of the fact that they are generally memorable, grounded in experience, and encourage reflection (Greenhalgh and Hurwitz, 1999).

Systems Theory

In systems theory, relationships are seen as part of a more or less complex system of relations (and, in theory, the entire cosmos) that may be described in relational terms. The structure and function of long-lasting relationships, from this perspective, tend toward a state of equilibrium by establishing norms that delimit and reinforce patterns of behaviour through a homeostatic mechanism (Caldwell, 1994; Watzlawick and Weakland, 1977).

According to systemic theory, the patient is regarded as a system, consisting of interacting relationships between many sub-systems. From this perspective, a professional's engagement with a patient affects, and is affected by, other persons or systems outside of the dyadic exchange process. For example, the professional's approach to the patient is not only affected by the therapeutic paradigm of the therapeutic setting in which he or she operates, but the availability of the treatment itself may be delimited by a fiscal third-party

(Chodoff, 1978), or by the financial resources of the health care system (Tuttman, 1997).

The family may be affected by the changes in a patient's behaviour, thinking or experience of life following treatment (Chubb, 1990). Indeed, a study examining the perceptions of the significant other of the effects of psychotherapy revealed that considerable changes were perceived to have taken place from the therapy, affecting the couple's relationship, the patient's parenting relationship, the children, and to a lesser degree, the extended family (Roberts, 1996). Thus, all sub-systems, including the therapeutic relationship, may be regarded as active and mutually-interacting within space and time at one level; or each element may be studied as a complete system in itself (as one of many related systems) at another level (Clarkson, 1993).

It has been suggested that schizophrenic patients may suffer from cognitive and empathetic 'decoding deficits' that reduce their tolerance toward affect-oriented interaction patterns resulting in increased sensitivity to expressed affect (Stark, 1991; Stark et al., 1992). From this perspective, individuals with schizophrenia are less able to cope with high levels of expressed emotion within a family because of this decoding deficit, resulting in greater vulnerability to psychotic episodes. Expressed emotion was first identified by Brown and Rutter (1966) who observed a higher relapse rate among mentally ill patients that rejoined their families following hospitalisation, compared to those that returned to live independently. Further investigation led to the classification of expressed emotion which is described as "excessive emotional over-involvement (based on evidence of an exaggerated emotional response and self-sacrificing, overprotective, or intrusive behaviours) or a critical or hostile attitude toward the patient or both" (Barrowclough et at., 2001; Moore and Kuipers, 1999). A number of studies have revealed that patients that live with a caregiver rated as high in expressed emotion have a higher rate of relapse than those living with low expressed emotion (Leff, 1994; Leff, 1998; Vaughn and Leff, 1976; Moore and Kuipers, 1992; Oliver and Kuipers, 1996; Willets and Leff, 1997; Moore and Kuipers 1999; Tattan and Tarrier 2000; Harrison et al., 1998).

Research revealing that the level of expressed emotion by relatives of schizophrenic patients is strongly associated with symptomatic relapse (Vaughn and Leff, 1976; Moore et al., 1992; Oliver and Kuipers, 1996; Willets and Leff, 1997; Moore and Kuipers 1999; Tattan and Tarrier 2000) has led to interest in the effect of emotion expressed by mental health care professionals on the therapeutic relationship and patient outcome (Gamble, 2000; Ball et al., 1992; Snyder et al., 1995; Barrowclough et al., 2001). Furthermore, mental health care professionals who were rated highly in expressed emotion were found to have a more critical attitude towards patients compared to low expressed emotion staff (Moore and Kuipers, 1992; Bull et al., 1991). While low expressed emotion among mental health care professionals has not been found to predict clinical outcome (Tattan and Tarrier, 2000), it has been suggested that it may be a salient feature of successful therapeutic relationships (Moore and Kuipers, 1992; Bull et al., 1991). Gamble (2000) found that high expressed emotion among mental health staff predicted relapse and poor prognosis among their patients. Moore and Kuipers (1998) revealed that high expressed emotion by day hospital staff was also predictive of patient outcome. Tattan and Tarrier (2000) looked at expressed emotion by case managers in community care and found that clinical outcome could be effected by the attitudes and behaviour of case managers.

The Therapist-Patient Scales with Schizophrenic Patients derives from the theory of 'Expressed-Emotion' (Stark, 1994; Stark et al., 1992). In the 16-item therapist version of the scale, specific types of professional communication indicative of high expressed emotion are assessed according to four categories: rejection / inadequacy; insecurity / detachment; personal acceptance; and professional acceptance (Stark, 1994; Stark et al., 1992) The 30-item patient version assesses the patient's perception of, and emotional capacity to engage with, the professional: rejection / incompetence; therapist indifferent / vague; therapist stimulating; therapist demanding (Stark, 1994; Stark et al., 1992) Using this scale, professional differences were identified according to gender: while female therapists are more likely to be emotionally over-caring; male professionals appear to exhibit more detached or critical behaviour towards patients (Stark, 1994; Stark et al., 1992). A more detailed description and its use in psychiatry will be described later in this thesis.

As one of many relations, the triad of key relative-patient-clinician may be considered as the basic component of the therapeutic system (Priebe and Pommerien, 1994; Priebe, 1989). The patient's key relative is considered relevant to the therapeutic system, in view of the fact that patients' presenting problems are often developed and maintained in a system of interaction within the family (Bloch et al., 1991; Caldwell, 1994; Priebe and Pommerien, 1994).

From this perspective, the mental illness of a family member (the patient) may be central to maintaining the homeostasis of the family system (the function of their illness may bring other family members closer together by reacting to the patient's symptomology, for instance). The patient's recovery may therefore disrupt the homeostasis of the family system. It has been observed by clinicians of hospitalised schizophrenic patients that family members often attempt to sabotage the treatment process and that a patient's improvement is often accompanied by the appearance of symptoms of severe mental illness in some other family member (Jackson and Yalom, 1974), reflecting the attempt of the family system to maintain equilibrium. The members of the therapeutic system are not considered in absolute terms, but rather in a relational way, by comparison with the system, whereby only differences are relevant (Priebe and Pommerien, 1994; Priebe, 1989). A structurally similar pattern of interaction between the key relative and patient and psychiatrist and patient would be regarded as a reinforcement to the homeostatic mechanism of the former system, whereas a structurally different pattern may disrupt the same system (Priebe and Pommerien, 1994; Priebe, 1989).

Systemic methodological approaches that examine the structural and functional differences between members of a therapeutic system include: Priebe's two-part question assessing the relational attitude differences toward patient illness (1989); and descriptive clinical case studies (Hahn et al., 1988). Relational structural and functional differences between members of a therapeutic system have been found to predict better outcome among depressive in-patients (Priebe, 1989; Priebe and Haug, 1992); and in psychiatric community care (Priebe and

Gruyters, 1994). In general medical practice, clinical case study descriptions reveal that many patients seek to form a 'compensatory alliance' with the physician for deficits in the family system (Hahn et al., 1988).

In chaos theory, dynamical systems are said to evolve through three basic stages: stable, bifurcation (the stage in which internal or external influences promote a critical point, where the properties of a system can change abruptly), and chaos (Butz, 1997). Applied to the therapeutic system, the stable state may represent the family system from which a patient's symptomology may have emerged and been maintained. In the relative-patient-therapist triad, the therapist-patient relationship can be regarded as a condition of bifurcation, an influence that promotes the patient to disrupt the stable properties of the family system. As a result, the family system may no longer be able to maintain its previous stability, and chaos may ensue, from which new order may emerge (Butz, 1997). From this perspective, treatment outcome measures may be regarded as assessments of the patient's emergent new order.

Within an institutional setting, professional staff and the patient may define their roles in relation to one another - the actions of each arising from their responses to one another, which may then create, and be limited by, the logical structure of the system that they have formed (Caldwell, 1994). Thus, the staff's 'helper' role may require them to engage in a combination of nurturing and controlling behaviours, while the patient's role identity may require them to engage in symptomatic behaviours - this pattern of behaviour and interaction potentially evolving into an established norm to maintain the evolved equilibrium of their system (Caldwell, 1994).

A systemic approach does not consider the patient and clinician in isolation, but in relation to other persons, groups, and/or institutions that may affect, and be affected by, the therapeutic relationship. Consideration may thus be given to the effects of the therapeutic relationship and process on the patient's family, and the influence of the family system on the therapeutic relationship and process. That repercussions of individual treatment may spread extensively within a family may theoretically and clinically blur the boundaries between individual and family therapy (Roberts, 1996). A psychiatrist's or therapist's awareness of the relevance of his/her structural and functional relationship with the patient in relation to the patient's structural and functional relationship with the patient's key relative is central to this approach. In clinical practice, this may require that a session be held with the patient and members of their family to gain insight into the patterns of interaction and established norms within the patient's family system, and their possible implications in the working alliance. Training thus emphasises the development of observation skills, which may include the use of live observation, practice with supervision, and video review, in addition to more reflective seminar work and case discussion (Launer and Lindsey, 1997; Watzlawick, 1979). Bowen et al. (2002) suggest an approach to understand and address blame in systemic therapy. A video extract of five families was used as a focus for semi-structured interviews with each patient (Bowen et al., 2002). Transcripts were analysed according to the procedures of grounded theory (Bowen et al., 2002). On the basis of this analysis, a set of overarching themes was identified that was used in discussion of blame within the family (Bowen et al., 2002). The model provides a framework for analyzing the style and content of therapy conversations with a view to addressing blame within the family and helping therapists facilitate therapeutic change (Bowen et al., 2002). Within an inpatient setting, patterns of interaction that may be developed and maintained by the patient and psychiatric staff may be investigated with regard to the extent to which they may maintain the patient's symptomatic behaviour - this may be done with a view to disengaging staff from this pattern, and to establish a new one to prevent the old pattern from re-emerging (Caldwell, 1994).

Social Psychology

Social Psychology emphasises the interpersonal context of human interaction. Two models are offered from this approach: the therapeutic relationship defined by social exchange, and the therapeutic relationship defined by social influence. Social exchange theory has been used to frame the therapeutic relationship by specifying the type of exchange and tangible or intangible resources that the patient and professional may give and receive. Social power theory emphasises the capability of the professional to influence the patient on the basis of his/ her access to particular resources. Social influence examines the process by which groups establish norms of behaviour.

According to social exchange theory, social experiences (when two or more people come into contact with one another) are regarded as interpersonal encounters in which resources may be given or taken away (Schaap et al., 1996;

Brehm, 1992; Foa and Foa, 1980; Foa and Foa, 1974). 'Resources' are described as anything that is transacted in an interpersonal situation, and have been grouped into six classes: 'love', an expression of regard, comfort or warmth; 'status', an expressed evaluative judgement that conveys high or low regard, prestige or esteem; 'information', which includes enlightenment, opinions, instructions, or advice, but excludes behaviours that would be classified as love or status; 'money', currency, coin or token that has some standard exchange unit value; 'goods', tangible objects, products or materials; and 'services', activities on the body or belongings of a person by the labour of another (Schaap et al., 1996; Foa and Foa, 1980; Foa and Foa, 1974). These resources may be further classified according to their properties of 'concreteness' versus 'symbolism', the extent to which they are tangible or intangible and 'particularism' versus 'universalism', the degree to which the resources are associated within a particular exchange system (Schaap et al., 1996; Foa and Foa, 1980; Foa and Foa, 1974).

The therapeutic relationship may be regarded as a setting that specifies the type of exchange, and the tangible and intangible resources that each party may give and receive: the professional may provide 'love' (warmth, comfort), 'status' (regard), 'goods' (medication), 'information' (interpretation, insight, feedback), and/or 'services' (form-filling for social services or accommodation) to their patients in exchange for 'money' (income) and/or 'status' (prestige or esteem). Private practice aside, in the United Kingdom this exchange is typically mediated by the National Health Service, which provides the professional's income in exchange for their service (the treatment and/or containment of the mentally ill).

Social exchange theory may provide support for the increasing interest in the development of computer-based ‘self-help’ treatments for some psychiatric disorders. While the transmission of some resources requires face-to-face interactions, such as love (warmth), status (regard), and some information (interpretation, insight); other resources do not, such as goods (medication prescriptions), information (side-effect advice, etc.), and services (form filling for social services or accommodation). National services, such as NHS Direct Online, provide health information to patients without direct contact being established between the user and the professional. Here, the clinician may provide information to a suspended audience when compiling a database that is to be used by individuals who seek relevant information to their symptoms or conditions. In the field of psychiatry, there is said to be a ‘growing’ interest in the development of computer-based ‘self-help’ treatments for depression, and ‘touch-telephone’ packages which may offer an easily accessible, and inexpensive support to depressed and anxious persons, (Crawford, 1999). Whether or not this is viable - or ethically acceptable - in mental health care may be related to patient need. While prescriptions and information may be provided on-line, more intangible resources, such as warmth and regard, may be equally important to the patient, and thus face-to-face interactions may be a necessary component of mental health care.

Social power is described as “the capability attributed to a person to influence cognitive or behavioural aspects of another on the basis of their power over and accessibility to particular resources” (Schaap et al., 1996). From this perspective, the professional may influence the patient according to his/ her access to resources that may help the client attain his/ her goal of containment or recovery. Sources of social power that may be relevant to the therapeutic relationship include 'expert power', the extent to which the patient perceives the professional as possessing specialist knowledge; 'referent power', the extent to which the professional offers the patient a standard for comparison; 'legitimate power', the extent to which the patient accepts the therapeutic role division and process; 'informational power', the extent to which the professional is perceived as possessing information that extends beyond the therapeutic context; and 'ecological power', the extent to which the professional can influence the patient's environment by causing them to change certain aspects of their lives (Schaap et al., 1996; Brehm, 1992).

The extent to which the patient perceives the professional to be expert, trustworthy, and attractive provides the latter with the social influence to promote change, according to this theory (Hovarth and Luborsky, 1993; Brehm, 1992). The benefits that the patient is likely to gain from treatment are regarded as proportionate to the strength of the attributions made by the patient of the professional (Hovarth and Luborsky, 1993). Underscoring the power that the professional may have in influencing the patient, according to this perspective, is the extent to which the patient desires the resources offered by the professional, and the extent to which the professional is perceived as capable of providing them. Therefore, excessive self-disclosure on the part of the professional, for instance, would be expected to undermine the patient's confidence in the professional's status as an expert, from this perspective (Schaap et al., 1996).

Social influence may nevertheless be affected by individuals who have no claim to legitimacy or expertise. Sherif examined the development and perpetuation of group norms by inviting subjects into a darkened room with a pinpoint of light at some distance in front of them, and effected a perceptual illusion so that the light appeared to move, and asked the subject how far the light had moved, resulting in highly variable estimates (Argyle, 1998; Ross and Nisbett, 1991). When subjects performed the same task in pairs, or in groups of three, the subjects' estimates would converge, establishing a group norm - and while different groups agreed on different norms, members of any pair or triad appeared reluctant to offer divergent estimates form the standard of their group (Argyle, 1998; Ross and Nisbett, 1991). In another study, a confederate would participate with one naive subject, and would consistently estimate much higher or lower than the one offered by the subject (Ross and Nisbett, 1991). The subject quickly adopted confederate's high or low standard (Ross and Nisbett, 1991) suggesting the confederate's willingness to be consistent and unwavering in the face of the subject's uncertainty was sufficient to influence the latter to internalise the auto-kinetic norms (Ross and Nisbett, 1991). Applied to the therapeutic dyad, the norms that are established by the patient and professional may be related to the frame of reference within which they operate. From this perspective it would be expected that if the frame of therapeutic reference is ambiguous, as in the former study conducted by Sherif, the patient and professional would attempt to converge in establishing the norms of the relationship. However, if one member of the therapeutic dyad provides a more certain and consistent frame of reference than the other, it would be expected that he or she would have greater influence -

where the latter would align him or herself to the norms that are delimited by the former. The setting itself may provide the frame of reference that delimits the norms of the therapeutic relationship (Furnham, 1986).

A study examining the relationship between client perceptions of therapist use of social influence strategies and perception of the quality of their therapy revealed that therapist's reputation as an expert, and use of personal reward influence strategies and compromise were positively related to clients' perceptions of the quality of their therapy; while therapist use of coercive influence strategies and certain types of expert influence strategies were negatively associated with clients' perceptions of the quality of their therapy (McCarthy and Frieze, 1999). Phenomenological research reveals that assertive community treatment may be experienced by some patients as coercive (Watts and Priebe, 2002).

Social influence may provide insight into the techniques that may be employed by 'burnt-out' clinicians that may negatively impact on the therapeutic relationship. Clinician 'burnout' - characterised by depersonalisation (the development of cynical, negative attitudes towards clients), emotional exhaustion (feelings of being emotionally drained by one's job), and reduced personal accomplishment (feelings of ineffectiveness in one's professional role) - has been associated with uses of different influence strategies (McCarthy and Frieze, 1999). Clinician use of personal coercive influence strategies, direct expert influence strategies, and indirect expert influence strategies, has been associated with burnout, which in turn, may impact on the quality of care experienced by the patient (McCarthy and Frieze, 1999). An awareness of coercive influence strategies in clinical practice may provide markers of clinician burnout, as a signal for the need of respite for the professional.

Cognitive Behaviour Model

The therapeutic relationship may be viewed in the light of reinforcement principles, causal schemata and emotional processing.

Principles of reinforcement have been applied to the therapeutic relationship. Goldfried and Davison (1994) suggest that cognitive-behaviour therapists should use the therapeutic relationship to continually monitor their own emotional reactions and behaviours during the course of the session with the goal of determining what the patient might have said or done to bring them out. Therapists are encouraged to disclose their immediate, personal reactions to the patient in the therapeutic interaction (Linehan, 1993). Here, self-disclosure of the therapist's reactions to the patient is consistent with traditional principles of reinforcement in that behaviour is maintained by its consequences (Goldfried et al, 2003). The professional encourages the use of adaptive interpersonal behaviours and discourages problematic behaviours by differentially responding to the patient's effective and ineffective behaviours (Goldfried et al., 2003). The reinforcing patterns of behaviour that may facilitate or impede the development of a good working relationship through the process of conditioning have also been considered (Schaap et al. 1996; Horvath 2000). A coached client method is used where clients rate the interaction with their counsellor from 'very low rapport' to 'very high rapport' has been successfully used in professional training programmes for counselling (Sharpley and Ridgway 1992). Here trainee counsellors are assessed at one-minute intervals by two coached clients (prompted by a 'bug in the ear' device) using a five-button rating assessment device to identify particular behaviours that are associated with heightened rapport, permitting the examination of behaviour relevance during different stages of the interview (Sharpley and Ridgway, 1992). Knowledge of clinician/ patient cognitions, affect and behaviours that contribute to, or detract from, the development of an effective therapeutic relationship may inform clinical practice and specific skill training. The successful use of these training programmes may suggest that facilitative professional behaviour reflects a skill that may be taught (Des Marchais et al., 1990), rather than an individual's interpersonal competence - which would not necessarily translate into successful training programmes. Three primary reinforcement polarities have been identified by Everly et al. (2004) that explain variations in personality: belief in the source of reinforcement (reliance on the self for reinforcement versus reliance on others); instrumental reinforcement patterns and processes (active, self-initiating and engaging versus passive and reactive); and type of reinforcement (positive reinforcement, or the pursuit of pleasure versus negative reinforcement, or the avoidance of pain and suffering). According to Everly et al. (2004), by identifying and adjusting to the patient's unique reinforcement beliefs therapists can effectively engage with the patient, thereby establishing a good therapeutic alliance.

Causal schemas, which represent an individual's beliefs and assumptions regarding cause and effect (Kelly 1971; Kelly 1972; Berley and Jacobson 1984; Fiske and Taylor 1991), have been used to analyse professional approaches to patients on the basis of attributions of patient responsibility for their illness (Brewin 1988). In psychiatry, medical students tended to be more willing to prescribe drugs to patients viewed as victims of uncontrollable life stress than to patients whose problems were viewed as 'of their own making' (Brewin 1988). Hospital staff may provide more-or-less help for different categories of patient: Brewin (1988) found that suicide victims, drug addicts and prostitutes were pronounced dead more quickly than patients regarded as 'respectable citizens' by staff; and resources allocated according to moral conceptions of 'deservingness'. Thus, a professional's response to a patient may be influenced, in part, by their causal schemas about illness and their perception of a patient's responsibility for their illness. A cognitive approach may emphasise the process by which relevant schemata and attributions informs both patient and professional expectations of the relationship, treatment and outcome. That a patient's initial assessments of therapeutic treatment tends to predict outcome (Bröker et al., 1995; Priebe and Gruyters, 1995; Priebe and Gruyters, 1994; Rosenberg and Kesselman, 1993) may be related to the 'primacy effect', a concept used to account for the fact that disproportionate weight tends to be given to early information (which is said to provide a cognitive structure by which subsequent information can be assimilated) (Fiske and Taylor, 1991; Kelly, 1972; Kelly, 1971; Thibault and Kelly, 1967).

That therapist or professional alliance scales tend to provide poorer predictions of outcome than patient or independent observer rating scales (Hovarth and Luborsky, 1993) may be related to a 'self-serving bias', a cognitive attribution error where individuals tend to attribute actions of another person that are consistent with their own interest (Kelly, 1971). In an experiment where teachers were asked to account for the performance of two pupils (one who was 'programmed' to perform consistently badly in the study; and the other who was programmed to consistently perform well), the teachers tended to attribute the latter's performance to themselves, and the former's performance on the pupil (Kelly, 1971). Because it is in the professional's interest to engage with, and effect change in the patient by establishing a positive working relationship, it may be expected that they will tend to account for the relationship according to this interest, according to this perspective.

The role of emotional processing on the therapeutic alliance has also been explored. Emotional processing is viewed as a continuum of stages: first, patients must approach emotion by attending to their own emotional experiences; second, patients must allow and tolerate being in contact with their emotions (Pos et al., 2003). Optimal emotional processing involves the integration of affect and cognition (Greenberg, 2002; Greenberg and Safran, 1987). Patients are encouraged to view emotional experience as information that can be reflected on, explored and made sense of (Pos et al., 2003). This encourages the emergence of new reactions and meanings that can be integrated into existing cognitive-affective meaning structures (Greenberg and Safran, 1987). Pos et al. (2003) suggest that some measures of the working alliance and emotional processing overlap (i.e., emotional processing is a task and goal of experiential treatment and some alliance measures include agreement on the tasks and goals of treatment). Furthermore, a good working alliance offers a safe environment for optional emotional processing to occur (Pos et al., 2003). In a study to explore the importance of early and late emotional processing to change in 34 patients receiving experiential treatment for depression, over half of the outcome variance that early alliance explained, when considered alone, could also be explained by emotional processing variables (Pos et al., 2003).

There are no specifically designed scales to measure the therapeutic relationship in cognitive or cognitive behaviour therapy. The two most widely used measures of the therapeutic relationship in this setting are the Working Alliance Inventory (WAI), which is uses a trans-theoretical approach to the construct based on Bordin's conception of congruence regarding the task, goals and bond in treatment (Klein et al., 2003; Safran and Wallner, 1991; Schwartz et al., 2003; Raue et al., 1997) - and the California Psychotherapy Alliance Scales (CALPAS), with dimensions that are based on Greenson's reality based relationship, Bordin's goodness of fit model and Roger's humanistic approach (Safran and Walner, 1991). A full description of these scales and their use in psychiatry will be discussed in the next section of this thesis.

Chapter 3

Scales designed to assess the therapeutic relationship

Several scales have been designed to assess the quality of the therapeutic relationship. Most are not based explicitly on a single theoretical framework of the therapeutic relationship and many are based on a generic approach to the concept. The exact definition of the alliance in most cases is elusive. Meta-analyses of associations between the therapeutic relationship - as measured by different scales to assess the alliance - and outcome have produced moderate effect size values, from (r) .11 (Stevens et al., 2000) to (r) .17 (Beutler et al., 2004) to (r) .23 (Martin et al., 2000) to (r) .26 (Horvath and Symonds, 1991).

The scales vary according to their structure and components, number of items, rater, format, time to rate, psychometric properties and emphasis. An outline of different measures of the therapeutic relationship used in psychiatric settings complied by McCabe and Priebe (2004) is offered in Table 1.

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 contributions
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-retest reliability and high inter-rater reliability FA 2 factors: alliance, therapist influence; CALPAS-P highly correlated with the WAI-P and VTAS and moderately with	Client contributions

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 α=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	
TA	Perceived need of treatment; Treatment involvement; Insight	6	Expert rater	Questionnaire (chart material)	30 mins	2	High inter-rater reliability	Patient contribution
TCRS	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 contributions
TPSS	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	CA of therapist: 4 factors: rejection/inadequacy, insecurity/ detachment, personal acceptance, professional acceptance CA of patient: 4 factors relating to therapist behaviour	Therapist contribution
TWA	1. Positive & negative aspects of relationshi	20	1. Client 2. Therapist	Questionnaire	20 mins	1	High test-retest reliability.	

	p 2. Positive & negatives aspects of co-operation							
VTAS	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 internal consistency Highly correlated with CALPAS and VTAS Subscales highly inter-correlated	Common and Therapist contributions

Abbreviations: BLRI: Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962); CALPAS: California Psychotherapy Scales (Gaston & Marmar, 1991); CFI: Camberwell Family Interview (Vaughn & Leff, 1976); HAcs and HAr: Helping Alliance counting signs and rating (Luborsky et al., 1983); HAM: Helping Alliance Measure (Klinkenberg et al., 1998); Helping Alliance Scale (Priebe & Gruyters, 1993); PSR: Psychotherapy Status Report (Stanton et al., 1984); SATA: 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 (Marziali, 1984); TCRS: Therapist Client Relationship Scale (Bennun et al., 1986); TPSS: Therapist-Patient Relationship Scales for Schizophrenic Patients (Stark et al., 1992); VTAS: Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983); TWA: Therapeutic Working Alliance (Hentschel et al., 1997); WAI: Working Alliance Inventory (Horvath & Greenberg, 1989)
CA: Cluster Analysis; FA: Factor Analysis; PCA: Principal Components Analysis

For the purpose of this thesis, eight established scales designed to assess the therapeutic relationships will be considered in greater detail on the basis that: (1.) they have been previously used in more than one empirical study of the therapeutic relationship in a psychiatric context; (2.) the rating form is a questionnaire; and (3.) they do not require completion by an expert rater, as this would not be practical in community care settings if applied under routine conditions. A description of these scales and their use in the context of psychiatry is considered below.

Helping Alliance Scale

The professional version of Priebe and Gruyters' (1993) Helping Alliance Scale (HAS) comprises seven questions regarding the patient-professional relationship:

(i) how do you get along with the patient?; (ii) how well do you understand the patient and his or her views?; (iii) how actively involved do you feel you are involved in the patient's treatment; (iv) do you look forward to meeting the patient?; (v) do you feel the patient has trust in you and your professional competence?; (vi) what do you like about the patient?; (vii) what do you dislike about the patient? Answers to the first five questions are self-rated on 100-mm long visual analogue scales with the extreme points "not at all" (= 0) and "entirely" (=10). The final two questions are open-ended (Priebe and Gruyters, 1993).

The patient version of the HAS has six questions regarding the patient-professional relationship: (i) do you feel understood by your key worker?; (ii) do you feel criticised by your key worker?; (iii) how much is your key worker committed to and actively involved in the treatment; (iv) is the treatment you are currently receiving right for you?; (v) do you trust in your key worker and in his / her professional competence?; (vi) how do you feel immediately after a session with your key worker? Answers to the first five questions are self-rated on a 100-mm long visual analogue scale as above. The sixth question is multiple choice: patients could say that they felt better, unchanged or worse than before treatment (Priebe and Gruyters, 1993).

Priebe and Gruyters (1993) used the patient version of the HAS to determine its value as a predictor of treatment outcome in psychiatric community care. The study was carried out in a community care system providing long-term treatment with severe and chronic mental illness serving an inner-city district of Berlin, Germany. Clinical case managers provide continuity of care. This group includes psychiatrists, social workers or nurses with a clinical background and some psychotherapeutic training. A sample of 72 patients seen exclusively by their case managers took part in the study. The number of days of full and partial hospitalisation during a 20-month period after the interview was recorded. Changes in accommodation and work were also recorded. Patients' assessments of the extent to which they were receiving the right treatment were correlated to the number of days of partial hospitalisation ($r = -.40$, $p < .05$). How the patients felt immediately after a session with their case manager predicted the number of days of full ($r = -.21$, $p < .05$) and partial ($r = -.27$, $p < .05$) hospitalisation. The number of days of full ($t = 1.74$, $p < .05$) and partial ($t = 2.28$, $p < .05$) hospitalisation was more than twice as high for patients who felt unchanged or worse after a session with their case managers than those who felt better. Changes in work circumstances were correlated with case managers' understanding ($r = .40$, $p < .05$) and criticism ($r = -.35$, $p < .05$).

McCabe et al. (1999) used the HAS to investigate subjective quality of life and therapeutic relationships in first admission ($N = 90$) and long-term ($N = 168$) schizophrenia patients each at two points in time. For the first admission sample the follow-up period was 9 months and for the long-term sample, 1.5 years. A significant relationship was found between assessments of therapeutic relationships and quality of life in long-term, but not in first-admission patients, suggesting that the therapeutic relationship may become more central to the quality of life of patients in long-term care as views of this relationship are increasingly incorporated in their overall appraisal of life (McCabe et al., 1999).

While the HAS does demonstrate a predictive relationship between the therapeutic relationship and outcome in a community care setting, the scale was developed more or less empirically to quantify and operationalize both patients and clinicians views of the therapeutic relationship in community mental health care (Priebe and Gruyters, 1993). A more rigorously developed test may provide a better assessment tool for this setting.

Psychotherapy Status Report

Frank and Gunderson's (1990) professional-rated Psychotherapy Status Report (PSR) contains 6 items where ratings are made on a 5-point Likert-type scales pertaining to the patients' in-therapy behaviours.

The scale consists of the following items: (i) stable, active and collaborative participation in the treatment process; (ii) full and spontaneous sharing of relevant material with the therapist and responsiveness to the therapists interventions; (iii) expressions of value of the psychotherapy and optimism about its potential usefulness; (iv) presence of a generally clear and realistic picture of the therapist and the therapeutic relationship, and amenability to confrontation or interpretation of transference or other distortions of that relationship; (vi) affective involvement in the treatment and relatedness to the therapist. Each scale has 5 ratings ranging from poor to good, where the endpoints were defined by clinical descriptors.

This scale makes use of Greenson's 'reality based' relationship (as described in the section of this thesis on the psychotherapeutic approach to the therapeutic relationship). While the first three items measure the patient's day-to-day motivation, the last three assess the patient's capacity to perform therapeutic work in a non-distorted, friendly way.

Frank and Gunderson (1990) examined the relationship between the therapeutic alliance (as assessed by the PSR) and outcome (as measured by continuance in psychotherapy, medication compliance and in-patient functioning) of 143 hospital in-patients with non-chronic schizophrenia over a 2-year period. The authors suggest that the first 6 months of therapy is a critical time for the development of alliance. If therapists had not been able to secure a good alliance in the first 6 months of treatment the odds of subsequently doing so were fairly low (only 2 of 39 patients who had a poor alliance in the first six months went on to develop a good one).

Patients who become actively engaged with their therapists during the first six months are less apt to drop out of psychotherapy than those who are not. Only 26.1% of patients with good alliances at 6 months failed to fully comply with their prescribed medication during the next 1 ½ years, compared to 74.4% of patients with fair alliances and 72.2 of those with poor alliances at 6 months were noncompliant thereafter.

More gains were made by patients who formed stronger alliances in the first 6 months of treatment in the 2-year study than patients who did not. Better alliances were associated with greater reductions in psychopathology ($r = .39$, $p < .01$) and positive symptoms of schizophrenia, such as hallucinations-delusions-expansiveness ($r = .29$, $p < .01$), less denial of illness ($r = .39$, $p < .01$), and better social functioning, i.e., the development of more stable, trusting, intimate relationships ($r = .27$, $p < .01$), more extensive and satisfying involvement in socially expected activities ($r = .32$, $p < .01$) and fewer manifestations of behavioural disturbance in social relations ($r = 41$, $p < .05$).

Svensson and Hansson (1999) investigated the development of the therapeutic alliance (using the PSR) in cognitive therapy for schizophrenic and other long-term mentally ill patients and its relationship to outcome in an in-patient treatment programme over a 62-week period. The therapists (who were psychiatric nurses trained in cognitive therapy) assessed the alliance with the 26 patients every 5 weeks. Therapist ratings of the alliance predicted outcome in terms of better patient functioning at discharge. The therapists' ratings showed a more positive relationship between initial alliance and favourable outcome of treatment at discharge. Therapists rated a good initial alliance for 23.1% of the patients, a fair alliance for 65.4% and a poor alliance for 11.5%. In the working phase 3.8% of the patients were rated as having a poor alliance, 69.3% a fair alliance and 26.9% a good alliance. In the discharge phase7.7% of the patients were rated as having a poor alliance, 53% a fair alliance and 38.5% a good alliance.

Some methodological rigour went into the making of the PSR to ensure its validity and reliability. Evidence of the validity of the scales has been obtained from significant correlations (r = .59, p < .01) between it and a similar set of tape-based ratings of engagement. The scale has shown a high level of internal consistency (Cronbach's alpha = .89) and has demonstrated good test-retest reliability (r = .72). The association between alliance and outcome found by Frank and Gunderson (1990) is limited in that it does not offer predictive validity, but only correlational evidence. Furthermore, this scale is clearly rooted in psychoanalytic presuppositions, with end point descriptors such as "patient has grossly distorted or transference-dominated perceptions of the therapist...". The appropriateness of this measure for use with professionals without a psychoanalytic background may be questioned.

Scale to Assess the Therapeutic Alliance (SATA)

Scale to Assess the Therapeutic Alliance (SATA) from a Psychoanalytic Perspective by Allen et al. (1984) is a six-point, example-anchored rating scale with detailed descriptions at each point. The scale points are defined generally as follows: 6, optimal collaboration with active participation in all phases of the treatment programme; 5, general collaboration with minor limitations (e.g., transient interruptions) that the patient wishes to change; 4, some collaboration with significant limitations (e.g., collaborating on one significant issue but not on others); 3, passive compliance or pseudo-alliance, with participation more apparent than real; 2, non participation in treatment; 1, active sabotage of treatment, with all efforts directed at defeating treaters and obstructing change. The scale may be rated from written material, an interview, or a direct treatment relationship with the patient. In any case, the rater must be clinically sophisticated and familiar with the particular treatment process with regard to which the patient is being evaluated. Four mediating variable scales are also included, again, on a six-point, example-anchoring rating scale with detailed descriptions at each point. These mediating variables include: 1. trust in the therapist's commitment, skill and motives; 2. sense of acceptance; 3. optimism about the outcome of therapy; 4. expression of affect.

In developing the scale (Allen et al. 1984), the authors used transcripts from sessions with 15 patients in individual psychotherapy. The raters were experienced psychoanalytically oriented psychotherapists who participated in the development of the scales and rating methods. The Spearman-Brown corrected reliability coefficient for the average rating is .79 for the collaboration scale. The reliabilities for the mediating variables are: trust, .67; sense of acceptance, .72; optimism, .74; and expression of affect, .60.

This scale is conceptually related to Greenson's reality based relationship concept - whereby the patient's day-to-day motivation is measured by the extent to which he or she makes optimal use of the treatment – within the context of his or her capacity to perform therapeutic work in a non-distorted, friendly way (Allen et al., 1984). It aims to distinguish the therapeutic alliance as separate from the transference by referring to the patient's collaborative work and not his or her experience of the relationship with the therapist.

The SATA was used to look at the association between therapeutic alliance and outcome among 37 patients in long-term hospital treatment (whose mean stay was 10.6 months in hospital). Alliance, likeability and improvement at admission and discharge were rated. Ratings of alliance and likeability were highly intercorrelated, both at admission and discharge (r = .72 and .79, respectively, p < .01). The alliance score was significantly correlated with the level of functioning at admission as measured by the Global Assessment Scale (r = .53, p < .01) and the individualised profile level (r = .48, p < .01). The relationships of alliance and likeability to level at functioning at discharge were stronger than those at admission. Changes in alliance and likeability were highly related to changes in the severity of pathology and changes in the individualised profile scores. Alliance scores were relatively homogenous at admission, with some patients subsequently increasing in alliance and others decreasing. The authors concluded that alliance appears to be highly related to treatment outcome partly by virtue of its inter-correlation with global level of pathology at all points. Alliance appears to be inextricably linked to the level of functioning. Improvement in clinical condition and alliance seem to go hand in hand. As the patient improves, he or she is capable of more productive engagement in the treatment, and with increasing engagement, functioning further improves. By contrast, as the patient's functioning deteriorates, he or she becomes less engaged in the treatment and increasingly unable to use help and regress further.

Allen et al. (1988) used the SATA to assess long-term hospital patients' collaboration between 79 patients and staff members (19 psychiatrists, 9 social workers, 31 registered nurses, 21 mental health technicians and 10 activity therapists) in milieu treatment and their working relationships with various staff members. Patient and staff member perceptions of their working relationships corresponded to a significant but modest degree ($r = .26$, $p < .01$). Only nurses' ratings of progress related significantly to patient ratings (primary nurse, $r = .35$, $p < .05$; associate nurse, $r = .28$, $p < .05$). This highlights the divergent perceptions of the treatment process. The authors highlight the need for different perspectives to be openly discussed and clarified in the service of improved collaboration.

Like the PSR, the SATA is clearly rooted in psychoanalytic presuppositions with end point descriptions such as "... At such times, resistances (conscious or unconscious) may take the form of avoiding some significant issues, holding back information or feelings, or being reluctant to work actively with material that does emerge. For example, the patient may censor or forget to bring up certain sexual fantasies..." and "... the patient may frequently intellectualise..." or "... the impediments to collaboration are relatively ego syntonic.". Again, the appropriateness of such a tool for professionals without a background in psychoanalytic theory may be called into question. Furthermore, as alliance, as measured by this scale, is inextricably linked to patient functioning, its value as a predictive tool is limited.

The Therapist Patient Scales with Schizophrenic Patients (TPSS)

The 16-item professional version of the Therapist Patient Scales with Schizophrenic Patients (TPSS) by Stark et al. (1992) includes ratings on therapist's self-perception within the therapist-patient relationship, self-assessments of their therapeutic competence as well as on their feeling of acceptance on both a personal and professional level. A cluster analysis of this scale revealed four factors: 1, rejection / inadequacy; 2, insecurity / detachment; 3, personal acceptance; and 4, professional acceptance. The internal consistency measures (Kuder-Richardson alpha) ranged from .59 to .68. The 30-item patient version measures how the patients rate their therapists at relationship level and with reference to their specific therapeutic skills. Cluster analysis shows four factors interpreted as: 1, rejection / incompetence; 2, indifferent / vague; 3, stimulating; and 4, demanding. Internal consistency varied from .41 to .77. Both versions of the questionnaire use an alternate-choice (yes / no) type format.

These scales are informed by the theory of expressed emotion where schizophrenic patients are believed to suffer from cognitive and empathetic decoding deficits that reduce their tolerance to affect-oriented interaction resulting in an increased sensitivity to expressed affect - and therefore aims to assess components indicative of high expressed emotion on the part of the professional (Stark, 1992).

A study by Stark et al. (1992) aimed to look at the dyadic aspects of the therapist-patient relationship, the interaction between therapists ratings and patients psychopathology, and the predictive value concerning the course of illness among 34 schizophrenic outpatients and their therapists ($n = 8$) receiving one of two behaviour-oriented therapeutic approaches. as a predictor of the course of illness. Results show a significant association with gender. Male therapists were inclined to reduce their therapeutic commitment when confronted with patients who suffered from disturbances of ego-function ($r = 33$, $p < .05$), attention ($r = .39, p < .05$) or perception ($r = .36, p < .05$). Female therapists felt rejected by patients with delusions ($r = .31, p < .05$) and formal thought disorder ($r = .31, p < .05$), but perceived themselves as competent when dealing with anergic patients ($r = .37, p < .05$). At the 2 year follow up, higher relapse rates were found with those patients with whom both male and female therapists had a high degree of emotional response on the relationship scale post therapy. Emotional response showed itself as rejection in male therapists ($r = .32, p < .05$) and emotional commitment in female therapists ($r = .34, p < .05$).

Stark (1994) reviews a study that assesses the therapist-relative-patient triad using patient and professional versions of the TPSS and a parallel version to assess the relative-patient relationship. 12 therapists, 21 patients and 21 key relatives participated. 50% of the therapists showed an overemotional attitude towards at least one patient. 33% of the parents were rated high on EE. On the relative-patient relationship scale, high EE relatives showed stronger feelings of insufficiency and rejection towards the patients. Patients rejected the high EE relatives more resolutely and rated them as more inscrutable. On the therapist-patient relationship scale high EE therapists rated themselves as considerably less personally committed. Patients did not discriminate between high and low EE therapists. None of the 21 patients had both a high EE key relative and a high EE patient. The results suggest that high EE attitudes are to be found not only in familial settings but also in therapeutic relationship.

The TPSS does appear to provide a valid measure of expressed emotion by staff. In line with research on expressed emotion among family members and patient relapse (Leff, 1994; Leff, 1998; Vaughn and Leff, 1976; Moore and Kuipers, 1992) Stark and colleagues have demonstrated the existence of EE by clinical staff, as measured by the TPSS. In one study the link between high EE and patient relapse was demonstrated. The implications for clinical practice are numerous. Professionals should be aware of over emotional attitudes. Regular supervision would be recommended. An unambiguous communication style would be helpful in the therapeutic process with respect to the particular demands of schizophrenic patients. As this tool was developed for and validated with schizophrenic patients, its value for other patient populations is unknown.

Working Alliance Inventory

Horvath and Greenberg's (1986) Working Alliance Inventory (WAI) contains three subscales: agreement on tasks, agreement on goals and development of bonds. The long-version consists of 36 items rated on a 7-point Likert-type scale (1 = never, 7 = always). The following are examples from items from the task scale: "The therapist and client agree about the things the client needs to do in therapy to help improve the client's situation"; from the goal scale: "The goals of the sessions are important for the client and the therapist"; and from the bonds scale: "The therapist and the client respect each other".

Reliability and validity of the instrument have been established with various populations (Horvath and Greenberg, 1989). The short-version of the WAI contains 12 items derived from the 36-item version. Again, each item is rated on a 7-point scale. Internal consistency reliability data of the short version compare favourably with those of the longer form, alpha coefficients ranging from .90 to .92 (Tracey and Kokotovic, 1989). The internal consistency reliability rates were .94, .86, .84 and .90 for the total, bond, task and goal scores, respectively. The validity of the instrument is supported by the consistent finding that it is predictive of outcome from both the professional and patient's perspectives (Horvath and Greenberg, 1986).

The WAI is based on Bordin's 'goodness of fit' model, where patient and professional alignment with regard to the goal, task and bond in treatment are proposed to be the three central components of a good relationship (Horvath and Greenberg, 1986; Bordin, 1979).

Gehrs and Goering (1994) used the WAI to assess the relationship between the working alliance and rehabilitation outcomes among 22 schizophrenic patients in an active rehabilitation programme. A significant correlation was found between the working alliance and rehabilitation outcomes at Time 1 and ($r = .72$, $p < .01$) Time 2 ($r = .69$, $p < .01$). Rehabilitation therapist and client perceptions showed moderately high congruence at Time 1 ($r = .53$, $p < .05$) and Time 2 ($r = .56$, $p < .05$). The generalizability of the findings to the larger population of patients with schizophrenia may be limited due to the small sample. However the findings do support the importance of the working alliance when providing psychiatric rehabilitation for individuals with schizophrenia.

Solomon et al. (1995) used the WAI to measure the strength of the therapeutic relationship between seriously mentally disabled patients ($N = 96$) and their case managers in a randomised trial of consumer-provided case management services. While there was no difference in the strength of the alliance between the consumer and non-consumer teams of case managers, there were some positive relationships between alliance and some outcomes, including quality of life ($t = 4.52$, $p < .05$,) attitudes toward medication compliance ($t = 3.38$, $p < .05$) and satisfaction with mental health treatment ($t = 7.58$, $p < .05$). This data indicates that the relationship between a case manager and patient may be particularly useful in improving patients' subjective experiences of community living. In this study the WAI was collected after 2 years of service. Patients who remained in treatment for 2 years are likely to have developed a strong alliance with their case manager, regardless of whether they were a consumer or not. As the relationship between outcome and alliance is correlational, it is unclear as to whether a strong alliance predicts outcome, or treatment improvement results in a strong alliance.

Neale and Rosenheck (1995) used the WAI to measure the relationship between the therapeutic alliance of patients ($N = 143$) and their case managers in a Veterans Affairs intensive case management programme and outcome. Alliance was measured 2 years after being in the programme. Strong alliance was associated with reduced symptom severity ($r = -.20$, $p < .05$) and improved global functioning ($r = .36$, $p < .05$) and community living skills ($r = .23$, $p < .05$) and positive outcome ($r = .36$, $p < .05$). The study relied on retrospective rather than prospective appraisal of the alliance. Therefore causal or interactive explanations about alliance and outcome cannot be made.

Titchenor and Hill (1989) compared six measures of the working alliance (CALPAS), the Penn Helping Alliance Rating Scale (Penn), the Vanderbilt Therapeutic Alliance Scale (VTAS), Working Alliance Inventory-Observer form (WAI-O), Working Alliance Inventory-Client form (WAI-C) and the Working Alliance Inventory-Therapist form (WAI-T) between 8 therapists and 8 patients in psychotherapy. All measures were internally consistent as indicated by the coefficient alphas (CALPAS = .90; Penn = .93; VTAS = .93, WAI-O =.98; WAI-C = .96; WAI-T = .95). In comparing the six measures, the CALPAS, VTAS and WAI-O were highly intercorrelated. The Penn was related only to the WAI-O. The WAI-C and WAI-T were not significantly related to each other, nor to any of the observer-rated measures. This suggests that patients, therapists and observers clearly do not agree when it comes to a consensus on what working alliance is. However the sample size is very small, and the generalisability of the results are therefore limited.

A review of 24 studies relating the quality of the working alliance to therapeutic outcome revealed a moderate, but reliable association between a positive working alliance and good therapeutic outcome (Horvath and Symonds, 1991). The reliability of the Working Alliance Inventory in predicting outcome across a range of treatment settings and patient diagnoses indicates that it may be a useful assessment tool of the therapeutic relationship.

California Psychotherapy Alliance Scales

The California Psychotherapy Alliance Scales (CALPAS) assess four subscales: Patient Working Capacity (PWC), Patient Commitment (PC), Working Strategy Consensus (WSC) and Therapist Understanding and Involvement (TUI). The PWC subscale reflects the patient's ability to work actively and purposefully in treatment. The PC subscale reflects the patients' attitude toward the therapist and therapy, including affectionate trusting feeling toward the therapist and a commitment to go through the completion of treatment even if it entails difficult moments and sacrifices. The WSC subscale reflects the degree of agreement between the patient and therapist views about how to proceed in therapy. The TIU subscale reflects the therapist's empathetic understanding of the patient's difficulties and sufferings and active participation in therapy for the sake of the patient.

While the patient working capacity and commitment items are aligned to Greenson's concept of the 'reality based' relationship, the working strategy consensus derives from Bordin's 'goodness of fit' with regard to the tasks and goals of therapy (Gaston and Marmar, 1991; Gaston, 1990). Therapist understanding and involvement is based upon Rogers' humanistic approach that emphasises the centrality of the professional's attitudes toward the patient (Gaston and Marmar, 1991; Gaston, 1990).

The scales offer patient (a 24-item long or 12-item short), professional (24-item), and independent-rater (with protocol) versions. Both the 24-item patient and professional versions of the California Psychotherapy Alliance Scales are comprised of six questions for each of the four components, rated on a 5-point Likert-type scale.

Weiss et al. (1997) examined the role of the alliance (as measured by the CALPAS) in the pharmacologic treatment of 31 depressed outpatients. Treatment outcome was measured by the Hamilton Rating Scale for Depression and the Beck Depression Inventory and the Symptom, Sign and Side-effect Checklist. The project was designed to focus on the process of pharmacotherapy rather than solely on its outcome thus alliance was measured after each session. A multiple time-series design was employed to investigate the alliance-outcome association over time, within and across patients. This design also allows the investigation of the time frame of the association between alliance and outcome, to see whether it is concurrent or lagged. The alliance measures accounted for between 21% and 56% of the variance in the three outcome measures. By averaging across outcome measures, therapist perceptions of the alliance predicted 41% of the variance in improvement in depressive symptoms, where patient perceptions predicted 25%. As in all correlations, it is impossible to determine cause and effect. Although the time-series data does lend some support for the association between alliance and outcome for most patients.

Gaston et al. (1998) investigated alliance (using the CALPAS), technique and their interactions in predicting outcome of behavioural therapy (BT), cognitive therapy (CT) and brief dynamic therapy (BDT) among 91 elderly depressed patients. A positive effect of working alliance on depression scores at post-treatment was found with a moderate post-treatment symptom specific effect size (r = .30).

Bachelor and Salame (2000) studied the course of diverse dimensions of the therapeutic alliance as seen by 30 therapy participants and 20 therapists. The CALPAS, WAI and Helping Alliance Questionnaire were used. Alliance was measured at sessions 5 and 10. Pre-post differences in clients' self rated symptomatic status and in therapists' ratings of patients' level of functioning 2 weeks following termination. No significant change in participants' average alliance scores on the measures from the 5th to 10th sessions. Few differences were found between the therapists' and clients' average ratings and the relationship was generally perceived differently within dyads. Given that alliance perceptions for the most part proved stable from the 5th to the 10th therapy session both in therapists and patients, it may be that many facets of the alliance stabilised by the 5th session. However findings regarding the course of the relationship over time were limited to broad time intervals. More frequent assessment would have allowed for a more sensitive analysis of the developmental course of the therapy relationship and its components.

The CALPAS offers a valid and reliable scale. Gaston (1991) reported satisfactory reliability (alpha = .83) for the total patient scale and therapist scale (alpha = .73) as well as evidence of criterion-related validity. Adequate test-retest reliability coefficients of .52 and .59 respectively were obtained when scores were gathered at the second and eighth sessions of pharmacotherapy. This indicated some variation as well as some stability in alliance scores. The association between the CALPAS-P and CALPAS-T was found to equal .23 and .31 at the second and eighth sessions. Low correlations between patient and therapist version of alliance measures are also found in psychotherapy research. Based on a meta-analysis of 58 studies a correlation of .17 was found between ratings of the therapeutic relationship using the CALPAS and outcome by Martin et al. (2000).

Therapeutic Alliance (TA)

Clarkin et al. (1987) developed the 6-point Therapeutic Alliance (TA) scale to make one global rating of each patient's therapeutic alliance throughout his or her hospital stay. This 6-point ordinal scale considers whether the patients are actively, passively or not at all involved in the various aspects of their hospital treatment. It also assesses whether the patient's alliance with the goals and procedures of their treatment characterises all or only one part of their hospitalisation. The scale was constructed by abstracting phrases and comments of the therapists, social workers and nursing staff from hospital charts. These phrases and comments formed the anchor points of the scale. Independent ratings made after the training showed satisfactory reliability in the use of the scale (intraclass correlation coefficient = .89).

The TA is based on Greenson's 'reality based' relationship concept by measuring the patient's motivation in therapy within the context of having the capacity to perform work in a realistic way, from the "Patient is actively involved in therapy – explores problems, makes realistic plans for discharge, and so forth" to the

"Patient sees no need for hospitalisation and is constantly demanding discharge; sees no need for aftercare or therapy; totally denies emotional problems; actively refuses treatment".

Using this scale Clarkin et al. (1987) investigated the effect of the therapeutic alliance on treatment outcome in a stratified sample of 96 hospital inpatients. Alliance was correlated with improvement at discharge. At the time of discharge there was a highly significant relationship between global assessment of symptoms and therapeutic alliance ($r = -.36$, $p < .05$). Significant contributions to the total variance of functioning at discharge were accounted for by the alliance ($F = 19.56$, $df = 1,85$, $p < .05$). Symptom patterns and personality dysfunction were shown to be differentially related to the quality of the alliance. The results suggest that the patient's alliance in the hospital setting is correlated with a better condition at discharge. As the sample consisted of in-patients the generalizability of the results outside of an inpatient setting is unknown. Furthermore, as the study only used a correlational design, a cause and effect relationship between alliance and outcome cannot be claimed.

Beauford et al. (1997) used the TA to see if initial therapeutic alliance was a predictor of the risk of violent behaviour during short-term hospitalisation. The admitting physician's written evaluation for each of 328 patients hospitalised on a locked inpatient unit was reviewed using the TA. Acute symptoms were rated at admission by physicians using the Brief Psychiatric Rating Scale (BPRS). Nurses rated aggressive behaviour in the hospital with the Overt Aggression Scale. Patients who had a poorer therapeutic alliance at the time of admission were significantly more likely to display violent behaviour during hospitalisation. Logistic regression analysis showed that the quality of the initial therapeutic alliance remained a strong predictor of violence even when other clinical and demographic correlates of violence were considered concurrently. A significant correlation between inpatient aggressive behaviour and therapeutic alliance was found ($t = .42$, $p < .05$). The weaker the therapeutic alliance during the initial evaluation of the patient, the higher the risk of the patient exhibiting physical attacks or fear-inducing behaviour during the first week of hospitalisation. This study advances the field by being the first to link alliance and the outcome variable of violent behaviour.

Barrett-Lennard Relationship Inventory (BLRI)

Barrett-Lennard's (1962) 92-item patient and professional-rated Barrett-Lennard Relationship Inventory (BLRI) was designed to measure four therapist qualities: 1, empathetic understanding; 2, level of regard; 3, unconditionality of regard; and 4, congruence. Empathetic understanding is measured by items like "My therapist tries to see things through my eyes"; level of regard is rated by items such as "My therapist respects me"; unconditionality of regard is measured by items such as "My therapist always responds to me with warmth and interest"; and congruence is measured by items like "My therapist behaves just the way he / she is, in our relationship".

The BLRI derives from Rogers' conception of the 'necessary and sufficient conditions' of therapeutic personality change (Barrett-Lennard, 1962). From this perspective, "the client's experience of his therapist's response is the primary locus of therapeutic influence in the relationship" (Barrett-Lennard, 1962).

Salvio et al. (1992) examined the strength of the alliance using the WAI and BLRI in three treatments (focused expressive psychotherapy, cognitive therapy and supportive / self-directed therapy) for depressed patients (N = 46). The WAI, BLRI and their subscales were highly inter-correlated (the correlations of the WAI subscale scores with the BLRI subscale scores, for instance, ranged from .65 to .85). While no difference was found in the strength of the therapeutic alliance between the different forms of therapy, the strength of the alliance in early therapy predicted its strength at the end of therapy (i.e., the task scores at week 5 correlated .78 with task scores at week 20). These results that although the WAI and BLRI intended to measure different aspects of the therapeutic relationship, their subscales were highly inter-correlated, indicating that they are measuring a similar underlying construct. That early alliance predicts later alliance suggests that the alliance is established quite quickly. Failures to establish a good relationship early may need prompt identification to correct it early in the therapeutic process.

Chapter 4

The therapeutic relationship and outcome

Treatment type as a potential moderator of the impact of the therapeutic relationship on outcome has been considered. A positive therapeutic relationship appears to lead to better patient outcome across a range of treatment conditions, including behaviour therapy, brief dynamic therapy, gestalt therapy, focused expressive psychotherapy, cognitive therapy, supportive/ self-directed therapy, exploratory, and insight-oriented therapy (Martin et al., 2000; Salvio et al., 1992; Frank and Gunderson, 1990; Alexander and Luborsky, 1986; Luborsky, 1976). That similar therapeutic gains appear to be made from a positive therapeutic relationship across different treatment conditions may support the argument that the therapeutic relationship is a pan-theoretical factor leading to positive patient outcome (Martin et al., 2000; Hovarth and Luborsky, 1993).

Another potential moderator of the impact of the therapeutic relationship on outcome is patient diagnosis. A positive therapeutic relationship has predicted positive outcome across a number of patient diagnoses, including neurotic, schizophrenic, drug dependent, and depressed patients (Raue et al., 1997; Alexander and Luborsky, 1986). However some symptom patterns and personality dysfunction may be differentially related to the quality of alliance and outcome, namely: patients with axis 1 substance abuse, adjustment and somatoform disorders (Clarkin et al., 1987); older, depressed patients (Gaston, 1991) and alcoholic patients (Connors et al., 1997) appear to have poorer therapeutic alliances and outcome. A study of community psychiatric nurses revealed that 84% of staff felt that dealing with patients with borderline personality disorder was more difficult than dealing with other patient groups (Cleary et al., 2002). Patients with non-affective psychotic illness, particularly those lacking insight, reported being significantly less satisfied with their care in a study investigating patient satisfaction in an acute psychiatric in-patient ward (Barker et al., 1996). Within psychiatry, it has been suggested that the poorest ratings of the therapeutic relationship among long-term hospitalised patients with schizophrenia, psychopathology could account for 3-28% of relationship variance (McCabe and Priebe, 2000).

How patient (versus clinician) ratings of the relationship predict outcome has not been established. While some approaches emphasise clinician contribution to the therapeutic relationship (Barrett-Lennard, 1962), and suggest therapist contribution to the therapeutic relationship may be more important to outcome in cognitive therapy and psychotherapy (Bennun et al., 1986; Marziali, 1984) many maintain that patient contribution to the alliance may be a better predictor of therapeutic outcome across treatments (Krupnick et al., 1996; Barkham et al., 1993; Frank and Gunderson, 1990; Allen et al., 1988; Marmar et al., 1986; Suh et al., 1986; Hartley and Strupp, 1983; Moras and Strupp, 1982; Marmar et al., 1986; Marziali et al., 1981). That patient contribution to the relationship may be a more relevant factor than therapist contribution may mean a greater emphasis should be placed upon the clinician's ability to engage the patient in training and clinical practice.

A substantial body of research in psychotherapy indicates that patient ratings of alliance predict outcome better than clinician ratings (Bachelor and Horvath, 1999; Krupnick et al., 1996; Hovarth and Luborsky, 1993; Barkham et al., 1993; Frank and Gunderson, 1990; Allen et al., 1988; Marmar et al., 1986; Suh et al., 1986; Marziali, 1984; Marziali et al., 1981). However, others suggest that clinician ratings may provide better predictive value in the treatment of depression (Weiss et al., 1997) and schizophrenia, psychosis or major affective disorder (Gehrs and Goering, 1994; Neale and Rosenheck, 1995). A better understanding of this discrepancy between the patient and clinician's perception of the alliance is needed to improve clinical practice, based upon a more effective use of the alliance construct (Hovarth and Luborsky, 1993). A meta-analysis of 79 studies by Martin et al. (2000) revealed no difference in the ability of raters (patient, clinician and observer) to predict outcome.

The time of alliance assessment has been identified as a potential moderator of the impact of the therapeutic relationship on outcome. Some research indicates that early alliance is correlated with outcome (Luborsky et al. 1983; Svensson and Hansson, 1999; Schwartz et al., 2003; Horvarth and Symonds, 1991). In the attempt to control for influence of pre-treatment scores on post-treatment scores in the analysis of associations between initial alliance and outcome, for instance, standardised residual change scores derived from regression analysis with the pre-treatment score as the independent variable and post treatment scores as the dependent variable were used as a measure of improvement in outcome (Svensson and Hansson, 1999). Taking this, plus Martin et al.'s (2000) suggestive finding that patients' view of the alliance is more stable over time – it could be suggested that the professional's success in initially engaging the patient is crucial. If the professional fails to establish a good relationship from the outset, it may be difficult to do so later. Alliance difficulties may therefore need to be addressed early. A summary of research on the alliance outcome relationship by Horvath and Bedi (2002) led the authors to suggest that in the opening phase the professional should aim to flexibly respond to the client's needs. A convergence of alliance assessments appears to accompany effective treatment in medium- to long-term therapies (Horvath and Bedi, 2002). And in some cases, high initial ratings by patients indicates unrealistic expectations resulting in plummeting ratings due to the subsequent discrepancy between expectations and benefits experienced (Horvath and Bedi, 2002). It has been suggested that early alliance as a slightly more powerful predictor of outcome may reflect the rupture-repair cycle in successful therapies predicted by Zetzel (1956) – wherein a strong initial alliance is followed by a disruption or rupture, which is in turn followed by a re-attainment of a strong alliance. A rupture in the therapeutic alliance has been defined as "a tension or breakdown in the collaborative relationship between patient and therapist" (Safran et al. 2002). A review of research on rupture and repair resolution by Safran et al. (2002) suggests that there is preliminary evidence of that a 'tear and repair' pattern of alliance for some patients over the course of treatment that is associated with outcome. However other research has found that the alliance uniquely contributed to outcome with increasing variance as therapy progressed (Gaston et al., 1991; Gaston et al., 1998). Other research has found no temporal relation between alliance and outcome (DeRubeis and Feeley, 1990; Feeley et al., 1999). Feeley et al. (1999) suggest that in many studies where early alliance is said to predict outcome - the predicted variable incorporated symptom change that had occurred before the alliance was assessed, confounding prior and subsequent change. When the alliance is assessed in a given session, the temporal confound may be avoided by assessing symptom change that occurs prior to and subsequent to that session.

It may be questioned whether a positive therapeutic relationship is an artefact of the treatment progress, rather than a predictor of patient outcome. If alliance is an artefact of successful treatment, it would be expected that its development would follow therapeutic progress (Horvath and Luborsky, 1993). In the long-term unit of a psychiatric hospital patient collaboration appeared to be a manifestation of patient general functioning in one study (Allen et al., 1985) and was significantly related to staff perception of patient progress in another (Allen et al., 1988), providing support for the alliance-as-artefact argument. By contrast, that much evidence indicates that an early alliance predicts therapeutic outcome may support the argument that the therapeutic relationship may contribute to, rather than be a by-product of, therapeutic progress.

Among chronic and severely mentally ill patients, the therapeutic goal may not be to effect change through treatment, but rather to manage it. This could include providing containment and to sustain the physical wellbeing of the patient (Gunderson, 1978). Among homeless persons with severe mental illness, it was revealed that while a strong alliance predicted consumer satisfaction and less severe global symptom severity after two months, the only outcome associated with alliance after fourteen months was consumer satisfaction (Klinkenberg et al., 1998). In contrast to in short-term intervention programmes such as cognitive behaviour therapy for a phobia, for instance, where the relationship terminates once the patient recovers from the phobia, chronically mentally ill patients typically engage in long-term relationships with their clinicians and other mental health care professionals to manage, rather than recover from, illness. Furthermore, a shift in locus from hospital to community aftercare planning requires that patients can rely, over time, upon associations with a clinician, case manager or other mental health care professionals, who are interested in, and respond to them on a personal level to ensure their continuity of care (Wasylenski et al., 1985). A positive therapeutic relationship appears to lead to greater aftercare commitment on the part of mental health care workers, where better alliances are associated with higher administrative measures of rates of follow-up, promptness of follow-up, and continuity of outpatient care (Druss et al., 1999). It has been suggested that different 'curative factors' may be more relevant to different stages of a therapeutic relationship among long-term mentally ill patients: while a relationship between encouragement, reassurance and awareness has been associated with the initial stage of the alliance, in-depth sessions and 'talking to someone who understands' was related to the working phase of the relationship; and self-understanding and problem solution was associated with the alliance at the discharge phase (Svensson and Hansson, 1999), which may reflect different patient needs at different points of time during the course of their illness and treatment in clinical practice.

While a relationship of some description must exist in order for the patient and clinician to engage in the treatment process (a necessary condition) and appears to positively contribute to patient outcome - it may not be enough (a sufficient condition) to effect therapeutic change. Client-centred, humanistic and some psychoanalytic schools regard the therapeutic relationship as both a necessary and sufficient condition for change (Rogers, 1957; Clarkson, 1990; Schaap et al., 1996; Meissner, 1999). While most other orientations agree that this relationship is necessary, there is a lack of consensus as to whether it is sufficient to promote change. Here one's confidence in attributing treatment change to the therapeutic relationship may be discounted by other possible causes of change that are also present in a therapeutic process (Kelly, 1971), such as the treatment programme and recovery over time. There is much evidence to suggest that the therapeutic alliance is related to outcome (Martin et al., 2000; Horvath and Symonds, 1991), although it sometimes produces quite small associations or fails to predict it at all (Lambert, 1992). Whether the therapeutic relationship is a sufficient condition to produce change or not – it is certainly a necessary condition.

Chapter 5

Research aim of this thesis

The therapeutic relationship is at the core of community mental health practice. While much research exists on the therapeutic relationship in psychotherapy and in-patient psychiatry, there is a dearth of information on the therapeutic relationship in community care. Indeed, most measures used to assess the therapeutic relationship in community care were developed for the patient-clinician relationship in other therapeutic settings (i.e., California Psychotherapy Alliance Scales (Gaston, 1991), Therapist Patient Scales with Schizophrenic Patients (Stark, 1992)) or at best, more or less empirically specifically for this setting (i.e., Helping Alliance Scale, (Priebe and Gruyters, 1993)).

In contrast to the relationship that exists in conventional psychotherapy, community care relationships are characterised by heterogeneous treatment goals and components (treatment adherence, rehabilitation, stability rather than change, public safety, prevention of relapse, accessing services) and the formal statutory responsibility of the clinicians. The clinicians come from different training backgrounds (social workers, community psychiatric nurses, occupational therapists, psychologists, psychiatrists, general practitioners). The patients have long- term mental health problems (persistent and severe disturbances of thought, feeling and behaviour as a result of psychotic illness) accompanied by a range of social, medical and personal needs. Furthermore, patients frequently find it difficult to accept the services that may help them maintain a sufficient level of independence.

The aim of this thesis is to develop a valid and reliable measure of the therapeutic relationship for community mental health care. To this end, I developed patient and clinician versions of a quantitative rating scale for a community care setting in four stages. In stage one, qualitative data collection, I held semi-structured interviews with both clinicians and patients to identify specific elements deemed relevant to the therapeutic relationship in community care. Items of existing scales were also evaluated by this sample for their applicability to this setting. In stage two, the main quantitative data collection phase, I applied those items of existing scales that were found to be applicable and comprehensible and additional items as identified in the semi-structured interviews to a number of clinicians and patients in East London. On the basis of the results, I condensed the item pool. In stage three, I administered the reduced item pool twice to assess test-retest reliability of items to develop the final scale. In stage four, I analysed fit of factorial structure of the final scale when applied to a new sample.

Chapter 6

Part one: Qualitative data collection

The aim of stage one is twofold: to reveal elements of the therapeutic relationship that may be specifically relevant to patients and clinicians in community mental health care; and to determine the applicability of established assessments of the therapeutic relationship in this setting.

Sample

I made presentations at one rehabilitation team and three community mental health team meetings in East London to describe the study and invite clinicians to participate. An opportunity sample of 12 mental health professionals was obtained with the aim to attain proportional representation from each of the professional groups[1]. The sample included 5 social workers, 4 community psychiatric nurses, 2 psychologists and 1 occupational therapist. There were 7 females and 5 males. 6 were white British, 4 African-Caribbean and 2 from other ethnic origin. The patient sample was obtained from the participating clinicians and included 5 females and 5 males. 6 were African-Caribbean, 3 were white British and 1 was Asian. I selected patients on the basis that they have severe mental illness and are in the care of a community mental health care team. The study was approved by the local Ethics Committee.

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[1] This was based on clinician data from three CMHTs in East London (the South, West and East teams). Across the 3 teams there were 17 community psychiatric nurses (40%), 22 social workers (51%), 2 occupational therapists (.05%) and 2 psychologists (.05%). 29 were female (67%) and 14 were male (33%). In this sample I obtained 4 community psychiatric nurses (33%), 5 social workers (42%), 1 occupational therapist (1%) and 2 psychologists (16%). 7 were female (58%) and 5 were male (42%).

Protocol

I invited participants to participate in an interview at a location that would be convenient for them. All clinicians requested that the interview be held at their respective offices - at one of three Community Mental Health Team offices and a rehabilitation centre. All but one patient requested that the interview be held at their home that requested that the interview be held at a Community Mental Health Team office. I provided participants with an information sheet (See Appendix 1) on the research project, and asked them to complete a written consent form (See Appendix 2).

Seven open-ended questions were asked of the patients regarding the therapeutic relationship in community care. The questions were hypothetical and did not address any specific relationship: 1, Imagine an ideal clinician-patient relationship. How would you describe it - and what would be the characteristics of it that would make it an ideal relationship?; 2, Imagine a difficult clinician-patient relationship. How would you describe it - and what would be the characteristics of it that would make it a difficult relationship?; 3, What personal qualities or characteristics can a clinician have that makes a good relationship with patients? Or what can a clinician do to foster a good relationship with patients?; 4, What personal characteristics do you think that the patient can have that makes them form good relationships with clinicians? Or what can patients do to foster good relationships with clinicians?; 5, What other persons – other than the clinician and patient – do you think can affect the relationship between the clinician and patient? Do you think that anybody else can affect the relationship?; 6, Do you think that where you see your clinician – whether you meet them at your home, at the hospital, or at the team – makes a difference in how you interact in your relationship?; 7, Are there any other issues relating to the relationships between clinicians and patients that you think haven't been addressed, but you think are important, that you would like to raise.

Eight open-ended questions were asked of the clinicians regarding the therapeutic relationship in community care. Again, the questions were hypothetical and did not address any specific relationship: 1, Imagine a good relationship that you have had with a patient. Could you describe the characteristics of it that made it a good relationship?; 2, Imagine a difficult relationship, and describe it briefly, and the characteristics of it that made it a good relationship.; 3, What personal characteristics do you think a clinician can have to facilitate or impede a good relationship with a patient?; 4, What personal characteristics do you think that a patient can have that will facilitate or impede the development of a good relationship with a clinician?; 5, What other persons, other than the patient or clinician can facilitate or impede the development of a good relationship?; 6, Do you think that where you see a patient (here, the hospital, their home) makes a difference in how you interact in your relationship?; 7, Do you think that there are other issues regarding the therapeutic relationship that haven't been addressed that you think are important?; 8, What training do you think that clinicians should be provided with to help them form good relationships with patients?

Following the semi-structured interview questions I then presented the participants with pre- established scales that have been used to investigate relationships between a helping professional and patient to determine their applicability to community mental health care settings.

The clinicians were presented nine scales: the clinician version of the HAS (Priebe and Gruyters, 1993); the clinician version of the WAI (Horvath and Greenberg, 1986); the clinician version of the CALPAS (Gaston and Marmar, 1991); the SATA (Allen et al., 1988); the TA (Clarkin et al., 1987); the PSR (Frank and Gunderson, 1990); the clinician version of the BLRI (Barrett-Lennard, 1962); the clinician version of the TPSS (Stark et al., 1992); and the Homeless Engagement and Acceptance Scale (Park et al., 2002).

The patient sample was presented with five scales: the patient version of the HAS (Priebe and Gruyters, 1993); the patient version of the WAI (Horvath and Greenberg, 1986); the patient version of the CALPAS (Gaston and Marmar, 1991); the patient version of the BLRI (Barrett-Lennard, 1962); and the patient version of the TPSS (Stark et al., 1992).

These scales (and not others) were selected on the basis that: (1.) they have been previously used in more than one empirical study of the therapeutic relationship in a community psychiatric context; (2.) the rating form is a questionnaire; and (3.) they do not need to be completed by an expert rater, as this would not be practical or relevant in community care settings if applied under routine conditions.

Each participant was presented participants with the measures and asked: ‘Could you please have a look at these scales and tell me which scales you think are most relevant to the patient- clinician relationship in community care?’

Analysis

The interviews were audio taped and I transcribed verbatim. I analysed 44 pages of transcript using a grounded theory approach. This means that theory is grounded in themes emergent from the participants’ contributions rather than a priori assumptions. Grounded theory uses a concept-indicator model (Strauss, 1988). This directs the conceptual coding of a set of empirical indicators. The empirical indicators are actual data in the words of the interviewees. Using a constant comparison technique, comparing indicator to indicator – similarities, differences and degrees of consistency of meaning among indicators are examined. This generates an underlying uniformity, which in turn results in a coded category – a node. Once a conceptual node is generated then indicators are compared to the emerging concept. Based on the comparisons of additional indicators to the conceptual nodes, the nodes are then sharpened to achieve their best fit to the data. Further properties of categories are then generated, until the nodes are verified and yield nothing new.

The transcriptions were content-analysed using the qualitative package Nudist (N4 Classic) using a framework approach to reveal categories that are regarded significant by both parties with regard to the quality of the clinician-patient relationship in community care. The framework approach included five stages: 1, familiarisation; 2, identifying a thematic framework; 3, indexing; 4, charting; and 5, mapping and interpretation (Pope et al., 2000). In the familiarisation stage (Pope et al., 2000), the transcripts were read several times with the aim to generally identify recurrent themes. I imported the transcripts into the qualitative data analysis package Nudist (N4 Classic), and established a general thematic framework (Pope et al., 2000) by highlighting each discrete semantic unit of speech (i.e., "[The patient should]... be honest at all times") each unit of speech was assigned a free node: (i.e., "Free Node: Patient Honesty"). In the third stage, Indexing (Pope et al., 2000), I refined and systematically indexed the thematic framework. Recurring free nodes were made into formal nodes by being assigned a title and address (i.e., (1) patient, (1.1) patient honesty). The data was analysed by a second researcher independently, revealing good inter-rater reliability[2]. This permitted the fourth stage of analysis, Charting (Pope et al., 2000) where I grouped shared "nodes" from different interviewees in a report-form, displaying each respondent's semantic unit of speech to the corresponding node. In the final stage, mapping and interpretation (Pope et al., 2000), I created a node tree to display the themes that have emerged from the data – the categories regarded as significant by both clinicians and patients with respect to the quality of their relationship. Items mentioned by 4 or more interviewees (18% of the total sample) were noted with the aim to have an over-inclusive number of items. This

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[2] A second independent researcher coded 15% of the transcripts (2 patient interviews and 2 clinician interviews) to determine inter-rater reliability. The researcher was presented with the four transcripts and a sheet detailing the formal nodes and was asked to assign the formal nodes to the semantic units that comprised the interviee responses. Good concordance was found between the formal nodes that I assigned to the semantic units and those assigned by the independent rater ($\kappa=0.95$, $p<0.01$).

approach was adopted due to the small sample size to ensure a large range of items that could always be lost at a further stage.

Based on the clinician and patient evaluations of the pre-existing scales, those scales rejected by five or more clinicians or four or more participants (40% of each group) were discarded. Again, as a range of items could be lost at a later stage, an over-inclusive, rather than under-inclusive approach was taken.

Findings of qualitative data collection

Concepts raised 4 or more participants (18% of the total sample) are outlined in Table 2.

Table 2: Elements of a therapeutic relationship in community mental health care mentioned by 4 or more of participants

Clinician contribution	Patient contribution	Mutual Contribution	Other Contribution
Helpfulness with services: 13	Aggression: 12	Open communication: 9	Family interference: 10
Reliability: 11	Trust of clinician: 9	Expectations: 8	
Support of patient: 10	Willingness to engage: 9	Honesty: 8	
Facilitates, not directs: 9	Co-operation: 9	Trust: 7	
Understanding: 8	Accepts treatment: 8	Rapport: 6	
Perspective taking: 8	Respect: 7	Mutual respect: 4	
Authoritarianism: 8	Does not see self as ill: 6		
Respect for patient: 7	Commitment: 5		
Frequency of contact: 7	Openness: 5		
Listens to patient: 7			
Empathy: 6			
Sensitivity to culture: 6			
Patience: 6			
Flexibility: 5			
Criticism: 5			
Accessibility: 5			

More items related to clinician contribution (i.e. helpfulness with services, reliability and support of patient) than patient contribution (i.e. aggression toward clinician, trust of clinician and willingness to engage) or mutual contribution by both the clinician and patient (i.e. open communication, shared expectations and honesty). Only family interference was reported as an external influence on the clinician-patient relationship.

Whilst clinicians account for 68% of the responses, patients account for 32%. Both clinicians and patients reported the impact of the clinician's helpfulness in accessing services and obtaining benefits (8 clinicians, 5 patients) and patient aggression (8 clinicians, 4 patients) on the therapeutic relationship. However, 8 clinicians emphasised the effect of family interference, 8 patient trust, 8 clinician facilitation, 8 clinician perspective taking 7 patient willingness to engage and 7 mutual explicit and realistic expectations of patient progress while 6 patients emphasised clinician reliability, 6 support, 6 contact, 5 open communication, and 4 the patient's acceptance of treatment.

Many of the elements revealed by the semi-structured interviews are similar to items contained in pre-existing scales designed to assess the therapeutic relationship. With respect to clinician input, elements that relate to pre-existing scale items include: understanding (CALPAS, HAS, TPSS, BLRI); respect (BLRI); empathy (CALPAS, TPSS); authoritarianism (TPSS), patience (TPSS, BLRI); and criticism (HAS, TPSS, BLRI, CALPAS). Patient items that correspond to scale items include: trust (HAS, TPSS), willingness to engage (HEAS), co-operation (PSR, CALPAS), accepts treatment (CALPAS, TA), commitment (CALPAS) and openness (CALPAS, TPSS). Collaboration elements that map onto scale items include: trust (WAI, TPSS), respect (WAI), expectations (WAI) and rapport (HAS).

Several items identified by the semi-structured interviews do not map onto pre-existing measures of the therapeutic relationship, namely: clinician reliability; clinician facilitates, not directs; clinician frequency of contact; clinician listens to patient; clinician sensitivity to patient's culture; clinician flexibility; clinician accessibility; patient does not see self as ill; open communication; mutual honesty; and family interference. These items may be particularly relevant to the therapeutic relationship in community care.

Based on the evaluations made by the clinicians and patients after the semi-structured interviews, 4 of the 9 scales were deemed unsuitable for a community care setting.

6 clinicians rejected the TA (Clarkin et al., 1987) on the grounds that it would be more appropriate for in-patient, rather than community, care. Many of the items are rated according to the patient's readiness for discharge (i.e., "Patient is actively involved in therapy – explores problems, makes realistic plans for discharge, and so forth" to the "Patient sees no need for hospitalisation and is constantly demanding discharge"). By contrast, patients who receive care from clinicians in the community typically suffer from long-term mental illness and the goals and components of treatment are often characterised by an emphasis on stability, rather than change.

3 clinicians rejected the SATA (Allen et al., 1984) on the grounds that that the questions appear more to assess patient functioning. 2 clinicians rejected the SATA on the grounds that it seemed inappropriate to the clinician-patient relationship in this setting (i.e., end-point descriptors such as, "the patient may censor or forget to bring up certain sexual fantasies" or "the patient may frequently intellectualise").

5 clinicians rejected the PSR (Frank and Gunderson, 1990) on the grounds that it was overtly rooted in psychoanalytic jargon (i.e., "patient has grossly distorted or transference-dominated perceptions of the therapist..."). In community mental health care clinicians typically come from a range of professional training backgrounds, including social work and community psychiatric nursing, however few are likely to have received psychoanalytic training, and are therefore unlikely to frame the therapeutic relationship in terms of transference dynamics.

4 patients rejected the 92-item BLRI (Barrett-Lennard, 1962) due to the length of time that would be required to complete it.

Chapter 7

Part two: Main quantitative data collection

The aim of this stage is to apply those items of existing scales that were found to be applicable and comprehensible and additional items as identified in the semi-structured interviews to a number of clinicians and patients in East London. On the basis of the results, this item pool may be condensed.

Sample

The clinician sample was recruited from five different community mental health centres across East London. I attended team meetings held by each centre to describe the study and invite clinicians to participate. By way of incentive, clinicians were offered a £50 gift voucher of their choice if they would complete 10 questionnaires regarding 10 patients on their caseload.

An opportunity sample of 26 clinicians was obtained[3]. 50 of the 76 clinicians across the five community mental health teams were not interested in participating (thus 34% of the total potential sample did participate). There were 16 community psychiatric nurses, 8 social workers, 1 occupational therapist and 1 psychologist. Their average age was 41 years, and there were 14 females and 12 males. With respect to ethnicity, 12 were white, 7 black Caribbean, 4 were

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[3] The aim was to attain proportional representation based on clinician data from the five community mental health teams. Across the 3 teams there were 31 community psychiatric nurses (41%), 40 social workers (53%), 3 occupational therapists (4%) and 2 psychologists (2%). In this sample I obtained 8 community psychiatric nurses (31%), 16 social workers (62%), 1 occupational therapist (4%) and 1 psychologist (4%).

black African, 1 was Pakistani, 1 was Chinese, and 1 was of other ethnic origin. The mean caseload size of this sample was 22 patients.

The patient sample was recruited from the case list of participating clinicians from community mental health centres across east London. They were selected on the basis that they have severe mental illness, and are in the care of a community mental health team. A consort diagram outlines the process by which participating patients was obtained [See appendix 3].

Names and contact details of 481 patients were provided by clinicians, however 6 were regarded as unsuitable, 3 were withdrawn from the clinicians' case load and 13 were listed as residents of inpatient hospitals. Letters were sent informing them about the study and requesting their participation, however the contact details of 8 patients were incorrect or outdated, leaving a total of 451 possible patients to participate in the study. A total of three patients replied by post that agreed to participate in the study. Follow-up calls were made, however 287 of the possible total were without a contact telephone number and 6 listed telephone numbers were incorrect. Of those who were contacted by telephone, 31 refused to participate in the study (a non-consent rate of 19%). The total number of people interviewed (133 patients), all in face-to-face interviews, represented 28% of the potential sample.

I randomly selected contactable patients from the lists of clinicians' caseloads. The average patient age was 40 years, and 53% were female. 50% of patients were white, 14.2% African-Caribbean, 11.9% black African, 3.7% black other, 7.5% Indian, 3.7% Pakistani, 1.5% Bangladeshi, and 7.5% of other ethnic origin. Most of the patient sample lived alone (48%) – while some others lived with a child under 18 years of age (16%), with their partner (14%), with their parents (11%) or in another living arrangement (11%) – with an average income of £471 ($880.37, €707.94) per calendar month. 74.4% lived in housing association accommodation, 16.5% in owner-occupied accommodation, 1.5% rented privately, 5.3% were boarding out, and 2.3% had other living arrangements. Most patients were diagnosed with schizophrenia (58.2%) or mood disorder (35.1%), followed by personality disorder 2.2%, mental disorder due to substance abuse 1.5%, neurosis 1.5%, some other disorder .7% or unknown .8%. The mean onset of illness was 21 years before the interview (i.e., at 19 years of age), with an average number of 5 hospitalisations, and an average of 9 months spent in hospital in total.

Measures

I developed amalgamated patient and clinician versions of a quantitative rating scale (the original item pool). The scales included: (1.) dimensions that were highlighted by the in-depth interviews; and (2.) existing scales that have been used in a community psychiatric context and were regarded as applicable to a community care setting – the Helping Alliance Scale (Priebe and Gruyters, 1993), Working Alliance Inventory (Horvath and Greenberg, 1986), California Psychotherapy Alliance Scales (Gaston and Marmar, 1991), Therapist-Patient Scales with Schizophrenic Patients (Stark et al., 1992), and Homelessness Engagement and Acceptance Scale (Park et al., 2002).

The clinician original item pool is comprised of 106 items divided into nine parts. Part one consists of one global question ('How would you rate your relationship with your patient?') using a visual analogue scale (from 0 to 10). Parts two to six consist of the pre-existing scales used to assess the therapeutic relationship: the 5-item Helping Alliance Scale (Priebe and Gruyters, 1993); the 12-item Working Alliance Inventory (Horvath and Greenberg, 1989), the 16-item Therapist-Patient Scale with Schizophrenic Patients (Stark et al., 1992); the 24-item California Psychotherapy Alliance Scale (Gaston and Marmar, 1991); and four of the five items in the Homelessness and Engagement Scale[4] (Park et al., 2002). Part seven is a 32-item visual analogue rating scale (from 0 to 10) that comprises items mentioned by four or more separate interviewees in stage one of this project, including a second global relationship rating ("Are you the right clinician for your patient?"). For items mentioned by eight or more separate interviewees, nine additional yes / no questions were added, comprising part eight. In part nine, three open-ended questions are included to address issues that may be important to the clinician with respect to the quality of the relationship and may otherwise be neglected in the questionnaire. See Appendix 4 for the original item pool.

The 118-item patient original item pool is also divided into nine parts, beginning with a single global rating of the clinician-patient relationship using a visual analogue scale ("How would you rate your relationship with your clinician?"). Parts two to five pre-existing scales used to assess the therapeutic relationship: the 7-item Helping Alliance Scale (Priebe and Gruyters, 1993); the12-item

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[4] One item, patient attitude towards housing, was removed from the scale on the grounds of being inappropriate for this setting (i.e., 'The patient refuses all offers of housing or is unable to express a choice').

Working Alliance Inventory (Horvath and Greenberg, 1989), the 30-item Therapist-Patient Scale with Schizophrenic Patients (Stark et al., 1992); and the 24-item California Psychotherapy Alliance Scale (Gaston and Marmar, 1991). In view of the fact that the interviews in stage one of the project revealed an influence of the patient's significant others on the therapeutic relationship, part six is a validated[5] systemic two-part question assessing the relational attitude differences toward patient illness (Priebe, 1989) with the aim to investigate the structural pattern of interaction between the key relative and patient and clinician and patient. Part seven is a 31-item visual analogue rating scale (from 0 to 10) to address items mentioned by four or more separate interviewees including a second global relationship rating ("Is your clinician the right one for you?"). For items mentioned by eight or more separate interviewees, nine additional yes / no questions were added, comprising part eight. In part nine, three open-ended questions are included to address issues that may be important to the patient with respect to the quality of the relationship and may otherwise be neglected in the questionnaire. See Appendix 5 for the patient original item pool.

In each version all new items derived from the semi-structured interviews were identical. The patient version of the HAS focuses on the clinician's commitment,

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[5] This scale has been validated by two studies (Priebe, 1989; and Priebe and Pommerien, 1992). In the first study (Priebe, 1989) the structural relationship between 41 depressive inpatients and their psychiatrist was assessed with a two part question: who regards your illness as more severe: 1, significant others or you yourself; 2, the psychiatrist or you yourself. Improvement was reported significantly more in patients who had structurally different therapeutic systems ($x^2 = 9.92$, df = 1, $p < .01$).

An expanded study (Priebe and Pommerien, 1992) was carried out in the same setting with 56 patients who were asked the same two-part question as in the original study. At a 3-month follow up, patients who viewed their therapeutic system as structurally similar deteriorated and those who had a structurally different one improved. This finding is supported by the significant results of two-factorial analyses of variance (structure of the system x time) for: depressive symptoms ($F = 3.76$, df = 2, $p < .05$) and a visual analogue scale regarding whether they felt better or worse ($F = 3.66$, df = 2, $p < .05$).

understanding and criticism in addition to their own view of treatment and feeling after the session. The clinician version of the HAS focuses on how well they understand, are actively involved look forward, feel trusted and get along with the patient. Both versions of the WAI aim to assess congruence with regard to the shared bond and tasks and goals of treatment. The patient version of the TPSS assesses professional rejection, detachment, direction and acceptance; whereas the professional version measures rejection, inadequacy, detachment, professional acceptance and personal acceptance. Both versions of the CALPAS assess patient commitment and working capacity, professional understanding and involvement and goal strategy and working consensus. Four questions from the HEAS are included in the professional and not the patient version with regard to: how the patient feels about the professional, the degree to which they can be engaged; their attitude towards help; and how they engage with others. The patient version contains Priebe's (1989) systemic two-part question as described above.

Protocol

I asked participating clinicians to provide me with the contact details of each person on their caseload. All patients on the caseload were contacted by me and invited to participate in the study. For those patients that agreed to participate, I asked their clinician to fill in a corresponding questionnaire. Clinicians with caseloads of 10 or more were asked to fill out 10 questionnaires. For these clinicians, if the number of participating patients was less than 10, I asked them to fill in additional questionnaires to bring the total to 10. For example, if 7 questionnaires were completed by patients on a clinician's caseload, the clinician was asked to complete a further 3 questionnaires based on their relationships with 3 randomly selected patients. 175 clinician-version scales were completed. Of the 26 participants, 11 completed 10 questionnaires, 2 completed 9 questionnaires, 2 completed 7 questionnaires, 3 completed 4 questionnaires, 4 completed 2 questionnaires and 3 completed 1 questionnaire. In two of the cases, the low response rate is justified by a small caseload (one had a caseload of 5; the other a caseload of 1). The remaining did not complete all 10 questionnaires on the grounds that it was too much work (10 questionnaires x 106 questions).

In alignment with recommendations made by Parkman and Bixby for community interviewing (1996), I invited patients to participate in an interview at a location that would be convenient for them. All requested that interviews be conducted in their homes. In alignment with the East London and The City Health Authority Research Ethics Committee guidelines, I provided patients an information sheet on project, and invited them to talk and ask questions about the study before asking them to fill in a consent form. I went through the questionnaire on the therapeutic relationship with the patient, before collecting demographic details, a quality of life assessment (Priebe et al., 1999), and psychiatric symptom (Overall & Gorham, 1962) details. At the end of the interview, I gave each patient a box of chocolates in gratitude for their participation.

Statistical methods in terms of pre-existing scales

Factor analysis is applied as a data reduction or structure detection method (the term factor analysis was first introduced by Thurstone in 1931). The main applications of factor analytic techniques are to determine: 1, clusters of variables; 2, which variables belong to which group and how strongly they belong; 3, the number of dimensions are needed to explain relations among variables; 4, a frame of reference to describe the relations among variables more conveniently; and 5, scores of individuals on such groupings.

Exploratory factor analysis typically involves two stages. The first condenses the variance among the variables and defines the number of factors. The second stage, rotation, makes the final result more interpretable.

Common factor analysis is based on a correlation matrix with estimated communalities (percentage of variance a variable shares with the common factors) on the diagonal. The goal is to extract as many latent variables (factors) as necessary to explain the correlations among the items. The factors are considered to be the hypothetical causes that account for item inter-correlations (Reise et al., 2000).

Principal Factor Analysis (PFA) determines the least number of factors that can account for the common variance in a set of variables. This is appropriate specifically to test whether one factor can account for the bulk of the common variance in the set.

Principle Components Analysis (PCA) determines the factors that can account for the total (unique and common) variance in a set of variables. This is appropriate for creating summaries of observed variables. Principal components are best conceived as the effects rather than the causes of the variable correlations (Reise et al., 2000). Because PCA is most successful in locating clusters, it was chosen as the initial solution in this thesis.

Once an initial solution is obtained, the loadings are rotated. Rotation is a way of maximizing high loadings and minimizing low loadings so that the simplest possible structure is achieved. Rotation will: 1, strengthen the relation between the factors and variables so that, rather than representing variables that don't belong to it, the factors will better represent the variables; 2, concentrate the variance shared by two highly correlated variables on a single factor rather than several factors; and 3, tend to level the variance of the factors.

There are two basic types of rotation: orthogonal and oblique. Orthogonal means the factors are assumed to be uncorrelated with one another. Oblique rotation derives factor loadings based on the assumption that the factors are correlated.

In exploratory factor analysis one typically does not have a theoretical basis for knowing how many factors there are or what they are, much less whether they are correlated. Researchers conducting exploratory factor analysis usually assume the measured variables are indicators of two or more different factors, a measurement model which implies orthogonal rotation. For this reason, orthogonal rotation was chosen for this thesis. Two main algorithms for orthogonal rotation are quartimax and varimax.

The Quartaimax method maximises the sum or variances in rows of the structure matrix to relate variables more closely to factors. This uses a fundamental consequence of simple structure: the variance of elements in each row of the structure matrix should be as large as possible. Here factors are rotated so that a variable correlates highly with one factor and poorly with others. This results in variance of these correlations that is relatively large so that the variable is a relatively pure measure of the factor. By contrast, when a variable correlates moderately with several factors the variance of the correlations is relatively small. The maximisation criterion is applied to the squared elements rather than to the elements themselves since the variance of any row is affected by the sign of the structure elements as well as their size. A variance is based on squared observation. This becomes squares of scares in this case (i.e., the prefix quarti) and the algorithm maximises the resulting fourth powers (i.e., the suffix max). When one wishes to stress a general factor in which all variables correlate, this method is most useful. Because initial factor 1 typically gives a better definition of a general factor, the quartimax is not suitable when a general factor is undesirable. This analytic orthogonal method has mostly given way to varimax as it locates clusters more successfully (Nunnally and Bernstein, 1994).

The varimax method of rotation maximises the sum of variances of squared structure elements in the columns of the structure matrix (rather than the rows as in quartimax) – thereby producing some high and low correlations in each column of the matrix (Nunnally and Bernstein, 1994). The squared elements in each row of the structure matrix are divided by the sum of squares to normalise the variables before computing the variance of squared structure elements in each column, making them equally important in determining the rotated solution.

Designed to eliminate general factors it captures the meaning of simple structure within the confines of an orthogonal framework. The purpose of this work is not to strictly obtain a single general factor, therefore I chose the varimax method of rotation for this thesis.

Factor loadings determine the strength of the relationships between the items and the factors (Dancey & Reidy, 2002). The strength of a loading required for inclusion is fairly arbitrary, but usually varies between 0.3 and 0.5 (Dancey & Reidy, 2002). Eigenvalues show the proportion of variance accounted for by each factor and any factor that has an eigenvalue of 1.00 is usually noted (Dancey & Reidy, 2002).

Strictly speaking, PCA is not a statistical technique, but rather a way of altering the direction from the data is viewed. It is therefore possible to use many fewer cases than variables. However if PCA is treated as a form of factor analysis – as I did in this study – then sample size is an issue. A small sample is likely to yield unstable findings. Larger samples are better than smaller samples because larger samples tend to minimize the probability of errors, maximize the accuracy of population estimates and increase the generalizability of the results. There are few sample size guidelines for researchers using EFA or PCA, and many of these have minimal empirical evidence (Osborne and Costello, 2004). Two different approaches have been taken: suggesting a minimum total sample size, or examining the ratio of subjects to variables, as in multiple regression. Comfrey and Lee (1992) suggest that "the adequacy of sample size might be evaluated very roughly on the following scale: 50 – very poor; 100 – poor; 200 – fair; 300 – good; 500 – very good; 1000 or more – excellent" (p. 217). Guadagnoli and

Velicer (1988) review several studies that conclude that absolute minimum sample sizes, rather than subject to item ratios, are more relevant. These studies range in their recommendations from an *N* of 50 (Barrett & Kline, 1981) to 400 (Aleamoni, 1976). Others claim that the ratio of subjects to variables is a superior guideline to the total *N* for PCA and/or EFA methodologies. The goal for both of the analyses is the same: to take individual variables and create optimally weighted linear composites. While the mathematics and procedures differ in the details, the essence and the pitfalls are the same. Both EFA/PCA and multiple regression experience shrinkage, the over-fitting of the estimates to the data (Bobko & Schemmer, 1984), both suffer from lack of generalizability and inflated error rates when sample size is too small. The ultimate concern is error. At the end of the analysis, if one has too small a sample, errors of inference can easily occur, particularly with techniques such as EFA or PCA. To this end, it may be useful to test the fit of the data with a fresh sample to determine the stability of the model. This was accomplished in part 4 of the thesis.

While EFA is useful for generating hypotheses, Confirmatory Factor Analysis (CFA) is used to test the hypothesis that the empirical data fits the proposed theoretical model (Crowley & Fan, 1997). CFA seeks to determine if the number of factors and the loadings of measured (indicator) variables on them conform to what is expected on the basis of pre-established theory. Indicator variables are selected on the basis of prior theory and factor analysis is used to see if they load as predicted on the expected number of factors. The researcher's à priori assumption is that each factor (the number and labels of which may be specified à priori) is associated with a specified subset of indicator variables. A minimum requirement of confirmatory factor analysis is that one hypothesize beforehand the number of factors in the model, but usually also the researcher will posit expectations about which variables will load on which factors (Kim and Mueller, 1978b: 55). One seeks to determine, for instance, if measures created to represent a latent variable really belong together. This can be done by means of structural equation modelling (SEM). Analysis of Moment Structures (AMOS) is a statistical package distributed by SPSS that implements SEM. SEM enables you to explore multiple associations between your measures. It can be used for confirmatory factor analysis to predict factor pattern. AMOS offers a graphic version in which you draw your model on a screen, or a text version in which you write the equations. I used the former. Amos Graphics accepts a path diagram as a model specification, and displays parameter estimates graphically on a path diagram. Rectangles are observed variables, ellipses are unobserved variables, one-way arrows symbolise regression weights and two-way variables represent covariances. Once the model is complete, Model-fit is clicked, then Calculate estimates.

In CFA degrees of freedom are not based on sample size as is usually the case in other statistical analyses but rather they are the difference between the number of unique elements in the covariance matrix and the number of parameters to be estimated (Crowley & Fan, 1997). The test for statistical significance is the chi square (χ^2) test, where the null hypothesis is that the model fits the data (Crowley & Fan, 1997). Other indices for assessing model fit are also used, including Goodness of Fit and the root mean square error of approximation. IFI is the incremental fit index, which varies from 0 to 1. IFI close to 1 indicates a good fit and values above .90 an acceptable fit. RMSEA, the root mean square error of approximation, incorporates the discrepancy function criterion (comparing observed and predicted covariance matrices) and the parsimony criterion (models with relatively few parameters to estimate in relation to the number of variables and relationships in the model). By convention, there is good model fit if RMSEA less than or equal to .05. There is adequate fit if RMSEA is less than or equal to .08.

With the aim to explore the applicability of four widely-used measures of the therapeutic relationship (the Working Alliance Inventory (WAI) (Horvath and Greenberg, 1986), California Psychotherapy Alliance Scales (CALPAS) (Gaston, 1991), Therapist Patient Scales with Schizophrenic Patients (TPSS) (Stark, 1992) and the Helping Alliance Scale (HAS) (Priebe and Gruyters, 1993)) to this sample, I explored the factorial structure of both patient and clinician responses to these scales.

The WAI and CALPAS were chosen on the basis that they are the most widely used measures of the therapeutic relationship (Safran and Walner, 1991). The TPSS was chosen on the grounds that it targets a highly representative group of patients in community care. The HAS was included in view of the fact that it is the only scale designed to assess the therapeutic relationship that was specifically developed for a community care setting to date.

In this analysis, Principal Components Analysis (PCA) was used on the measures individually, to determine if the factor structures revealed by this sample are in alignment with those proposed by the authors of the scales. Confirmatory Factor Analysis (CFA) was then used to compare the fit of the factor structures derived from the PCAs and the original factor models proposed by the authors of the scales. Finally, Spearman's rho was used to determine the correlations between the scale means.

Results in terms of pre-existing scales

I conducted PCA on both the clinician and patient versions of the WAI to determine if they would be condensed according to the three expected components – alignment in task, bond and goal – as outlined by Horvath and Greenberg (1986). Both the clinician and patient versions were reduced to one global factor, explaining 79.13% and 73.75% of the total variance, respectively. A Confirmatory Factor Analysis (CFA) was used to compare the fit of the factor structures derived from the original factor model of the Working Alliance Inventory (Horvath and Greenberg, 1986) and the factor structure derived from the PCAs. The clinician three-factor model proposed by Horvath and Greenberg (1986) proved to be a poorer fit to the data χ^2 (66, n = 195) = 1631.60, p < .01; IFI = .78; RMSEA = .33 than the one factor model derived from the PCA[6] χ^2 (54, n = 195) = 645.85, p < .01; IFI = .92; RMSEA = .23. Horvath and Greenberg's (1986) patient three-factor model similarly provided a poorer fit to the data χ^2 (66, n = 133) = 1745.14, p < .01; IFI = .68 than the one-factor model derived from PCA χ^2 (54, n = 133) = 626.02.14, p < .01; IFI = .89; RMSEA = .23. Despite the suggestion by Horvath and Greenberg (1986) that the therapeutic alliance comprises three distinct elements (congruence regarding the tasks and goals of treatment and the existence of a mutual bond), when applied to a

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[6] It is possible to compare a one-factor model to a three-factor model. If you fit them by maximum likelihood then you can test the difference. You get a chi-squared.

community psychiatry sample, it appears that the Working Alliance Inventory can be reduced to one global factor.

PCA of the five-item clinician version and seven-item patient version of the HAS both revealed one global factor, explaining 79.13% and 60.72% of the total variance, respectively. The HAS, which was developed more or less empirically for community psychiatry, appears to measure one global factor.

To determine whether the present sample results are in accordance with the TPSS subscales outlined by Stark (1992) for the clinicians and patients PCA was conducted on both versions of the questionnaire. A PCA of the clinician version of the TPSS yielded five factors, explaining 64.09%. Factor 1, which may be interpreted as non-supportive clinician input, explained 21.05% of the total variance. Factor 2, explaining 12.28% of the total variance may be interpreted as positive clinician input. Factor 3, which explains 11.15% of the variance may be interpreted as treatment appropriateness. Factor 4, which may be interpreted as clinician emotional difficulty, explains 10.23% of the variance. Finally, factor 5, explaining 9.38% of the total variance may be interpreted as mutual bond.

The patient version of the TPSS was reduced to 6 factors that account for 63.82% of the total variance. Factor 1, which may be interpreted as positive clinician input, accounted for 23.13% of the total variance. Factor 2 accounted for 15.26% of the variance, and may be interpreted as the mutual bond. Factor 3 may be interpreted as clinician emotional difficulty, and accounts for 9.03% of the variance. Factor 4 accounts for 7.15% of the variance and may be interpreted as non-supportive clinician input. Factor 5 consisted of one item, patient responsibility, and accounts for 5.07% of the variance. Factor 6 accounts for 4.18% of the variance and also consists of one item, clinician openness.

To compare the fit of the factor structures derived from the PCAs and the original factor models proposed by Stark (1992) a CFA was used. The five-factor model derived from the PCA of the clinician ratings provided a better fit χ^2 (351, n = 195) = 962.54, $p < .01$; IFI = .94, RMSEA = .17 to the data than Stark's (1992) four-factor model χ^2 (405, n = 195) = 1317.89, $p < .01$; IFI = .92; RMSEA = .27. Similarly, the patient six-factor model derived from the PCA proved to fit the data better χ^2 (92, n = 133) = 405.36, $p < .01$; IFI = .96, RMSEA = .10 than the four-factor model proposed by Stark (1992) χ^2 (104, n = 133) = 750.39, $p < .01$; RFI = .89; RMSEA = .17.

Unlike the WAI and HAS that appear to measure one global factor, when applied to community psychiatry the TPSS reveals five factors for the clinician and six for the patient versions (rather than 4, as suggested by Stark, 1992). These factors do not fit the structure proposed by the Stark (1992).

PCA was conducted on both the 24-item clinician and patient versions of the CALPAS. In the clinician version, six factors were found explaining 63.97% of the total variance. Factor 1, which may be interpreted as positive collaboration, accounts for 20.82% of the variance. Factor 2 accounts for 15.63% of the variance, and may be interpreted as collaboration difficulty. Factor 3 may be interpreted as patient commitment, and accounted for 8.45% of the variance.

Factor 4, which may be interpreted as patient contribution, accounted for 7.71% of the variance. Factor 5 consisted of one item, patient attendance, and accounted for 5.76% of the variance. Factor 6, which accounted for 5.59% of the variance, also consisted of one item, patient openness.

The patient version of the CALPAS was also reduced to six factors that explain 69.46% of the total variance. Factor 1 accounts for 20.31% of the variance, and may be interpreted as positive collaboration. Factor 2, which explains 14.2% of the variance, may be interpreted as non-supportive clinician input. Factor 3 may be interpreted as treatment success, and accounts for 12.35% of the variance. Factor 4 may be interpreted as treatment difficulty, and accounts for 11.74% of the variance. Factor 5 accounts for 6.8% of the variance, and may be interpreted as patient contribution. Finally, factor 6, which accounts for 5.67% of the variance, may be interpreted as collaboration difficulty.

CFA was then used which determined that, in this sample, the factor structure derived from the PCAs proved a better fit than the original factor model of the CALPAS proposed by Gaston (1990). The clinician six factor model derived from the PCA provided a better fit χ^2 to the data (301, n = 195) = 740, $p < .01$; IFI = .95; RMSEA = .10 than Gaston's (1990) four-factor model χ^2 (252, n = 195) = 1389.34, $p < .01$; IFI = .87; RMSEA = .15. Similarly, the patient six-factor model derived from the PCA proved to fit the data better χ^2 (233 n = 133) = 691.62, $p < .01$; IFI = .95; RMSEA = .06 than the four factor model proposed by Gaston (1990) χ^2 (252, n = 133) = 1317.89, $p < .01$; IFI = .92; RMSEA = .06.

The CALPAS, which were reduced to six factors for both the clinician and patient versions (rather than 4, as suggested by Gaston, 1990), do not fit the proposed structure.

In the three cases where a factor structure was proposed (the WAI, TPSS and CALPAS) the data derived from this sample did not fit the model. The factor structure derived from the PCAs proved a better fit than the factor model proposed by the authors. This could suggest that the scales provide a less appropriate model of the therapeutic relationship in community care than a scale developed by and for patients and clinicians in this setting. However no conclusions can be drawn at this point. The apparent instability of the model structure of the pre-existing scales could simply reflect the fact that it was tested against a model derived from the same population within which it was developed. While the use of CFA to test the factor structure of different models may be interesting, the use of PCA and CFA on data derived from the same sample is questionable. A more appropriate test would use a fresh sample.

Many of the total scores of the clinician ratings of the four measures correlated with one another (See table 3). There was a strong association between scores on the clinician versions of the WAI and CALPAS ($r = .90$, $p < .01$), the WAI and the HAS ($r = .90$, $p < .01$) and the HAS and CALPAS ($r = .84$, $p < .01$). A moderate association was found between scores on the clinician versions of the WAI and TPPS ($r = .53$, $p < .01$) and the TPPS and the CALPAS ($r = .49$, $p < .01$).

Table 3: Patient scale mean scores

	HAS	WAI	TPSS	CALPAS
HAS	1	0.71*	-.64*	0.71*
WAI	.71*	1	-.52*	.67*
TPSS	-.64	-.52	1	-.67
CALPAS	.71*	.67*	-.67	1

* Significant at the .05 level

The total scores of the patient ratings on the four measures also correlated with one another (See table 4). There was a strong association between scores on the patient versions of the WAI and CALPAS (r = .95, p <.01); the WAI and TPPS (r = .78, p <.01) and the TPPS and CALPAS (r = .81, p <.01). There was a moderate association between scores on the patient versions of the HAS and TPPS (r = .49, p <.01). Finally, there was a weak association between scores on the patient versions of the HAS and WAI (r = .23, p <.01) and the HAS and CALPAS (r =.19, p <.01).

Table 4: Clinician scale mean scores

	HAS	WAI	TPSS	CALPAS
HAS	1	.62*	-.58*	0.71*
WAI	.62*	1	-.55*	.66*
TPSS	-.58	-.55	1	-.50
CALPAS	.71*	.66*	-.50*	1

* Significant at the .05 level

Many of the total scores of the clinician ratings on the four measures did not correlate with the patient ratings, suggesting that clinicians and patients emphasise different aspects in ratings of the therapeutic relationship. There was a weak association between the clinician version of the TPPS and the patient version of the TPPS (r = .14, p <.05), the patient version of the WAI (r = .20, p <.01), and the patient version of the CALPAS (r = .25, p <.01). All other associations between clinician and patient ratings of the scales failed to reach significance.

Inter-correlations among different measures is in line with previous research (Bachelor, 1991; Hatcher and Barends, 1995; Titchenor and Hill, 1989). This does not suggest that the scales measure the same construct (Horvath and Bedi, 2002). While many share certain core elements (i.e., bond, goal, task, etc.) – each puts different weight on these dimensions and / or assesses certain features of the relationship the others do not (Horvath and Bedi, 2002).

Statistical methods in development of the new scales

PCA was used on the patient and clinician original item pools to condense the data set to the most discriminating items. As mentioned earlier, PCA is a 'data-driven' technique used to discover the underlying structure of data, without the imposition of a hypothesised model (Crowley & Fan, 1997). It is an exploratory statistical technique that aims to reduce a large data set into a smaller set (Ferguson and Takane, 1989) that is often applied to generate structure, a theoretical model, and an empirically testable hypothesis and is therefore useful in the early stages of instrument development - as important insights about the data structure can often be revealed (Crowley and Fan, 1997). For subscale construction I retained factors with three or more items, as well as factors with an acceptable internal consistency, i.e. Cronbach's alpha over 0.65 (Cronbach, 1951). Construction of the reduced item pool was based on the retained factors and items.

As some items were removed from the factors, a Confirmatory Factor Analysis was conducted by means of structural equation modelling with the factors and items of the reduced item pool using Analysis of Moment Structures (AMOS) (Arbuckle, 1999) to ensure that the data still fit the model. Each of the three latent variables was measured by indicator variables consisting of the individual items loading on each factor.

Results in development of new scales

Clinician version results

Using the Varimax method of rotation, PCA was conducted on data from the clinician original item pool. The number of factors with eigenvalues greater than 3 were noted and those with factor loadings of 0.5 or greater were retained. For the clinician version the Principal Component Analysis revealed 6 factors with an eigenvalue of 3 or more explaining 53.16% of the variance. Factor one accounted for 24.67% of the variance (eigenvalue = 25.41) and is interpreted as a 'positive collaboration'. Factor two accounted for 9.29% of the variance (eigenvalue = 9.57) and is interpreted as a 'clinician emotional difficulties'. Factor three accounted for 6.52% of the variance (eigenvalue = 6.72) and is interpreted as a 'patient involvement factor'. Factor four accounted for 4.81% of the variance (eigenvalue = 4.95) and is interpreted as an 'ability to engage patient factor'. Factor five accounted for 4.62% of the variance (eigenvalue = 4.76) and is interpreted as a 'treatment appropriateness factor'. Factor six accounted for

3.25% of the variance (eigenvalue = 3.35) and is interpreted as a 'positive clinician input'. Variables representing each factor are outlined in Table 5.

Table 5: Clinician original item pool Principal Components Analysis

	Item	Factor Loading
1	*Trust (new3)	0.86
	* Global assessment	0.85
	P likes me (wai-bond)	0.82
	*Gets along with p (has)	0.82
	*Rapport (new1)	0.81
	P trust (new7)	0.8
	K empathy (new16)	0.8
	* Open communication (new5)	0.79
	P respect for k ability (new22)	0.78
	Looks forward to seeing p (has)	0.78
	Actively involved (has)	0.77
	Buit mutual trust (wai-bond)	0.76
	K right one for p (new19)	0.76
	Respect for p (new30)	0.75
	P openness (new21)	0.75
	Can help (has)	0.73
	K takes p perspective (new9)	0.72
	K reliability	0.72
	Ability to help p (new24)	0.7
	P commitment (new14)	0.69
	Confidence can help (wai-bond)	0.68
	P willing to work with k (new32)	0.68
	K accessibility (new23)	0.67
	P agency (new2)	0.67
	K flexibility (new20)	0.66
	K patience (new8)	0.64
	P disclosure to k (new25)	0.63
	Free will of p (new29)	0.63
	K listens to p (new11)	0.62
	* Shared expectations (new11)	0.62
	Way working correct (wai-goal)	0.62
	Understand changes needed (wai-task)	0.62
	Agree how to improve (new61)	0.61
	Desire to understand p (calpas-ui)	0.61
	Work on same goals (wai-task)	0.59
	K frequency of contact (new26)	0.58
	Appreciate p as person (wai-bond)	0.57
	P trust (wai-bond)	0.57
	Confidence to help (calpas-ui)	0.56
	Agree what work on (wai-goal)	0.55
	Degree p engaged (heas)	0.51
	Help p see difficulities differently (calpas-pwc)	0.51
2	Inferiority to p (TPSS-ri)	0.83
	Not give instructions p understands (calpas-ui)	0.75
	How p feels about k (heas)	0.75
	Cannot empathise (TPSS-iv)	0.67
	K critisism (new17)	0.66
	Not feel accepted by p (TPSS-d)	0.66
	P found medication difficult (calpas-pwc)	0.65
	P attitude towards help (heas)	0.65
	K irritated, annoyed, disappointed (calpas-gws)	0.65
	Would prefer to transfer p (TPSS-d)	0.63
	P goals differ from k	0.62
	P difficulty ask questions re medication (calpas-pwc)	0.6
	K dislike of p (calpas-gws)	0.54
3	P sets treatment goals (yn1)	0.54
	P sets treatment goals (new15)	0.54
4	P aggression (yn6)	0.73
	P aggression (new28)	0.68
	P engagement with others (heas)	0.62
5	Appropriateness of treatment (yn5)	0.61
	Could have benefited from other treatment (TPSS-iv)	0.59
	P brought up other issues re treatment (calpas-pwc)	0.52
6	K takes perspective of p (new yn7)	0.71
	K listens to p (new yn9)	0.67
	K is supportive (new yn4)	0.66

P = Patient; C = Clinician; WAI = Working Alliance Inventory; HAS = Helping Alliance Scale; CALPAS = California Psychotherapy Alliance Scales; TPSS = Therapist Patient Scales with Schizophrenic Patients, HEAS = Homelessness Engagement and Acceptance Scale; NEW = New Items; NEW-Y/N) = New yes / no items

* Starred items in factor 1 account for 83% of the variance for that factor

Patient version results

Using the Varimax method of rotation, Principal Components Analysis was conducted on data from the patient original item pool. The number of factors with eigenvalues greater than 3 were noted and those with factor loadings of 0.5

or greater were retained. Patient data were analysed using the same criteria as for clinician data. The Principal Components Analysis also showed six factors with an Eigenvalue of more than 3 explaining 57.27% of the variance. Factor one accounted for 28.51% of the variance (eigenvalue = 33.10) and is interpreted as a 'general positive factor'. Factor two accounted for 8.56% of the variance (eigenvalue = 9.23) and is interpreted as a 'negative key worker factor'. Factor three accounted for 6.37% of the variance (eigenvalue =7.39) and is interpreted as a 'patient involvement factor'. Factor four accounted for 6.10% of the variance (eigenvalue = 7.10) and is interpreted as an 'ability to engage patient factor'. Factor five accounted for 4.33% of the variance (eigenvalue = 5.02) and is interpreted as a 'treatment appropriateness factor'. Factor six accounted for 3.25% of the variance (eigenvalue = 4.0) and is interpreted as a 'positive key worker factor'. Variables representing each factor are outlined in Table 6.

Table 6: Patient original item pool Principal Component Analysis

	Item	Factor Loading
1	Confidence in k ability to help (wai-bond)	0.88
	*Shared understanding of changes needed (new6)	0.86
	*Open communication (new6)	0.86
	Feel appreciated (wai-bond)	0.85
	*Agree what to work on (wai-goal)	0.85
	Feel supported by k (new5)	0.84
	*Honesty (new11)	0.84
	P trust (new3)	0.83
	P openness (new20)	0.83
	*Working towards mutual goals (wai-task)	0.82
	K helpful (new23)	0.82
	K patience (new8)	0.8
	Trust in k's competence (has)	0.79
	K listens (new4)	0.79
	Willing to work with k (new31)	0.79
	Global assessment	0.79
	*Mutual trust (wai-bond)	0.79
	K frequency of contact (new25)	0.78
	Feels respected by k (new29)	0.78
	K likes me (wai-bond)	0.77
	P commitment (new14)	0.77
	K reliable (new7)	0.76
	K takes perspective (new9)	0.75
	K right one for p (new19)	0.75
	New ways of looking at problem (wai-goal)	0.75
	Agree what to do (wai-task)	0.74
	K empathy (new16)	0.73
	K availability (new22)	0.73
	P feels understood (has)	0.73
	K sensitivity to cultural background (new13)	0.72
2	K encouragement (TPSS-s)	0.7
	K helpful (TPSS-s)	0.64
	K regard (TPSS-ri)	0.64
	K understanding (TPSS-ri)	0.63
	K discuss p goals (TPSS-s)	0.63
	K allows open conversation (TPSS-s)	0.62
	Trust (TPSS-ri)	0.62
	K undersanding (TPSS-s)	0.6
	K perceptiveness (TPSS-iv)	0.58
	K positive regard (TPSS-ri)	0.55
	P would prefer another k (TPSS-s)	0.55
3	K withholds truth (TPSS-iv)	0.66
	K overwhelms (TPSS-d)	0.61
	K not understand what p wants (wai-goal)	0.56
	K empathy (TPSS-iv)	0.54
	K impatience (TPSS-d)	0.53
	K pressure (TPSS-d)	0.51
	K authoritarianism (TPSS-d)	0.51
4	Appropriateness of treatment (new18)	0.6
	Willing to take meds despite side effects (calpas-c)	0.6
	Set treatment goals for self (yn1)	0.59
	P able to involve self in decisions taken (calpas-c)	0.59
	Treatment matches expectations (calpas-wsc)	0.56
	Appropriateness of treatment (yn5)	0.51
5	Difficult to follow treatment (calpas-pwc)	0.75
	Sceptical about value of medication (calpas-wsc)	0.63
	Dissatisfied with treatment (calpas-c)	0.6

Factor	Item	Loading
	P feels respected by k (has)	0.71
	K approachable (new24)	0.7
	Rapport (new1)	0.69
	K desire to understand p (calpas-ui)	0.68
	Way working on problem correct (wai-task|)	0.66
	P feels free to express worries (.65)	0.65
	K listens to p (yn9)	0.6
	K supportive (yn4)	0.6
	K gives satisfactory answers (calpas-ui)	0.6
	K understands what p wants (calpas-gws)	0.58
	Last appointment important (calpas-pc)	0.56
	Free will of p (new28)	0.56
	Trust (yn3)	0.55
	Different goals (calpas-gws)	0.52
	K positive feedback (TPSS-ri)	0.52
	How p feesl after seeing k (has)	0.52
	P respect for k professional ability (new21)	0.52
	K takes perspective (yn7)	0.51
	K lack of confidence in helping p (calpas-ui)	0.57
6	P aggression	0.6
	P aggression	0.54

P = Patient; C = Clinician; WAI = Working Alliance Inventory; HAS = Helping Alliance Scale; CALPAS = California Psychotherapy Alliance Scales; TPSS = Therapist Patient Scales with Schizophrenic Patients, HEAS = Homelessness Engagement and Acceptance Scale; NEW = New Items; NEW-Y/N) = New yes / no items

* Starred items in factor 1 collectively account for 88% of variance for this factor

Correlations of patient and clinician original item pool components

To determine the convergent validity of the patient and clinician original item pool components, the six major factors that emerged from each were tested using Spearman's rho (See Table 7). Clinician factor one and patient factor one - both interpreted as a 'positive collaborative' relationship factor – were weakly and positively correlated (r = 0.32, p = < .01). Patient factor one ('positive collaborative relationship") and clinician factor six ("positive clinician input") were weakly and positively correlated (r = .24, p < .01). All other correlations failed to reach significance.

Table 7: Correlation between patient and clinician original item pool factors

	Patient F1	Patient F2	Patient F3	Patient F4	Patient F5	Patient F6
Clinician F1	.32*	0.03	0.01	-.02	0.19	0.13
Clinician F2	0.14	-.05	0.11	-.03	0.11	-.13
Clinician F3	0.02	.05	0.18	0.15	0.21	.09
Clinician F4	0.03	0.15	0	.02	0.13	.09
Clinician F5	.04	-.16	.09	-.11	-.23	-.12
Clinician F6	.24*	-.11	-.09	-.02	0.14	0.07

Original item pool associations with quality of Life Ratings

The relationship between the patient global factor and ratings of satisfaction with life as a whole on the Manchester Short Assessment of Quality of Life (MANSA) (Priebe et al., 1999) was found to be positively and weakly correlated ($r = +.33$, $p < .00$). Several other Quality of Life ratings (Priebe et al., 1999) were found to be positively and weakly correlated with the global factor, namely: satisfaction with unemployment / retirement ($r =+.28$, $p <.01$); satisfaction with the number and quality of their relationships ($r = +.19$, $p < .05$); satisfaction with leisure activities ($r = +.31$, $p <.00$); satisfaction with accommodation ($r = +.20$, $p <.04$); satisfaction with personal safety ($r = +.28$, $p <.00$); satisfaction with the people they live with ($r = +.30$, $p <.00$); satisfaction with their physical health ($r = +.25$, $p <.01$); and satisfaction with their mental health ($r = +.25$, $p <.01$).

Original item pool associations with BPRS Ratings

To trim for extreme psychopathology the PCA was repeated with patients who scored in the better two-thirds of the sample according to: disorientation; conceptual disorientation; blunted affect; and emotional withdrawal of the Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962). While this analysis resulted in six factors that explain more total variance than the analysis without the psychotic deletions, the difference was negligible (57.64% versus 57.12%). It may be therefore suggested that this scale is appropriate for severely mentally ill patients receiving community care.

The patient global factor yielded from the varimax principal components analysis (explaining 28.8% of total variance) was correlated with BPRS items (Overall &

Gorham, 1962). Several items of the BPRS (Overall & Gorham, 1962) were found to be negatively and weakly correlated with the global factor, namely: hostility (r = -.22, p <.03); suspiciousness (r = -.25, p <.01); tension (r = -.25, p <.01); excitement (r = -.21, p <.03); and motor hyperactivity (r = -.21, p <.03).

Chapter 8

Reduced item pool subscale construction

Clinician reduced item pool subscale development was based on the complete data set comprising a total of 195 Care co-ordinator-version questionnaires. The six groupings based on the Principal Components Analysis using Varimax rotation of the 103-item questionnaire were the starting point for item reduction and subscale information. Factors with three or more items were retained. Based on the calculations of the cronbach's alpha coefficients, factors with alpha ratings over 0.65 were retained. Factors three and five were respectively dropped because an insufficient number of items (two items) and a lower than acceptable reliability coefficient ($\alpha = 0.17$). A weak relationship was found between factors one and four using Spearman's rho ($r = .2$, $p < .01$), therefore factor four was also dropped. Subscale construction was based on the retained items with the greatest factor loadings that provided the highest alpha reliability coefficient. The process yielded three subscales comprising the reduced item pool.

The first factor comprised items relating to a 'positive collaborative' therapeutic relationship. Six items accounted for 83% of the variance in factor one (adjusted R^2) with an alpha coefficient of .94. The second factor consisted of items relating to 'emotional difficulties' of the clinician. Five items accounted for 82% of the variance of factor two with an alpha reliability coefficient of .88. The third factor captured aspects of 'positive clinician' input. Three items accounted for 65% of the variance in factor three with an alpha reliability coefficient of .73.

As some components and items had been dropped, CFA was used to see if the data still fit the proposed model by means of structure equation modelling using AMOS (Arbuckle, 1999). Each of the three latent variables was measured by indicator variables consisting of the individual items loading on each factor. The model was estimated using the maximum likelihood method, and the chi-square value was statistically significant, χ^2 (77, n = 175) = 323.33, p <.01. The Incremental Fit Index (IFI) was .97, and the RMSEA was .12 indicating an acceptable fit of the measurement model to the data.

The newly devised 14-item clinician reduced item pool consists of three subscales. Subscale one comprises six items to assess ‘positive collaboration’: “I get along well with my patient”; “My patient and I share a good rapport”; “I believe my patient and I share a good relationship”; “My patient and I share similar expectations regarding his / her progress in treatment”; “My patient and I are open with one another”; and “My patient and I share a trusting relationship”. Subscale two consists of three items to assess ‘positive clinician behaviour’: “I listen to my patient”; “I feel that I am supportive of my patient”; and “I am able to take my patient’s perspective when working with him / her”. Finally, subscale three comprises five items to assess ‘negative clinician behaviour’: “I feel a certain dislike for my patient”; “I feel that my patient rejects me as a clinician”; “I feel inferior to my patient”; “I feel critical of my patient’s behaviour”; and “It is difficult for me to empathise with or relate to my patient’s problems”. Clinician reduced item pool is provided in Appendix 6.

In the construction of the patient reduced item pool the same criteria was applied as in the analysis of clinician data. Factors six and four were respectively dropped because an insufficient number of items (two items) and a lower than acceptable reliability coefficient ($\alpha = 0.58$). A weak relationship between factors two and five using Spearman's rho ($r = 0.19$, $p <.05$) therefore factor five was also dropped. Subscale construction was based on those items with the greatest factor loadings that provided the highest alpha reliability coefficient. The process yielded three subscales for the clinician reduced item pool.

Again, the first subscale of the patient reduced item pool consisted of items reflecting a 'positive collaborative' therapeutic relationship. Six items accounted for 88% of the variance in factor one (adjusted R^2) with an alpha consistency coefficient of .91. The second subscale comprised items relating to 'positive clinician input'. Five items explained 62% of the variance with an alpha coefficient of .86. The third subscale consisted of items relating to 'non-supportive clinician input'. Five items accounted for 71% of the variance in factor three with an alpha of .76.

Again, as some factors and items had been dropped in the construction of the reduced item pool a Confirmatory Factor Analysis was conducted to ensure that the data still fit the model by means of structural equation modelling with the patient sample using AMOS (Arbuckle, 1999). The model investigated consisted of the three latent variables already described. Each of the three latent variables was measured by indicator variables consisting of the individual items loading on each factor. The model was estimated using the maximum likelihood method, and the chi-square value was χ^2 (135, n = 133) = 642.76, p <.01. The analysis reported here resulted in IFI = .89 and RMSEA = 13, indicating an acceptable fit of the measurement model to the data.

The patient 18-item reduced item pool consists of three subscales. Subscale one comprises six items to assess 'positive collaboration': "My clinician and I have established an understanding of the kind of changes that would be good for me"; "My clinician and I are open with one another"; "We agree on what is important for me to work on"; "My clinician and I are honest with one another"; "My clinician and I work towards mutually agreed upon goals"; and "My clinician and I share a trusting relationship". Subscale two is composed of six items to assess 'positive clinician behaviour: "My clinician encourages me to talk about my feelings (anger, sadness, worries)"; "My clinician is very facilitating in helping me consider myself and my situation"; "My clinician lets me talk freely about anything"; "My clinician seems to like me regardless of what I do or say"; "I believe my clinician has an understanding of what my experiences have meant to me"; and "My clinician speaks with me about my personal goals and thoughts about treatment". Finally, subscale three comprises six items to assess 'negative clinician behaviour': "My clinician overwhelms me and does things without checking with me"; "I believe my clinician withholds the truth from me"; "I think that it is difficult for my clinician to empathise with or relate to me"; "My clinician is stern with me when I speak about things that are important to me and my situation"; "My clinician persists in making me do or try out things that I do not want to do"; and "My clinician is impatient with me". The patient original item pool is provided in Appendix 7.

Evolution of response formats

The clinician reduced item pool contains new items derived from the semi-structured interviews, the HAS, CALPAS and the TPSS. The patient reduced item pool contains items from the TPSS, new items derived from the semi-structured interviews and from the WAI. In the original item pool the HAS and the new items derived from the semi-structured interviews make use of the Visual Analogue Scale (VAS) format. Both the WAI and CALPAS use the Likert format in the original item pool. The TPPS uses a forced-choice, yes / no format in the original item pool. In the reduced item pool, a Likert format is used for all of the questions. A description of each format is described, then justification for a uniform format for the reduced item pool is provided.

An alternate choice item is where the respondent is given two choices from which to select a response (i.e., yes or no). This format was used for both the patient and clinician versions of the TPSS (Stark et al., 1992). The principal advantage of this format is that it is fast and easy to use. However respondents often find the narrow range of possible responses to be too restricting (Rust and Golombok, 1989). In addition the strength of the response cannot be assessed using this format. Furthermore, scales with two response items are less reliable than those with three or more (Rust and Golombok, 1989).

The Likert scale (1932) offers the respondent the opportunity to express their opinion in a continuum that starts from a low negative response to a high positive response. It is the most widely used scaling technique (Polit and Beck, 2004). The WAI (Horvath and Greenberg, 1986) and CALPS (Gaston, 1991) both use this format. The Likert scale has the advantage over the absolute Yes or No response format in that the strength of the response provided by the respondent can be assessed. Respondents are more able to express themselves precisely with this format than with alternate choice items (Rust and Golombok, 1989). Furthermore, scales with five response items have shown to be higher in reliability than those with just two. However, reliability appears to level off after five responses - so while a five point scale is better than a two point scale, ten is not necessarily better than five (Lissitz and Green, 1975). Too many response categories may lead to difficulties in choosing and too few may not provide enough choice or sensitivity, forcing the respondent to choose an answer that does not represent the person's true intent. Respondents differ in their interpretations of the response options (i.e., 'frequently' has a different meaning to different individuals) (Rust and Golombok, 1989). Some respondents tend always to choose the most extreme options (Rust and Golombok, 1989). When an uneven number of response options are used, many respondents tend to choose the middle one (i.e., 'don't know' or 'occasionally') (Rust and Golombok, 1989).

A Visual Analogue Scale (VAS) is a measurement instrument that tries to measure a characteristic or attitude that is believed to range across a continuum of values. Operationally a VAS is usually a horizontal line, 100 mm in length, anchored by word descriptors at each end. The respondent marks on the line the point that they feel represents their subjective evaluation. Markers are often added to the line and these are sometimes numbered. The VAS and Likert scales are comparable with regard to reliability and validity and yield similar results (McCormack et al., 1988). Disadvantages with the VAS are that it may involve more work than a Likert scale (Grunberg et al. 1996). Furthermore, it has been suggested that the VAS might be less specific and have worse precision than the Likert scale (Svensson, 2000).

Taking into account the respective advantages and disadvantages of each format, and with the aim to develop a straightforward, simple and easy to use scale – all items were formatted in a 5-point Likert scale format from never (= 0) to always (= 4).

Chapter 9

Stage 3: Retest reliability of new scales

Finally, in the longitudinal third stage I tested the stability of the reduced item pool with two new administrations. In the construction of STAR, those items with insufficient reliability were dropped.

Method

The 7-clinician sample was drawn from the group that participated in stage 2 of the project. All 33 were telephoned and asked to participate in the next phase of the project. Each clinician was asked if they would complete 10 short questionnaires twice with a two-week interval. No compensation was offered at this stage. 7 out of 26 agreed to participate (27% of the total potential sample). 3 were social workers, 3 were community psychiatric nurses and 1 was a psychologist. The mean caseload for this sample was 21. Five were female and two were male. The average age was 43. 4 were white, 1 was black Caribbean, 1 was Chinese and one other was of other ethnic origin.

I drew the 68-patient sample from the group of participants from stage 2 of the project. I first sent letters to all 133 patients to invite them to participate in a telephone survey[7], with a full description of what their involvement would entail. I made follow-up calls to arrange a date and time that would be convenient for

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[7] Telephone interviews, rather than face-to-face interviews were conducted because I had a newborn baby and moved to Bath from London.

them to participate. I was able to reach 68 patients (51% of the total sample[8]) – all of whom agreed to participate again.

More of the patient sample was female (41) than male (27). The average income of this sample was £475 ($853.86.37, €705.08) per calendar month. The patient sample had a mean of 1.14 children. The mean onset of illness for this sample was 18 years before the interview, with an average number of 6 hospitalisations, 5 of which were involuntary, and an average of 11 months spent in hospital in total.

The re-test date was calculated two weeks from the date of the initial telephone survey. Although this interval may underestimate the retest reliability of the scale, in community care this is a practical period because interventions with this patient group are typically on a long-term rather than a short-term basis.

All items with sufficient reliability were retained in the scale (using Cronbach's alpha coefficient).

Results

The retest-reliability for all items of the reduced item pool is shown in table 8.

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[8] The difference in time between data collection in stage 1 and stage 2 was between 6 months and 2 years. The main data collection phase (stage 2) started in January 2001 and ended in June 2002. The retest phase (stage 3) started in December 2002 and ended in January 2003.

Table 8. Clinician and Patient Test-Retest Reliability of the reduced item pool

Clinician Subscales

1. Positive Collaboration
Trust (Pearson's r = .73*)
Global Assessment(Pearson's r = .64*)
Get along (Pearson's r = .70*)
Rapport (Pearson's r = .59*)
Open communication (Pearson's r = .73*)
Shared expectations (Pearson's r = .60*)

2. Emotional Difficulties
Inferiority (Pearson's r = .48*)
Cannot empathise (Pearson's r = .64*)
Not feel accepted (Pearson's r = .72*)
Dislike P (Pearson's r = .45*)
Critical (Pearson's r = .44*)

3. Positive Clinician Input
Takes P's perspective (Pearson's r = .64*)
Listens to P (Pearson's r = .68*)
Supportive of P (Pearson's r = .53*)

Patient Subscales

1. Positive Collaboration
Shared understanding (Pearson's r = .78*)
Open communication (Pearson's r = .63*)
Agreement (Pearson's r = .80*)
Honesty (Pearson's r = .65*)
Mutual goals (Pearson's r = .65*)
Trust (Pearson's r = .72*)

2. Positive Clinician input
Encouragement (Pearson's r = .76*)
Regard (Pearson's r = .70*)
Understanding (Pearson's r = .79*)
Helpful (Pearson's r = .67*)
Allows open conversation (Pearson's r = .61*)
Discuss P goals (Pearson's r = .69*)

3. Non-supportive clinician input
Authoritarianism (Pearson's r = .57*)
Impatience (Pearson's r = .55*)
Withholds truth (Pearson's r = .64*)
Overwhelms (Pearson's r = .52*)
Pressure (Pearson's r = .44*)
Lacks empathy (Pearson's r = .44*)

** Significant at the .05 level*

Reliability coefficients varied between moderate and strong. With the aim to develop a brief scale and considering the minimum number of three items for a subscale, the number of items in each version was reduced to 12, i.e. 6 for the first factor of 'positive collaboration' and three for each for the other two factors, and dropped items with the lowest retest-reliability on each factor as appropriate.

A regression analysis showed that the items of the final scale explained 87% of the variance of the previous reduced item pool in the clinician version, and 94% in the patient version (adjusted R^2).

With respect to the new 12 item STAR scales, I repeated PCA, and confirmed the three factors for each version. In the clinician version, 'positive collaboration;

explained 62% of the variance, 'emotional difficulties' 17%, and 'positive clinician input' 10%. As items had been dropped - to ensure the data still fit the model - a CFA was conducted by means of structural equation modelling with the clinician test retest sample using AMOS (Arbuckle, 1999). The model investigated consisted of the three latent variables. The model was estimated using the maximum likelihood method, and the chi-square value was χ^2 (54, n = 68) = 295.54, p <.01). The analysis reported here resulted in IFI = .84 and RMSEA = .22, indicating an acceptable fit of the measurement model to the data.

In the patient version of STAR, 'positive collaboration' explained 71%, 'positive clinician input' 18%, and 'non-supportive clinician input' 7% of the variance. The model was estimated using the maximum likelihood method, and the chi-square value was χ^2 (54, n = 68) = 617.99, p <.01. The analysis reported here resulted in IFI = .73 and RMSEA = .34, indicating an acceptable fit of the measurement model to the data.

The correlation (Pearson's r) between the total and subscale scores of the two versions of STAR revealed a significant and negative association between clinician ratings of their emotional difficulties and patient total ratings (r = -.33, p < .05), positive collaboration (r = -.34, p < .05), and positive clinician input (r = -.34, p <.05). All other correlations failed to reach significance. The retest-reliability for the STAR scales revealed positive correlations for the mean total and subscale scores for both STAR-C (as illustrated in Table 9) and for STAR-P (as shown in Table 10).

Table 9. Correlation to measure the retest reliability of Clinician total scale and subscales of STAR

	Total T2	Positive Collaboration T2	C Difficulty T2	Positive C Inupt T2
Total T1	r = .68*	r = .66*	r = -.54*	r = .57*
Positive Collaboration T1	r = .66*	r = .72*	r = -.63*	r = .48*
C Difficulty T1	r = -.54*	r = .48*	r = .58*	r = -.44*
Positive C Inupt T1	r = .57*	r = .42*	r = -.46*	r = .73*

* Significant at the .05 level

Table 10. Correlation to measure the retest reliability of Patient total scale and subscales of STAR

	Total T2	Positive Collaboration T2	Positive C Inupt T2	Negative C Inupt T2
Total T1	r = .76*	r = .76*	r = .76*	r = -.56*
Positive Collaboration T1	r = .75*	r = .78*	r = .77*	r = -.64*
Positive C Inupt T1	r = .76*	r = .77*	r = .81*	r = -.63*
Negative C Inupt T1	r = -.58*	r = -.66*	r = -.65*	r = .68*

* Significant at the .05 level

Some patient mean ratings were related to mean ratings by clinicians of STAR. The total patient mean score was weakly and negatively correlated with clinician factor 2, clinician emotional difficulties ($r = -.33$, $p < .05$). Patient subscale 1, positive collaboration, was weakly and negatively correlated with clinician subscale 2, clinician emotional difficulties ($r = -.34$, $p < .05$). Finally, patient subscale 2, positive clinician input, was weakly and negatively correlated with clinician subscale 2, clinician emotional difficulties ($p = -.34$, $p < .05$). (See Table 11).

Table 11. Correlation to measure the association between mean Patient and Clinician ratings of STAR

	P Total	P Positive Collaboration	P Positive C Input	P Negative C Input
C Total	r = -.10	r = -.09	r = -.11	r = -.01
C Positive Collaboration	r = -.10	r = -.00	r = -.02	r = -.04
C C Difficulties	r = -.33*	r = -.34*	r = -.34*	r = -.08
C Positive C Input	r = -.05	r = -.04	r = -.06	r = .00

* = Significant at the .05 level

Inter-correlations of the total and subscale scores

The total mean score of the STAR patient version was strongly correlated with two of the mean subscale scores, factor 1, positive collaboration ($r = +.99$, $p < .05$), and factor 2, positive clinician input ($r = +.99$, $p < .05$). Factor 1, positive collaboration and factor 2, positive clinician input, were also highly correlated ($r = +.99$, $p < .05$).

Association between Quality of Life and patient mean scores

All of the mean scores of the patient ratings of the STAR were moderately correlated with the mean satisfaction score of the MANSA (Priebe et al., 1999). Significant relationships were found between patient QOL ratings and mean total score and subscale scores 1, 2 and 3 ($r = .45$; $r = .52$; $r = .48$ and $r = -.52$, respectively, $p < .05$). Satisfaction was positively related to the total mean score, factor 1, positive collaboration, and factor 2, positive clinician input, but was negatively correlated with factor 3, non-supportive clinician input. This research supports other research linking a positive therapeutic relationship to quality of life ratings (Alverson et al., 2000; McCabe et al., 1999).

Inter-correlations of the total and subscale scores

The total mean score of the clinician version of the STAR was strongly correlated with two of the mean subscale scores, factor 1, positive collaboration ($r = +.94$, $p < .05$), and factor 3, positive clinician input ($r = +.95$, $p < .05$). Factor 1, positive collaboration and factor 3, positive clinician input, were also highly correlated ($r = +.85$, $p < .05$).

Association between mean ratings of pre-existing scales, demographic variables, work variables, BPRS ratings and mean score ratings of the STAR.

To determine the concurrent validity of the new STAR scales, that is, whether the results from the new instruments concur with existing, known to be valid measures - the mean score for each version was correlated with the mean scores of the HAS (Priebe and Gruyters, 1993), WAI (Horvath and Greenberg, 1986), TPSS (Stark, 1992) and CALPAS Scales (Gaston, 1991). The results are offered in Tables 12 and 13.

Table 12: STAR patient mean score rating correlations with patient mean score ratings of pre-existing scales

HAS	.73*
WAI	.86*
TPSS	-.57*
CALPAS	.68*

* Significant at the .05 level

Table 13: STAR clinician mean score rating correlations with clinician mean score ratings of pre-existing scales

HAS	.87*
WAI	.69*
TPSS	-.51*
CALPAS	.67*

* Significant at the .05 level

Pearson's r was used to determine possible associations between the total and subscale scores of both STAR perspectives and socio-demographic characteristics and caseload of clinicians, and socio-demographic characteristics and psychopathology of patients. The problem with looking at correlations between STAR ratings and clinician professional and demographic data is that there is a cluster effect because each clinician has a number of patients. This, along with the small sample size may lead to an overestimate of the correlations. The data was therefore aggregated into summary cases for each clinician before correlating clinician variables and STAR ratings. These associations are outlined in Table 14.

Table 14: Association between clinician and patient variables and ratings of STAR

	C m	C sub m 1	C sub m 2	C sub m 3	P m	P sub m 1	P sub m 2	P sub m 3
C profession	r = .28	r = .23	r = .25	r = .36	r = .68	r = .73	r = .34	r = .50
C gender	r = .19	r = .24	r = .19	r = .04	r = .52	r = .53	r = .25	r = .45
C age	r = .51	r = .44	r = .53	r = .53	r = .41	r = .38	r = .50	r = .05
C ethnicity	r = .19	r = .18	r = .21	r = .12	r = .61	r = .32	r = .63	r = .44
C caseload	r = .23	r = .29	r = .25	r = .02	r = .07	r = .32	r = .11	r = .01
P gender	r = .13	r = .10	r = .07	r = .21	r = .10	r = .09	r = .10	r = .09
P age	r = .29	r = .16	r = .32	r = .29	r = .32	r = .31	r = .31	r = .16
P ethnicity	r = .06	r = .01	r = .11	r = .07	r = .09	r = .07	r = .07	r = .13
P BPRS m	r = -0.23	r = -0.16	r = -0.1	r = -.28*	r = -0.04	r = -0.08	r = 0.03	r = -.04

* Significant at the .05 level
For nominal data, chi square was used to measure association

Patients' ratings were neither significantly associated with their own socio-demographic characteristics nor with those of their clinicians. Clinicians' ratings were neither significantly associated with their own socio-demographic characteristics nor with those of their patients. No relationship was found between ratings of the therapeutic relationship and the professional background of the clinician. There was a tendency for less favourable ratings of therapeutic relationships with patients with higher BPRS scores. Yet, this reaches statistical significance only for the subscale 'positive clinician input'.

Chapter 10

The STAR

Patient Version

Description and protocol of the patient STAR

The patient version of STAR comprises three subscales, positive collaboration, positive clinician input, and non-supportive clinician input, that includes 6, 3 and 3 items, respectively. This scale is provided in Appendix 8. Positive collaboration is measured by the extent to which the clinician and patient have a shared understanding of changes needed, open communication, they agree on what to work on, they are honest with one another, they are working on mutual goals, and they experience mutual trust. Positive clinician input includes items on clinician encouragement, clinician regard, and clinician understanding. Finally, non-supportive clinician input is measured by clinician authoritarianism, clinician impatience, and the extent to which the patient believes that the clinician withholds the truth. The items are rated on a 5-point Likert-type scale that ranges from 0 – 4. Following each statement that describes experiences that a clinician and patient may have, the patient is asked to decide which category best describes their experience with their clinician using the scale provided (i.e., 0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = always) and to circle the number that corresponds to that category. It takes approximately 5 minutes for the patient to complete the 12-item patient version of the STAR.

A total patient score and three subscale (positive collaboration, clinician input, and non-supportive clinician input) scores can be obtained. Before scoring the patient version of the STAR, one must ensure that scores for the non-supportive clinician input subscale items are reversed. To do this, one may subtract each of the item ratings in this subscale from 4; therefore, a rating of 1 becomes 3 (4 minus 1); a rating of 2 remains 2 (4 minus 2); a rating of 3 becomes 1 (4 minus 3); and a rating of 4 becomes 0 (4 minus 4). After reversing items for this subscale, the total patient version of the STAR score is obtained by adding the scores for each of the 12 items (the lowest possible total score being 0, and the highest total score being 48). The three subscale scores are each obtained by summing the identified item rating for each scale and dividing it by the total number of items (i.e., 6 for Positive Collaboration; 3 for Non-supportive Clinician; and 3 for Positive Clinician Input) to procure the mean rating.

Norm values of the patient STAR

To identify the scale norms for the STAR, I obtained the total scores and standard deviation for the total sum, and for the three subscales of the patient version of the STAR. The total sum score for the patient version is 38.44 with a standard deviation of 11.99. The total sub-scale scores for factor 1, positive collaboration, was 19.86 with a standard deviation of 6.72. The total score of factor 2, positive clinician input was 9.25 with a standard deviation of 9.25. The total score for factor 3, non-supportive clinician input, was 7.40 with a standard deviation of 2.96.

The clinician version

Description and protocol of the clinician STAR

The clinician version of the STAR comprises three subscales: positive collaboration (with 6 items), clinician emotional difficulties (that includes 3 items), and positive clinician input (that comprises 3 items). This scale is provided in appendix 9. Positive collaboration is measured by: trust, global assessment, how the clinician gets along with the patient, rapport, open communication and the extent to which they share similar expectations. Emotional difficulties are measured by clinician feelings of inferiority, lack of empathy and not feeling accepted by the patient. Finally, positive clinician input is measured by the extent to which the clinician can take the patient's perspective, can listen to the patient, and is supportive of the patient. The items are rated on a 5-point Likert-type scale that ranges from 0 – 4. Following each statement that describes experiences that a clinician and patient may have, the clinician is asked to decide which category best describes their experience with their patient using the scale provided (i.e., 0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = always) and to circle the number that corresponds to that category. It takes approximately 5 minutes for the clinician to complete the 12-item clinician version of the STAR.

A total clinician STAR score and three subscale (positive collaboration, emotional difficulties, and positive clinician input) scores can be obtained. Before scoring the clinician version of the STAR, one must ensure that scores for the emotional difficulties subscale items are reversed. Again, to do this, one may subtract each of the item ratings in this subscale from 4; therefore, a rating of 1 becomes 3 (4 minus 1); a rating of 2 remains 2 (4 minus 2); a rating of 3 becomes 1 (4 minus 3); and a rating of 4 becomes 0 (4 minus 4). After reversing items for this subscale, the total clinician version of the STAR score is obtained by adding the scores for each of the 12 items (the lowest possible total score being 0, and the highest total score being 48). The three subscale scores are each obtained by summing the identified item rating for each scale and dividing it by the total number of items (i.e., 6 for positive collaboration; 3 for clinician emotional difficulties; and 3 for positive clinician input) to procure the mean rating.

Norm values of clinician STAR

To identify the scale norms for this sample, the total score and standard deviation were obtained for the total sum, and for the three subscales of the clinician version of the STAR. The total sum score for the clinician version is 31.54 with a standard deviation of 6.86. The total sub-scale score for factor 1, positive collaboration, was 15.28 with a standard deviation of 4.07. The total sub-scale score of factor 2, clinician emotional difficulties was 8.87 with a standard deviation of 2.65. The total sub-scale score for factor 3, positive clinician input, was 7.40, with a standard deviation of 1.58.

Chapter 11

Stage 4: Testing STAR in a new sample

The aim of stage four is to apply STAR to a new sample and to test the fit of the factorial structure of the scale.

Method

The STAR was administered to a new sample of 180 community mental health care patients and their 84 care coordinators. The data collection was part of the ECHO study (Experiences of Continuity and Health and social Outcomes in mental health). This project is a two-site prospective longitudinal study with yearly follow-up, preceded by an exploratory phase involving the development of a user-centred measure of continuity. Service users were recruited from two areas, covered by two organisations: South West London and St. George's Mental Health NHS Trust (SWLSTG) and South London and the Maudsley Mental Health NHS Trust (SLAM). One of the aims of this study is to assess the impact of continuity of care for patients on process variables – such as the therapeutic alliance.

Confirmatory factor analysis models were fitted to both the new clinician and new patient data to test the hypothesis that the new data fits the stage 3 theoretical model. In each case, a model with 3 factors derived from stage 3 was fitted.

Patients were aged 18-65, had a psychotic illness, had been in a relationship with the clinician for an average of 29 months and were on the enhanced level of the CPA. Researchers approached or tried to approach all eligible patients until a sufficient number had been recruited. 100 of the patient sample were male and 80 were female. 73 lived alone, 27 with their partner and / or children, 19 with their parents, 11 with relatives and 50 with others. Their mean age was 43.1 and mean age of illness onset was 24.91. The mean number of admissions was 2.27. 120 were White, 32 were African-Caribbean, 14 were Asian Indian/Pakistani and 14 were of some other ethnic origin.

36 of the clinicians were male and 48 were female. Their mean age was 45.1. Most were community psychiatric nurses 61, followed by social workers 10, occupational therapists 9, psychologists 3 and 1 psychiatrist. 43 were White, 11 Asian Pakistani/ Bangladeshi/ Other, 2 Black Caribbean, 19 Black African, 2 Black Other, 6 Chinese and 1 Other.

Results

Fitting the stage 3 three factor model to the new patient data resulted in a χ^2 (51, n = 180) = 118.43, $p < .01$; IFI = .91; RMSEA = .09, indicating an acceptable fit of the model to the data.

Fitting the stage 3 three factor model to the new clinician data resulted in a χ^2 (51, n = 180) = 114.62, $p < .01$; IFI = .92; RMSEA = .08, indicating an acceptable fit of the model to the data.

Significant correlations were found between the total mean and subscale scores within and between patient and clinician ratings (see Tables 15, 16 and 17).

Table 15: Stage 4 patient mean rating correlations

	Total mean	Positive collaboration	Positive c input	Non-supportive c input
Total mean	1	.95*	.86*	.55*
Positive collaboration	.95*	1	.77*	.34*
Positive c input	.86*	.77*	1	.27*
Non-supportive c input	.55*	.34*	.27*	1

* = significant at the .05 level

Table 16: Stage 4 clinician mean rating correlations

	Total mean	Positive collaboration	C emotional difficulties	Positive c input
Total mean	1	.95*	-.14*	.87*
Positive collaboration	.95*	1	-.40*	0.82
C emotional difficulties	-.14*	-.40*	1	-.38*
Positive c input	.87*	0.82	-.38*	1

* = significant at the .05 level

Table 17: Stage 4 correlation of clinician and patient mean ratings

	Total p mean	P Positive collaboration	P Positive c input	P non-supportive c input
Total C mean	.35*	.37*	.31*	0.01
Positive collaboration	.36*	.37*	.33*	0.01
Positive c input	-.01	-.01	-.01	-.04
C emotional difficulties	.25*	.28*	0.17	0.1

* = significant at the .05 level

No significant relationship was found between the clinician's professional discipline and ratings of the therapeutic relationship. Female clinicians gave significantly higher ratings than male clinicians (r = .28, p < .01). Non-white clinicians gave higher ratings of the relationship than white clinicians (r = .41, p < .01). The age of the clinician was also relevant, where older gave higher ratings of the relationship than younger clinicians (r = .28, p < .01). Finally, relationship duration related to clinician ratings of the therapeutic relationship. Here, those clinicians who had a longer relationship with the patient rated the relationship more positively ($r = .31$, $p < .01$). No significant relationships were found between the patient's total score and their own or clinician variables.

Chapter 12

Discussion of the STAR

STAR has been specifically developed to assess the relationship between clinicians and patients with severe mental illnesses in community care settings. Thus, the development had to go through all stages from item generation in open interviews to testing of test-retest-reliability, and the results had to be brief and easy to administer so that it can be applied in the challenging conditions of community mental health care practice. This research process involved the use of both qualitative (the content analysis of semi-structured interviews) and quantitative (including principal components analysis) methodologies enabling the identification of new items that may be particularly relevant in community mental health care and to determine the validity of pre-existing measures in this setting.

The preliminary clinician scale consisted of 106 items derived from semi-structured interviews in addition to pre-existing scales used to assess the therapeutic relationship, including the HAS (Priebe and Gruyters, 1993), WAI (Horvath and Greenberg, 1989), TPSS (Stark et al., 1992), CALPAS (Gaston and Marmar, 1991), and HEAS (Park et al., 2002). The final scale consists of three factors, with a total of 12 items. The first factor, positive collaboration, comprises five items derived from the semi-structured interviews (trust, openness, shared expectations for treatment, global rating, and rapport) and one from the HAS (the extent to which the clinician and patient 'get along') (Priebe and Gruyters, 1993). While it has been argued that most scales designed to assess the therapeutic relationship essentially measure the extent to which there exists a positive collaboration (Hatcher and Barends, 1996; Horvath and Luborsky, 1993, Salvio et al. 1982, Bachelor, 1991, Tichenor and Hill, 1989, and Tracey and Kokotovic, 1989), that most items for this factor derive from the semi-structured interviews, and not from other pre-existing scales, suggests that the combination of specific items identified here may be particularly relevant to clinicians in community mental health care. The second factor, positive clinician input, comprises three items that originate from the semi-structured interviews (takes patient's perspective, listens to patient, and supports patient). Again, that none of the items derive from pre-existing scales, but rather from the semi-structured interviews, suggests the importance of eliciting items from the intended users of the measure. The three items that comprise the third factor, clinician emotional difficulties, all derive from the TPSS, namely, inferiority, inability to empathise, and not feeling accepted by the patient (Stark et al., 1992). As the TPSS was developed from the theory of expressed emotion (Stark et al., 1992), it may be suggested that negative expressed emotion on the part of the clinician, namely, a critical or hostile attitude and / or emotional over-involvement (Kuipers et al., 2002) may be of particular relevance to the therapeutic relationship this setting where the majority of patients suffer from schizophrenia, delusional, and schizoaffective disorders. Other features of the TPSS, such as its focus on professional input, and the possible existence of professional burnout, may also make it relevant here. More of this will be discussed later.

The 118-item preliminary patient version consisted of items derived from semi-structured interviews, in addition to scales designed to assess the therapeutic relationship, including Priebe's systemic two-part question (1989) the HAS (Priebe and Gruyters, 1993), WAI (Horvath and Greenberg, 1989), TPSS (Stark et al., 1992), and CALPAS (Gaston and Marmar, 1991). The first factor, positive collaboration, consists of three of the items that were generated by the semi-structured interviews (trust, openness, and honesty), and three from the WAI (agreement on the changes needed, congruence regarding what to work on, and shared goals). The last three focus on the 'tasks' and 'goals' of treatment, whereas the first three may be descriptive of the extent to which there exists a mutually shared 'bond'. While the concept of patient-clinician congruence regarding the bond, task, and goals of treatment derives from Bordin's theory (1979), and was operationalised by Horvath and Greenberg in the WAI (1986), the specific items that suggest the existence of a mutual bond derive from the semi-structured interviews and not the WAI (or any other measure). Items that comprise the second factor, positive clinician input (encouragement, regard, and understanding) and non-supportive clinician input (authoritarianism, impatience, and the withholding of the truth), all derive from the TPSS (Stark et al., 1992). This suggests that patients in this setting may be particularly sensitive to the expressed emotion of clinicians in their rating of the therapeutic relationship. Again, the focus of the TPSS on clinician, rather than patient input – including the possibility of professional burnout - may also make it relevant. More on this will be discussed later.

Positive collaboration

Positive collaboration appears to be a key factor in the maintenance of a good working relationship. Both clinician and patient versions of the STAR emphasise the importance of 'trust', 'open communication', and an agreement or shared expectations regarding the patient's 'treatment' (clinician version of the STAR), of the 'changes needed', 'what to work on', and of their 'goals' (patient version of the STAR). While the patient version of the STAR notes the importance of 'honesty', the clinician version of the STAR highlights the harmony of the relationship with items including the 'global assessment', 'rapport' and 'my patient and I get along with one another'.

Both versions of the STAR highlight the importance of 'trust', a confident reliance in one another. 'Trust' may be particularly important in this setting compared to others, where people with severe mental illness, especially those that suffer from paranoid schizophrenia, may be more reluctant to place their trust in another person. Trust is seen to be pivotal in engaging patients so that they feel able to confide their problems to mental health professionals. Furthermore it has been suggested that some patients express distrust in the therapeutic relationship based on previous experience (Watts and Priebe, 2002). Indeed, many patients in community care are 'suspicious' or 'rejecting' of attempts of engagement, presenting a tremendous challenge to mental health professionals (Repper et al., 1994).

The clinician may similarly be reluctant to trust some patients in view of the fact that many clinicians who work in psychiatric settings are vulnerable to abuse. A survey study in South Wales revealed that 17% of psychiatrists reported being victim to one or more violent assaults, and 32% reported receiving one or more threats by patients (Davies, 2001). Clinicians meet a range of patients with severe mental illness in the community who vary according to their clinical diagnoses and symptoms. Patients with a 'dual diagnosis' of both severe mental illness (i.e., mania, acute schizophrenia) as well as maladaptive patterns of behaviour (a disordered personality) have been identified as most prone to violent behaviour (Tyrer et al., 1998). Acute psychotic symptoms, and certain types of delusions have also been found to pose greater risk of violence (Davies, 2001; Shaw, 2000; White et al., 1997). Despite the requirement in the United Kingdom that "any risk to the public or to patients is minimal and is managed effectively" before patients are discharged into the community (The Department of Health, 1995) the risk of violence committed by patients with mental illness in the year following discharge has been calculated at 20% (Kennedy, 2000). For patients with combined substance abuse, this risk is said to increase to 31% (Kennedy, 2000).

'Open communication', or unrestricted and frank discussions, is also highlighted in both versions of the STAR. While openness on the part of the patient is imperative for the clinician to be able to effectively establish the patient's ability to cope, the clinician's openness is similarly important to the patient to receive appropriate feedback. Open communication is important to the clinician-patient relationship in a variety of therapeutic settings. In primary care, patient satisfaction was best predicted by the patient's perception of communication (Little et al., 2001). Engagement with people with serious, long-standing mental health problems is difficult, and it is suggested that communication / openness is a key factor in community care settings (Hall et al., 2001). Patients in community care have been described as being more uncommunicative, thereby causing feelings of frustration, annoyance and hopelessness in the case manager that tries to engage him or her (Repper et al., 1994).

Clinician Subscales: Positive Collaboration

Shared expectations' is featured in the clinician version of the STAR. Because most patients served by community mental health services suffer from chronic and severe mental illness, the goal for treatment is often stability rather than change. To this end, the extent to which the clinician and patient establish explicit and realistic expectations for treatment progress may be integral to the maintenance of a good working relationship. The emphasis on stability, rather than change in community mental health care was reflected by a 12-year follow-up survey that revealed high levels of patient problems and needs at both points, and little evidence of significant improvement or deterioration – prompting the investigators to argue that "the challenge for current service providers is not only to keep clients stable, but also to help improve the clinical and social functioning of people who may no longer be the highest priority" (Reid et al., 2001). Furthermore, it has been suggested that some patients may lack 'insight' into their condition, and that half of people with schizophrenia and bipolar disorder may suffer from anosognosia, or "unawareness of illness," where "people will come up with illogical and even bizarre explanations for symptoms and life circumstances stemming from their illness" (Amador, 2002). Here, particular resistance may be faced by clinicians that attempt to engage with, and effect change in patients that do not perceive any need for treatment.

The harmony of the relationship is emphasised by the clinician version of the STAR. Here, the global assessment of the relationship, the 'rapport', and how the clinician and patient 'get along' are items indicating a positive collaboration. Several scales developed to assess the therapeutic relationship in different therapeutic settings aim to measure the dimension of patient-clinician 'bond', including the Barrett-Lennard Relationship Invetory (1962), and the Working Alliance Inventory (Horvath and Greenberg, 1986). While not necessarily specific to this setting, patient-clinician harmony is crucial to the therapeutic relationship in community care.

Patient Subscales: Positive Collaboration

A 'shared understanding of the changes needed', 'agreement on what to work on' and 'mutual goals' appear in the patient version of the STAR. Much research suggests that a collaborative relationship (defined by a non-hierarchical mode of communicative interaction in which the patient and clinician work together toward a common goal) is associated with better outcome (Ong et al., 1995; Docherty and Fiester, 1985; Rosenberg and Kesselman, 1993; Priebe and Gruyters, 1999). While congruence in the establishment of tasks and goals of treatment may be important in any therapeutic relationship, it may require particular clarification in community care. Firstly, patient-professional collaboration is distinct from other therapeutic settings where help is sought on a voluntary basis. In community mental health care, the professionals have the statutory responsibility to ensure that patients receive adequate health and social care – regardless of whether the patients themselves perceive the need for help

(Godin, 2000; Holloway et al., 2000; Pinfold and Bindman, 2001). Secondly, in this setting, patients may be allocated a clinician from a variety of mental health professions: social workers, psychiatric nurses, occupational therapists, or psychologists. The tasks and goals of treatment might require clarification depending on the professional background of the clinician. Clinicians from different professions may focus on different aspects of the patient's needs. Social workers typically focus on the 'life management' of patients, whereas community psychiatric nurses who may be responsible for injections, focus more on treatment (Wooff et al., 1988). Despite interdisciplinary training differences, all clinicians may be expected to play varying roles at different points in time while caring for patients in the community. This has led to some clinicians with the experience of 'role confusion' (Mitchell and Patience 2002). Furthermore, some clinicians may lack the expertise expected of them. Lack of training is attributed as one of the main causes of stress among community mental health care professionals (Becker and Thornicroft, 1998; Posser et al., 1996) – where staff often feel "ill equipped for the demands of the job" (Burgess and Pirkis, 1999; Chinman et al., 2001). Congruence in terms of establishing the tasks and goals of treatment requires particular clarification in this setting.

'Honesty', or candid and truthful dealings with one another, was highlighted by the patient version of the STAR. Honesty in the therapeutic relationship may be of particular importance to community care, where patients may feel reluctant to be candid about their symptomology to their case worker. It has been suggested that patients in community care may be dishonest about their symptoms because of fear that they would not be discharged or referred elsewhere (Repper et al., 1994).

Clinician input

Both factors, ‘emotional difficulties’ and ‘positive clinician input’, in the clinician version of the STAR imply that the onus is on the clinician, rather than patient for the maintenance of a good working relationship. Similarly, the patient version highlights the impetus of the clinician – with two of the three factors being ‘positive clinician input’ and ‘non-supportive clinician input’. That clinician, rather than patient, input is emphasised in both versions, suggests a measure of passivity on the part of the patient, who relies on the ‘encouragement’, ‘regard’ and ‘understanding’ of the clinician (items comprising ‘positive clinician input’ in the patient version of the STAR) and is potentially thwarted by ‘authoritarianism’, ‘impatience’ and the clinician’s ‘withholding of the truth’ (items comprising ‘non-supportive clinician input’ in the patient version of the STAR). The clinician similarly recognises the importance of ‘taking the patient’s perspective’, ‘listening to the patient’, and being ‘supportive of the patient’ (items comprising ‘positive clinician input’ in the clinician version of the STAR) whereas feelings of ‘inferiority’, an ‘inability to empathise’, and ‘not feeling accepted by the patient’ (items comprising ‘emotional difficulties’ in the clinician version of the STAR) may be potentially detrimental to the relationship.

As the onus appears to be on the clinician in maintaining a good working relationship, it may be suggested that the clinician's role in community care is distinct from other therapeutic settings. While in psychotherapy, the patient typically seeks help from the professional and ultimately determines the course of the relationship, in community care, it is the responsibility of the clinician to initiate and maintain contact with the patient. The vital link between a single clinician and his or her caseload of patients is individual responsibility and professional autonomy (Marshall and Lockwood, 1998). The clinician's initiative in maintaining contact with their patients requires the clinician to meet them in a variety of settings, often making home visits, to ensure that their health and social needs are being met, and to monitor their ability to cope independently.

Clinician subscale: Positive Clinician Input

Positive clinician input, to 'take the patient's perspective', to 'listen to the patient', and to be 'supportive of the patient' promote the development and maintenance of a good therapeutic relationship. Symptoms of schizophrenia have been described as confusing and alienating for patients, calling for a need for much support and understanding on the part of mental health professionals (Barker et al., 2002). It has been suggested that patients with long-term mental illness undergo an 'identity dilemma' (Watts and Priebe, 2002). An analysis of narrative interviews with schizophrenic patients reveals a need for mental health professionals to facilitate patients in understanding the subjective impact of the illness on the self (Barker et al., 2001). Items in this subscale suggest that clinicians recognise their role in facilitating the patient's adaptation to their illness, by being heard, understood and supported. Indeed, patients are demanding a greater focus upon recovery by communicating hope, encouraging personal responsibility for health, and developing of a sense of self that is not illness-dominated (Torrey and Wyzik, 2000).

Clinician subscale: Emotional Difficulties

Emotional difficulties on the part of the clinician poses a threat to the integrity of the relationship in community care. Clinician 'inferiority', 'inability to empathise' and 'not feeling accepted by the patient' suggest the clinician's difficulty in his or her ability to relate to the patient in a supportive or productive way. In 1913 Jaspers wrote that schizophrenia is characterised by the non-understandability of mental functions ('praecox feeling') (Broome, 2002). It has been suggested that the clinician's inability to empathise with the patient may be further obscured by the biomedical explanatory paradigm in psychiatry (Bhui and Bhugra, 2002). It has been suggested that an attempt to empathise with patients with severe mental illness requires that the clinician understand the patient's symptoms in the light of the patient's world view (Broome, 2002). Community work has been described as 'inherently stressful', in part because of the effect of making home visits in deprived inner-city areas (Becker and Thornicroft, 1998; Prosser et al., 1996). It has been suggested that the shift from the institutional to community care setting has led to the development of 'psychiatric ghettos' (Tyrer et al., 1998). While home-visits have been found to improve certain aspects of social functioning and to decrease in-patient hospital bed usage for patients in the community (Dunn 2001), the living conditions of community care patients are often wanting, and the cumulative effect of visiting numerous patients in their homes may detrimentally effect clinicians. Furthermore, the caseload held by each clinician necessarily effects the time that they may be able to allocate to each patient. It has been suggested that clinicians with high caseloads may experience stress and subsequent burnout, which in turn, affects the quality of care that they can provide (Burgess and Pirkis 1999). Clinician burnout may also lead to high turnover, which impacts further on patients receiving care in the community (Burgess and Pirkis 1999). A study comparing stress experienced by hospital and community based mental health care staff revealed that the latter experienced significantly more 'emotional exhaustion' than hospital based in-patient, day care, or out-patient staff (Prosser et al., 1996). The subscale 'emotional difficulties' in the clinician version of the STAR may flag up possible problems of clinician burnout that may detrimentally affect the therapeutic relationship. The items in this subscale derive from the TPSS, a scale designed for schizophrenic patients with a focus on clinician behaviour indicative of expressed emotion, which may potentially result in patient relapse. The scales were developed specifically for schizophrenic patients and their therapists, with reference to other relevant measuring instruments, including the Barrett-Lennard Relationship Inventory (Stark et al., 1992; Stark et al., 1994; Barrett-Lennard, 1962). The tension between the specific care required by severely mentally ill patients, and the pressure put on the clinician to meet the needs of the patient in an inherently stressful environment, presents a particular challenge to the therapeutic relationship in this setting.

Patient subscale: Positive Clinician Input

As in the clinician version, the patient version of the STAR similarly emphasises 'positive clinician input' in the therapeutic relationship. Here, 'encouragement', 'regard', and 'understanding' are of key importance. Patients in community care are often relatively socially isolated and over time come to rely on visits from community clinicians. Research by Barrowclough et al. (2001) illustrates that patients with schizophrenia are sensitive to staff feelings of them. It has been suggested that in building relationships with patients in community care, it is crucial for case managers to "envisage themselves in the client's situation in order to understand it" (Repper et al., 1994). Indeed, a survey conducted to assess patients' opinions on what constitutes good psychiatric care revealed that 'being understood' by staff formed the most central aspects of good care (Johansson and Eklund, 2003).

Patient subscale: Non-supportive clinician input

As in the clinician version, the patient version of the STAR similarly addresses possible negative clinician behaviour that may detrimentally affect the therapeutic relationship in community care. Here, 'authoritarianism', the 'withholding of the truth' and 'impatience' are regarded as potential threats to a good working relationship.

Much research suggests that 'authoritarianism' on the part of a clinician results in poorer patient outcome (Britten et al., 2000; Geller et al., 1976). However, the statutory responsibility of clinicians in community care relationships requires clinicians in this setting to adopt an 'authoritarian' approach when necessary. Strategies may be employed by the clinician in the attempt to engage the patient in services (Pinfold and Bindman, 2001; Repper et al., 1994) however treatment may be legally enforced if the patient resists all social efforts on the part of the clinician. The aim of compulsory community treatment is to prevent relapse and to ensure that services are accessed before patients deteriorate to a state where they require hospital admission (Pinford and Bindman, 2001). The use of involuntary outpatient treatment in people with a mental illness is increasing (Godin, 2000; Holloway et al., 2000). Supporters for the use of involuntary outpatient treatment maintain that it may: reduce patients' psychiatric symptoms and dangerous behaviour; improve their social functioning; and reduce the chance of illness relapse and re-hospitalisation (Swanson et al., 1997). Opponents of compulsory community treatment describe it as: "a quick fix; a panic response to the wrong problem; a further step towards a custodial approach to community care; destructive of therapeutic relationships; discriminatory; drastic; and unethical" (Pinfold and Bindman, 2000). It has been suggested that developments in legal, chemical and administrative methods of control, once limited to the asylum, are now operating in the community (Godin, 2000). The clinician's ability to effectively engage and build trust with 'resistant' or 'non-compliant' patients without the use of threat or control is central to the integrity of the aims of community mental health care.

The 'withholding of the truth' on the part of the clinician is also of concern to patients as a potential threat to the therapeutic relationship. It has been suggested that there is a 'conspiracy of silence' where clinicians avoid discussing diagnosis with their patients (Clafferty et al., 2001) and that the avoidance of any discussion about diagnosis may “heighten patients’ anxieties” (Carstairs et al., 1985). Conversation analysis with patients with psychotic illness in routine conditions revealed that patients attempt to discuss the content of their psychotic symptoms in consultation with repeated direct questions and utterances, whereas doctors hesitate, respond with a question rather than an answer, and smile or laugh – suggesting that they are reluctant to engage with patient’s concerns regarding their psychotic symptoms (McCabe et al., 2002). Focus groups conducted with women living with schizophrenia reveal that they are not adequately informed about the side effects of psychopharmacologic treatment, resulting in further distress (Chernomas et al., 2000).

Finally, ‘impatience’ on the part of clinicians may threaten the therapeutic relationship. Some patient diagnoses have been identified as creating more ‘reactions’ in the staff who care for them, namely, paranoid schizophrenia and severe personality disorder (Hinshelwood, 1999). Impatience may be an indication of ‘malignant alienation’, characterised by a “loss of sympathy and support from members of staff, who tend to construe these patients' behaviour as provocative, unreasonable, or over-dependent” (Watts and Morgan, 1994). The ‘non-supportive clinician’ subscale may alert potential threats to the therapeutic relationship in this setting, by highlighting problems in clinician ‘authoritarianism’, ‘withholding of the truth’ and ‘impatience’.

Cross-perspective correlations

Cross-perspective correlations were found between clinician ratings of emotional difficulties and patient ratings of a positive collaboration and positive clinician input in both in stage 3 and in stage 4 of the study. In the two separate samples, the emotional difficulties on the part of the clinician (the clinician's experience of inferiority, not feeling accepted by the patient and their inability to empathise) are related to the patient ratings of shared collaboration (their experience of shared understanding, open communication, agreement on what to work on, mutual honesty, shared goals and trust). In stage 3 clinician emotional difficulties were also related to patient ratings of positive clinician input (the patient's experience of the clinician's encouragement, regard and understanding). In stage 4 clinician emotional difficulties (the clinician's experience of inferiority, not feeling accepted by the patient and their inability to empathise) were related to the patient's total mean score. These findings collectively highlight the importance of emotional difficulties on the part of the clinician in relation to the patient's experience of a good working alliance. A meta-analysis of 58 published and 21 unpublished studies investigating the therapeutic alliance by Martin et al. (2000) found that patients tend to view the alliance as stable, whereas observers and professionals tend to report more change in their alliance ratings over time. The authors therefore highlight the importance of establishing positive alliances with their patients early on (as patients who view the relationship as positive at their initial assessment are more likely to continue to view it positively at termination). Taking the findings of this thesis into account, it could be suggested that clinicians may need to address emotional difficulties they experience early on in the course of the relationship to secure the patient's experience of a good therapeutic alliance. That emotional difficulties on the part of the clinician are correlated with the patient's experience of the alliance may highlight the impact of staff burnout on the relationship. Prosser et al. (1996) found evidence of high levels of emotional exhaustion among community mental health team staff compared to hospital based inpatient, day care or outpatient staff. The three elements that comprise clinician emotional difficulties (feelings of inferiority, not feeling accepted by the patient and their inability to empathise) are conceptually similar to those that indicate professional burnout (emotional exhaustion, depersonalisation and lacking a sense of personal accomplishment). Where the professional's inability to empathise may be symptomatic of emotional exhaustion and depersonalisation – not feeling accepted by the patient could be related to the professional's sense of lacking in personal accomplishment. Perhaps future studies could investigate a possible relationship between staff burnout and clinician emotional difficulties. In stage 4, clinician ratings of a positive collaboration (the extent to which they feel they get along, share a good rapport, share a good relationship, share similar expectations, are open, and share a trusting relationship) were related to the patient's total mean score, their ratings of a positive collaboration (their experience of shared understanding, open communication, agreement on what to work on, mutual honesty, shared goals and trust) and of positive clinician input (the patient's experience of the clinician's encouragement, regard and understanding). Furthermore, the mean total clinician rating was related to the mean total patient rating, patient ratings of a positive collaboration (their experience of shared understanding, open communication, agreement on what to work on, mutual honesty, shared goals and trust) and patient ratings of positive clinician input (the patient's experience of the clinician's encouragement, regard and understanding). These findings do not only underscore the importance of the relationship between patient's perception of the clinician's input and the clinician's experience of a positive collaborative relationship – but they suggest something happening between the participants rather than within each – the chemistry between the patient and clinician. The concept of 'complementarity' has been investigated. Two perspectives are offered: competing versus complementing interpersonal behaviours; and complementing versus similar personality structures of the patient and professional (Horvath and Bedi, 2002). It has been suggested that harmonious, positive moment-to-moment interactions are correlated with good alliance - and the inverse is true for negative forms of interaction (Horvath and Bedi, 2002). In a study by Gunderson et al. (1997) the degree of similarity between patient and professional ratings of the therapeutic relationship in mid and late phases of treatment were positively related to outcome. Perhaps this could be tested in future studies in community care settings.

Link to patient psychiatric ratings

Patient psychopathology played a weak role in the assessment of the therapeutic relationship using the STAR. To trim for extreme measures due to psychopathology, principal components analysis was repeated with patients in the stage two participants who scored in the better two-thirds of the sample according to the Brief Psychiatric Rating Scale (BPRS). Although more variance was explained by this group, the difference was negligible. It could be concluded that the STAR is not much affected by patient symptomatology, and is therefore a robust measure of the patient-clinician relationship in this setting. However, the lack of influence of patient symptomatology on STAR ratings could also reflect the possibility that those patients who are more severely ill did not participate in the study. Indeed, over 70% of the total potential sample did not participate. This group could contain patients with more severe symptomatology, those who have a poorer therapeutic relationship with their clinician, or both. Within psychiatry, it has been suggested within that the poorest ratings of the therapeutic relationship among long-term hospitalised patients with schizophrenia, psychopathology could account for 3-28% of relationship variance (McCabe and Priebe, 2000). With the re-test sample, there was a tendency for less positive ratings of the therapeutic relationship with patients with higher BPRS scores, however this only reached significance for one subscale, the clinician rating of positive clinician input. This suggests that clinicians find it more difficult to take the patients perspective, to listen to the patient and to be supportive of patients who have higher ratings of psychopathology according to the BPRS. This finding could reflect the non-understandability of patients with mental illness as described by Jaspers (1913).

Link to Quality of Life

A significant relationship was found between the STAR and the patients' subjective evaluation of their quality of life. Among patients that participated in the main data collection phase in stage two, there was a relationship between the original item pool and quality of life. In the re-test phase in stage two a relationship was also found between patients' evaluation of quality of life and the mean total rating of STAR. While the finding of this study is in line with other research that suggests a link between the therapeutic relationship and quality of life in community care (McCabe et al., 1999; Alverson et al., 2000) it is useful to bear in mind some limitations. The findings here are correlational, so a causal relationship cannot be inferred. Objective conditions - such as social network, living situation, leisure activities, employment status, family contact and safety also have some impact on the subjective quality of life (Roder-Wanner and Priebe, 1998). Furthermore a study by Priebe et al. (2000) revealed that individual changes in quality of life ratings over time among schizophrenic patients were correlated with changes in anxiety and depression. The authors suggested that changes in these symptoms should be considered when interpreting changes in satisfaction with life. It could be suggested that the association between quality of life ratings and ratings of the therapeutic relationship could reflect a global affective factor on the part of the patients, rather than separate domains.

Implications for service designs

How applicable the STAR is to other community care management designs has yet to be established. Assertive outreach models are part of the mental health care evolution from hospital to community settings. They were developed around the same time as case management to address the same problem: 1, to keep patients in contact with services; 2, to reduce hospital admissions (and therefore costs); and 3, to improve outcome (Marshall and Lockwood, 1998). Assertive Community Team (ACT) management is sometimes confused with case management. However, despite superficial similarities, key differences remain.

Compared to case management, which stresses the link between individual team members and their patients, ACT emphasises team working and team responsibility. The vital link here is between the team and the patient group. Case management emphasises professional autonomy and individual responsibility – the vital link being between the single case-manager, or clinician and his or her case load of patients. Under ACT, team members share responsibility for individuals in their care. ACT management appears to be a relatively successful approach to caring for the mentally ill in the community. A systematic review investigating the effectiveness of Assertive Community Treatment (ACT) including 75 randomised controlled trials, quasi-experimental and pre-post designed, and three independent randomised controlled trials found that, compared with usual care, this type of case management: improved the maintenance of contact with care; decreased reliance on hospital-based care; improved patient-reported outcomes (satisfaction with care; perceived health status; quality of life); reduced levels of symptomatology; and increased housing stability (Mueser et al., 1998). A comprehensive review by Marshall and Lockwood (1998) revealed that those patients receiving ACT, compared to standard community care, were more likely to remain in contact with services; to be admitted to hospital and spend less time in hospital. There were no differences between ACT and standard community care on mental state or social functioning, however significant differences were found on accommodation status, employment and patient satisfaction. While ACT reduced the cost of hospital care, when other costs were taken into account, it did not have a clear-cut advantage over standard care. The STAR was developed with and for patient-professional relationships in standard community care. Case management is more widely practised than ACT (Marshall and Lockwood, 1998). While some case managers in standard community care may adopt elements of the ACT model, case management, as generally practiced, has little in common with ACT. Patient characteristics are also likely to be different between standard case management and assertive outreach. Priebe et al. (2003) sampled subjects from all 24 mental health services in greater London that operated assertive outreach teams. They found that routine assertive outreach serves a wide range of patients with significant rates of substance abuse (29%) and violent behaviour (3% had been physically violent in the past 2 years). Over a 9-month period, 39% were hospitalised and 25% compulsorily admitted. Given the difference in emphasis between team management versus individual clinician responsibility and differences in terms of patient characteristics perhaps the applicability of the STAR to assertive outreach models may be tested in future studies.

Strengths and weaknesses of the STAR

To date, there have been no established measures of the therapeutic relationship in community care. Rather, measures developed more or less empirically, or for other therapeutic settings (i.e., psychotherapy and in-patient psychiatry) have been applied to community care. It is hoped that the STAR will offer a valid and reliable assessment tool, and may contribute to the understanding of the therapeutic relationship in community mental health care settings, where a paucity of research on this subject exists.

The psychometric properties such as internal consistency and reliability appear acceptable. The retest-reliability for the patient version is not high. Yet it should be taken into account that the two-week interval between the two assessments was rather long, and that the scale was rated by patients with severe mental illnesses. Self-ratings in this group rarely achieve higher test-retest-reliabilities than found for STAR (Schene et al., 2000; Ritsner et al., 2001). Only a few of the clinician and patient ratings of their relationship were weakly correlated. This is in line with the extensive literature on psychotherapy settings, which also shows that patients and clinicians may perceive their relationship differently with only weak to moderate associations between the two ratings (Horvath and Greenberg, 1986; Marmar et al., 1986). When applied to a new sample the data fit the proposed 3-factor model. How well the model fits other samples may be determined by future studies.

Neither clinicians' nor patients' ratings were strongly associated with socio-demographic characteristics of clinicians and patients, although some weak correlations were found with patient ratings. In stage 3, patients were more likely to give higher ratings for 'positive collaboration' and 'positive clinician input' if the patient was female, or if the clinician was Chinese or African-Caribbean. Patients rated 'positive clinician input' more favourably in relationships with female clinicians. Patients with younger clinicians gave higher ratings for 'negative clinician input'. In stage 4, older, non-white female clinicians gave more positive ratings of the therapeutic relationship than younger, white male clinicians. These might be tested in future studies.

McCabe and Priebe (2003) suggest that psychopathology may account for 3-28% of patient ratings of the relationship in various settings. Patients' ratings of STAR were not significantly related to symptomatology in this sample, but clinicians tended to assess relationships less favourably when patients were more symptomatic. Yet, the correlations were weak and reached statistical significance only in the case of positive clinician input. Thus, one may conclude that STAR scores are not dominated by the degree of patient psychopathology.

When using the scale, some limitations of this study should be considered. STAR was developed in a deprived area of East London and it remains to be seen whether it will be useful in other areas with different patient groups and other services.

The scale was necessarily developed and tested within a selective sample, i.e. those patients who agreed to take part in research and provided sufficiently complete ratings. Many suitable patients did not take part in this research project. The most difficult to engage patients are unlikely to participate in such research, and STAR might not adequately capture the views of that patient group. Indeed, 287 out of 481 possible patients were without a contact telephone number. It is likely that this group not only includes a greater proportion of those who are difficult to engage, but who also likely have a poor therapeutic relationship. The STAR is therefore likely biased towards the opinions of a more engaged patient.

The usefulness of conducting CFA on the same dataset to test the fit of the data to the model derived from the PCA may be called into question. This approach could not be used for the purpose of cross-validation. However it was useful to ensure that the data still fit the proposed model after removing some components and items from the scale. For the purpose of cross-validation, the fit of the model was tested on an independent sample in stage 4 of the project – demonstrating a good fit of the model to the data.

Concerns about the power of the study should be noted. In the development of the scale only 133 patients and 26 clinicians participated. While PCA is not a statistical technique, but rather a way of altering the direction from the data is viewed and it is therefore possible to use many fewer cases than variables - if PCA is treated as a form of factor analysis, as I did in this study – then sample size is an issue. A small sample is likely to yield unstable findings. Larger samples are better than smaller samples because larger samples tend to minimize the probability of errors, maximize the accuracy of population estimates and increase the generalizability of the results. To this end, it was useful to test the fit of the data with a new sample.

Benefits of the research

The quality of the relationship that exists between frontline staff and patients is critical to the success of community mental health care. Clinicians provide the main link between mental health services and people with severe mental disorder. The STAR may be used as a standard that outlines the essential elements that comprise a good working relationship specifically in this setting. While in most therapeutic settings it has been suggested that a single general alliance factor may account for most of the explainable variance in alliance scores (Hatcher and Barends, 1996; Horvath and Luborsky, 1993, Salvio et al. 1982, Bachelor, 1991, Tichenor and Hill, 1989, and Tracey and Kokotovic, 1989) the combination of specific items that comprise a positive collaboration may be more or less relevant from setting to setting. In addition to a positive collaboration, there are other distinct factors that may be relevant to the therapeutic relationship in community care. Other measures used to assess the therapeutic relationship may fail to capture elements specific to this setting.

Clinician training may take these factors into account. STAR captures three factors in each version that are similar. The first subscale, 'positive collaboration', might capture the general quality of the relationship, the "chemistry" between the two participants and the degree to which the relationship functions. 'Positive clinician input' is characterised by more behavioural aspects, which might be easier to change through efforts of clinicians than the other factors. Finally, 'emotional difficulties' in the clinicians' rating and 'non-supportive clinician input' in the patients' assessment reflect problems in the relationship. Whilst such feelings are clearly not helpful in establishing or maintaining a positive relationship, changing them might be difficult and require supervision and additional skills. Further research might identify the extent to which each of these aspects can be affected through specific clinical interventions or, possibly, changing the clinician in the case of a very unfavourable relationship. It has been suggested that in the light of research evidence on the effects of expressed emotion, policy around the assessment of staff recruitment should be reconsidered, and the training of staff should address potential clinician behaviour that may detrimentally affect patients (Moore and Kuipers, 1999). A study by Billings et al. (2003) revealed that community mental health team staff felt that one of the most important gaps in their training were with regard to assertive outreach techniques for the difficult to engage patients. Ball et al. (1992) call for a re-examination of attributes required of new recruits to mental health service, and emphasise the importance of training staff to use interventions that are low in expressed emotion. It remains unclear whether the ability of a clinician to promote a good therapeutic relationship reflects competence on the part of the professional or a skill that can be learned. Indeed, "our increasing knowledge of therapists' actions that is likely to contribute to alliance improvements do not necessarily translate directly to effective training paradigms" (Hovarth and Luborsky, 1993). It is debatable whether a clinician's ability to effectively engage patients reflects a social skill that the clinician has developed (a skill that is learned and therefore may be taught to clinicians) or reflects a personality trait, such as 'high self monitoring', resulting in the clinician's particular sensitivity to interpersonal cues, social norms and situations regarding how to behave (Fiske and Taylor, 1991) which may facilitate the formation of a positive alliance. Support for the former perspective comes from research investigating interpersonal professional relationship skills training programmes where clinicians show marked improvement in their ability to engage and maintain a positive relationship with clients following participation in such training programmes (Schaap, 1996; Des Marchais et al., 1990; Lamb, 1988). By contrast a study by Strupp and Binder (1984) found that intensive training that focused on the relationship between the patient and professional neither improved the outcome of therapy, nor their ratings of the alliance.

There is currently great interest in improving community care for a core group of patients classified as severely mentally ill. This is perhaps the most challenging group of individuals (not just clinically but in public perception) in the mental health services. Identifying the most important qualities of a positive therapeutic relationship may have direct implications for clinician education, which will in turn impact on the patient's experience of mental health care. While improving care is important on a structural service level, it is also imperative on an individual treatment level, i.e., one-to-one relationships between patients and clinicians.

The benefits of this research will be twofold in that it will benefit both patients and health care professionals. More immediately, previous experience suggests that the opportunity for patients to assess their experience of therapeutic interactions and give feedback to clinicians and health service researchers has a positive impact. However there are few scales that ask patients with severe mental illness to rate anything. The increasingly popular view that the patients, including those with severe mental illness, are partners in the therapeutic process rather than passive recipients of treatment highlights the importance of integrating patients' perspectives into systematic research on the therapeutic relationship. This scale can be used to assess the therapeutic relationship as an outcome measure or as a mediating factor in other trials by explaining variance. The true value of the scale will be shown by the extent to which it is used.

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Appendix 1

Information to Participate in a Research Project

THERAPEUTIC RELATIONSHIPS IN COMMUNITY MENTAL HEALTH CARE

You are invited to take part in a research study, which we think may be important. The information that follows tells you about it and what will happen if you decide to take part in it. It is very important that you understand what is in this leaflet before agreeing to take part.

It is YOUR choice whether or not you take part.

Please ask questions you want to about the research and I will try my best to answer them.

- Why have you been identified as suitable to take part in the research?

You are asked to take part in this research as you are treated as an out-patient by a key worker based in a community mental health team.

- What is the purpose of the research?

The goal of the research is to investigate key worker-patient relationships in community mental health care.

- What would participation in the research involve?

If you participate in the research, you will be asked about your mental health and the treatment you receive (your quality of life, your relationship with your key worker).

- How will you or others benefit from taking part in the research?

You may value the opportunity to reflect on your health and the treatment you receive. The information you provide may help to address issues that are specifically important to patients receiving care in the community from their key workers.

- Are there potential risks for taking part in the study?

No.

- What will happen to the information you provide?

All information gathered during the study will be strictly confidential. If you require more information about the study, please contact Rebecca McGuire, William Harvey House, St Bartholomew's Hospital, EC1 7BE

You don't have to join the study. You are free to decide not to be in this study or to drop out at any time.

- What happens if you would like more information about the study?

You will always be able to contact an investigator to discuss the study:
Name: Rebecca McGuire
Address: William Harvey House, St Bartholomew's Hospital, EC1 7BE
Telephone Number: 0207-601-8680

Appendix 2

Written Consent Form

The Therapeutic Relationship in Community Mental Health Care

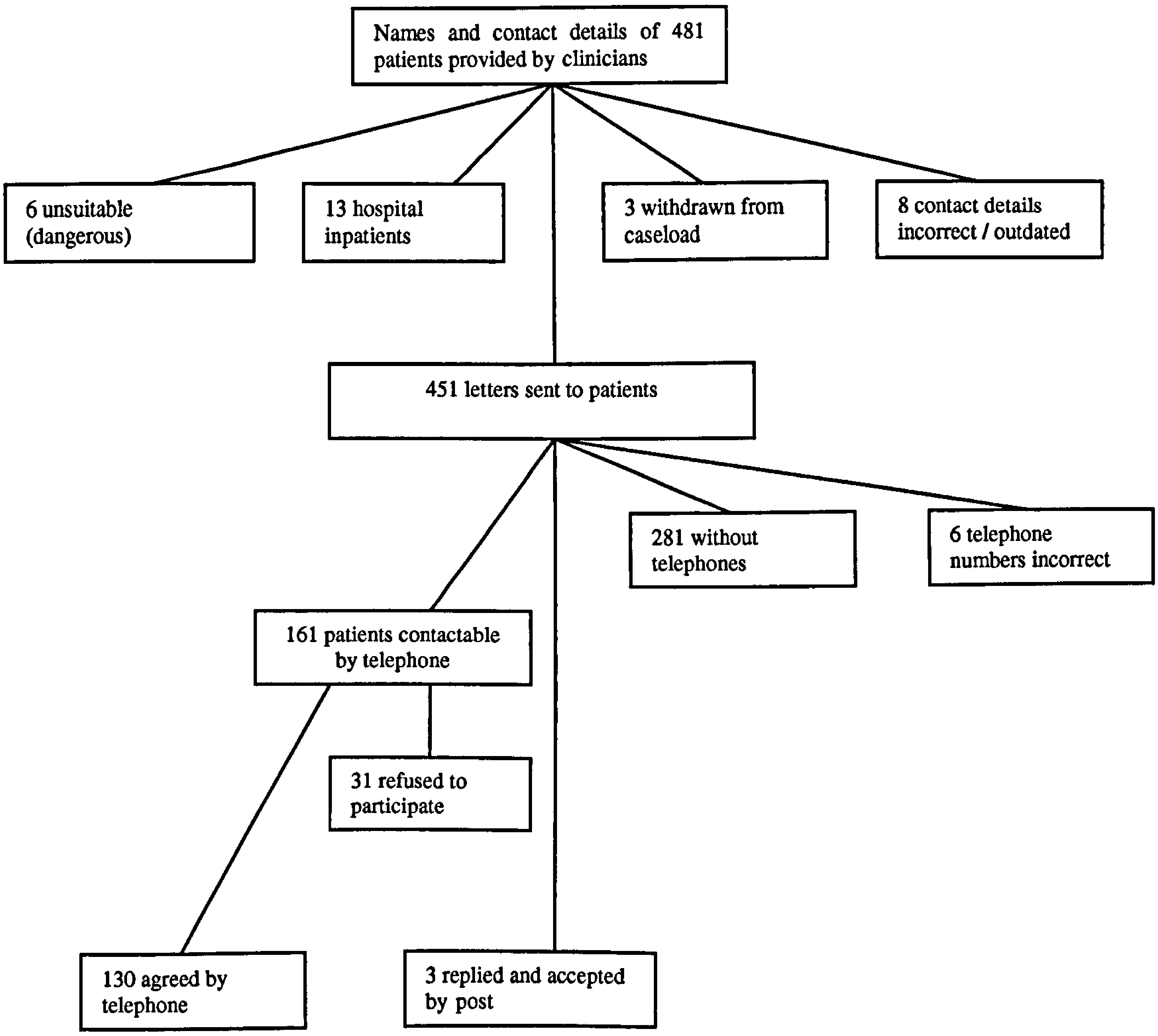
Name of participant:
Address:

- I understand what is in the leaflet about the research. I have a copy of the leaflet to keep. ☐
- I have had the chance to talk and ask questions about the study. ☐
- I know what my part will be in the study and how long it will take. ☐
- I understand that personal information is strictly confidential. ☐
- I freely consent to be a subject in the study; no one has put pressure on me. ☐
- I can stop taking part at any time. ☐
- I know that the East London and The City Health Authority Research Ethics Committee has seen and agreed to this study. ☐
- If there are any problems I know I can contact Rebecca McGuire, William Harvey House, St Bartholomew's Hospital, EC1 7BE ☐

Participant's Signature:
Date:

Witness' name:
Signature

Appendix 3: A consort diagram outlines the process by which participating patients was obtained



Appendix 4: Clinician original item pool

Clinician Scale:

Thank you for taking the time to complete this questionnaire.

There are nine parts, each with separate instructions (if applicable).

Please fill them out accordingly.

These questions are CONFIDENTIAL.

Work fast, your first impressions are the ones we would like to see.

QUESTIONS ARE PRINTED ON BOTH SIDES OF THE PAPER.
PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Part 1

1. How would you rate your relationship with your patient?

0 1 2 3 4 5 6 7 8 9 10
very poor |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| excellent

Part 2

1. Do you get along with the patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| extremely well

2. Do you understand the patient and his/her views?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| extremely well

3. Do you look forward to meeting the patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

4. Do you feel you are actively involved in the patient's treatment?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

5. Do you feel you can help the patient and treat him/her effectively?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

Part 3
Instructions:

Below each statement inside there is a seven-point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it *never* applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

1. My patient and I agree about the steps to be taken to improve his/ her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My patient and I both feel confident about the usefulness of our current activity.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe my patient likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I have doubts about what we are trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident about my ability to help my patient.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciate my patient as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for my patient to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. My patient and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. My patient and I have different ideas on what his/ her real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding between us of the kind of changes that would be good for my patient.

1	2	3	4	5	6	7

Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. My patient believes the way we are working with her/ his problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Part 4
Instructions:

Below there is a list of statements. Think about your relationship with your patient and decide if each statement applies to your relationship or not. If the statement does apply to your relationship, circle *yes*. If the statement does not apply to your relationship, circle *no.*

1. I am optimistic about the outcome and long-term results (prognosis) for the patient. yes no
2. I did not have to guide this patient a great deal, because he/ she was fairly independent. yes no
3. I have the impression that this patient could have profited more from a different/ alternative treatment programme. yes no
4. I sometimes felt a certain dislike towards this patient. yes no
5. I sometimes feel anxious/ uneasy when I had to deal therapeutically with this patient. yes no
6. I can well imagine socialising with this patient in public. yes no
7. I think the therapeutic strategy used in the sessions with this patient was correct. yes no
8. I feel inferior to the patient. yes no
9. The way the patient behaves towards me makes me behave in an insecure manner. yes no
10. Sometimes I feel this patient refused to accept what I had to offer. yes no
11. I felt confident that this patient trusted me. yes no
12. It would have been preferable had this patient been transferred to a different place. yes no
13. I would have liked more professional/ therapeutic experience to deal with this patient. yes no
14. I could not empathise or relate to this patient's problems. yes no
15. I did not feel that this patient accepted me as a clinician. yes no
16. With this patient, I felt I could be natural. yes no

Part 5
Instructions:

Below there is a list of items that describe experiences clinicians and patients may have. Think about the last time you saw your patient and, for each item, decide which category best describes your experience using the scale provided below. Circle the number corresponding to that category.

0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Very Much

1. It was easy for me to show a sincere desire to understand the patient and his or her problems. 0 1 2 3
2. The patient expressed things that were worrying him/ her. 0 1 2 3
3. The patient is confident that efforts will lead to change. 0 1 2 3
4. The patient had difficulties in asking questions concerning the medication/ illness. 0 1 2 3
5. I understood what the patient wished to accomplish in the treatment. 0 1 2 3
6. When I commented about one aspect of the medi cation, the patient brought up other related issues. 0 1 2 3
7. I put pressure on the patient to make necessary changes. 0 1 2 3

8. The patient's comments led me to believe that his/ her goals for treatment differ from mine.	0	1	2	3
9. At times, I felt irritated, annoyed, or disappointed with the patient.	0	1	2	3
10. I made sure that my answers were satisfactory for the patient.	0	1	2	3

0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Very Much

11. The patient participated in the treatment despite moments of doubt, confusion or mistrust.	0	1	2	3
12. I followed my view of how treatment should proceed, even if it was counter to the patient's plan.	0	1	2	3
13. The patient is willing to take the medication despite the fact that negative side effects have occurred or may occur.	0	1	2	3
14. When I commented about one aspect of patient illness, the patient brought up other related aspects of his / her illness.	0	1	2	3
15. It was important for the patient to come to this appointment.	0	1	2	3
16. The patient was sceptical about the value of taking medication.	0	1	2	3
17. I understood what the patient hoped to get out of this treatment.	0	1	2	3
18. The patient finds it hard to follow the treatment as prescribed, that is, the amount and timing of medication.	0	1	2	3
19. Making use of my comments, the patient was able to see his/ her difficulties in a new light.	0	1	2	3
20. The patient is committed to go through treatment to completion.	0	1	2	3
21. I may have failed to provide the patient with instructions that he/ she could easily understand.	0	1	2	3
22. The treatment matches the patient's ideas about what helps people in overcoming his/ her difficulties.	0	1	2	3
23. I feel confident in helping the patient with his/ her problems.	0	1	2	3
24. The patient involved himself/ herself in the decisions that were taken during this appointment.	0	1	2	3

Part 6
Instructions:

Circle the letter of the statement that comes closest to your assessment of the patient for each item.

1. This rating concerns: How the patient feels about you as the worker.
a) The patient is well disposed towards me and looks forward to my visits.
b) The patient is mildly positive towards me.
c) The patient is neutral in attitude towards me.
d) The patient is suspicious of my intentions or mildly hostile.
e) The patient is overtly hostile and antagonistic towards me.

2. This rating concerns: The degree to which the patient can be engaged.
a) The patient goes to great lengths to avoid contact.
b) The patient generally avoids contact and only occasionally agrees to be seen.
c) The patient does not seek contact but usually agrees to be seen.

d) The patient is easy to contact and reliable over appointments.
e) The patient frequently initiates contact.

3. This rating concerns: The patient's attitude to help.
a) The patient is keen on being helped and is an active participant in making plans.
b) The patient is prepared to accept help but there are difficulties in agreeing a common plan.
c) The patient claims not to need help but is prepared after some persuasion to accept some degree of intervention.
d) The patient insists no help is needed and actively resists all attempts at intervention.

4. This rating concerns: The way the patient engages with others.
a) Active hostility towards others.
b) Actively avoids most contact with others.
c) Passive avoidance of others, company usually tolerated silently.
d) Variable engagement, unpredictably withdrawn and friendly.
e) Appropriate social engagement with spontaneous conversation.

Part 7

1. Do you feel that you share a rapport with your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

2. Does your patient negotiate his or her treatment with you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| always

3. To what extent do you share a trusting relationship with your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

4. How supportive do you feel of your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

5. Do you feel there is open communication between you and your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

6. How reliable are you in meeting with your patient?

	0	1	2	3	4	5	6	7	8	9	10	
not at all	|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------|											entirely

7. To what extent do you feel trusted by your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

8. How patient do you feel with your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

9. Do you take your patient's perspective when working with him or her?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

10. Does your patient's family interfere in your relationship with him or her?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

11. Do you listen to your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

12. To what extent do you feel you share an honest relationship with your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

13. How sensitive do you feel you need to be of your patient's cultural background (if applicable)?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

14. How committed is your patient to working with you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

15. Does your patient set some treatment goals for him / herself?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| always

16. How empathetic do you feel toward your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

17. Do you feel critical toward your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

18. To what extent do you feel the patient's treatment is right for him / her?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

19. How flexible are you with the patient's care plan?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

20. How open is your patient with you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

21. Do you feel respected by your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

22. How accessible are you for your patient?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

23. To what extent are you able to help your patient with his or her problems?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

24. Does your patient talk about things that are upsetting him / her?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

25. Do you contact your patient as often as he or she would like?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

26. To what extent do you direct the goals of your patient's treatment?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

27. Is your patient aggressive toward you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

28. To what extent do you think your patient is your patient seeing you of his or her own free will?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

29. Does your patient have personal qualities that you respect?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

30. Do you and your patient have similar expectations for his or her treatment?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

31. How willing do you think your patient is in working you?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

Part 8
Instructions:

Below there is a list of statements. Think about your relationship with your patient and decide if each statement applies to your relationship or not. If the statement does apply to your relationship, circle *yes*. If the statement does not apply to your relationship, circle *no*.

1. My patient sets some treatment goals for him / herself. yes - no
2. I am able to help my patient with his or her problems. yes - no
3. I feel trusted by my patient. yes - no
4. I am supportive of my patient. yes - no
5. The treatment my patient is currently receiving is right for him or her. yes - no
6. My patient is aggressive toward me. yes - no
7. I take my patient's perspective when working with him or her. yes - no
8. My patient's family interferes in my relationship with my patient. yes - no
9. I listen to my patient. yes - no

Part 9

1. What are the positive aspects of your relationship with your patient?

2. What are the negative aspects of your relationship with your patient?

3. If there are any issues relating to your relationship with your patient that haven't been addressed in this questionnaire, but that you would like to mention, please write below.

Appendix 5: Patient original item pool

Thank you for taking the time to complete this questionnaire.

There are nine parts, each with separate instructions.

Please fill them out accordingly.

These questions are CONFIDENTIAL.

Work fast, your first impressions are the ones we would like to see.

QUESTIONS ARE PRINTED ON BOTH SIDES OF THE PAPER.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Part 1

1. How would you rate your relationship with your clinician?

0 1 2 3 4 5 6 7 8 9 10

very poor |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| excellent

Part 2

1. Is the treatment you are currently receiving right for you?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

2. Do you feel understood by your clinician?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

3. Do you feel criticised by your clinician?

0 1 2 3 4 5 6 7 8 9 10

entirely |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| not at all

4. Is your clinician committed to and actively involved in your treatment?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

5. Do you trust in your clinician and in his/her professional competence?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

6. How do you feel immediately after a session with your clinician (please circle one)?

Worse Unchanged Better

Part 3
Instructions:

Below each statement inside there is a seven-point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it *never* applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

1. My clinician and I agree about the things I will need to do in therapy to improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe my clinician likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. My clinician does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in ____________'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. ____________ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I feel that ____________ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. ____________ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. ____________ and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7

Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Part 4
Instructions:

Below there is a list of statements. Think about your relationship with your clinician and decide if each statement applies to your relationship or not. If the statement does apply to your relationship, circle *yes*. If the statement does not apply to your relationship, circle *no*.

My clinician...
1. Tends to criticise me. yes no
2. Most of the time, gives me positive feedback on my efforts in coping/considering my problems. yes no
3. Often makes me observe my behaviour (between sessions) and then reports on it afterwards. yes no
4. Has spoken to me about my personal goals and my thoughts about treatment (My regime/ programme). yes no
5. Apparently liked me whatever I did or said. yes no
6. Was very facilitating in helping me consider myself and my situation. yes no
7. Was firm with me, when I spoke about things that are important to me and my situation. yes no
8. Lets me talk freely about anything, regardless of its relationship to the current topic. yes no
9. Has fairly concrete opinions about how I should behave. yes no
10. Encourages me to talk about my feelings (e.g.. anger, sadness, worries). yes no
11. Never talks about his/ her feelings. yes no
12. Always notices the occasions when I have tried to hide things from him/ her. yes no
13. Sometimes persists in making me do or try out things which I initially did not want to do. yes no
14. Makes me feel so safe that I can openly and genuinely talk about how I feel. yes no
15. Would withhold the truth from me if he/ she was convinced it would be of help. yes no
16. Is understanding. yes no
17. Sometimes overwhelms me and does not always check things with me. yes no

I...
18. sometimes feel inhibited/ reluctant to tell my clinician the thoughts that occupy me. yes no
19. would have preferred a different clinician. yes no
20. think he/ she holds back and does not offer true opinions. yes no
21. could basically manipulate my clinician and do whatever I wished. yes no
22. think my clinician cannot empathise with me. yes no
23. think my clinician can get along with others better than me. yes no
24. believe my clinician has an understanding of what my experiences have meant to me. yes no
25. have been shown that I plainly have to take responsibility for my actions. yes no
26. have the impression that my clinician acted as if he/ she already had the perfect solution to everything. yes no
27. felt that, to some extent, my clinician is impatient with me. yes no
28. think that my clinician appeared easy going and feels good towards me. yes no
29. could have achieved the same outcome/ benefit, if my clinician was not here. yes no
30. felt that my clinician behaved in a way that was different to how he/ she felt. yes no

Part 5
Instructions:

Below there is a list of questions that describe attitudes people might have about their treatment and clinician. Think about the last session with your clinician and, for each item, decide which category best describes your attitude. Using the scale provided below, circle the number corresponding to that category.

0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Very Much

1. Did your clinician show a sincere desire to understand you and your problems?	0	1	2	3
2. Did you feel free to express the things that were worrying you?	0	1	2	3
3. Do you feel confident that efforts will lead to change?	0	1	2	3
4. Did you find it difficult to ask questions concerning your medication/ illness?	0	1	2	3
5. Did your clinician understand what you wanted to accomplish in your treatment?	0	1	2	3
6. When your clinician commented about one aspect of your medication, did you think of other related issues?	0	1	2	3
7. Did you feel pressured by your clinician to make changes before you were ready?	0	1	2	3
8. Did your clinician's comments lead you to believe that his or her goals for treatment differ from yours?	0	1	2	3
9. Did your clinician seem irritated, annoyed, or disappointed with you?	0	1	2	3
10. When you asked for additional information, did you get satisfactory answers?	0	1	2	3
11. Do you feel that even if you might have moments of doubt, confusion or mistrust that over all the treatment was worthwhile?	0	1	2	3
12. Did your clinician follow his or her own plans, ignoring your view of how treatment should proceed?	0	1	2	3
13. Are you willing to take the medication despite the fact that negative side effects have occurred or may occur?	0	1	2	3
14. When your clinician commented about one aspect of your medication/ illness, did it bring to mind other related aspects?	0	1	2	3
15. Did you feel that it was important for you to come to your last appointment?	0	1	2	3
16. Did you feel sceptical about the value of taking medication?	0	1	2	3
17. Did you feel that your clinician understood what you hoped to get out of this treatment?	0	1	2	3
18. Did you find it hard to follow your treatment as prescribed, that is, the amount and timing of your medication?	0	1	2	3
19. Did your clinician's comments help you to see your difficulties in a new light?	0	1	2	3
20. Do you feel so dissatisfied with your treatment that you consider stopping it before the time it would ordinarily come to an end?	0	1	2	3
21. Did your clinician fail to provide you with instructions that you could easily	0	1	2	3

understand?				
22. Did the treatment you received match with your ideas about what helps people in overcoming their difficulties?	0	1	2	3
23. Did your clinician show a lack of confidence in helping you with your problems?	0	1	2	3
24. During the session, have you been able to involve yourself in the decisions that were taken?	0	1	2	3

Part 6
Instructions:

Please circle the answer that most applies to you.

1. Who regards your illness as being more severe: you or your significant others (please circle one)?

   You Significant Others

2. Who regards your illness as being more severe: you or your clinician (please circle one)?

   You Clinician

Part 7

1. Do you feel that you share a rapport with your clinician?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------| entirely

2. Do you negotiate your treatment with your clinician?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------| entirely

3. To what extent do you share a trusting relationship with your clinician?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------| entirely

4. Do you feel your clinician listens to you?

0 1 2 3 4 5 6 7 8 9 10

not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|-------| entirely

5. How supportive do you feel your clinician is of you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

6. To what extent do you feel that there is open communication between you and your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

7. How reliable is your clinician in meeting with you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

8. Is your clinician patient with you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

9. Do you feel that your clinician takes your perspective?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

10. Do you trust your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

11. To what extent do you feel you share an honest relationship with your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

12. Do you feel that your family interferes in your relationship with your clinician?

	0 1 2 3 4 5 6 7 8 9 10	
not at all	|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------|	entirely

13. How sensitive do you feel your clinician is to your cultural background (if applicable)?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

14. How committed are you to working with your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

15. Do you set some treatment goals for yourself?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| always

16. Does your clinician empathise with you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

17. Do you feel your clinician is critical of you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

18. To what extent do you feel your treatment is appropriate to your needs?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

19. Is your clinician the right one for you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

20. How open do you feel you can be with your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

21. Do you have respect for your clinician's professional abilities?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

22. Does your clinician make him/ herself available to you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

23. To what extent is your clinician able to help you with your problems?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

24. Do you feel free to approach your clinician concerning things that upset you?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

25. Is your clinician in contact with you as regularly as you would like?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

26. To what extent does your clinician set out the goals of your treatment?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

27. Do you feel aggression towards your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

28. Is your involvement with your clinician one of free will?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

29. Do you feel respected by your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

30. Do you and your clinician share expectations of the progress of your treatment?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

31. How willing are you to work with your clinician?

0 1 2 3 4 5 6 7 8 9 10
not at all |-------|-------|-------|-------|-------|-------|-------|-------|-------|--------| entirely

Part 8
Instructions:

Below there is a list of statements. Think about your relationship with your clinician and decide if each statement applies to your relationship or not. If the statement does apply to your relationship, circle *yes*. If the statement does not apply to your relationship, circle *no*.

1. I set treatment goals for myself. yes no
2. My clinician is able to help me with my problems. yes no
3. I trust my clinician. yes no
4. My clinician is supportive of me. yes no
5. The treatment I am receiving is appropriate to my needs. yes no
6. I feel aggression towards my clinician. yes no
7. My clinician takes my perspective. yes no
8. I feel my family interferes in my relationship with my clinician. yes no
9. My clinician listens to me. yes no

Part 9

1. What are the positive aspects of your relationship with your clinician?

2. What are the negative aspects of your relationship with your clinician?

3. If there are any issues relating to your relationship with your clinician that haven't been addressed in this questionnaire, but that you feel are important, please write below.

Appendix 6: Clinician reduced item pool

Below there is a list of statements that describe experiences clinicians and patients may have. For each item, decide which category best describes your experience with your patient using the scale provided below. Circle the number corresponding to the category.

1. I get along well with my patient.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
2. I feel a certain dislike for my patient.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
3. My patient and I share a good rapport.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
4. I listen to my patient.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
5. I feel that my patient rejects me as a clinician.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
6. I believe my patient and I share a good relationship.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
7. I feel inferior to my patient.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
8. My patient and I share similar expectations regarding his / her progress in treatment.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
9. I feel critical of my patient's behaviour.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
10. I feel that I am supportive of my patient.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
11. It is difficult for me to empathise with or relate to my patient's problems.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
12. My patient and I are open with one another.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
13 I am able to take my patient's perspective when working with him / her.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
14. My patient and I share a trusting relationship.	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always

Appendix 7: Patient reduced item pool

Below there is a list of statements that describe experiences clinicians and patients may have. For each item, decide which category best describes your experience with your clinician using the scale provided below. Circle the number corresponding to the category.

1. My clinician speaks with me about my personal goals and thoughts about treatment.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

2. My clinician and I are open with one another.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

3. My clinician overwhelms me and does things without checking with me.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

4. My clinician and I share a trusting relationship.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

5. I believe my clinician withholds the truth from me.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

6. My clinician encourages me to talk about my feelings (anger, sadness, worries).

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

7. My clinician and I are honest with one another.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

8. I think that it is difficult for my clinician to empathise with or relate to me.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

9. My clinician and I work towards mutually agreed upon goals.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

10. My clinician is very facilitating in helping me consider myself and my situation.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

11. My clinician is stern with me when I speak about things that are important to me and my situation.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

12. My clinician lets me talk freely about anything.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

13 My clinician persists in making me do or try out things that I do not want to do.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

14. My clinician and I have established an understanding of the kind of changes that would be good for me.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

15. My clinician is impatient with me.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

16. My clinician seems to like me regardless of what I do or say.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

17. We agree on what is important for me to work on.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

18. I believe my clinician has an understanding of what my experiences have meant to me.

0	1	2	3	4
Never	Rarely	Sometimes	Often	Always

Appendix 8: Clinician STAR

STAR[9]

Scale To Assess Therapeutic Relationships in Community Mental Health Care

Clinician Version

Instructions

Overleaf, there is a list of statements that describe experiences clinicians and patients may have. For each item, decide which category best describes your experience with your patient using the scale provided (0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = always). Choose the number corresponding to the category.

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[9]

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STAR
Scale To Assess Therapeutic Relationships in Community Mental Health Care
Clinician Version

	Never 0	Rarely 1	Sometimes 2	Often 3	Always 4
1. I get along well with my patient.					
2. My patient and I share a good rapport.					
3. I listen to my patient.					
4. I feel that my patient rejects me as a clinician.					
5. I believe my patient and I share a good relationship.					
6. I feel inferior to my patient.					
7. My patient and I share similar expectations regarding his / her progress in treatment.					
8. I feel that I am supportive of my patient.					
9. It is difficult for me to empathise with or relate to my patient's problems.					
10. My patient and I are open with one another.					
11. I am able to take my patient's perspective when working with him / her.					
12. My patient and I share a trusting relationship.					

STAR
Scale To Assess Therapeutic Relationships in Community Mental Health Care
Clinician Version

Rating Protocol

It takes approximately 5 minutes for the clinician to complete the 12-item STAR-C. The clinician indicates the degree to which each statement describes his or her experience with the patient (0 = Never; 1 = Rarely; 2 = Sometimes; 3 = Often; 4 = Always).

Scoring Protocol

A total STAR-C score and three subscale (Positive Collaboration, Emotional Difficulties, and Positive Clinician Input) scores can be obtained. Before scoring the STAR-C, one must ensure that scores for the Emotional Difficulties subscale are reversed. To do this, one may subtract each of the item ratings in this subscale from 4; therefore, a rating of 1 becomes 3 (4 minus 1); a rating of 2 remains 2 (4 minus 2); a rating of 3 becomes 1 (4 minus 3); and a rating of 4 becomes 0 (4 minus 4). After reversing items for this subscale, the total STAR-C score is obtained by adding the scores for each of the 12 items (the lowest possible total score being 0, and the highest total score being 48). The three subscale scores are each obtained by summing the identified item rating for each scale and dividing it by the total number of items (i.e., 6 for Positive Collaboration; 3 for Emotional Difficulties; and 3 for Positive Clinician Input) to procure the mean rating.

Positive Collaboration: 1, 2, 5, 7, 10, 12
Emotional Difficulties: 4, 6, 9
Positive Clinician Input: 3, 8, 11

Appendix 9: Patient STAR

STAR[10]

Scale To Assess Therapeutic Relationships in Community Mental Health Care

Patient Version

Instructions

Overleaf, there is a list of statements that describe experiences clinicians and patients may have. For each item, decide which category best describes your experience with your clinician using the scale provided (0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = always). Choose the number corresponding to the category.

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STAR
Scale To Assess Therapeutic Relationships in Community Mental Health Care
Patient Version

	Never 0	Rarely 1	Sometimes 2	Often 3	Always 4
1. My clinician speaks with me about my personal goals and thoughts about treatment.					
2. My clinician and I are open with one another.					
3. My clinician and I share a trusting relationship.					
4. I believe my clinician withholds the truth from me.					
5. My clinician and I share an honest relationship.					
6. My clinician and I work towards mutually agreed upon goals.					
7. My clinician is stern with me when I speak about things that are important to me and my situation.					
8. My clinician and I have established an understanding of the kind of changes that would be good for me.					
9. My clinician is impatient with me.					
10. My clinician seems to like me regardless of what I do or say.					
11. We agree on what is important for me to work on.					
12. I believe my clinician has an understanding of what my experiences have meant to me.					

STAR
Scale To Assess Therapeutic Relationships in Community Mental Health Care
Patient Version

Rating Protocol

It takes approximately 5 minutes for the patient to complete the 12-item STAR-P. The patient indicates the degree to which each statement describes his or her experience with the clinician (0 = Never; 1 = Rarely; 2 = Sometimes; 3 = Often; 4 = Always).

Scoring Protocol

A total STAR-P score and three subscale (Positive Collaboration, Positive Clinician Input; and Non-Supportive Clinician Input) scores can be obtained. Before scoring the STAR-P, one must ensure that scores for the Non-Supportive Clinician Input subscale are reversed. To do this, one may subtract each of the item ratings in this subscale from 4; therefore, a rating of 1 becomes 3 (4 minus 1); a rating of 2 remains 2 (4 minus 2); a rating of 3 becomes 1 (4 minus 3); and a rating of 4 becomes 0 (4 minus 4). After reversing items for this subscale, the total STAR-P score is obtained by adding the scores for each of the 12 items (the lowest possible total score being 0, and the highest total score being 48). The three subscale scores are each obtained by summing the identified item rating for each scale and dividing it by the total number of items (i.e., 6 for Positive Collaboration; 3 for Positive Clinician Input; and 3 for Non-Supportive Clinician Input) to procure the mean rating.

Positive Collaboration: 2, 3, 5, 6, 8, 11
Positive Clinician Input: 1, 10, 12
Non-Supportive Clinician Input: 4, 7, 9