Michael Coffey

Public Health And Policy Studies, College of Human and Health Sciences, Swansea University, Wales, SA2 8PP

Therapeutic working relationships with people with schizophrenia:

Literature review.

Jeanette Hewitt RMN RGN BScN

Lecturer, School of Health Science, University of Wales, Swansea, UK

Michael Coffey, RMN RGN BSc(HONS) MSc

Lecturer, School of Health Science, University of Wales Swansea

---

Correspondence:

Jeanette Hewitt,
School of Health Science,
University of Wales Swansea,
Singleton Park
Swansea SA2 8PP,
UK.

Abstract

Background

The value of therapeutic relationships in mental health nursing has been the subject of some debate within the profession. This debate has centred on the spectrum of beliefs about therapeutic relationships ranging from the position that the relationship is both necessary and sufficient to enable change to more technical approaches to therapeutic intervention that de-emphasise the influence of the relationship.

Aims of the paper

The purpose of this paper is to review the evidence for the necessity and sufficiency of therapeutic relationships when working with people with enduring mental health problems such as schizophrenia.

Methods

The paper reviews literature on therapeutic relationships, working alliances, therapeutic alliances and nurse-patient relationships in both classical application of psychotherapeutic approaches and more recently the use of cognitive behavioural interventions with people with enduring mental health problems.

Findings

People who experience a relationship as being therapeutic appear to have better outcomes. A consistent finding of a number of meta-analyses is that therapeutic relationships characterised by facilitative and positive interpersonal relationships with the helper have in-built benefits and that this is an important fundamental of advanced techniques. In order for cognitive behavioural therapy to be successful, people need to feel understood and involved in the therapeutic relationship.

Conclusion

Therapeutic relationships are necessary but not sufficient to enable change when working with people with schizophrenia.

Keywords: Therapeutic relationships, working alliances, therapeutic alliances, nurse-patient relationships, cognitive behavioural therapy, literature review.

Introduction

The primacy of therapeutic relationship has been viewed as fundamental to mental health nursing for over 50 years (Barker 1998) and has been advocated as the underpinning success of all types of psychological therapy (DoH 2001).

This vision has however been the subject of some debate within the profession, due to a seeming lack of supportive evidence (Gournay 1994). The shift towards evidence-based practice has led to an increased emphasis on measurable outcomes of interventions and a professed acceptance of treatment methods only where scientific evidence appears to prove effectiveness (Coleman & Jenkins 1998). This has led to a neglect of accounts describing the process of care delivery and the relationship between mental health practitioners and people (Repper 2002).

The therapeutic relationship is rarely discussed in literature pertaining to the care and treatment of people with schizophrenia. Ultimately, psychotherapeutic approaches have not been rigorously pursued with people who have serious mental illness, due to the belief amongst mental health practitioners that they are unable to collaborate in a therapeutic relationship (Repper 2002).

The following work reviews the arguments surrounding the value of therapeutic relationships to people with schizophrenia and discusses recent research on this topic. The value of such debate lies in its facility to challenge assumptions regarding the current role of the mental health nurse and provides the stimulus for nurses to analyse the relevance of theoretical debate, to the day to day practice of nursing.

Search Methods

Databases searched for published material in English between the dates of 1986 and 2003 were Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, Applied Social Sciences Index and Abstracts (ASSIA), Sociological abstracts, and social service abstracts. Search terms included therapeutic alliance, therapeutic relationship, working alliance and nurse-patient relationships. Papers chosen for inclusion were those with a research focus on the elements and potential benefits/costs of therapeutic relationships in nursing. Specific theory based papers on therapeutic relationships were included to establish background, context and principles reflecting the main schools of thought in this area. Particular emphasis was placed on papers demonstrating efficacy of cognitive behavioural therapy.

Historical Overview

The determining principle of mental health nursing has traditionally involved the development of working relationships with people (Barker 1998). Over 50 years ago, Peplau's (1952) theory for nursing practice formally identified the primacy of the nurse–patient relationship and the phases of the nurse's development of the alliance (Barker et al 1999). O'Brien (2001) has argued that the concept of the therapeutic relationship has even earlier roots in the asylum era, emerging as part of a general international development of therapeutic movement, in mental health in the middle of the 19th century.

In the early 1900s Freud used the term to describe the relationship between healer and patient, which centred on the perception of positive transference as the means by which successful outcome was facilitated (Howgego 2003). Rogers' (1957) humanistic therapeutic movement, was founded on the supremacy of the therapeutic

relationship and this person-centred approach has been awarded distinction in mental health nursing literature for over 30 years (Watkins 2001).

O'Brien (2001) described the growth of emphasis on the therapeutic relationship in post-war British mental health nursing, as a result of the psychodynamically oriented therapeutic communities, and open door asylum policies. Empirical research on the therapeutic relationship began in 1976 where early models were still embedded in the psychodynamic theory (Howgego et al 2003) and outcome was still measured by the achievement of positive transference.

The growth of interest in interpersonal relationships continued, due in part to its formulation as a theory of nursing, providing a language which enabled nurses to see the application of interpersonal theory to their day to day practice (O'Brien 2001). Peplau's (1952; 1988) work is still considered seminal and her broadly humanistic view of the nurse-patient relationship is still considered influential in current mental health nursing literature (Watkins 2001).

A number of terms are used interchangeably in the literature on therapeutic relationships. These include therapeutic alliance (Frank and Gunderson 1990), working alliance (Bordin 1994) and the nurse-patient-relationship (Peplau 1952:1988). The central emphasis of these approaches is on providing a helping working relationship with people with mental illness and in many cases the philosophical origins are rooted in humanism.

Characteristics of the Therapeutic Relationship

The therapeutic relationship has been varyingly defined in literature, according to the underpinning philosophical orientation, perceived requisite conditions for therapy and necessary characteristics of the mental health practitioner.

The psychodynamic perspective stems from Freudian concepts of unconscious processes and positive transference. The patient's immediate reactions to the practitioner exist in conjunction with transference and counter-transference, the fantasy elements of the alliance (Howgego et al 2003). Patient and practitioner are required to acknowledge and work through these elements for change to be collaboratively achieved.

The humanistic or person-centred definition originates from the work of Carl Rogers (1902-87). Rogers' (1957) work was founded on the non-specific factors that constituted the therapeutic relationship and contributed to the success of therapy. The practitioner's use of warmth, empathy, genuiness and unconditional positive regard in the immediate therapeutic encounter were seen as being necessary and sufficient conditions for change to take place (Mace 2002). The person-centred approach to the relationship has been seen as a 'way of being' with the patient, in a way that creates a climate for growth and change through the therapeutic use of self (Nelson 1997; Watkins 2001).

The contextual or pantheoretical model of therapy focuses on the general factors, which are provided in relationships with people and cut across different psychological schools or techniques (Stiles et al 1986). Barkham (2002) identified these elements as including an emotionally charged, confiding relationship with the helper and a healing setting in which the person expects that the practitioner will help them.

Non-specific elements of the relationship identified by Barkham (2002) include supportive factors using the therapeutic presence of the helper, ability to facilitate catharsis and perceived warmth. The bond between patient and practitioner is created through trust, empathy, liking, support, respect, challenge and valuing

(Bordin 1994; Egan 2002).Goals are set with the mutual agreement and valuing of the outcomes of therapy (Bordin 1994), with a rationale that provides a plausible explanation of the person's problems and how they can be addressed by reciprocal action (Barkham 2002).

Nursing theorists have increasingly considered the personal qualities required by mental health practitioners, in developing relationships with patients. For example, Grencavage and Norcross (1990) assert that it is the personal qualities rather than the therapeutic orientation of the mental health practitioner, which facilitate therapeutic change.

Self-awareness, sensitivity, warmth, and a positive non-blaming attitude are advocated as essential characteristics for effective helpers (Barker 2001; Watson 2001; Repper 2002). Gamble (2000) has argued that the ability of the helper to appear 'ordinary' and approachable, with a sense of fair play and humanity, promotes affinity between client and practitioner. Empathy is seen as being the cornerstone of all therapeutic nurse–client relationships (Dennis 2000) and Reynolds (2000) observes that it is difficult to imagine how nurses can meet patients' needs, without the capacity to convey empathic awareness of the other's experience. Ultimately, patients would be unable to trust nurses if they did not discern an empathic appreciation of their individuality (Reynolds 2000).

The therapeutic relationship appears to escape succinct quantification, given that its premise is often philosophical. The humanistic approach would appear to be the most frequently adopted by mental health nurse theorists in advocating the qualities of the practitioner, although its sufficiency in itself has been questioned (Egan 2002; Repper 2002). Pantheoretical concepts have a multi-disciplinary

relevance (Howgego et al 2003) and would seem to provide a framework for the therapeutic relationship, which is not solely defined in terms of values and attitudes.

Contemporary Opinion

Current literature would suggest that the medical model of schizophrenia is gaining pre-eminence in mental health services (Dawson 1997; Keen 1999), which has led to calls for nurses to convert to biomedical models of care, through the use of cognitive behavioural techniques and pharmacological treatment (Gournay 1994).

Gottesman (1994) and Gournay (1995) have directed nursing towards acceptance of biological explanations of schizophrenia. Gournay (1994) argues that the principles that underpinned the education and practice of mental health nurses, namely the primacy of the nurse patient relationship are now redundant, emphasising the need for specialist skills with which to treat the behavioural and cognitive manifestations of the disease state. Amongst the specialist skills identified as being necessary to contemporary mental health nursing, are a basic understanding of pharmacology, neuroanatomy, molecular genetics and brain imaging, which it is argued, would then put nurses on a more equitable footing with other mental health professionals (Gournay 1996).

Conceptualisation of schizophrenia as a biological disorder has negated the importance of the therapeutic relationship and denied the possibility that serious mental illness could be amenable to psychotherapy (Repper 2002). Coleman and Jenkins (1998) have identified that using the relationship to be with patients is now criticised as being indefinable and therefore irrelevant to mental health practice. Lambert and Gournay (1999) are representative of the scepticism with which the worth of the therapeutic relationship as a means for change is now viewed. The

absence of randomised, controlled evidence to support the usefulness of the relationship being seen as proof of its lack of efficacy. A consequence of this is that certain techniques, which are more easily defined and measured, such as cognitive behavioural therapy are suggested as one way in which mental health nurses can provide help to people who have a diagnosis of schizophrenia, (Gournay & Sandford 1998; Trenchard et al 2002).

Barker et al (1997) have challenged the biomedical model of mental health practice, arguing that it is the nature of the person's human problems and development that need to be addressed, rather than diagnosis and packaging. Arguments for the continuing centrality of interpersonal relationships within nursing focus on the moral imperative of providing people with a humanised service, which emphasises the personal dimensions of their problems and promotes healing through support, understanding and acceptance (Barker & Jackson 1996; Barker 2001a; Repper 2002). Higgon and Coffey (2001) have further argued that this focus on the medical model can lead to mental health nurses responding in potentially unhelpful ways to some symptoms such as auditory hallucinations despite strong evidence for alternative more person-focused approaches.

Barker (1995) asserts that exploration of the person's lived experience through narrative should transcend 'psychotechnology', which focuses on defining and fixing illness. However, the growing movement towards an anti-emotional climate in nursing, militates against nurses' ability to get close enough to patients to explore with them their experience of health and illness (Reynolds 2000; Clarke 2002). Collins and Cutliffe (2003) argue that where technical elements of treatment, such as those prescribed in cognitive behavioural therapy (CBT), are prized above the

relationship, it is perceived that the nurse does not care about the personhood of the client and a sense of hopelessness is exacerbated.

Arguments surrounding the 'psychotechnology / humanism' debate appear to relate in part, to the long-standing difficulty of defining the nature of nursing, and whether nursing care should evolve into treatment. In Barker's (2001b) view, purist use of the medical model to categorise and quantify serious mental illness, deflects attention away from the unique experience of the person, transforming all the person's perspectives into indisputable pathology. If this premise were correct, then conversion to biomedical models of care would appear at odds with the vision of nursing care as individualised and holistic.

Whilst cognitive and behavioural therapies are an effective and evidence based intervention in the treatment of schizophrenia (Wiersma et al 2001; Chan & Leung 2002), it would seem unreasonable to expect people to reveal distressing thoughts and feelings without being first able to develop trust and respect for the practitioner. The measurement and cataloguing of pathology may be conceivably perceived as judgements, leading people to deny and distort their true thoughts and feelings.

The Question of Research

The absence of randomised controlled trials (RCTs), supporting the effectiveness of the therapeutic relationship has been seen as proof of its lack of efficacy (Gournay 1994; Lambert & Gournay 1999). Conversely, a growing number of studies have appeared to show the evidence-based value of CBT in reducing the symptoms of schizophrenia (Birchwood 1999; Inoue & Kawabata 1999; Wiersma et al 2001; Chan & Leung 2002).

Questions can however be raised about the concepts of effectiveness and efficacy of therapeutic approaches for people with schizophrenia. Roth and Parry (1997) identified that RCTs measure outcome rather than process, and efficacy rather than effectiveness. They dispute the possibility of studying psychological approaches to treatment with methods normally used to evaluate the effectiveness of drug treatments, arguing that truly skilled practice is eclectic, and cannot be standardised. The skilled mental health practitioner adapts technique in order to maintain the integrity of the treatment and relationship, which reduces the possibility of achieving a measurable standardised approach.

Outcome studies are incompatible with psychotherapy research because standardised treatments are assigned on the basis of psychiatric diagnosis rather than individualised assessment (Persons 1991). The medical model does not recognise the distinction between consequences and values because it seeks to correct a deviation from the norm. Psychological health is however pluralistic and requires substantial therapeutic adaptation and diversity (Stiles et al 1986). Substantial research has not been undertaken in widely practised psychological therapies which focus on the relationship and therefore the absence of evidence cannot be categorised as evidence that disproves efficacy (Roth & Parry 1997).

Comparative studies may be a poor method of evaluating the superiority of treatment methods. Where practitioners are expected to deliver techniques counter to their allegiance, these may be delivered with unequal skill. Practitioners in comparative studies may have unclear or mistaken ideas of what each treatment consists of and may therefore fail to deliver the distinct methods consistently (Stiles et al 1986). Luborsky et al (1986) examined possible distortions in the results of comparative treatment studies due to researcher allegiance. Twenty-nine studies were

reviewed by the usual reprint method and also by ratings by colleagues and self-rating by researchers. Results showed that researcher allegiance was significantly associated with effect size of treatment outcomes. Luborsky et al (1986) hypothesised that where outcomes of a study ran contrary to therapeutic allegiance, the report may be suppressed. They observed that there were no published articles by a first author who is a founder of a treatment, where the results are counter to that author's allegiance. Perhaps contrary to Luborsky et al's (1986) assertion there is some evidence now emerging from leading proponents of CBT that the effect of this approach may have only slight benefits over supportive counselling (Tarrier et al 2004).

There is evidence to suggest that non-professional helpers, not trained in specific techniques, are equally as effective as their professional colleagues (Hattie et al 1984). Such data would appear to support the assertion, that where the practitioner and client have established a meaningful alliance, the client's experience will be therapeutic, regardless of other psychological interventions used (Barkham 2002).

The effectiveness of psychological therapy may not be due to specific strategies, but may be achieved through non-specific factors, which do not require the learning of elaborate techniques (Frank 1974; Mace 2002). Considerable variations in success rates exist between therapists of the same practice orientation (Luborsky et alliance 1986; Ahn & Wampold 2001), underlines the argument that outcome of psychological therapy has more to do with the practitioner and the relationship than the type of therapeutic help offered.

Evidence of Value

Midence (2000) observes that research into psychological treatments for schizophrenia has been carried out since the 1970's, but despite evidence of

effectiveness, they have not been recognised or accepted into practice. Recent research on the outcome of treatment for schizophrenia has tended to focus on technical aspects of treatment and to ignore non-specific factors such as the quality of therapeutic relationships with practitioners (Bentall et al 2003). Researchers, who have concentrated on the non-specific factors of therapy, have tended to emanate from the field of psychology and counselling rather than mental health nursing and have not focused on serious mental illness.

Howego et al (2003) examined evidence specifically in mental health literature, on positive therapeutic relationships in order to assess effective outcome for people with a mental illness, managed in the community. They reviewed 84 published articles within the field of mental health and case management, which used a validated measure of the therapeutic alliance and outcomes. Their examination of the literature, which included prominent meta-analyses and research papers, suggests a correlation between the therapeutic relationship and improved outcomes for patients. More interestingly, Howego et al's (2003) review clearly indicates that the alliance was both measurable and had the potential to improve patient outcome with those with enduring mental illnesses.

Meta-analyses of psychotherapeutic techniques have challenged the view that the components of specific techniques, such as those used in CBT, are responsible for improved outcomes for patients. Ahn and Wampold (2001) examined component studies to determine the degree to which these studies produced the evidence that supports the specificity of psychological treatments. In their analysis of 27 studies, no evidence was found that specific components of therapy were responsible for beneficial outcomes and variability in outcomes occurred between practitioners even

when they were experts in a particular approach. Common factors, such as the therapeutic relationship were therefore proposed as a reason for beneficial outcomes.

In a meta-analysis of 79 studies, Martin et al (1999) found a consistent relationship with the therapeutic alliance and outcome regardless of the many other variables that had been posited to influence the relationship. Bambling and King (2001) reviewed literature spanning 25 years and concluded that the therapeutic alliance was the central component of all successful therapy and that the quality of the relationship was more predictive of outcome than technique.

Comparison studies have also supported the ascendancy of the therapeutic relationship counter to specificity in psychological treatments. Paulson et al (1999) examined which components of counselling, people found most helpful using concept mapping, an approach combining qualitative and quantitative strategies. 36 people had received an average of 11 sessions, from six counsellors who had used a wide variety of approaches. The techniques used were CBT, humanistic, behavioural and family systems. Results showed that meaningful self-disclosure only took place where a facilitative interpersonal relationship existed with the counsellor. The presence of a positive relationship was the best predictor of outcome, regardless of the type of counselling used. The patient's experience of the therapist's trustworthiness and ability to experience empathy appeared to be prerequisites for alliance development, and were closely linked with the patient's perception of the appropriateness of the technical aspects of treatment.

In an earlier study, Raue et al (1996) investigated the quality of the therapeutic relationship in psychodynamic and CBT amongst 57 people. Results showed that higher alliance scores were positively correlated with high impact sessions (e.g., readiness to go beyond superficial discussion of emotions), session depth, smoothness

and people's rating of mood, regardless of the type of psychological technique employed.

Significant research concentrating on the value of the therapeutic relationship specifically to people with schizophrenia appears to be limited. Bentall et al (2003) report on two recent clinical trials on the impact of the therapeutic relationship to outcomes, specifically for people with schizophrenia. They report that patient ratings of the relationship significantly predicted positive symptoms and general psychopathology and were better predictors of attitude towards neuroleptic medication than symptoms, insight, knowledge or experience of side effects. Bentall et al (2003) conclude that their findings suggest the effectiveness of both pharmacological and psychosocial interventions might be improved by optimising therapeutic relationships between clinicians and people with schizophrenia.

Compliance with medication, reductions in global psychopathology and better social functioning, have been positively linked with the development of a therapeutic relationship in people with schizophrenia (Pfammatter & Brenner 2000; Howego et alliance 2003). Frank and Gunderson (1990) studied the correlation of the therapeutic alliance, to the treatment course and outcome of representative sample of adults with nonchronic schizophrenia. 143 people who received psychological counselling were selected from consecutive hospital admissions during a seven-year period and a total of 81 therapists participated. Assessments of the alliance were obtained from the Psychotherapy Status Report, a 15-item questionnaire that therapists completed monthly. This instrument was used to supplement process measures derived from audiotapes of therapy sessions. Medication compliance was evaluated by measuring the regularity, duration and amount of medication taken relative to that prescribed.

Results showed that patients who formed good relationships with their therapists, within the first six months of were significantly more likely to remain in psychotherapy, comply with prescribed medication regimes and achieve better outcomes after two years, with less medication than people who did not.

Only 26.1% of people who formed good relationships with their therapists failed to comply fully with their prescribed medication regimens during the next one and half years. By contrast, 72.2% of those with poor relationships at six months were non-compliant thereafter. People with poor relationships were functioning significantly worse at two years, relative to the baseline.

Significantly, Frank and Gunderson (1990) found that people who had longer initial hospitalisations formed better relationships with their therapists and also noted from their previous study (Frank & Gunderson 1984) that better alliances were formed by people with schizophrenia whose therapists shared the same treatment orientation as the hospital staff.

Whilst most comparative research into the effectiveness of the therapeutic relationship has not been undertaken by mental health nurses, findings from studies undertaken by clinicians in psychology and psychiatry, have significant implications for mental health nursing practice. Substantiation for the superiority of specific psychological techniques is not conclusive and counter evidence for the supremacy of the therapeutic relationship continues to proliferate. Calls for conversion to biomedical models of treatment therefore appear premature. The dichotomy between mental health nurses and psychotherapists is challenged by Frank and Gunderson's (1980; 1994) work which appears to show the positive impact of continuing psychological therapies at ward level.

What People Want

The rise of the service user movement over the past ten years, has emphasised the issue of empowerment and obligation to discover what people want most from mental health practitioners (Jackson & Stevenson 2000; Adam et al 2003). Whilst studies have focused on the link between the therapeutic relationship and reduced pathology, the exclusive focus on effectiveness does not clearly identify whether the alliance is as valued by patients as it is by clinicians.

Read (1996) reported on eight professed requirements of service users, which were full information, choice, accessibility and advocacy from mental health practitioners. In a series of focus groups conducted to elicit users and cares views of core competencies of mental health workers (IHCD 1998), patients valued a trusting relationship and appraised values and attitudes over technical skills.

Two notable surveys have identified the importance of the therapeutic relationship to patients. The Mental Health Foundation (1997) reported that people professed a need for, somewhere to feel safe and accepted, where there was someone to talk to when in distress, help in managing feelings and support from someone who would listen. Rogers and Pilgrim (1994) conducted a survey of 516 people receiving mental health services, and also found that the quality of nursing valued most highly was their ability to relate through talking, listening and expressed empathy.

Barker et al (1999) studied the expressed need for psychiatric nursing by people, their carers and mental health professionals, using an adapted grounded theory methodology. Theory was inducted from statements made by participants, including data provided by focus groups, comprising of people who had received psychiatric nursing services, family members, friends and other mental health professionals. 92 people participated in the groups of between six and 12 members.

There was some consensus across both recipients and providers of mental health services suggesting that central to good practice was a demand for high empathy nurses, who were able to establish what the patient expected or needed from the nurse at any given moment. Patients expressed a hope for closer relationships in which nurses were more intimate, sharing information about their selves. Nurses were also expected to be able to interpret professional jargon, and give facts about medication, diagnosis, health status and prognosis. Truth telling was particularly valued within the context of the relationship.

People appear to prize both practical and interpersonal aspects of treatment above the technical components of psychological therapy. Watkins (2001) has discussed the resemblance between what users stated nurses contributed to their recovery and what Rogers (1957) identified as the necessary and sufficient conditions for change: a working alliance with a practitioner who is empathic, accepting and genuine. It appears that patients find these qualities essential in their relationships with mental health practitioners and that the relationship itself is central to recovery (Watkins 2001; Repper 2002). However emerging evidence now suggests that people with schizophrenia see the relationship as necessary but not sufficient on its own and that they would value the opportunity to have access to technical aspects of therapy such as CBT (Coffey et al 2004).

Implications for Practice

The therapeutic relationship clearly remains focal for patients and practitioners. However, the relationship in itself may not lead to sustainable outcomes and may conversely shadow the task of therapy where it does not lead to the development of self-management strategies (Nelson-Jones 1997).

Mcleod (1998) cautioned that a reliance on the sufficiency of the relationship might be inappropriate for emotionally inexpressive people, or those expecting practical solutions. As the non-directive approach to psychotherapy relies wholly on the therapeutic relationship as means for effecting change, this process cannot be time limited and may be too lengthy or unworkable in the realities of clinical practice (McLeod 1998). The achievement of an alliance may prove to be a difficult task that requires considerable time. Frank and Gunderson (1990) found that people with psychosis had greater difficulty forming relationships than others in psychotherapy; it was not until they had been in treatment for six months that a significant increase in numbers of patients, with a good relationship over initial levels, was observable.

Research into the effectiveness of CBT for people with schizophrenia is promising (Midence 2000) and may ultimately provide the greatest opportunity for empowerment through the development of self-efficacy (Baguley & Baguley 2000). It has also been noted that better outcomes are associated with non-specific therapies, such as supportive counselling and befriending, when used in controlled conditions in evaluations of CBT (Bentall et al 2003). This suggests that positive and constructive social support may be fundamental to creating the conditions in which individuals with schizophrenia can begin to control their symptoms. It would seem however, given Frank and Gunderson's (1990) findings, that CBT for people with psychosis may only prove to be effective in the context of an established therapeutic relationship.

Repper (2002) argues that the process of recovery may be due to the experience of the relationship promoted by CBT. The therapeutic relationship is important for all types of psychological therapy with schizophrenia, because of the necessary sense of safety it provides (Nelson 1997). In order for CBT to be

successful, people need to feel understood and involved in disclosing important and often distressing information (Fowler et al 1998).

This discussion leads to a number of implications for the education, training and practice of mental health nurses. Recovery model principles, derived from US and New Zealand literature, explicitly acknowledge the need for mental health practitioners to develop competencies of self-awareness, interpersonal skills, knowledge of services and resources and non-discriminatory practices, which respect the person's rights and diverse needs, (Mental Health Commission 2001). Central to this premise is the belief that recovery is best achieved through the encouragement of client autonomy and collaboration in care (Townsend et al 2000).

Mental health nurse education should focus on producing practitioners with the requisite abilities to establish and build helpful relationships with patients. This would be underpinned by the essential building blocks of mental health nursing; an exploration of values, attitudes and an awareness of the uniqueness of individuals, respect for this individuality and a perception of mental illness as being only one part and not the totality of the person (Estroff 1989). Education and training could then focus on equipping mental health nurses with evidence-based technical skills, that will improve outcomes for people with mental illness. Opportunities in training should be available for nurses to rehearse, practice and be assessed in using these skills to establish skill development.

The therapeutic relationship should be explicitly recognised in the process of care planning and delivery. The underpinning theoretical constructs of specialist sessional work, undertaken with psychologists and therapists, should be incorporated in to the philosophy of care to promote continual reinforcement of therapeutic processes.

Conclusion

The therapeutic relationship has historically been seen as the cornerstone of mental health nursing. This view has recently been challenged through arguments that only evidence obtained through positivistic research should inform mental health practice and the seemingly vaguer aspects involved in developing therapeutic relationships should be ignored in favour of psycho-technology. Opponents of this view consider this perspective to be constructed under a biomedical model and therefore irrelevant to mental health nurses, users and carers.

It has been suggested that people greatly value the therapeutic relationship and that its contribution to recovery is considerable. However, the sufficiency of the alliance as a means to sustainable improvement is questionable and more structured approaches to psychological therapy may prove to be increasingly relevant to the future practice of mental health nursing. Whilst traditionally, CBT practitioners have prized the technical components of method, the development of a therapeutic relationship is not exclusive to the person-centred approach and is crucial to the assessment, formulation and treatment in cognitive behavioural techniques. The combination of relationship and process may prove to be the most effective treatment for people with schizophrenia.

Word Count: 5010

References

Ahn H.N. & Wampold B.E. (2001): Where Oh Where Are the Specific Ingredients? A Meta-Analysis of Component Studies in Counseling and Psychotherapy. *Journal of Counseling Psychology* **48**, 251-257.

Bamling M., King, R. (2001): Therapeutic alliance and clinical practice. *Psychotherapy in Australian.* **8**, 38-43.Barker P (1995) Promoting growth through community mental health nursing. *Mental Health Nursing* **15**, 3. 12-15.

Barker P. (1998) Sharpening the focus of mental health nursing: Primary health care. *Mental Health Practice* **1**, 7, 14-15.

Barker P. (2001a) The Tidal Model: the lived experience in person-centred mental health nursing care. *Nursing Philosophy* **2**: 213-223.

Barker P. (2001b) The Tidal Model: developing an empowering, person-centred approach to recovery with psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing* **8**, 233-240.

Barker P. & Jackson S. (1996) Seriously misguided. *Nursing Times* **92,** 34, 56-57.

Barker P., Jackson S. & Stevenson C. (1999) What are psychiatric nurses needed for? Developing a theory of essential nursing practice. *Journal of Psychiatric and Mental Health Nursing* **6** 273-282.

Barker P. J., Reynolds W. & Stevenson C. (1997) The human science basis of psychiatric nursing: Theory and practice. *Journal of Advanced Nursing* **25,** 660-667.

Barkham M. (2002) Common factors in psychological therapies. *Psychiatry* **1**, 3, 5–8.

Baguley I. & Baguley C. (2002) Psychological treatment for anxiety and depression in schizophrenia. In *Psychosocial Interventions for People with Schizophrenia* (Harris N., Williams S. & Bradshaw T. eds.), Palgrave, Hampshire. 84-101.

Bentall R.P., Lewis S., Tarrier G., Haddock Drake R. & Day J. (2003) Relationships

matter: The impact of the therapeutic alliance on outcome in schizophrenia.

International Congress on Schizophrenia Research **20**, 319.

Birchwood M. (1999) Psychological and socials treatments: course and outcome.

Current Opinion in Psychiatry **12**, 61-66.

Bordin E. (1994) Theory and research on the working alliance: new directions. In *The*

Working Alliance: Theory, Research and Practice (Hovath A. & Greenberg L.

eds.), Wiley, New York.

Burnard P. (2002) Not waving but drowning: a personal response to Barker and

Grant. *Journal of Psychiatric and Mental Health Nursing.* **9**, 230–233.

Chan W. & Leung K. (2002) Cognitive behavioural therapy for clients with

schizophrenia: Implications for mental health nursing practice. *Journal of Clinical*

Nursing **11**, 214-224.

Clarke L. (2002) Doubts and certainties in the nursing profession: a commentary.

Journal of Psychiatric and Mental Health Nursing **9**, 225-228.

Coffey, M., Higgon, J. and Kinnear, J. (2004) "Therapy as well as the tablets": An

exploratory study of Service User views of Community Mental Health Nurses

(CMHNs) responses to hearing voices. *Journal of Psychiatric and Mental Health*

Nursing. **11**: 000-000

Coleman M. & Jenkins E. (1998): Developments in mental health nursing: a critical

voice. *Journal of Psychiatric and Mental Health Nursing* **5**, 355-359.

Collins S. & Cutliffe J.R. (2003) Addressing hopelessness in people with suicidal

ideation: building upon the therapeutic relationship utilising a cognitive

behavioural approach. *Journal of Psychiatric and Mental Health Nursing* **10**, 175-

185.

Dennis S. (2000) Professional considerations In *Working with Serious Mental Illness: A Manual for Clinical Practice* (Gamble C & Brennan G. eds.), Balliere Tindall, London. 317-328.

Department of Health. (2001) *Treatment Choice in Psychological Therapies and Counselling: Evidence–Based Clinical Practice Guidelines.* DoH, London.

Egan G. (2002) *The Skilled Helper: A Problem -management and Opportunity-Development Approach to Helping* (7th Edition). Brooks/Cole Publishing Co, Pacific Grove.

Estroff S.E. (1989): Self, identity, and subjective experiences of schizophrenia: in search of the subject. *Schizophrenia Bulletin* **15**, 189-96.

Fowler D., Garety P. & Kuipers L. (1998) Cognitive therapy for psychosis: Formulation, treatment effects and service implications. *Journal of Mental Health* **7**, 123-33.

Frank J.D. (1974) Psychotherapy: The restoration of morale. *American Journal of Psychiatry* **131,** 272 – 274.

Frank A.F. & Gunderson J.G. (1984) Matching therapists and milieus: Effective engagement and continuance in psychotherapy. *Psychiatry* **47**, 201–210.

Frank A.F. & Gunderson J.G. (1990) The role of the therapeutic alliance in the treatment of schizophrenia: Relationship to course and outcome. *Archives of General Psychiatry* **47**, 228-236.

Gamble C. (2000) Using a low Expressed Emotion approach to develop therapeutic alliances. In *Working with Serious Mental Illness: A Manual for Clinical Practice* (Gamble C & Brennan G. eds.), Balliere Tindall, London. 115-123.

Gottesman I.I. (1994) Schizophrenia epigenesis: past, present and future. *Acta Psychiatrica Scandinavica* **90** (Suppl 384), 26-33.

Gournay K. (1994) Reflecting the emphasis to serious mental illness. *Nursing Times* **90**, 40-41.

Gournay, K. (1995) New facts on schizophrenia. *Nursing Times* **91**, 32-33.

Gournay K. (1996) Schizophrenia: a review of the contemporary literature and implications for mental health nursing theory, practice and education. *Journal of Psychiatric and Mental Health Nursing* **3**, 7-12.

Gournay K. & Sandford T. (1998) Training for the workforce. In*: Serious Mental Health Problems in the Community: Policy, Practice and Research* (eds Brooker, C. & Repper, J.), Baillière Tindall, London. pp. 291 310.

Grencavage L.M. & Norcross J.C. (1990) Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice* **21,** 372 – 378.

Hattie J.A., Sharpley C.F. & Rogers H.J. (1984) Comparative effectiveness of professionals and paraprofessional helpers. *Psychological Bulletin* **95,** 534 – 541.

Higgon, J. and Coffey, M. (2001) Auditory Hallucinations. *Mental Health Nursing*. **21,** 2, 18-22.

Howgego I.M., Yellowlees P., Owen C., Meldrum L. & Dark F. (2003) The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry* **37**, 169-183.

Inoue K. & Kawabata S. (1999) Cognitive therapy for a major depressive episode in residual schizophrenia. *Psychiatric and Clinical Neurosciences* **53**, 563-567.

Institute for Health Care Development (1998) *Core competencies for Mental Health Workers.* NHS Executive Office, North West.

Jackson S. & Stevenson C. (2000) What do people need psychiatric and mental health nurses for? *Journal of Advanced Nursing* **31**, 378-388.

Keen T.M. (1999) Schizophrenia: orthodoxy and Heresies: A review of alternative possibilities. *Journal of Psychiatric and Mental Health Nursing* **6**, 415-424.

Lambert G. & Gournay K. (1999) Training for the mental health workforce: a review of developments in the United Kingdom. *Australian and New Zealand Journal of Psychiatry* **33,** 694-700.

Luborsky L., Crits-Christoph P. & Mellon, J. (1986) Advent of objective measures of the transference concept. *Journal of Consulting and Clinical Psychology* **54,** 39–47.

Luborsky L., Diguer L., Seligman D.A., Rosenthal R., Krause E.D., Johnson S., Halperin G., Bishop M., Berman J.S. & Schweizer E. (1999): The Researcher's Own Therapy Allegiances: A "Wild Card" in Comparisons of Treatment Efficacy.*Clinical Psychology* **6**, 95-106.

Mace C. (2002) The history of psychotherapy. *Psychiatry* **1**, 3, 1–3.

McLeod J. (1998) *An Introduction to Counselling* (2nd Edition). Open University Press, Buckingham.

Mental Health Commission (2001) *Recovery Competencies for New Zealand Mental Health Workers.* Wellington.

Mental Health Foundation (1997) *Our Own Minds,* London, MHF.

Midence K. (2000) An introduction to and rationale for psychosocial interventions. In *Working with Serious Mental Illness: A Manual for Clinical Practice* (Gamble C & Brennan G. eds.), Balliere Tindall, London. 11-28.

Nelson-Jones R. (1997) *Practical Counselling and Helping Skills* (4th Edition). Cassell, London.

Nelson H. (1997) *Cognitive Behavioural Therapy with Schizophrenia: A practice Manual.* Nelson Thornes, Cheltenham.

O'Brien A.J. (2001) The therapeutic relationship: Historical development and contemporary significance. *Journal of Psychiatric and Mental Health Nursing* **8**, 129-137.

Peplau H (1952) *Interpersonal Relations in Nursing.* Putnam, NY.

Peplau H (1988) *Interpersonal Relations in Nursing.* Macmillan, Basingstoke.

Paulson B.L., Truscott, D., Stuart, J. (1999): Client's perceptions of helpful experiences in counselling. *Journal of counseling psychology* **46**, 317-324.

Persons J.B. (1991) Psychotherapy outcome studies do not accurately represent current models of psychotherapy: a proposed remedy. *American Psychologist* **46**, 2, 99-106.

Pfammatter M. & Brenner H.D. (2000) Psychological therapy in schizophrenia: What is the evidence? *Acta Psychiatrica Scandinavica* (Suppl 407) 74-77.

Raue P.J., Goldfried M.R. & Barkham, M. (1997) The therapeutic alliance in psychodynamic-interpersonal and cognitive behavioural therapy. *Journal of Consulting and Clinical Psychology* **65**, 4, 582-587.

Read J. (1996) What do we want from mental health services? In: J. Read & J. Reynolds (Eds) *Speaking Our Minds*, pp. 175-179. Open University Press, Milton Keynes.

Repper J. (2002) The helping relationship. In *Psychosocial Interventions for People with Schizophrenia* (Harris N., Williams S. & Bradshaw T. eds.), Palgrave, Hampshire. 39-52.

Reynolds W.J. (2000) Do nurses and other professional helpers normally display much empathy? *Journal of Advanced Nursing*. **31**, 1, 226 – 234.

Rogers A. & Pilgrim D. (1994) Service users' views of psychiatric nurses. *British Journal of Nursing* **3**, 16-18.

Rogers C.R (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology* **21**, 95-103.

Roth A.D. & Parry G. (1997): The implications of psychotherapy research for clinical practice and service development: Lessons and limitations. *Journal of Mental Health* **6**, 367-380.

Stiles W.B., Shapiro D.A. & Elliott R. (1986) Are all psychotherapies equivalent? *American Psychologist* **41**, 2, 165-180.

Tarrier N., Lewis S., Haddock G., Bentall R., Drake R., Kinderman P., Kingdon D., Siddle R., Everitt J., Leadley K., Benn A., Grazebrook K., Haley C., Akhtar S., Davies L., Palmer S. & Dunn G. (2004): Cognitive-behavioural therapy in firstepisode and early schizophrenia: 18-month follow-up of a randomised controlled trial. *British Journal of Psychiatry* **184**, 231-239.

Townsend, W., Boyd S., Griffen G., Larkins G & Hicks P (2000) *Emerging Best Practices in Mental Health Recovery.* Columbus, OH. Ohio Department of Mental Health.

Trenchard S., Burnard P., Coffey M. & Hannigan B. (2002) Education For Community Mental Health Nurses: a summary of the key debates *Nurse Education Today* **22**, 1–7.

Watkins P. (2001) *Mental Health Nursing: The Art of Compassionate Care.* Butterworth Heinemann, Oxford.

Wiersma D., Jenner J.A., van de Willege G., Spakman M. & Nienhuis F.J. (2001) Cognitive behavioural therapy with coping training for persistent auditory

hallucinations in schizophrenia: A naturalistic follow-up study of the durability of effects. *Acta Psychiatrica Scandinavica* **103**, 393-399.