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The relevance of professionals' attachment style, expectations and job attitudes for therapeutic relationships with young people who experience psychosis

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ABSTRACT

Background: Therapeutic relationships are a central component of community treatment for psychosis and thought to influence clinical and social outcomes, yet there is limited research regarding the potential influence of professional characteristics on positive therapeutic relationships in community care. It was hypothesised that professionals' relating style and attitudes toward their work might be important, and thus this exploratory study modelled associations between these characteristics and therapeutic relationships developed in community psychosis treatment.
Methods: Dyads of professionals and young patients with psychosis rated their therapeutic relationships with each other. Professionals also completed measures of attachment style, therapeutic optimism, outcome expectancy, and job attitudes regarding working with psychosis.
Results: Professionals' anxious attachment predicted less positive professional therapeutic relationship ratings. In exploratory directed path analysis, data also supported indirect effects, whereby anxious professional attachment predicts less positive therapeutic relationships through reduced professional therapeutic optimism and less positive job attitudes.
Conclusions: Professional anxious attachment style is directly associated with the therapeutic relationship in psychosis, and indirectly associated through therapeutic optimism and job attitudes. Thus, intervening in professional characteristics could offer an opportunity to limit the impact of insecure attachment on therapeutic relationships in psychosis.

1. Introduction

Young community mental health patients suggest that a positive relationship with a particular optimistic professional influences their outcomes; perhaps to a greater extent than a specific therapy or techniques thereof [1–3]. Recent research suggests that the therapeutic relationship plays a causal role in clinical outcomes [4] and predicts social and vocational outcomes for young people with psychosis [5]. There may be, however, an added complexity to therapeutic relationships in community care compared to psychotherapy, due to the former's myriad of professional roles and tasks [6,7]. Forming positive therapeutic relationships with young people experiencing psychosis may be especially difficult and time-consuming [8–10], but there is a particular potential for professionals to facilitate positive long-term outcomes when intervening early [11,12]. A key professional in UK community care is the care co-ordinator. Care co-coordinators come from a variety of professional backgrounds, including nursing, social work and occupational therapy. The care co-ordinator arguably provides the most contact and support and co-ordinates all other services received [13]. Thus exploring care co-ordinator characteristics associated with positive therapeutic relationships in youth psychosis care is warranted. Furthermore, additional exploration of correlates of both professional and patient ratings of therapeutic relationship ratings is important, for these ratings commonly differ [14,15].

Two therapeutic relationship models are particularly relevant for community care; the working alliance and the emotional climate [14,16]. The working alliance is defined as a reciprocal helping relationship, comprised of therapeutic goal and task agreement, and the affective bond [17]. It has been suggested that through this therapeutic bond, professionals exhibit positive personal qualities (e.g. warmth), which increase their social

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attractiveness and thus, their social influence on patients' behaviours [18]. The emotional climate model here refers to the caregiver's (negative) 'expressed emotion' (criticism, hostility and emotional over-involvement) toward the patient [19]. Qualitative analysis [19,20] suggests that high expressed emotion professionals are less tolerant, less warm, and have low progress expectations.

Professionals' own attachment style may influence their therapeutic relationships [21]. Attachment theory suggests early life experiences influence the development of secure or insecure attachment styles, and these attachment styles affect interpersonal relationships in later life [22]. It is theorised that therapeutic relationships are a form of attachment relationship [21]; thus a professional with a secure attachment style may better provide a secure base, but also space, for patients to grow and develop. The self-report measure tradition conceptualises insecure attachment as a) anxious; high need for approval, fear of rejection and negative self-image, or b) avoidant; negative images of others, social withdrawal, fear of dependence, and excessive self-reliance [21,23]. Previous research suggests anxious and avoidant self-reported attachment styles of psychiatric keyworker/care co-ordinators correlate with less positive observer-rated therapeutic relationships and interactions with patients [21,24], and also with psychotherapist-rated therapeutic relationships with clients [25]. Links between professional attachment styles and patient-rated therapeutic relationships seem as of yet unexplored.

Socio-cognitive theory [18,26] suggests individuals' behaviours are influenced by others' expectations, perhaps especially so in the absence of conscious awareness of such expectations. Thus, professionals' beliefs may influence the therapeutic process [27]. Especially in psychosis, professionals may have low expectations regarding patient capacities for work and community involvement, and these may influence both therapeutic relationships and patient outcomes [28]. Patients value hopeful and optimistic professionals, but report pessimistic interactions with professionals, perceived to have a detrimental effect on hopefulness and well-being [27–29]. Professionals' implicit projection of hopefulness is thus considered part of forming a positive therapeutic bond [27,30]. Professional expectations can be operationalised as a) therapeutic optimism; global expectations of the possibility of recovery and professional's ability to facilitate this, and b) outcome expectancy; specific expectations of patient abilities to achieve social and occupational outcomes. Both types of expectations are hypothesised to facilitate more positive therapeutic relationships, but empirical exploration is required.

Models from nursing and addiction intervention [31,32] suggest therapeutic relationships are influenced by professionals' attitudes towards their job; namely role security, therapeutic commitment, and empathy. Role security (perceived legitimacy of job tasks and requisite knowledge to perform them) and therapeutic commitment (work satisfaction and perceived willingness and ability to utilise therapeutic qualities) are thought necessary for professionals to provide facilitative conditions needed for therapeutic relationships [31,32]. Associations between these two attitudes and inpatient nurse therapeutic relationships have been observed [33]. Patient views concur; suggesting their relationship perceptions are more positive for professionals considered to be knowledgeable, skilful, interested and committed [34,35].

Empathy, the emotional and cognitive "capacity to think and feel oneself into the inner life of another person" [36], p. 82), is a widely accepted facilitator of the therapeutic relationship [37,38]. Rogerian theory suggests that empathy is one of three necessary and sufficient conditions through which to facilitate therapeutic change; the others being genuineness and unconditional positive regard [39]. Within Cognitive Behavioural Therapy for psychosis, therapist self-rated empathy correlated with their therapeutic alliance ratings [40]. Qualitative research suggests that patients perceive relationships with empathic professionals as more positive [34], but further empirical research is needed.

In addition to the predicted direct association, professional attachment style may indirectly predict therapeutic relationships through expectations and job attitudes. Theoretically, attachment style influences perceptions of one's own ability to help clients and others' coping abilities [41]. Thus own attachment style may affect professionals' perceived ability to help patients (therapeutic optimism) and perceptions of patients' abilities to cope and succeed (outcome expectancy). Attachment security may also predict professionals' job attitudes, through associations with:

- positive appraisals of one's resources, clear vocational self-concept and greater self-reported care-giving competence and self-efficacy [41–43], i.e. role security;
- greater work confidence and positive appraisals of contextual factors at work [43], i.e. therapeutic commitment;
- greater self-reported empathy of nursing students [44] and observers' ratings of Clinical Psychology trainees' empathic responding to videotaped 'alliance rupture' vignettes [45].

Therefore, it was hypothesised that professional anxious and avoidant attachment styles would be associated with less positive therapeutic relationships, rated by both professionals and young patients experiencing psychosis. It was also hypothesised that this association would be mediated by professionals' expectations (therapeutic optimism and outcome expectancy) and job attitudes (role security, therapeutic commitment, and empathy). This study is the first known exploration of these associations with both professional and patient-rated therapeutic relationships in community psychosis care.

2. Methods

2.1. Participants and procedure

A convenience sample of professional and patient dyads was assessed cross-sectionally. Professionals and young patients with psychosis were recruited from local Community Mental Health, Assertive Outreach and Early Intervention in Psychosis (EIP) services. The young people were aged 18 to 36 years with a primary diagnosis of either first episode psychosis (FEP) or psychotic spectrum disorder, including schizophrenia, schizoaffective disorder, bipolar disorder, schizophreniform disorder, and delusional disorder (as denoted by the treating psychiatrist). The professional was the care co-ordinator unless the patient reported greater current contact with another professional (i.e. another professional temporarily functioning as care co-ordinator). Dyads with an existing working relationship of three or more months were recruited to ensure the therapeutic relationship had developed prior to measurement [46]. Separate confidential face-to-face assessments were conducted within two weeks for patient and professional. Both patients and professionals provided informed consent in writing before undertaking any research procedures. Professionals rated their general attitudes and outcome expectancies before the specific therapeutic relationship with the identified patient. Patients separately rated the therapeutic relationship and measures of potential covariates were obtained.

2.2. Measures

2.2.1. Therapeutic relationship

2.2.1.1. Patient-rated. The working alliance was captured using the short (12 item) Working Alliance Inventory (WAI-s) [47]. Previous