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Therapeutic alliance in vocational rehabilitation

Abstract

The chapter begins by providing a brief description of the components thought to be important in the therapeutic relationship and in developing a strong therapeutic or working alliance. Many decades of research have established that a good therapeutic alliance is related to better treatment outcomes for people engaged in psychotherapy. However, there has been relatively little of this research which has focused on individuals with severe mental illnesses such as schizophrenia. A brief review of these studies indicates 'promising' findings with regard to the link between therapeutic alliance and more positive treatment outcomes, but it is argued that a strength-based emphasis in treatment may be particularly important for those with severe mental illnesses. A detailed review is then provided of the research related specifically to the role of therapeutic alliance in vocational rehabilitation contexts. Given the relatively small number of studies focusing on vocational outcomes, this starts with a review of four studies comprising individuals with traumatic brain injury and is followed by a description of the two studies that used participants with mental illness. Again, the data are promising and together suggest a positive relationship between stronger therapeutic alliance and a range of more positive vocational outcomes. This is followed by a description of the main measures used to assess therapeutic alliance and an overview of the key components thought to strengthen the alliance. Finally, the chapter finishes with a section describing how to therapeutically manage difficulties in the alliance. These are described as 'strains and ruptures', and the chapter concludes with strategies for identifying and resolving these fluctuations in the quality and strength of the therapeutic alliance.

Keywords

vocational, rehabilitation, alliance, therapeutic

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

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Chapter 7

THERAPEUTIC ALLIANCE IN VOCATIONAL REHABILITATION

Frank P. Deane, Trevor P. Crowe and Lindsay G. Oades

Chapter overview

The chapter begins by providing a brief description of the components thought to be important in the therapeutic relationship and in developing a strong therapeutic or working alliance. Many decades of research have established that a good therapeutic alliance is related to better treatment outcomes for people engaged in psychotherapy. However, there has been relatively little of this research which has focused on individuals with severe mental illnesses such as schizophrenia. A brief review of these studies indicates 'promising' findings with regard to the link between therapeutic alliance and more positive treatment outcomes, but it is argued that a strength-based emphasis in treatment may be particularly important for those with severe mental illnesses. A detailed review is then provided of the research related specifically to the role of therapeutic alliance in vocational rehabilitation contexts. Given the relatively small number of studies focusing on vocational outcomes, this starts with a review of four studies comprising individuals with traumatic brain injury and is followed by a description of the two studies that used participants with mental illness. Again, the data are promising and together suggest a positive relationship between stronger therapeutic alliance and a range of more positive vocational outcomes. This is followed by a description of the main measures used to assess therapeutic alliance and an overview of the key components thought to strengthen the alliance. Finally, the chapter finishes with a section describing how to therapeutically manage difficulties in the alliance. These are described as 'strains and ruptures', and the chapter concludes with strategies for identifying and resolving these fluctuations in the quality and strength of the therapeutic alliance.

Components of therapeutic relationship

Rogers (1957) suggested that therapists require the personal qualities of accurate empathy, non-possessive warmth and unconditional acceptance, and genuineness to establish a quality therapeutic relationship. It was thought that this therapeutic relationship would in turn facilitate a positive change. This

conceptualisation of these relationship factors was broadly thought to constitute what is known as 'bond' in therapy and each of these elements are briefly described below.

Accurate empathy

There is some debate regarding the meaning of accurate empathy, but it is essentially a cognitive and affective state that involves recognising and engaging with the client's affect or cognition and reflecting this back to them from moment to moment (Duan & Hill, 1996). Thus, a counsellor needs to be able to imagine or understand the client's experience and then to accurately reflect this back. This reflection could be a verbal statement or affective (emotional) response. Accurate empathy involves listening carefully to what clients say, how they say it and being aware of the nonverbal information that might also help understand their experience. Trying to imagine or understand someone else's experience can be difficult. While practitioners can draw on their own reactions in similar circumstances in order to get a sense of a client's view, they cannot presume that their experiences and reactions are the same as those of their clients. In this respect, they need to remain open to different perspectives.

Non-possessive warmth and unconditional acceptance

Non-possessive warmth refers to caring, respect, support and valuing the client without attempting to control them (Todd & Bohart, 1994). Part of this stance is accepting and respecting the client's autonomy. Unconditional acceptance refers to the ability to listen and respond to others without being judgemental or disapproving.

Genuineness

Genuineness refers to the ability of a clinician to be honest, open and authentic in his or her interactions with clients. Genuineness is reflected in the consistency between how a person acts and how they think and feel (Todd & Bohart, 1994).

Empathy, warmth, acceptance and genuineness are generally considered important clinician characteristics for the development of a good therapeutic relationship. However, the client-therapist working relationship involves reciprocity and this is captured in the broader term *therapeutic alliance*.

Therapeutic alliance

Therapeutic or working alliance is a more specific term that was described by Bordin (1979) as comprising a mutual understanding and an agreement about goals, an agreement on the necessary tasks to move toward these goals and the

establishment of a bond between the partners involved in the work (typically the health care provider and the client). Tasks are distinguished from goals in that they involve specific activities that are undertaken either during the session or out of session to facilitate change. They can also be proposals for client action such as between session homework activities such as 'making a telephone call to prospective employers' or 'writing out a list of strengths that might be attractive to prospective employers'. Negotiation between counsellor and client around goals and tasks is considered integral to building alliance (Bordin, 1994). Bond in the therapeutic relationship is consistent with the core characteristics described by Rogers (1957), and Bordin (1994) described this as 'expressed and felt in terms of liking, trusting, respect for each other' and 'a sense of common commitment and shared understanding in the activity' (p. 16). The bond in the therapeutic relationship is often considered the 'glue' that helps maintain the partnership through what can be difficult and challenging personal demands on clients and therapists in therapy over time. To summarise, the following characteristics have been suggested as common components of therapeutic alliance: the client's positive affective relationship with the therapist, the client's capacity to purposefully work in therapy, the therapist's empathic understanding and involvement and the client-therapist agreement on the goals and tasks of therapy (Gaston, 1990).

Therapeutic alliance and treatment outcomes

There is a substantial body of evidence to support the role of therapeutic alliance factors in treatment outcome. However, relatively little of this research has been with clients with severe mental illness and as we will see in the next section, even less of this has been completed in the context of vocational rehabilitation.

A meta-analytic review of 79 studies over an 18-year span found a minority of studies (23%) included more severely disordered clients (i.e. psychotic or severe personality disorders) (Martin et al., 2000). The meta-analysis found a moderate positive relationship between therapeutic alliance and outcome (overall weighted correlation of .22). No other moderator variables influenced the alliance-outcome relationship, which is consistent with the hypothesis that the alliance is therapeutic, in and of itself, and regardless of other psychological interventions (Martin et al., 2000).

Research on the role and impact of therapeutic alliance in working with individuals with chronic and recurring psychotic mental illnesses such as schizophrenia is relatively limited but there has been increasing interest amongst such groups (Couture et al., 2006; McCabe & Priebe, 2004; Priebe & McCabe, 2006).

At a general level, the therapeutic alliance has been found to be related to treatment adherence (including medications) and other outcomes amongst

patients with schizophrenia (e.g. Gehrs & Goering, 1994; Svensson & Hansson, 1999). For example, in a study of clients with non-chronic schizophrenia, it was found that the alliance-predicted medication adherence was negatively related to psychopathology, frequency of positive symptoms and treatment dropout. The alliance also predicted improved social functioning and illness acceptance, and accounted for more outcome variance than social class, intelligence, insight, baseline symptom level, optimism, motivation to change and level of pre-morbid functioning (Frank & Gunderson, 1990).

A descriptive review that focused on studies of alliance outcome in community psychiatry and case management located five studies assessing the relationship in these contexts (Howgego et al., 2003). Most of the clients in these studies had severe mental health problems such as schizophrenia, and the review concluded that there was 'minimal' but 'encouraging' evidence that stronger case manager-client therapeutic relationships resulted in improved outcomes. The authors suggested that this population may require a longer time period to develop a positive alliance and that the social or relationship competence of clients may influence the formation of the alliance. The issue of specific skills to address alliance issues amongst clients with severe mental illnesses such as schizophrenia has also been raised by other authors (e.g. Priebe & McCabe, 2006). Currently, there is little empirical research to support the notion that there are different techniques that might be needed to impact on the therapeutic alliance amongst this group compared to other diagnostic groups. Until such data are available, therapists should endeavour to bring the attributes and skills that promote a strong working alliance in any psychotherapeutic relationship (e.g. Ackerman & Hilsenroth, 2003). However, our experience working with individuals who have severe mental illnesses, which are often of long duration and fluctuating course, does provide us with anecdotal evidence that specific stances in relation to rehabilitation are helpful to the therapeutic relationship. A very common theme amongst people with severe mental illness is the loss of hope that often accompanies many years of struggle with the illness. This is exacerbated by stigma and social exclusion. Consequently, we strongly endorse a strengths-based approach and an emphasis on building hope through exploration of values, clarification of a recovery vision, establishment of goals and specific action plans to achieve these goals.

Importance of strengths-based approaches

In clinical contexts and in general life, it is common for people to focus on problems, weaknesses or deficits. This phenomenon has been referred to as 'bad is stronger than good' (Baumeister et al., 2001). Vocational rehabilitation is no exception in this regard. If problems and deficits are the sole focus, this is likely to impact on the rehabilitation alliance, eroding confidence and

self-belief, and thus leading the person to a form of 'contraction' or withdrawal. Focusing on strengths, however, can help the person build confidence and hope, buffer against being overwhelmed in the face of challenges and difficulties, and increase their motivation to engage in their rehabilitation and recovery. Confidence and hope are the key pillars of recovery, and if they can be increased by exploring strengths within the working relationship, the relationship itself can be strengthened. This is important as the alliance between the worker and the client can be viewed as the holding framework within which the risk taking of therapeutic work can occur. In this regard the alliance should represent a safe psychological space for the person. Safe places are a fundamental need to support recovery and growth.

Linley and Harrington (2006a) define strength as 'the natural capacity for behaving, thinking or feeling in a way that allows optimal functioning and performance in the pursuit of valued outcomes'. Everybody has strengths and if we are looking for them we will find them. One place to start is to recall memories and feelings associated with achievements or positive actions. It is also important to recognise that strengths are not just talents. They include memories or situations when people have been able to put their core values into action. This allows people to draw on memories when their confidence needs a boost. Strengths can also be social supports, safe and meaningful places and other resources. In effect, strengths are those things that keep the person strong and will often perform a function of confirming the person's preferred identity and desired place within the world.

In terms of building a therapeutic or working relationship with the person, finding common ground to build a conversation is helpful, but exploring the person's strengths, hopes and desires also helps in terms of increasing engagement and ownership of the recovery plan. The rehabilitation relationship in this regard may be conceptualised as a form of 'strengths coaching' (Linley & Harrington, 2006b). The focus remains on human potential and positive consumer attributes. Details of a structured approach to exploring values, establishing a recovery vision, goal and action planning has been elaborated elsewhere as the Collaborative Recovery Model (Clarke et al., 2006; Crowe et al., 2006; Oades et al., 2005). This approach has a strong focus on strengths, which is driven by the belief that the quality of the working relationship is improved by placing it in the context of a focus on client's strengths.

Therapeutic alliance and vocational rehabilitation outcomes

In this section, the few empirical studies of the relationship between therapeutic alliance and vocational rehabilitation outcomes are reviewed in sufficient detail to allow consideration of the strengths, weakness and implications of these studies. Although there have been many studies that have assessed variables that

influence successful employment outcomes, only relatively recently has there been research related to the effects of the relationship between counsellors and clients on outcomes. One of the first studies used data from a telephone-administered questionnaire with 2732 vocational rehabilitation clients from 1999 to 2000 (Lustig et al., 2002). The researchers developed a 9-item 'Working Alliance Survey' guided by Bordin's definition of working alliance (bond, goals, tasks) and expert ratings to refine items. They also included measures of the clients' view of their future employment prospects and satisfaction with their current job if they had one. Slightly more than half of the sample was male (56%) and most respondents were employed (67%). Respondents had a range of primary disabilities, with 33% having chronic medical conditions, 27% ($n = 727$) having psychiatric disorders, 19% mobility and orthopaedic impairments, 11% mental retardation and the remaining 10% visual, hearing or traumatic brain impairment. Comparisons between the employed and unemployed groups revealed that a significantly higher proportion of those in the unemployed group had a psychiatric disability. Comparison of the employed and unemployed groups revealed significantly weaker working alliance in the unemployed group compared to the employed group (effect size of $d = .73$). Stronger working alliance was associated with higher levels of satisfaction with the current job ($r = .15, p < .001$). For both employed and unemployed groups, working alliance was also significantly correlated with clients' views of future employment prospects ($r = .51$ and $.52$ respectively). The authors concluded that 'rehabilitation counselors may be able to improve outcomes by facilitating a strong working alliance with their clients' (Lustig et al., 2002, p. 30). However, there were several limitations to the study that suggested caution with this conclusion. First, in the context of the current chapter, only 27% of the sample had a psychiatric disability as their primary disability. Second, contact was attempted with over 10 000 clients, and only 46% were able to be contacted and completed the questionnaires. Of this 46%, only 57% of the completed questionnaires were useable (e.g. due to missing data). It is unclear to what extent these selection issues biased the sample. The measure of therapeutic alliance was developed by the authors but has very limited reliability and validity data. Finally, the data are cross-sectional and predominantly correlational, which prevents any causal conclusions being drawn. For example, it is possible that those who find employment retrospectively view the therapeutic relationship more positively because they are employed. Still, this study establishes that there is some relationship between therapeutic alliance and employment outcomes.

Therapeutic alliance and rehabilitation for traumatic brain injury

Several studies with adults who were receiving rehabilitation for traumatic brain injury also provide relevant data regarding the role of therapeutic alliance on vocational outcomes. A subsequent study to Lustig et al. (2002) used the same

recently has there been between counsellors and clients from a telephone-based sample of 9-item 'Working alliance (bond, included measures of satisfaction with the sample was Respondents had medical conditions, and orthopaedic % visual, hearing employed and un- of those in the of the employed g alliance in the size of $d = .73$). satisfaction with employed groups, views of future thors concluded es by facilitating 2, p. 30). How- caution with this % of the sample contact was at- e contacted and completed ques- to what extent eputic alliance d validity data. ational, which s possible that ic relationship shes that there ent outcomes.

telephone interview method and assessed working alliance and vocational rehabilitation outcomes amongst 49 adult clients who had traumatic brain injury (Lustig et al., 2003). Slightly more than half (53%) were unemployed and most of the sample were male (63%). Those in the employed group had significantly stronger working alliance (9-item Working Alliance Survey) compared to the unemployed group. For the employed clients only, working alliance was significantly correlated with their view of their future employment prospects ($r = .49$) but not with current job satisfaction. For unemployed clients, stronger working alliance was associated with a more positive view of future employment prospects ($r = .51$). Overall, this study supported the earlier findings by Lustig et al. (2002), confirming the relationship between client's perceptions of working alliance with their vocational counsellor and more optimistic views of future employment. However, it also suffered the same limitations as the earlier study.

Other research teams have provided further evidence for the link between working alliance and subsequent employment (Schonberger et al., 2006b). Participants were 98 adult patients undergoing post-acute neuropsychological rehabilitation in a brain injury programme in Copenhagen. During the programme, two expert raters (neuropsychologist and physiotherapist) judged working alliance using four items adapted for the study. The items assessed the percentage of client attendance, quality of verbal agreement between therapist and client as to the course of action, client appreciation of accomplishments and services, and client engagement. Clients received a dichotomous working alliance rating based on these four elements and were categorised as having 'poor or fair' or 'good or excellent' alliance. Follow-up of the clients occurred between 2 months and 3 years after programme completion ($M = 16$ months). At this time, occupational status was determined and unemployed clients were compared to those who had some form of competitive or voluntary work.

The percentage of clients rated as having 'good or excellent' alliance was 59 and 46% for each of the two raters. Both raters agreed that 35% of clients had good or excellent alliance and 30% had poor or fair alliance. For both raters a significantly higher proportion of clients who were employed had 'good/excellent' alliance compared to those who were unemployed. The raters' working alliance ratings were significantly related to employment at follow-up. Limitations of the study included the measure of working alliance which was not clearly consistent with or explicitly derived from models of alliance (e.g. Bordin). There was also low interrater agreement and internal consistency on the alliance measure. Further, the authors noted that alliance ratings were completed retrospectively, so that raters' knowledge of client's outcomes may have biased their ratings (Schonberger et al., 2006b).

Schonberger et al. (2006a) subsequently addressed most of these limitations by collecting alliance ratings prospectively in a sample of 86 clients attending a brain injury rehabilitation programme. The short form of the Working Alliance

Inventory (WAI; Tracey & Kokotovic, 1989) was completed by both clients and therapists at 2, 6, 10 and 14 weeks into the programme and then again at the end of the programme. It was found that task, bond and the total WAI score for therapist ratings significantly improved over time. However, there were no significant changes over time on the client-completed alliance ratings, although clients did rate the therapeutic alliance more positively on all scales and at all time points compared to therapist ratings. Overall, clients and therapists ratings were 'weak-to-moderate' on the total WAI scale (r 's ranged from .19 at Time 1 to .45 at Time 4). In general, agreement between client and therapist regarding the strength of the alliance increased over the course of treatment and they tended to converge over time. The authors also hypothesised that a good therapeutic alliance would help increase client's awareness of the impact of their brain injury on their lives (including 'working life'). It was found that the WAI Bond scale was significantly positively correlated with awareness ($r = .28$). The authors concluded:

The basis of successful work is that the patients experience a good working relationship, including good emotional bond, with their therapist. This is both true for psychotherapeutic work and for cognitive and physical training, because therapeutic success is dependent on patients' engagement and patients' compliance is affected by their experience of a good working alliance and their awareness (p. 453).

A further study of clients with traumatic brain injury attending a rehabilitation programme also assessed alliance, awareness and 'productivity' status (Sherer et al., 2007). The sample comprised 69 clients who were mostly young ($M = 29$ years), male (62%) and had received their injuries following a motor vehicle collision (79%). The California Psychotherapy Alliance Scales (CALPAS; Gaston & Marmar, 1994) was used to assess therapeutic alliance from client, family and clinician perspectives. Similarly, the ratings of awareness were also taken from these three perspectives. Clients were also rated as productive or non-productive at discharge. Those who returned to work or school or were functioning independently as a 'homemaker' were designated as productive, with all others categorised as non-productive. Sixty-two percent were considered productive. Productivity status was predicted by both client and family ratings of therapeutic alliance. However, the direction of this relationship was different for client and family ratings. Stronger family ratings of alliance were associated with a greater likelihood of being in the productive group, whereas higher patient perceptions of therapeutic alliance [were found] to be associated with greater odds of a poor productivity outcome' (p.669). Similarly, stronger therapeutic alliance as rated by clients was associated with greater dropout from the programme. The study failed to find any association between awareness and therapeutic alliance. It was thought that this and the

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paradoxical finding that higher client ratings of alliance were associated with both higher dropout and poorer productivity may have been due to measures being taken early in treatment (within 2 weeks). It was argued that clients' perceptions of alliance may be more inaccurate early in treatment because there had not been sufficient time to establish a bond and to clarify the goals and tasks that would form part of the treatment and the alliance. However, the study did highlight that family members' early perceptions of therapeutic alliance may be important for longer-term outcomes.

Therapeutic alliance and rehabilitation for severe mental illness

There have been two studies conducted that look at the role of working alliance on vocational outcomes amongst people with severe mental illness. In the first, 305 people with severe mental illness who had received rehabilitation services were contacted by telephone and classified as either employed (36%) or unemployed (64%) (Donnell et al., 2004). They completed the 9-item Working Alliance Survey (as in Lustig et al., 2002, above). Those who were employed provided significantly stronger ratings of therapeutic alliance than those who were unemployed. In both the employed and unemployed groups, working alliance was significantly correlated with their view of future employment prospects ($r = .70$ and $r = .54$ respectively). Employed clients' ratings of alliance were significantly related to their current job satisfaction ($r = .23$), albeit of only modest magnitude. As with their prior study a major limitation of the survey was the measure of therapeutic alliance, which has very limited reliability and validity data.

In a relatively small study involving 26 participants diagnosed with schizophrenia ($n = 12$) or schizoaffective disorder ($n = 14$), the researchers aimed to determine whether therapeutic alliance formed in individual counselling midway through a 26-week vocational rehabilitation programme was related to current and subsequent ratings of work performance (Davis & Lysaker, 2007). Participants were all considered in a stable phase of their illness, with no recent hospitalisations or changes in housing or medications. The observer-rated 12-item version of the WAI was used and multiple blind-raters scored 10 cases in the current study and produced an intraclass correlation of .87, suggesting satisfactory interrater reliability. The Work Behaviour Inventory (WBI; Bryson et al., 1997) was used and involved trained raters directly observing participants' work behaviour and interviews with supervisors. The WBI was completed during Weeks 1, 11 and 23 of work. Satisfactory interrater reliability was found in the study, with intraclass correlations over .82. The type of work was described as involving between 10 and 20 regular hours of work per week in 'entry-level' positions (e.g. housekeeping, medical administration). In the vocational rehabilitation programme, all participants received group or cognitively based individual counselling once a week. The individual counselling

sessions focused on dysfunctional beliefs about work and were videotaped to allow for subsequent observer ratings. Using a median split of WAI scores, participants were allocated to a high ($n = 13$) and low ($n = 13$) alliance group. There were no differences between these groups on a range of demographic or symptom-orientated measures. However, there were significant differences between the high and low alliance groups for all five subscales of the WBI. There was a significant improvement for the whole sample on Work Quality and Personal Presentation over time (Weeks 1, 11, 23). However, most notable was a group (high/low alliance) by time interaction, which suggested that those in the high alliance group had higher Work Quality and Cooperativeness scores than the low alliance group at week 23. 'The higher alliance group showed a steady increase over time while the lower alliance group showed initial improvement followed by a decline' (Davis & Lysaker, 2007, p. 355). Although the findings from this study suggest a relationship between alliance and work performance, there are a number of limitations that also need to be considered. The stage of counselling for the assessment of alliance was not clear (i.e. which sessions); the use of median splits to allocate to alliance groups does not have a strong rationale; and the sample was small. Finally, as with other studies assessing alliance and vocational outcomes, the study design does not allow for any conclusions regarding causality.

Summary

There are very few studies that assess the relationship between therapeutic alliance and vocational outcomes in individuals with severe mental illness. However, there are several studies involving people with brain injury which provide additional supporting data. Together these studies suggest a positive relationship between stronger therapeutic alliance and a range of more positive vocational outcomes. Now, there is clearly a need for more longitudinal or experimental designs in more diverse work contexts to allow more causal conclusions to be drawn. There is also a need to clarify the mechanisms and potential mediators of the relationship between alliance and vocational outcomes. For example, does better alliance lead to greater motivation and better compliance with treatment programmes, which in turn lead to better work performance? Or does better work performance occur because a positive alliance models the kinds of work relationships that an individual will experience in the workplace? Until there is clarification of these issues, counsellors should be attentive to the alliance and work to enhance it in counselling contexts. In the future, better understanding the role of alliance in vocational rehabilitation contexts may allow for more specific therapeutic interventions to strengthen the alliance.

Assessment of therapeutic alliance

Although the causal direction of this relationship still requires clarification, preliminary evidence suggests that alliance improves over the course of treatment and this ultimately has an impact on how well people do in treatment and their subsequent success with regard to productive activities and employment. Although several mediating and moderating variables in the alliance–employment relationship have been proposed, these have not been well established. However, there is sufficient evidence to suggest that formally assessing and monitoring the development of the therapeutic alliance over treatment may be useful. This would allow clinicians to check for discrepancies in client, family and/or their own perceptions of the alliance over time. Where there are discrepancies or where views appear to be diverging over time, specific strategies can be implemented. For example, if Client = Family < Therapist, this suggests that the client and family both think the alliance is not as strong as does the therapist. Thus, the therapist may need to rethink his or her views of how things are going and work with both the client and the family to clarify why view of the alliance is weaker. This allows the therapist to review the various elements of the alliance to determine whether it is the bond or a lack of clarity and agreement about goals and tasks in treatment. If the following discrepancy was present, Client < Family = Therapist, then it may be that clarification with the client is needed and the family's congruent views of the alliance with the therapist may mean that they can be helpful in this process. We would argue that measures of alliance should be taken on multiple occasions throughout the course of counselling in order to monitor the development of alliance from multiple perspectives. There are several measures that are likely to have utility in practice.

Probably the two most widely used measures are the WAI (Horvath & Greenberg, 1989) and the CALPAS (Marmar et al., 1989). Both measures have client-, therapist- and observer-rated versions. The WAI has 36 items rated on a 7-point Likert-type scale with subscales that assess bond, task and goals. There is also a shorter 12-item version (Tracey & Kokotovic, 1989). The CALPAS has 30 items and factor analysis has confirmed four factors although the questions are described as mostly reflecting 'purposive mutual work' between the patient and the therapist (Elvins & Green, 2008). A recent review indicated that both were 'well triangulated' with other measures and had good validity data (see Elvins & Green, 2008).

These scales have been adopted from psychotherapy research, and it has been argued that there are important differences between psychotherapy contexts and psychiatric settings that work with individuals with severe and enduring mental illnesses such as schizophrenia (e.g. Elvins & Green, 2008; Priebe & McCabe, 2006). This led to the development of the Scale for the Assessment

of Therapeutic Relationships (STAR; McGuire-Snieckus et al., 2007), which focuses on goal and bond aspects of the alliance for people with severe mental illnesses in community mental health settings. The measure comprises 12 items and has both client and clinician scales, but no observer version. However, it is a relatively new measure with limited validity data so far. It is contended that measures specific to these problems and contexts are needed because clients with psychosis have unique symptoms that may affect the therapeutic relationship. For example, it has been argued that clients with psychosis may be more difficult to engage and specific skills to improve communication may be needed (Priebe & McCabe, 2006). Similarly, we have argued that there is a need to emphasise strengths and hope, given that prior life and treatment experiences have often been discouraging for people with long-term, recurring mental illness.

In some studies of alliance in relation to vocational outcomes, family perceptions of the individual patient and therapist relationship were also taken using the CALPAS (e.g. Sherer et al., 2007). Although there are family therapy alliance scales available (e.g. Friedlander et al., 2006) in the context of vocational rehabilitation counselling, these are not likely to be used unless the family is involved in therapy.

Attributes and skills to improve the therapeutic alliance

Ackerman and Hilsenroth (2003) conducted a qualitative review of therapist characteristics (11 studies) and in session activities (16 studies) that were associated with improved therapeutic alliance across a wide range of psychotherapy approaches and settings. Therapist attributes that were found to be related to positive alliance included conveying a sense of being trustworthy, experienced, honest, flexible respectful, confident, interested, alert, friendly, warm and open. It was proposed that these attributes lead to a stronger alliance, which in turn improves outcome. The process was described as 'A benevolent connection between the patient and therapist helps create a warm, accepting, and supportive therapeutic climate that may increase the opportunity for greater patient change' (Ackerman & Hilsenroth, 2003, p. 7). It was further suggested that the client's belief that the treatment relationship is a collaborative effort with the therapist in turn leads to greater investment in the process.

The technique factors found to contribute positively to alliance were exploration, depth, reflection, supportive, active, affirming and conveying understanding. In addition, alliance was related to noting past therapy success, how much they attended to the patient's experience and facilitated expression of affect (Ackerman & Hilsenroth, 2003). The amount of interpretive technique used by therapists was also found to be related to alliance in two studies, but this may be of less utility in vocational rehabilitation contexts. As can be seen,

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many of these attributes and skills are closely linked to empathy (e.g. warmth and understanding) and other components of the therapeutic relationship proposed by Rogers (1957). Ackerman and Hilsenroth observed that many of the therapist attribute and technique factors associated with positive alliance were also useful in the identification and repair of ruptures to the alliance.

Managing difficulties in the alliance: strains and ruptures

The importance of managing the alliance should not be overlooked. As relationships in general require work to keep them healthy and functional, so too the working alliance is prone to setbacks and challenging periods. There are numerous factors and events that can contribute to a strain in the alliance, or more seriously what is known as an alliance rupture. Signs of problems emerging in the alliance may vary from one or both parties losing motivation through to significant interpersonal conflict. Safran and colleagues suggest that alliance strains and ruptures are common and perhaps should be expected, but if managed well can represent potent change events (e.g. Safran et al., 1990; Safran & Muran, 1996).

It is important to bear in mind that the working relationship (alliance) is not just about being supportive and agreeing upon goals and tasks. It is embedded within the broader landscape of human experience and relationship dimensions (e.g. transference, authentic person-to-person relationship, modelling). This being the case, many of the factors that influence the establishment of, and fluctuations in, the alliance often emanate from ongoing, perhaps unresolved, interpersonal patterns and existential factors (e.g. identity, safety, personal power, place in the world). Although the working relationship within the context of vocational rehabilitation may not aim to address these contextual factors directly, it is a mistake to fail to utilise some basic principles and strategies to keep the person moving forward, supported by an effective alliance. It is also a mistake for workers to fail to address the part they may play in impeding the establishment of a working alliance and/or contributing to alliance strains and ruptures.

Repeating relationship patterns

Each of us has developed patterns of relating associated with our life experiences. The alliance is influenced by the quality of both current and past interpersonal relationships, and the client's relationship style has an effect on therapeutic expectations from both client and worker (Hersoug et al., 2002). For example, clients with an 'under-involved' interpersonal style tend to have poorer alliance and treatment outcomes (Hardy et al., 2001). However, it is not the client's relationship patterns/style alone that explains these poorer

outcomes. Rather, difficult client relational style is more likely to elicit negative responses from the worker (Klee et al., 1990). In the under-involved example, the worker may conclude that the client is unmotivated and decide to put more of his or her energy into working with clients who may indicate greater desire for her or his support. Furthermore, the worker's relationship style can similarly elicit positive or negative responses from the client. For example, under-involved workers may demotivate clients, and a paternalistic relationship pattern may elicit a submissive or resistant response from the client. Worker gender differences have also been noted when working with people with psychosis problems and high-relapse-risk clients. Specifically, male workers may act like under-involved fathers and show little commitment to these clients and perhaps express criticism of these clients, while female workers may feel rejected and seek more connection (Stark, 1994; Stark et al., 1992; Stark & Siol, 1994). As found in 'expressed emotion' research, these patterns of relating can have negative impacts on client progress (e.g. Ball et al., 1992; Van Humbeeck et al., 2001).

Working with strains or ruptures in the alliance

Strains in the alliance can be viewed as motivational fluctuations related to the type of interactions occurring between the worker and the client. Although strains or mild tensions are parts of most relationships from time to time, if unchecked these strains could develop into more severe relationship ruptures. Alliance 'ruptures' usually indicate that the client (and/or perhaps the worker) is at best ambivalent about wanting to continue working with this person, or worse is actively seeking ways to terminate the relationship either confrontationally or through emotional and/or physical withdrawal (Safran et al., 1990; Safran & Muran, 1996). Typical features of alliance ruptures are common; interactional phenomenon; consist of both client and worker contributions; and vary in intensity, duration and frequency (Safran & Muran, 1996).

The measure of a skilled worker is in his or her ability to monitor and subtly intervene in negative fluctuations in the alliance as early as possible without creating more unnecessary strain (Safran et al., 1990). As relational strains and ruptures are associated with the types of perceived interactions that occur between the worker and the client, being prepared to examine these interactions is essential for managing the relationship. However, this requires some judgement in terms of identifying the source of the strain or rupture in a non-attached way. For example, a rupture might be related to the worker drifting into a paternalistic or aloof way of relating to the client, with the client reacting by not attending planned meetings or not following through with planned activities. Alternatively, a rupture might be related to the client having unresolved relationship dynamics from a previous relationship and subconsciously bring this into the current relationship (e.g. the client carrying trauma related to previous

breaches of trust). In this case the worker needs to explore the possible triggers for such a rupture and try to help the client stay in the present, dealing with current needs and discerning the present relationship from past relationships. In fact in both cases the way to work towards resolving the rupture is to bring the focus of the interaction back onto the interaction itself and taking responsibility for personal contributions to the rupture.

Safran et al. (1990) suggested six strategies to resolve alliance ruptures:

1. Directly discussing the current relationship dynamics and experiences
2. Working to increase awareness of alliance rupture indicators and a sensitivity to changes in the dynamics of the relationship
3. Tracking your own feelings as a signifier of relational change and also as a method of keeping track of what one might be bringing into the working relationship (e.g. one's own emotional refuse)
4. Taking responsibility for one's own contribution to the rupture
5. Working to understand or empathise with the client's experience
6. Practicing being mindful of the relational dynamics in a non-attached way (i.e. being a participant observer – reflection without being caught in automatic reactions)

For many clients, successfully working through relational strains and ruptures might be novel. It can often be a positive experience for clients to work with a worker who is committed to finding a resolution to the relationship difficulties, rather than declining into criticism or withdrawal. The working through of such strains can reinforce the normality of relationship fluctuations and demonstrate that relationship difficulties can be repaired. It has been shown that clients have better outcomes when workers deal with interpersonal conflict directly (Foreman & Marmar, 1985).

Although some clients may find it difficult to stay with the explorative and at times perhaps confrontational aspects of resolving ruptures, the creation of safe physical and psychological spaces to do the work is important. Easing forward initially by gentle probing and clarification rather than going directly to the immediate interpersonal dynamics might help with the re-establishment of safety, the holding frame within which the more difficult work can be done. An example of this might be a gentle reflection or sharing an observation about the changes in the interaction during the sessions (e.g. 'maybe it is just me but you seem to have less to say in our sessions lately'). Further probes might aim to clarify current and recent thoughts and feelings and other life events and experiences in the person's life that could be impacting upon the working relationship. A gentle way of exploring the relationship and examining one's own potential contribution to the strain or rupture can take the form of a reflective self-disclosure (e.g. 'I'm wondering if I may have disappointed you by something I said or did, or didn't say or do. I've been thinking that

not being able to get into the course you wanted two weeks ago would have been quite a big deal for you and I don't think I really let you know that I recognised your disappointment with this.'). The client's feelings about the working relationship might also be assessed by exploring how he or she is feeling about working together at the moment, the progress that is being made, what he or she thinks might help improve things, and so on. This line of questioning can also help reinforce the collaborative nature of the relationship and help the client reclaim some of his or her personal power, the loss of which may have been a contributor to the strain or rupture.

Conclusions

There is considerable research in the broad area of psychosocial interventions for mental health problems that indicate a strong therapeutic alliance independently contributes to improved treatment outcomes. There is growing evidence that these effects are also present and important to vocational rehabilitation outcomes. At present it is unclear whether specific strategies that strengthen alliance are necessary for working with individuals who have severe mental illnesses such as schizophrenia, or whether there are specific strategies that are more important in vocational rehabilitation contexts. Thus, the general characteristics and guidelines for assessing, establishing and maintaining a good quality therapeutic alliance are applicable. In addition, a strengths approach that emphasises hopefulness, establishment of a vision for the future, along with specific goals and tasks to achieve this vision is recommended.

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