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Investigating the anatomy of the helping relationship in the context of psychiatric rehabilitation: The relation between working alliance, providers' recovery competencies and personal recovery

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ABSTRACT

Professional helping relationships established with mental health consumers are vital in mental health recovery processes. However, little is known about how the constructs of alliance building and providers' recovery promoting strategies relate to each other and play a role in supporting recovery. To this end, we examined associations between consumer-reported working alliance, perceived providers' recovery competencies, and personal recovery. In a cross-sectional study design, 72 mental health consumers who established relationships with providers through a psycho-educational intervention over a period of 10 months in hourly weekly sessions were examined as part of a larger study conducted in mental health community settings in Israel. Participants filled in the Working Alliance Inventory (Tracey and Kokotovic, 1989), the Recovery Promoting Relationships Scale (Russinova et al., 2013), and Recovery Assessment Scale (Corrigan et al., 2004). Pearson correlations and linear regression analysis showed positive correlations between relational variables and recovery. A mediating model was identified whereby providers' recovery strategies positively impact the working alliance, which, in turn, positively impact consumers' recovery. Implications of the current study for future research and clinical practice are discussed, emphasizing the importance of examining recovery strategies and the working alliance with regard to the process of mental health recovery.

1. Introduction

In recent decades a shift towards a more optimistic view about the possibility of recovery of people with serious mental illnesses has gained prominence around the world (Andresen et al., 2010; Anthony, 1993; Moran et al., 2012; Morrison et al., 2013; Slade et al., 2012). A necessary building block on the road to recovery is a supportive relationship, often developed with practitioners (Angell and Mahoney, 2007; Deegan, 2001; Farkas and Anthony, 2010; Moran et al., 2014; Slade, 2009). Such relationships involve not just "what" clinicians do, but first and foremost "how" they do it; that is, the interpersonal context itself (Davidson et al., 2009; Slade, 2012).

Given the multi-layered challenges mental health consumers often face, it is not surprising that having a connection with someone who supports and provides hope is essential and often crucial (Deegan, 2001; Farkas et al., 2005; Slade, 2009). These challenges include the debilitating effects of impairment and disability due to mental illnesses (Deegan, 1988; Onken et al., 2007; Russinova, 1999); psychosocial consequences, economic and social disadvantages, deficient state of health care, and low quality of life (e.g. Thornicroft, 2006), as well as loneliness, reduced self-esteem, self-efficacy, and stigma (Hinshaw, 2007; Moran et al., 2012a; Rusch et al., 2010; West et al., 2011). Thus, consumers often experience deep and prolonged periods of despair. Such a state leaves recipients of services disempowered and discouraged when facing the daily tasks involved in acquiring skills and competencies as part of their rehabilitation processes. Having someone who is sensitive to one's multiple life challenges, acknowledges one's personhood, provides hope, and supports a self-determined approach helps alleviate some of these emotional burdens (Bedregal et al., 2006; Borg and Kristiansen, 2004; Deegan, 1993; Moran et al., 2012; Onken et al., 2007; Russinova, 1999).

Yet, establishing a professional and effective helping relationship with mental health consumers is easier said than done. Marrelli et al.

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(2005) highlight the complexity of psychiatric rehabilitation practitioner competencies as requiring an amalgam of knowledge, skills, abilities, and personal characteristics. In contrast to more traditional helping relationships (e.g., treatment/psychotherapeutic relations); here, the roles, tasks, and goals of providers vary considerably in terms of their focus, location, and duration. Perhaps what lies at the core of this complexity is the somewhat loose connection between rehabilitation and recovery. Recovery is an internal subjective and non-linear process, rather than the end target of a particular rehabilitating service. However rehabilitation often involves a focus on attainment of tangible goals (Anthony, 1993; Deegan, 1988; Slade, 2009). As a result of this loose connection, providers may experience recovery and rehabilitation needs as conflicting: attaining concrete goals within a realistic timeframe can be experienced as competing with time invested in forming a relationship that supports recovery. Such a relationship often involves being there for the person and attending to their feelings in support of their personal recovery process.

In recent years, the working alliance has emerged as a central relational concept, well known from the field of psychotherapy, which is comprised of the sense of bonding between client and therapist and their agreement on the tasks and goals of treatment (Horvath, 1994). The working alliance was found to positively impact processes and outcomes of therapies, irrespective of the type of treatment modality (Horvath, 2005; Horvath and Symonds, 1991; Lambert and Barley, 2001). More specifically, the working alliance was identified as important for people in psychiatric care relationships (Crowe et al., 2006; Priebe and McCabe, 2008). For example, a positive association was found between therapist working alliance ratings and outcomes in the treatment of depression (Weiss et al., 1997), schizophrenia, psychosis, and major affective disorders (McCabe and Priebe, 2003; Neale and Rosenheck, 1995). In addition, poorer alliance at admission to hospital predicted violent behavior during the first week of hospitalization (Beauford et al., 1997). In recent years the working alliance was specifically identified as relevant to promoting client engagement, overcoming disagreements, and enabling delivery of complex treatment programs in psychiatric practices (McCabe and Priebe, 2004).

More novel is the coneptual model and scale of Russinova et al. (2013), which address the perceptions of the consumer regarding the provider's use of recovery promoting competencies. They describe two components comprising such competencies: a. providers' core interpersonal skills, which involve a humanistic, empathic, and respectful approach; and, b. provider utilization of a set of specific recovery-promoting strategies (i.e., empowering, enhancing hope, and self-acceptance). Beyond conceptual development, their study demonstrates the feasibility of identifying specific provider competencies relevant to the population of people with serious mental illnesses.

1.1. The present study

The accumulating knowledge about the relational construct of alliance and consumer perceptions of provider's use of recovery promoting competencies suggest they may be, and that both are important for recovery. However, little is known about how recovery promoting competencies and alliance building relate to each other and play a role in supporting recovery. Thus, the purpose of the present study was to examine the relationship between working alliance (Horvath, 2005) and consumer perceptions of recovery promoting relationships (Russinova et al., 2013), as well as to examine how these variables relate to self-reported recovery. Such an examination was expected to broaden the knowledge about the characteristics of recovery promoting consumer-provider relationships.

Specifically, we hypothesized that:

1) There will be a positive relationship between consumers' experiences of the working alliance and their perceptions of providers' use of recovery promoting competencies.
2) There will be a positive relationship between the working alliance, perceptions of providers' use of recovery promoting competencies and consumers' self-reported recovery.
3) The working alliance will moderate the relationship between perceptions of recovery promoting competencies and consumers' self-reported recovery.
4) The working alliance will mediate the relationship between perceptions of recovery promoting competencies and consumers' self-reported recovery.

2. Methods

2.1. Research setting

This study was part of a larger research project conducted between October 2010 and September 2011 aimed to assess the effectiveness of illness management and recovery (IMR) (Gingerich and Mueser, 2005). It was administered over a 10 month period across 43 psychiatric rehabilitation community service agencies. The current study focused on 14 residential community services in the southern part of Israel. IMR intervention was conducted in small group format with trained providers in hourly weekly sessions. Participants were administered three self-report scales upon completion of the intervention (Working Alliance, Recovery Promoting Relationships, and Recovery Assessment). Ethical approval for the study was obtained by the Helsinki Ethics Committee. After receiving a detailed description of the study, study participants provided written informed consent.

2.2. Participants

Seventy-two people with serious mental illnesses whose ages ranged from 20 to 60 years ($M=43.2$, S.D.$=10.6$) participated in the study. All had at least a 40% psychiatric disability, which indicates substantial reduced work capacity and difficulties in social adaptation, as determined by a professional medical committee. This committee included a psychiatrist and was recognized by the Israeli National Insurance Institute. Participants were diagnosed with schizophrenia, schizoaffective, bipolar, and/or depressive disorders, and were living in supported residential facilities. Inclusion criteria were fluency in Hebrew and providing informed consent. About half were women (51%, $n=37$) and more than half had never been married (61%, $n=44$). Almost two-thirds had at least high school level education (65%, $n=47$).

2.3. Measures

The questionnaire includes three measures: Recovery Assessment Scale (RAS), Recovery Promoting Relationships Scale (RPRS), and Working Alliance Inventory (WAI).

2.3.1. Recovery Assessment Scale

The RAS (Corrigan et al., 2004; Roe et al., 2012b) is a 41-item scale that assesses perceptions of recovery from severe mental illness. Participants endorse items (e.g., "I have a desire to succeed") on a 5-point Likert scale (1=do not agree at all, and 5=very much agree). The RAS has good psychometric properties and is correlated with measures of self-esteem, empowerment and quality of life (Corrigan and Phelan, 2004). The current study used a short Hebrew 20-item version and analysis was performed on 12 items that supported four out of the five factors originally identified (Roe et al., 2012a). A confirmatory factor analysis (Roe et al., 2012a) yielded four factors: personal confidence and hope with three items (Cronbach's alpha=0.72), willingness to ask for help with three items (Cronbach's alpha=0.91), reliance on others with three items (Cronbach's alpha=0.66), and no domination by symptoms with three items (Cronbach's alpha=0.70). In the present study, Cronbach's alphas were 0.83, 0.93, 0.68 and 0.75 for personal confidence and hope, willingness to ask for help, reliance on others, and no domination by symptoms, respectively.

2.3.2. Recovery Promoting Relationships Scale

The RPRS (Russinova et al., 2011; Russinova et al., 2013) is a 24-item scale with each item ranging from 0 "disagree" to 3 "agree" (e.g., "My provider helps me recognize my strengths"). All items are phrased positively, so that greater scores represent higher provider competencies. For each item participants may also choose the option "not applicable". In previous assessments the RPRS demonstrated a high level of internal consistency with alphas ranging from 0.88 to 0.98 for the total scale. The RPRS has perspective norms for an acceptable level of practitioners' recovery promoting competence (Russinova et al., 2006).