



Hope-inspiring therapeutic relationships, professional expectations and social inclusion for young people with psychosis



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ABSTRACT

Objective: Personal recovery accounts suggest that a positive therapeutic relationship with an optimistic mental health professional may facilitate social inclusion. However, little empirical research has investigated the role of the therapeutic relationship in social outcomes or explored potential mechanisms of change within community psychosis care. This study investigated the direct predictive associations of the therapeutic relationship and professional expectancies for social inclusion and vocational activity for young people with psychosis, and indirect associations through hopefulness.

Method: Young people with psychosis and their main mental health professional ($n = 51$ dyads) participated across two time points. Measures of therapeutic relationships, professional expectancies, and vocational activity were obtained at baseline. Measures of hopefulness, social inclusion and vocational activity were obtained at follow-up. Direct and indirect associations between variables were analysed using path modelling.

Results: Directed path models were consistent with a positive therapeutic relationship and positive professional expectancies predicting social inclusion and vocational activity through mediation by increased patient domain-specific hopefulness. The professional-rated therapeutic relationship more directly predicts change in vocational activity status. Change in vocational activity status predicts increased patient hopefulness.

Conclusion: The therapeutic relationship between professionals and young people with psychosis appears hope-inspiring and important to patients' social inclusion and vocational outcomes. Vocational activity may produce reciprocal gains in hopefulness.

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1. Introduction

1.1. Social inclusion

Social inclusion is a positively-focused multi-dimensional mental health outcome construct, encapsulating social activity, occupational activity and subjective experience of belonging (Morgan et al., 2007; Social Exclusion Unit (SEU), 2001). Social inclusion is central to personal recovery in psychosis (Brenneman and Lobo, 2011), and may be especially important to young people with psychosis in the context of transition to adulthood and identity formation (Iarocci et al., 2008; Pitt et al., 2007). Vocational activity, i.e. formal and mainstream education and employment, is also indicative of positive outcome (Fowler et al., 2009; Priebe, 2007). Prompt and effective early intervention in psychosis can reduce social disability (Fowler et al., 2009), yet community services for this population are less likely to improve social, compared to clinical, outcomes (Marshall and Rathbone, 2011). Additional exploration of

facilitators and mechanisms of change in these outcomes for this population is thus required.

One promising area of research concerning the promotion of positive social outcomes is through a positive therapeutic relationship between young people experiencing psychosis and a key mental health professional. Amongst young people accessing mental health services, a positive therapeutic relationship is emphasised as important and beneficial more often than specific therapeutic techniques or treatments (O'Toole et al., 2004). Clinical symptoms and neurocognition may also influence social outcomes (Allott et al., 2011; Milev et al., 2005; Nuechterlein et al., 2011), and symptoms at least may themselves be influenced by a positive therapeutic relationship, perhaps both directly and through medication adherence (Goldsmith et al., 2015; McCabe et al., 2012; Melau et al., 2015).

1.2. The mental health professional

Although community services may struggle to facilitate social inclusion, personal recovery narratives emphasise the beneficial impact individual professionals can have in this setting through a positive therapeutic relationship (e.g. Lester et al., 2011; Romano et al., 2010). The key professional is most commonly the care co-ordinator; a

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'generic' role involving co-ordinating services received and possibly providing specific medication or psychosocial interventions themselves (Department of Health, 2001). There has been limited focus on therapeutic relationships outside of specific psychotherapies. A recent review identified 9 studies in psychosis community care, with 4 of these focusing on an association with functioning (Priebe et al., 2011). These 4 studies did suggest therapeutic relationships predict social outcomes in chronic psychosis (Priebe et al., 2011). Two known studies published since this review have 400 patients (Melau et al., 2015) and over 500 patients and professionals (Farrelly et al., 2014). The first found a cross-sectional association between a positive patient-rated therapeutic relationship and functioning (Melau et al., 2015), and the second found a similar association between the professional-rated relationship and patient functioning 18 months later (Farrelly et al., 2014). However, these previous studies are limited by their focus on objective, observer-rated and deficit-focused outcomes such as functioning (Priebe et al., 2011); despite the importance of broader social and subjective outcomes to personal recovery (Slade, 2009). Additional limitations of previous studies include i) rarely investigating mechanisms of the effect (Kazdin, 2007), ii) rarely involving young patients with psychosis, despite therapeutic relationship formation being especially challenging in this population (Lincoln and McGorry, 1995), and iii) rarely capturing both patient and professional relationship ratings although these commonly differ and predict different outcomes (Barrowclough et al., 2001; Neale and Rosenheck, 1995; Priebe et al., 2001).

Two models are simultaneously relevant to therapeutic relationships in the complex community setting (Priebe et al., 2011; Skeem et al., 2007), although previous studies have tended to focus only on one of these models. The first, the working alliance, is defined as a reciprocal helping relationship comprised of therapeutic goal and task agreement, and the affective bond (Bordin, 1979). The affective bond may allow professionals to exert social power to influence patient behaviours (Safran and Segal, 1996). The second model, the emotional climate is defined as the caregiver's 'expressed emotion'; criticism, hostility and emotional over-involvement towards the patient (King and Dixon, 1996). Professionals with high expressed emotion are described as less tolerant, less warm, and exhibit low expectations of outcome (Moore and Kuipers, 1992; Van Humbeek et al., 2001). Such professional expectancies may directly influence patient outcome (Social Exclusion Unit, 2004; Stanhope and Solomon, 2007), as other people's expectations provoke concordant goal-directed behaviours, even in the absence of conscious awareness of such expectations (Rosenthal et al., 1974; Safran and Segal, 1996). Professionals' positive outcome expectancies were found to predict patient employment over the subsequent two years in a chronic psychosis sample (O'Connell and Stein, 2011), but not yet known whether this would translate to social and broad occupational outcomes for young people.

1.3. Hopefulness

In addition to relational and professional influences, patients' own hopefulness may facilitate their social inclusion and vocational activity (Jacobson and Greenley, 2001; Pitt et al., 2007; Slade, 2009). Theory suggests that hopefulness is comprised of agency (the 'will') and pathways (the 'ways') towards a goal, with high hope motivating and sustaining goal-directed action (Snyder, 2000). Snyder (2000) identified a hierarchy of hopefulness; in which global dispositional hope (a general trait) underlies state (moment-by-moment) hope and domain-specific hope (hope in different life areas). The greater studied global dispositional hope may, however, be less relevant here as it represents more a 'possibility of hopefulness'; whereas domain-specific hope represents actual perceived ability and means to achieve goals in life areas (e.g. social, leisure) relevant to social inclusion and vocational activity (Snyder et al., 2002).

Positive relationships with significant others and social contacts may inspire hopefulness in recovery (Spaniol et al., 2002). Service users have

also suggested that interactions with professionals can engender (or hinder) their hopefulness (Ruscinova, 1999; SEU, 2004; Tooth et al., 2003). Emerging evidence suggests that a positive therapeutic relationship in more 'chronic' psychosis predicts improvements in global trait hopefulness (Hicks et al., 2012). Furthermore, a cross-sectional association between a positive therapeutic relationship and social functioning was found to be mediated by self-efficacy for 400 young people with psychosis (Melau et al., 2015). Therefore, therapeutic relationship represents a potentially important facilitator of the personal recovery relevant outcome of social inclusion and the more traditional outcome of vocational activity. The current research explores whether the therapeutic relationship has direct association with social inclusion, and an indirect association through domain-specific hopefulness, for young people experiencing psychosis. Domain-specific hopefulness, which reflects hopefulness in social and occupational life areas, is of particular interest due to theoretical links with social and occupational outcomes. The therapeutic relationship is defined for present purposes as both the presence of a positive working alliance and the presence of a positive emotional climate.

1.4. Aims of the study

The objective of the study was to test the hypotheses that the therapeutic relationship and professional expectancy predict patient social inclusion and vocational outcomes, and that this association is mediated by patient hopefulness.

2. Methods

2.1. Participants and procedure

Young people with psychosis and their main mental health professional participated. Patients were 18 to 36 years old with a primary diagnosis of first episode psychosis, schizophrenia, schizoaffective disorder, schizophreniform disorder, or delusional disorder, recruited from Early Intervention in Psychosis and adult Community Mental Health services. The main professional was the care co-ordinator unless the care co-ordinator and/or patient reported greater current contact with a different professional. Dyads had a prior working relationship of three or more months to ensure the therapeutic relationship had developed prior to measurement (Gumley, 2007; Neale and Rosenheck, 1995).

Separate face-to-face assessments in NHS or community locations were conducted at baseline within two weeks for patient and professional. Professionals completed measures (outcome expectancies, therapeutic optimism, therapeutic relationship) at baseline only. Professionals rated their general outcome expectancy (Case Manager Expectancy Inventory (O'Connell, 2000)), before rating the specific therapeutic relationship with the identified patient, in order to limit potential bias from reflecting on a specific patient. Patients completed measures of the therapeutic relationship at baseline. Consistent with hypotheses, young people were followed up longitudinally 5 months later with measures of hopefulness and social inclusion. Vocational activity (one item) was recorded at both time-points.

Potential covariates also measured included patients' clinical symptoms and neurocognitive impairment, which have some association with therapeutic relationships (Johansen et al., 2013) and social and vocational outcomes (Allott et al., 2011; Milev et al., 2005) in early psychosis. Neurocognitive impairment was captured at baseline only due to its predicted stability over the follow-up period. Clinical symptoms were captured at both baseline and follow-up. Neurocognitive impairment and clinical symptom measures were conducted and rated by the first author following training and supervision from the second author and an additional independent experienced research psychologist to ensure concordance.

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