

Psychosocial resources in a therapeutic relationship



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This essay considers the psychosocial resources implicated in a successful therapeutic relationship. Several fundamental theses seem to emerge from a review of the literature. Firstly, there is an abundance of relevant psychosocial factors, and these seem to vary across different settings. Secondly, factors such as empathy, trust, and warmth, seem crucial in most scenarios. Thirdly, the assumptions and beliefs of both therapists and patients regarding the therapeutic alliance need to be identified, and if necessary remedied, to achieve a successful interaction.

The terms ' patient' and ' therapist' may denote slightly different things, depending on whether the scenario is medical (Douglass et al, 2003) or psychological (or psychiatric) (Johansson & Elkund, 2004; Haarhoff, 2006). Psychosocial resources may play a much more important role where the therapy is psychological (e. g. psychoanalysis) and the therapist a psychologist or professional with similar training (e. g. social worker, counsellor). Peplau's theory of the nurse-patient relationship provides a useful basis for conceptualising the role of psychosocial resources in successful therapeutic relationships (Peplau, 1965, 1974a, 1974b; Douglass et al, 2003). Although Peplau focused primarily on nursing care, her model seems applicable to most therapist/carer-patient scenarios. According to Peplau a favourable therapeutic relationship is essential for successful treatment outcomes. She identifies several psychosocial variables that are pertinent. These include trust, interpersonal skills, effective communication, and anxiety. Crucially, these processes work gradually rather than abruptly as the patient and therapist develop a rapport, but what about empirical research? Studies suggest that basic psychosocial resources such as warmth,

empathy, trust, and good communication, are integral to a successful therapeutic relationship (Lambert & Barley, 2001).

Hewitt and Coffey (2005) carried out a review of the relevant literature that highlighted several themes. Firstly, there is a plethora of psychological variables that seem essential to a successful therapeutic relationship. These include having a carer or patient that exudes trust, respect, sensitivity, warmth, is approachable and likeable, and has a sense of fair-play. It is important for the carer to show empathy, listen, tell the truth, share personal information, be supportive, explain professional jargon concerning treatment and value the patient, for example by involving them in decision-making (Barker et al, 1999). These psychosocial resources can be negated if the carer has a negative attitude towards the patient. This is particularly the case with mental health patients, for example those who commit deliberate self-harm. If a therapist believes that a patient is too disturbed or ill to participate in/contribute to his or her own treatment then the therapeutic relationship is bound to suffer (Repper, 2002). Above all, the personal qualities (i. e. personality characteristics) of the practitioner are paramount. Patients need to view the therapist as trustworthy, able to identify deeply with their problem, and keen to engage in conversation at a deep emotional level (Paulson et al, 1999; Gamble, 2002).

Psychosocial factors are especially pertinent in psychotherapies, especially cognitive therapy. A successful therapeutic relationship is heavily influenced by what is referred to as a "therapeutic belief system" (Beck & Beck, 1995; Rudd & Joiner, 1997; Leah, 2001; Haarhoff, 2006). Both patient and therapist may have particular beliefs or assumptions about the course of treatment, <https://assignbuster.com/psychosocial-resources-in-a-therapeutic-relationship/>

themselves, and *each other*, which may trigger different emotional and behavioural responses. Consider for example a patient who perceives his therapist as impatient and overbearing. This negative thought may generate unfavourable emotions such as dislike and resentment. The patient may also become unnecessarily reluctant to follow psychological advice. The possibility of premature termination of treatment is increased, with detrimental consequences for the patients' psychological health. Similarly, a therapist who views a patient as lazy and dishonest, may dislike the individual as a result, and be less enthusiastic in administering therapy.

Haarhoff (2006) recently conducted a study that demonstrated the intricacies of such beliefs, and the potential impact they may have on the therapeutic relationship. Therapists enrolled in a cognitive behaviour therapy program were administered a 'Therapist's Schema Questionnaire', which measures fourteen typical mindsets therapists may hold about therapy, themselves, or their patients, including 'demanding standards', 'special superior person', 'excessive self-sacrifice', 'rejection sensitive', 'abandonment', 'autonomy', 'control judgement', 'need for approval', 'need to like others', and 'emotional inhibition'. Participants were required to indicate the extent to which specific assumptions within each domain applied to them. The most commonly identified assumptions were 'demanding standards', 'special superior person', and 'excessive self-sacrifice'.

The first item denotes a view that there is a correct way of doing things. This may be triggered by a patients' slow progress, or non-compliance. The therapist may regard the patient negatively (e. g. lazy, irresponsible),

believe that treatment should 'work', if only it were properly assimilated by
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the patient, and hence become overly demanding and controlling. The 'special superior person' mindset sees therapy as an opportunity to demonstrate one's excellence. The therapist feels special, unique, and superior to the patient. The result is a tendency to become overly close and idealise a patient who is improving, or distance oneself from patients who make little or no progress. 'Self-sacrifice' assumptions place too much emphasis on the patient-therapist relationship, leaving the practitioner perceiving the patient as needy and vulnerable, and bending over backwards to meet patient demands. Treatment boundaries aren't set, or if they are, aren't adhered to, resulting in prolonged treatment sessions, lack of structure, and other laxities. Overall, Haarhoff's (2006) study illuminates important psychological processes that may enhance or taint relations. Crucially, therapists may be *unaware* of their beliefs or assumptions, let alone how these may affect relations with their patients.

Patients' perceptions matter a great deal. Since it is the patients' (rather than the therapists) recovery that is the primary treatment objective, the success or failure of a therapeutic relationship is heavily dependent on the patients' own appraisals of the interaction. This view is consistent with existential (Cooper, 1999) and phenomenological (Dermot, 2000) philosophies, which define reality as viewed by an individual rather than observers or objective inquiry. Like therapists, patients retain beliefs and assumptions about the therapeutic relationship, with potential implications for treatment outcomes. This is supported by some empirical evidence. Johansson and Eklund (2004) conducted a study to assess how psychiatric patients in an in-patient ward appraise the therapeutic relationship, and

other related clinical characteristics (e. g. perceived ward atmosphere).

Patients suffered from a range of mental health problems including behavioural disorders, schizophrenia, affective disorders, mental retardation, and neurotic, stress-related and psychosomatic problems. They received supportive therapy, social skills training and other interventions. All participants completed one questionnaire assessing the strength of patient-therapist relationship (Luborsky et al, 1996) and another assessing their perceptions of therapeutic relationships, specifically 'involvement', 'support', and spontaneity (Moos, 1974). Data analysis revealed that perceived support and spontaneity were strongly correlated with the strength of therapeutic relations: the greater the level of support and spontaneity perceived the more successful the patient-therapist alliance. Clearly, this study demonstrates the importance of psychosocial factors, as perceived by the patient. Unfortunately, the correlational design precludes any inferences about causality. Thus, while it seems commonsensical that perceived support may strengthen relations with a therapist, a successful therapeutic relationship may also engender greater levels of support (e. g. a therapist may be more supportive of a patient if he/she gets on well with the individual).

Treatment models such as Peplau's theory (1965, 1974a) conceptualise psychosocial variables as precursors and hence determinants of a successful therapeutic relationship. So, for example, trust and empathy purportedly lead to a favourable rapport between patient and practitioner. Unfortunately, a paucity of randomised controlled trials negates any conclusive inferences about direction of causality. It is entirely plausible that an initially favourable

interaction between a patient and carer improves the patients psychosocial functioning, which in turn further enhances the therapeutic relationship, and crucially improves treatment outcomes. Simpson and Joe (2004) conducted a comprehensive longitudinal study in which the quality of therapeutic relationships at one point in time was used to predict psychosocial functioning and treatment outcomes after one month, as well as treatment retention after a year. The setting for this study was a community based outpatient methadone treatment program in two urban areas. Participants were users of opiates/cocaine admitted to the program, and subjected to various treatments and follow-up assessments. The favourableness of the therapeutic relationship between counsellor and patient was assessed using a scale that gauged six perceptions counsellors may have about their patients: “ easy to talk to”, “ warmth and caring”, “ honest and sincere”, “ understanding”, “ not suspicious”, and “ not in denial about problems”. Favourable psychosocial functioning was conceptualised as high self-esteem, social conformity and decision making, and low depression, anxiety, and risk-taking. Analysis revealed that a favourable therapeutic relationship predicted positive psychosocial functioning and improved treatment outcomes (no drug use) after four weeks.

All in all it is essential for practitioners to identify the system or beliefs and assumptions they have about their patients (Rudd & Joiner, 1997). This can be achieved through self-administered questionnaires, such as the ‘ personal belief questionnaire’ (Beck & Beck, 1995; Leahy, 2001). Hewitt and Coffey (2005) highlight the importance of equipping therapists with the necessary skills to develop successful therapeutic relationships. But perhaps it is

Haarhoff (2006) who offers recommendations specifically relevant to psychosocial factors. She highlights the importance of practitioners not blaming patients, losing interest, getting bored, making too many demands, or being overly structured in the approach. Instead, therapists must try to develop more empathy, identify/challenge assumptions about treatment, themselves, and the patient, and allow patients take the lead in making decisions.

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