



Contents lists available at ScienceDirect

## Archives of Psychiatric Nursing

journal homepage: [www.elsevier.com/locate/apnu](http://www.elsevier.com/locate/apnu)

## Therapeutic alliance, relationship building, and communication strategies for the schizophrenia population: An integrative review

Barbara A. Harris<sup>a,\*</sup>, Gina Panozzo<sup>a,b,c</sup><sup>a</sup> DePaul University, United States<sup>b</sup> Benedictine University, United States<sup>c</sup> Chamberlain University, United States

## ARTICLE INFO

## Keywords:

Schizophrenia  
Therapeutic relationship  
Therapeutic alliance

## ABSTRACT

**Background:** Schizophrenia is a chronic mental illness that affects the client, family, and community. Nurses are educated to use the nurse-patient relationship to provide health education and collaborative health decision-making. However, challenges abound for nurses and clients with schizophrenia to effectively utilize the relationship to reach these goals.

**Problem:** There is a lack of evidence-based information to assist nurses to meet the challenges of building effective therapeutic relationships with clients for whom schizophrenia hinders health education and decision-making.

**Purpose:** To examine current research findings on factors that influence therapeutic relationships in psychiatric treatment settings as an initial effort to provide empirically based guidance for psychiatric nurses who seek to better use the relationship to work with the client toward health-related goals.

**Method:** This integrative review of the literature follows Whittemore and Knaff's (2015) method, analyzes 15 studies from multiple databases between the years 2006–2017, and assesses the rigor of each.

**Findings:** Numerous methods are used to assess therapeutic relationships. Few studies included nurses. Provider perception of client symptoms can negatively affect provider assessment of quality of relationship; no such association was found on the part of clients. Providers and clients prioritize client needs differently, with providers influenced by treatment setting demands, but provider-training programs can have a beneficial effect on their relationships.

**Conclusion:** Nurses and nurse educators can use the findings to guide assessment of how perceptions and priorities influence relationships. Findings also provide the foundation for further study of nurses' perceptions of therapeutic relationship, in progress, to yield more detailed information on what nurses and educators need to strengthen therapeutic relationships.

Roughly 3.2 million Americans are diagnosed with schizophrenia (1.2% of the US population) and 100,000 new cases annually (Nemadé & Dombeck, 2009; Schizophrenia Statistics, 2017). Medications, both psychiatric and non-psychiatric, have become more effective over the past several decades. Clients with schizophrenia continue to struggle with symptoms, impacting ability to relate to others in a healthcare setting and receive effective care (Reitan, 2014). Clients diagnosed with schizophrenia can be likely to engage in risky behavior such as smoking, drug and alcohol use, medication noncompliance or other poor lifestyle choices. Risk for cardiovascular disease, diabetes, and obesity increase, ultimately, decreasing lifespan (Glasper, 2016; Tingle, 2012; Tranter, 2013).

The complex health needs of clients with schizophrenia can greatly

impact quality of life, despite better symptom control with recent advances in pharmacology and increased availability of different levels of care. Good quality of life with schizophrenia and comorbid illness requires individualized, interactive, and collaborative care (Frost et al., 2017). Clients themselves, in recent studies, have voiced their desire for more interaction with nurses and other mental healthcare professionals around the life and health issues they face (Gaillard, Shattell, & Thomas, 2009; Shattell et al., 2014).

Psychiatric mental health (PMH) nurses' practice foundation places value on the therapeutic benefits of nurse-patient interaction. They are well equipped to provide collaborative, individualized care in the roles of client advocate, educator, and first-line care provider (Boyd, 2017; Shives, 2002; Videbeck, 2017). However, as the medical model grows

\* Corresponding author.

E-mail address: [barbara.a.harris@depaul.edu](mailto:barbara.a.harris@depaul.edu) (B.A. Harris).

in influence, it poses challenges to therapeutic relationships between nurses and clients with schizophrenia. The nurse-patient relationship has been a unique and valued foundation of psychiatric nursing practice since the 1950s (Perraud, Delaney, Carlson-Sabelli, & Johnson, 2006; Reed & Crawford Shearer, 2006). Today, time constraints, increased tasks, and short inpatient stays can limit the nurse's availability to engage with the client. Aspects of the contemporary nurse's role can hinder trust building, such as having to administer medications against client will for safety reasons (Sheehan & Burns, 2011; Thibeault, 2016).

Nurses looking for guidance to address challenges to effective therapeutic relationships may find little available. Hewitt and Coffey (2005) suggest that the profession increasingly values evidence-based interventions. Phenomena that are more difficult to evaluate empirically are studied less, resulting less generation of knowledge for practice. Such phenomena include the nurse-patient relationship. Farrelly et al. (2015) agree, concluding that there are benefits to therapeutic relationships but these are difficult to achieve in practice settings. They urge the generation of a clearer evidence-base for use of therapeutic relationship. Both Farrelly et al. (2015) and Hewitt and Coffey (2005) found only a small number of studies that contained nurses in their samples and none of the studies were generated by or were about nurses. Silverstein (2006) suggests that increased valuation of evidence-based and quantifiable intervention in nursing practice contributes to this trend so that ultimately, the therapeutic potential of relationship becomes diminished, or even lost.

Nurses in today's mental settings are challenged to find ways to use therapeutic relationship to bring about collaborative health benefits with their clients. A dearth of research and educational resources adds to the challenge. This integrative review of the literature is the first step in a program of study. The ultimate aim is at provide relevant and effective resources to nurses committed to using the therapeutic nurse-patient relationship to produce collaborative health outcomes with their clients with schizophrenia. The purposes of this review are two-fold: 1) to provide a foundation for this program of study and 2) to communicate to practicing nurses and educators the most recent empirical work on factors, both positive and negative, that influence the therapeutic relationship and outcomes among psychiatric care providers, including nurses, and their clients with schizophrenia. The limited amount of nursing-specific research in this area requires that a broader net be cast to include studies with multiple types of providers in the samples. The findings may assist nurses and educators to assess therapeutic relationships, strengthen them for the benefit of their clients, and assess how they teach the relational dimensions of nursing practice. The findings will also be used to guide the development of a survey aimed at eliciting the perspectives of a broad swath of nurses and nurse-educators on the therapeutic nurse-patient relationship in today's healthcare settings. This, in turn, will provide the more targeted data needed to develop educational resources to assist the profession in maximizing the therapeutic relationship potential for clients with schizophrenia.

## Methodology

### Design

An integrative review of the literature was employed because it allows for the simultaneous inclusion of qualitative and quantitative research (Whittmore & Knaf, 2015). This is particularly important when studying phenomena for which empirical data is not well developed and methods of study vary.

### Data and Data Collection

### Sample

This review includes peer reviewed journal articles, written in English, and published within the years 2006–2017. All articles are

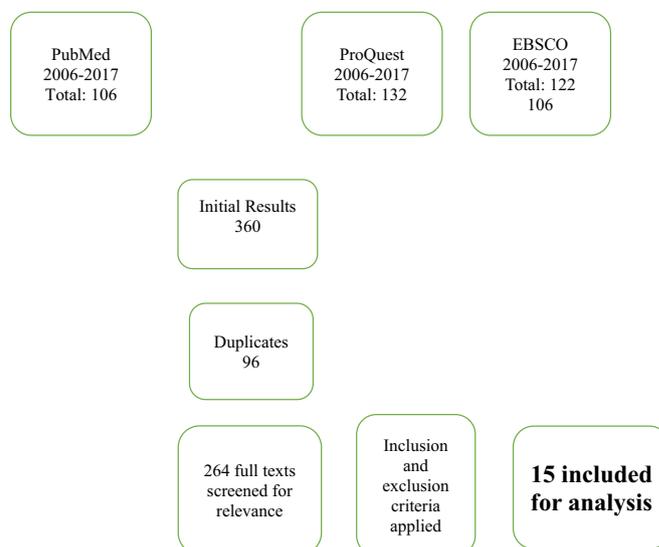


Fig. 1. Search methodology.

Search terms: schizophrenia and communication, therapeutic alliance and communication, Peplau's Theory of Interpersonal Relations and Schizophrenia, Peplau's Theory of Interpersonal Relations and schizo\*, schizophrenia and nurs\*, patient-centered communication and schizophrenia, schizophrenia and communication, therapeutic alliance and communication, patient centered communication and schizophrenia, therapeutic relationship and nurs\*.

reports of original research focused on communication and therapeutic relationship between professional providers and clients with schizophrenia or psychotic disorders. Only studies with samples of adults, aged 18 to 65, at least 50% with a diagnosis of schizophrenia, schizoaffective disorder or psychosis were included. Articles that involved any type of mental healthcare providers were included if all other criteria were met.

### Strategies

Databases were searched for relevant literature. Each author performed a separate search of the same databases using the same search criteria and compared findings. When reviewing the results of these searches, duplicate articles were excluded. Secondary sources were used only for the discussion of results. Ancestry searching, combing citations of included articles for additional articles, was also employed and yielded one additional article, for a total of 15 articles. See Fig. 1.

### Data Analysis

Once the data search was completed, data were placed in a grid in order to organize and facilitate analysis. Within this grid, studies were also assessed and scored for rigor, using a three-point scale with criteria (poor, fair, and good) delineated by Crawford and Rondinelli (2013) for both qualitative and quantitative studies, and originally developed by Polit and Beck (2004). The rigor criteria for both quantitative and qualitative studies address methodological soundness, sample size, and appropriateness of method. Qualitative rigor focuses on consistency with stated tradition of inquiry, triangulation, and adequate level of abstraction in analysis. For this review, researchers applied the criteria and rated each study separately. Each set of rigor scores were compared and discussed. Those with a rigor score of fair were flagged in the analytic process so that any findings could be considered in the light of the degree of rigor (Whittmore & Knaf, 2015).

Following assessment of rigor, each investigator independently analyzed all selected articles for common findings, questions, implications, gaps, and discontinuities. Following independent analysis, the investigators compared and discussed their findings, with the objective of obtaining consensus. Within that discussion, some themes were modified to encompass related findings, and a list of predominant

**Table 1**  
Sample characteristics.

Article	Country of origin	Sample/Diagnoses	Age range of participants	Setting
Barrowclough et al., 2010	United Kingdom	164 patients and their therapists non-affective psychotic disorder/alcohol or substance use disorder	19–63	Mental health services
Berry et al., 2016	United Kingdom	110 early intervention clients psychosis/schizophrenia without affective component/cannabis misuse/dependence	16–35	In therapy
Cavelti et al., 2016	Switzerland	133 outpatients and their therapists schizophrenia/schizoaffective	18–65	Outpatient center
Easter et al., 2015	United States	56 adults 25 providers with experience with population criminal justice history/high risk for disengagement	18–65	Various: homes, inpatient, community locations (21 agencies)
Farrelly et al., 2015	United Kingdom	50 service users 28 care coordinators 17 psychiatrists Psychotic disorders	Mean age = 64	Four community health settings
Goldsmith et al., 2015	United Kingdom	308 patients Acute first/second episode of non-affective psychosis	21–35	In therapy
Johansen, Iversen, et al., 2013	Norway	42 dyads of patients and their primary psychologist or psychiatrist Schizophrenia	18–65	Outpatient and inpatient
Johansen, Melle, et al., 2013	Norway	42 patients Schizophrenia of no more than 2 years	20–51	Outpatient and inpatient
Kvrgic et al., 2013	Switzerland	156 patients Not in acute or first episode schizophrenia	18–65	Community mental health centers
McCabe et al., 2012	Spain, Netherlands, Switzerland, Sweden, Germany	507 patients 134 providers Schizophrenia	18–65	Multiple community health service centers throughout Europe
McCabe et al., 2016	United Kingdom	97 patients 21 psychiatrists Schizophrenia/schizoaffective disorder	18–65	Outpatient clinics (community mental health centers)
Pitkanen et al., 2008	Finland	35 clients Schizophrenia/schizotypal/delusional disorders	18–65	24-Inpatient settings
Ruchlewska et al., 2016	Netherlands	195 dyads of outpatients and assigned therapist Psychotic/bipolar/major depressive disorder with or without substance abuse	Mean age = 39.6	12 community health centers and three institutions
van Meijel et al., 2009	Netherlands	118 patients 102 caregivers Schizophrenia/related psychotic disorder	Mean age = 37	Outpatient, clinical treatment setting, and group homes or assisted living centers
Wittorf et al., 2010	Germany	100 patients 7 therapists schizophrenia/schizophreniform/schizoaffective/delusional disorder	18–59	In CBT or supportive therapy

themes and unanswered questions was generated. The list guided a second review of the studies in the sample in order to find clarification and evidence to buttress conclusions about initial findings.

## Results

### Overview of Studies

Per the inclusion criteria of this review, at least 50% of the client samples in the studies had a diagnosis of schizophrenia. All clients were adults, with an age range of 18 to 65. Clients were both male and female, with males outnumbering females. See Table 1 for sample characteristics. Healthcare provider participants fell into a wide range of roles, with the majority being either psychiatrists or psychologists. Only two studies included nurses in their samples, with only one authored by nurses (Pitkanen, Hatonen, Kuosmanen, & Valimaki, 2008; van Meijel et al., 2009). The settings where participants were recruited also demonstrate a wide range, with the majority (13 of 15) including outpatients in their samples; only four included inpatients and only one exclusively used inpatient. Countries of origin also spanned a wide range, with 11 countries represented and with the UK and the Netherlands providing the majority of studies. Of note, only one study was from the United States.

### Assessment of Therapeutic Relationship

The studies in this sample used four self-report instruments and qualitative methods to assess quality of relationships (See Table 2). All four instruments were comprised of between five and 36 Likert scale items and all were designed to assess both client and provider appraisals of their therapeutic relationship. Each of the instruments in this sample was developed independently, and while there was limited information available regarding the theoretical foundation of each instrument or the nature of items in the instruments, there are some commonalities among them.

The Working Alliance Inventory (WAI) was the most frequently used instrument in this sample, used in seven studies. The WAI also had the most data on reliability of the scale for different populations, with alphas ranging between 0.69 and 0.94. It should be noted, however, that while there are short and long versions to the WAI, there was no consistent connection between version identified and total number of items. The WAI is the tool that has been most often translated into different languages. However, it contains identical provider and client versions, unlike the Scale to Assess Therapeutic Relationship (STAR) and the Helping Alliance Scale (HAS), which both contain different provider and client versions.

The WAI and STAR each contain three subscales (See Table 2). The WAI subscales focus on appraisal of therapeutic bond and level of agreement between provider and client in regard to tasks and goals and

**Table 2**  
Table of instruments.

Instrument	Description	Article	Reliability/Validity
Working Alliance Inventory (WAI)	Self-report scale that measures therapeutic bond, task agreement, and goal agreement 36-item version Likert scale	<a href="#">Barrowclough et al., 2010</a>	Therapist a = 0.926, client a = 0.849
(WAI-S)	12-item version Likert scale	<a href="#">Ruchlewska et al., 2016</a>	a = 0.94 and 0.92
(WAI-S)	20-item version Likert scale	<a href="#">Berry, Gregg, Lobban, &amp; Barrowclough, 2016</a>	Not provided
Scale to assess the therapeutic relationship	12-item Likert scale	<a href="#">Berry &amp; Greenwood, 2015</a>	a = 0.90
Patient version (STAR-P)	Three subscales: positive collaboration and positive clinician output in both versions, non-supportive input in patient version, emotional difficulties in clinician version	<a href="#">Johansen, Melle, et al., 2013</a>	a = 0.69–0.89
Clinician version (STAR-C)		<a href="#">Johansen, Iversen, et al., 2013</a>	a = 0.69–0.89
Helping Alliance Scale (HAS)	Patient version: 6-item Likert scale	<a href="#">Cavelti et al., 2016</a>	Not provided
HAS-P (patient version)	Clinician version: 5-item Likert scale	<a href="#">Kvrgic et al., 2013</a>	a = 0.71
HAS-C (clinician version)		<a href="#">McCabe et al., 2016</a>	Not provided
Semi-structured interviews	Researcher conducted interviews in the inpatient setting. Patient selected five most important areas of life with definitions. Areas involving QOL were built upon. Patients were willing and able to discuss nursing interventions. Average length of interview = 25 min Caregivers were asked to comment on their experiences of an interaction skills training course, how it affected how they provide care, and the quality of therapeutic alliance Interviews were audiotaped and lasted roughly for 1 h. Two interviewers audio-recorded the interviews, which included questions about starting, engaging in, and disengaging in mental health treatment, relationships with mental health providers, staff, and therapists, best and worst experiences, and criminal justice experience Focus groups and semi-structured interviews conducted that focused on participants' views about the joint crisis plan (JCP) development process, content, use, and impact. Interviews were audio recorded.	<a href="#">Catty et al., 2011</a>	Reliability = 23 Validity = 24 95% CI
Self-report version of the California Therapeutic Alliance Scales (CALPAS)	Self-report Scale used to measure alliance coded from (lowest alliance) to 0 (highest alliance) 21 item-Likert Scale	<a href="#">Pitkanen et al., 2008</a>	N/A
		<a href="#">van Meijel et al., 2009</a>	N/A
		<a href="#">Easter et al., 2015</a>	N/A
		<a href="#">Farrelly et al., 2015</a>	N/A
		<a href="#">Goldsmith et al., 2015</a>	Not provided

are identical in both client and provider versions. The STAR subscales place increased focus on appraisal of collaboration and potential barriers on part of both provider and client, with different items reflecting more specific dimensions of relationship deemed most relevant to each group. There was no information available regarding the differences in client and provider versions in the HAS or the California Therapeutic Alliance Scales (CALPAS) though the HAS client version contains an additional item.

The qualitative studies used broad interview questions to elicit from clients their thoughts about therapeutic relationships with nurses. [Pitkanen et al. \(2008\)](#) identified four themes from their interviews regarding what clients wished to have in therapeutic relationships with providers, which correspond with the subscales in the instruments above, particularly desire for collaboration (See [Table 3](#)). [Easter, Pollock, Pope, Wisdom, and Smith \(2015\)](#) and [Farrelly et al. \(2015\)](#) focused on factors that shape the ways providers and clients see their relationship while [van Meijel et al. \(2009\)](#) used qualitative data to assess client and provider assessments of relationship following a provider training course.

#### Intrapersonal Factors

Few associations between demographic variables and ratings of relationship were identified. [Ruchlewska, Kamperman, van der Gaag, Wierdsma, and Mulder \(2016\)](#) noted the overrepresentation of male gender in their client samples but were unable to account for effect. No studies sought to identify differences between male and female

providers or clients. As noted earlier, the studies in this sample were from 11 different countries, with only one from the United States. While it is possible that country of origin and related cultural factors, as well as the discipline of the providers influenced appraisals of therapeutic relationship, this could not be measured or controlled for in this integrative review.

The major factor that influenced how providers saw their relationships with their clients was the nature of the client's mental illness (See [Table 3](#)). Four studies found increased levels of client insight to be associated with higher provider ratings of relationship ([Johansen, Iversen, Melle, & Hestad, 2013](#); [Kvrgic, Cavelti, Beck, Rusch, & Vauth, 2013](#); [Ruchlewska et al., 2016](#); [Wittorf et al., 2010](#)). [Berry, Gregg, Lobban, and Barrowclough \(2016\)](#) also found that greater cannabis use among clients with schizophrenia and co-occurring substance use disorder were associated with lower provider ratings of relationship.

In contrast, clients' ratings of relationship were not associated with their providers' characteristics, but rather with their own characteristics. Further, the relationships between these characteristics and client ratings of relationship were inconsistent. [Ruchlewska et al. \(2016\)](#) found that when clients rated their symptoms to be more severe, they also rated their relationship with their provider more highly. In contrast, [Kvrgic et al. \(2013\)](#) found that clients who scored more highly on self-stigma rated their relationship with their providers lower. Another study found that higher levels of insight were associated with higher client ratings of relationship ([Barrowclough, Meier, Beardmore, & Emsley, 2010](#)).

A few studies found that the association between client illness and

**Table 3**  
Table of research findings.

Article	Factors that influence relationship	Implications
Barrowclough et al., 2010	<ol style="list-style-type: none"> <li>1. Patients rated relationship significantly better than their therapists (mean 2.95, SD = 11.58, <math>t = 2.32</math>, <math>df = 230</math>, <math>p = 0.021</math>).</li> <li>2. Statistically significant predictors of therapist rating of relationship included patient attitude toward medication, depression, insight, and living situation (<math>p = 0.0001</math>).</li> <li>3. Insight was a statistically significant predictor of patient rating of relationship (<math>SE = -1.651</math>, <math>p = 0.006</math>).</li> </ol>	<ol style="list-style-type: none"> <li>1. A difference exists between patient and therapist ratings of their relationship.</li> <li>2. Multiple patient characteristics influence providers' perceptions of relationship, whereas only insight had significant influence on the patients' ratings.</li> </ol>
Berry et al., 2016	<ol style="list-style-type: none"> <li>1. Strong agreement between patient and therapist ratings of relationship (<math>r = 0.60</math>, <math>p &lt; 0.001</math>)</li> <li>2. Therapist rating of relationship became more positive the longer therapy continued (<math>r = 0.590</math>, <math>p &lt; 0.001</math>) across therapy types, as did client ratings (<math>t = 3.177</math> (33), <math>p = 0.003</math>).</li> </ol>	<ol style="list-style-type: none"> <li>1. Patients and therapists show no discrepancy in ratings of their relationships.</li> <li>2. Both therapist and patient rating of therapeutic relationship increased over time, suggesting the relationship is subject to growth and change over time.</li> <li>3. A positive relationship appears to be associated with higher levels of patient function, demonstrating benefit of the relationship.</li> </ol>
Cavelti et al., 2016	<ol style="list-style-type: none"> <li>1. Clinicians rated therapeutic alliance lower with clients with higher levels of thought disorder at baseline, but not at 12 months (<math>B(SE) = -0.41</math> (0.18), <math>P = 0.03</math>).</li> <li>2. No significant association between client rating and symptom level</li> </ol>	<ol style="list-style-type: none"> <li>1. Clinician's lower assessment of therapeutic alliance potential at baseline may have a negative impact on development of therapeutic reliance.</li> <li>2. No evidence that symptoms or symptom severity influence patients' rating of therapeutic relationship</li> </ol>
Easter et al., 2015	<p>Three broad themes related to meaningful therapeutic alliance:</p> <ol style="list-style-type: none"> <li>1. Being present</li> <li>2. Dissimilar treatment goals between client and provider</li> <li>3. Certain approaches provide greater impact</li> </ol>	<ol style="list-style-type: none"> <li>1. Some aspects of therapeutic alliance are beneficial to outcomes.</li> <li>2. Reiterates others' findings that client and provider have different goals for therapeutic alliance</li> </ol>
Farrelly et al., 2015	<p>Key themes:</p> <ol style="list-style-type: none"> <li>1. Past mental health experience influences patient appraisal of therapeutic relationship.</li> <li>2. Patient perception of lack of consistency and personal regard on part of provider contributes to patient negative appraisal of relationship.</li> <li>3. Providers identify worry about managing safety risk and time constraints as negative impacts on their relationships with patients.</li> </ol>	<ol style="list-style-type: none"> <li>1. Institutional demands on providers can negatively impact performance in therapeutic relationship.</li> <li>2. Patients are sensitive to provider behaviors in relationship.</li> </ol>
Goldsmith et al., 2015		<ol style="list-style-type: none"> <li>1. Causal role of relationship in treatment outcomes</li> <li>2. A poor relationship has detrimental effect on the client and outcomes.</li> </ol>
Johansen, Iversen, et al., 2013	<ol style="list-style-type: none"> <li>1. Patient age and level of aggression/agitation were the only factors to show statistically significant influence on patient ratings of relationship (<math>R^2 = 0.19</math>).</li> <li>2. Level of patient insight had statistically significant influence on provider rating of relationship (<math>R^2 = 0.14</math>).</li> </ol>	<ol style="list-style-type: none"> <li>1. Patient characteristics influence patient and provider rating of therapeutic relationship.</li> </ol>
Johansen, Iversen, et al., 2013	<ol style="list-style-type: none"> <li>1. Higher patient assessments of relationships were significantly correlated with lower levels of the personality trait of neuroticism (<math>r = -0.325</math>, <math>p &lt; 0.05</math>) and higher levels of agreeableness (<math>r = 0.317</math>, <math>p &lt; 0.05</math>).</li> </ol>	<ol style="list-style-type: none"> <li>1. Personality traits of patients can influence their perception of the therapeutic relationship.</li> </ol>
Kvrgic et al., 2013	<p>Three patient factors contribute to better therapeutic alliance:</p> <ol style="list-style-type: none"> <li>1. Strength of patient's recovery orientation (<math>r = -0.393</math>, <math>p &lt; 0.01</math>)</li> <li>2. Level of self-stigma (<math>r = -0.150</math>, <math>p &lt; 0.01</math>)</li> <li>3. Level of insight (<math>r = 0.161</math>, <math>p &lt; 0.05</math>)</li> </ol>	<p>Three intrapersonal factors influencing therapeutic relationships were identified.</p>
McCabe et al., 2012	<ol style="list-style-type: none"> <li>1. Significant correlation bet clinician rating of therapeutic reliance and adherence (for each unit increase in clinician score, odds ratio of good compliance was increased by 65.9% (95% CI: 34.6% to 104.5%)).</li> <li>2. Weaker but still significant correlation between client rating of therapeutic reliance and adherence (<math>r = 0.13</math>, <math>p = 0.004</math>)</li> </ol>	<ol style="list-style-type: none"> <li>1. Quality of therapeutic relationship is associated with medication compliance.</li> <li>2. Raises questions as to what factors lead to the difference of provider and patient ratings</li> </ol>
McCabe et al., 2016	<ol style="list-style-type: none"> <li>1. Psychiatrist self-repair was significantly higher in the intervention group (adj. mean diff = 6.4/1000 words, 95% CI = 1.46–11.33, <math>p &lt; 0.011</math>).</li> <li>2. Psychiatrist confidence was significantly higher in the intervention group (<math>t = 5.19</math>, 95% CI = 1.0–2.4, <math>p0.01</math>).</li> <li>3. Psychiatrist and patient rating of therapeutic relationship improved significantly more in the intervention group (mean diff = 0.20, 95% CI = 0.03–0.037, <math>p = 0.022</math>; 0.21, 95% CI = 0.01–0.41, <math>p = 0.043</math>, respectively).</li> </ol>	<ol style="list-style-type: none"> <li>1. Intrapersonal therapist factors can be improved with training.</li> <li>2. Improvement in therapist factors has a positive impact on the quality of relationship, from both therapist and patient perspectives.</li> </ol>
Pitkanen et al., 2008	<p>Four themes of benefit interactive nursing interventions:</p> <ol style="list-style-type: none"> <li>1. Empowering</li> <li>2. Social</li> <li>3. Activating</li> <li>4. Security</li> </ol> <p>Four themes regarding what patients wanted from interaction with nurses:</p> <ol style="list-style-type: none"> <li>1. Interest in patient's life</li> <li>2. Empathy</li> <li>3. More time</li> <li>4. More information/education</li> </ol>	<p>These findings can be considered as therapeutic benefits and areas for improvement in interactional contexts between psychiatric nurses and patients.</p>

(continued on next page)

Table 3 (continued)

Article	Factors that influence relationship	Implications
Ruchlewska et al., 2016	<ol style="list-style-type: none"> <li>1. Concordance between patient and therapist rating of relationship was low (<math>r = 0.22</math> to <math>0.28</math>, <math>p = 0.00</math>), with patients slightly more positive about relationships than their providers.</li> <li>2. More severe symptoms associated with higher ratings of relationships by patients (<math>SE B = 0.16</math> to <math>1.01</math>, <math>p &lt; 0.09</math>).</li> <li>3. Higher patient internal LOC associated with higher ratings of relationship (<math>SE B = 0.36</math>, <math>p = 0.01</math>)</li> <li>4. Variables only explained a small percentage of variance regarding patient and provider rated working alliance.</li> </ol>	<ol style="list-style-type: none"> <li>1. Differences between patient and provider rating of their relationship</li> <li>2. Patients with more severe symptoms rate their relationship more positively, not known why.</li> <li>3. Novel finding of internal locus of control associated with higher patient rating of relationship</li> </ol>
van Meijel et al., 2009	<ol style="list-style-type: none"> <li>1. Caregivers expressed that therapeutic relationship can improve when their own attitudes are adjusted.</li> <li>2. Caregivers reported more reflection about relationship as well as greater flexibility and less judgment within therapeutic relationships.</li> </ol>	More caregiver training is required for those caring for schizophrenia and psychotic diagnosis patients. The use of caregiver training can increase quality of caregiver-patient relationships.
Wittorf et al., 2010	<ol style="list-style-type: none"> <li>1. MANOVA showed no effect of time on the differential course of the two therapies, thus showing that technique of cognitive dispute did not negatively influence patient perception of relationship.</li> <li>2. <i>t</i>-tests showed patient ratings of relationship to be significantly higher than therapist rating at each of 4-time points in both groups (<math>p &lt; 0.05</math>).</li> <li>3. Cluster analysis showed that patient level of insight (<math>M = 1.74</math>, <math>SD = 0.92</math>) and symptoms (<math>M = 16.40</math>, <math>SD = 3.15</math>) have an impact on rating of relationship.</li> <li>4. Cluster analysis showed that negative patient symptoms have an impact on rating of relationship (<math>M = 13.34</math>, <math>SD = 4.05</math>).</li> </ol>	<ol style="list-style-type: none"> <li>1. Cognitive dispute did not appear to influence patient ratings of relationship.</li> <li>2. Patients consistently rated the relationship higher than therapist, regardless of therapy type.</li> <li>3. Different factors were found to have statistical impact on ratings of relationship for therapists and patients.</li> </ol>

their provider's rating of their relationship were most notable early in the relationship. Johansen, Melle, Iversen, and Hestad (2013) found variance in provider ratings of early relationship to be associated with symptom status of clients. Cavelti, Homan, and Vauth (2016) also found that providers rated the early relationship lower than did their clients when their clients had high levels of thought disorder symptoms.

Another key finding in this review was variation between client and provider ratings of the shared relationships between them in five studies. McCabe et al. (2012), Ruchlewska et al. (2016), and Cavelti et al. (2016) all found weak associations between therapist and client ratings or significant variability between the two. Berry et al. (2016) also found that while therapist rating of relationship did not predict clients' symptom levels or general function, as measured by PANSS and GAF respectively, patient ratings of relationship did predict these, raising the question of what other factors shape therapist rating of relationship.

Overall, while a higher level of client symptoms or greater number of problems or diagnoses can negatively impact therapist rating of relationship, the evidence for the same among patient ratings of their therapeutic relationships was much weaker. It is not clear whether negative provider ratings of relationship negatively affect client outcomes. Cavelti et al. (2016) did find that low provider rating of therapeutic relationship and high levels of patient symptoms that occur at baseline in the relationship tended to decrease over time and some disappeared by 12 months. Wittorf et al. (2010) did not find any such trend in studying impact of therapist use of a cognitive behavioral therapy (CBT) technique, noting that analysis of five measures over one year showed little variance over time; low rated relationships remained low and high rated relationships remained high. However, they reported a lack of instrument validity and stated they could not rule out that sampling bias may have limited the strength of this finding (Wittorf et al., 2010).

#### Treatment Setting Factors

The qualitative studies in the sample provided findings relevant to treatment setting influences on relationship. Easter et al. (2015) found a prominent theme to be dissimilar treatment goals between client and provider. Clients were more focused on life factors, such as housing and job, while providers focused on medical goals such as symptoms and level of function, while at the same time dismissing clients' voiced needs as evidence of illness. Pitkanen et al. (2008) provide similar findings.

Clients suggested that more time with nurses who were actually present to them emotionally and invested in their life issues would be beneficial. Easter et al. (2015) suggested that the dominance of the medical model in treatment settings may be a key factor in shaping both lack of provider understanding of client need as well as the decreased time providers have for relationship. Farrelly et al. (2015) echo this finding in their qualitative study of the impact of a joint crisis-planning mandate on quality of relationship in outpatient care settings. While clients' priority concerns were that they were not seen for themselves and that their needs were not addressed, providers' priority concerns were managing safety risks and completing care tasks. This mismatch in relational priorities was exacerbated by the additional setting demand of the joint crisis-planning mandate (Farrelly et al., 2015).

#### Communication Training Programs

Two studies provide preliminary evidence that treatment setting-based training programs for providers can change their interactional patterns. Similar themes were found in two studies even though the programs studied differed (See Table 3). One program consisted of four sessions, one each on understanding, communicating with, and empowering the client and collaborative decision-making (McCabe et al., 2016) while the other was a generic communication skills training program for caregivers (van Meijel et al., 2009). In both studies, post-program assessment showed that both clients and therapists in the treatment group had statistically significant increases in positive ratings of the therapeutic relationship. McCabe et al. (2016) employed an observation method, counting the number of times therapists attempted self-repair, a method of amending a verbalization in response to perception of the needs of the other. The rate of self-repair increased by 44% among providers who were trained, leading the authors to conclude that the use of self-repair was a significant contributor to increased ratings of quality of relationship post-training program (McCabe et al., 2016).

#### Discussion

Similar to Hewitt and Coffey (2005), this review identified very few studies that included nurses in their samples. Only one study was done in the U.S.; the U.K. supplied seven of the studies in this sample. It is worth considering whether the increased interest in recovery models of

**Table 4**  
Implications for practice.

<p>Questions for reflection</p> <ul style="list-style-type: none"> <li>• How does my client's severity of illness or symptoms shape my expectations of our relationship?</li> <li>• How does my client's drug use shape my expectations of our relationship?</li> <li>• Can I see beyond my client's illness to the life issues he or she might have?</li> </ul> <p>Suggestions for action</p> <ul style="list-style-type: none"> <li>• Look for creative ways to make time for interaction with your client</li> <li>• Reflect before interaction</li> <li>• Be aware of how treatment setting demands impinge on quality of interaction</li> <li>• Prioritize rapport and actions that protect and repair rapport</li> </ul>
--

care in the U.K., with emphasis on the interpersonal and humanistic dimensions of care, may be responsible for the increased amount of research on therapeutic relationship there (Frost et al., 2017).

One of the clearest findings here is that the more symptomatic the client is, the more likely it is that the provider will rate the relationship as less positive. Studies outside of this sample have also found the same (Kondrat & Early, 2010). Client symptoms or severity were not consistently related to how they rated their relationships with providers. A consistent finding here was the mismatch between client and provider expectations of which client needs should be met through the relationship. Clients prioritize their real world, life problems while providers focus on diagnostic dimensions and medical priorities of safety and care criteria. The studies of training programs found that the programs resulted in better provider ability to manage or alter behaviors in order to more effectively participate in relationship with the client. For example, the simple technique of self-repair, or adjusting one's responses to better meet the client where he or she is at in the midst of interaction, resulted in significant positive assessments of quality of relationship. Another finding worth consideration for practice is that poorly rated therapeutic relationships may stay poorly rated. The unanswered question is whether poorly rated relationships impact client outcomes over the long run (Goldsmith, Lewis, Dunn, & Bentall, 2015). These findings also leave unclear what effect, if any, clients' ratings of their own symptoms have on their assessment of the quality of their relationship.

The studies in this review differed in several ways from typical nursing care settings. This was not unexpected, given the scarcity of nurse-focused, nurse-generated research in this area. While a majority of this sample included outpatient settings, a majority of nurses work in inpatient settings, when clients are acutely ill, with no pre-designated time for nurse and client to meet, and where interactions occur in between a multitude of other activities (Baker, Sanderson, Challen, & Price, 2014; Melrose, 2009). The studies that did include inpatient settings found that the demands of the setting, whether task and time demands, policy demands or the acuity of clients, influenced the nurse-patient relationship negatively. However, other frequently encountered psychiatric nursing phenomena identified within the broader literature, such as avoidance of clients who may become agitated, or rupture of trust when giving medications against client will were not represented here, perhaps due to the limited number of studies with nurses in the sample (Baker et al., 2014; Moreno-Poyato et al., 2017; Sheehan & Burns, 2011).

#### Implications

The evidence showing that treatment setting context impacts therapeutic relationship should spur practicing nurses to reflect on how clinical settings shape their actions in relationship. Particular focus should be on how policies, routines of care, and shared understandings of illness behavior shape their openness to forming relationships with clients. Practicing nurses can also identify how clients' symptoms, or intensity of these, impact their desire to interact with their clients. Even more importantly, the findings here suggest that providers can grow in

their ability to participate in relationships. The technique of self-repair alone appears to have beneficial effect on relationships and should spur nurses to attend closely to the client during interaction, and to look for ways to be responsive in the moment. Table 4 provides a summary of implications for practicing nurses.

Nursing education can be informed by findings here as well. Students learn about Peplau and the therapeutic relationship in school but whether educators spend enough time helping students learn the relational skills to surmount the barriers to relationship has not been answered (Silverstein, 2006). Educators can use guided reflections that sensitize and increase student awareness of the needs of clients with schizophrenia. Also, role playing or simulations can help students build strategies to balance needs of the setting with the needs of their clients.

Nursing research is vital to move these efforts forward. As stated earlier, this literature review is the first step in a program of study to identify the function of, experiences of, and barriers to therapeutic relationship between nurses and clients with schizophrenia. The ultimate goal is to create evidence-based resources for practitioners and educators to use to maximize the therapeutic potential of relational interventions. The next step, currently in progress, is deployment of a survey, developed from findings here, to access perceptions of the nurse-patient relationship, its potential and challenges, among a large population of practicing nurses and nurse educators. The results will be used to develop and test specific resources and educational interventions to maximize potential of the therapeutic relationship.

#### Limitations

A majority of limitations stem from the paucity of research on the topic. There was an insufficient amount of research by and about nurses in this area. There was also great variation in instruments and methods used to assess ratings of relationship. In addition, a variety of countries and clinical settings were represented in this sample. There was no method to assess or determine cultural influences on findings, though it might be expected that there would be, given that communication and relationship are interpersonal phenomena that are often subject to cultural norms. Also, the population of clients within the studies was not comprised of 100% schizophrenia or psychosis diagnoses. The decision was made to include studies with > 50% of the sample had diagnoses of schizophrenia, schizoaffective disorder or psychosis in order to obtain a larger enough sample for analysis.

#### Conclusion

The rising number of clients with schizophrenia who need collaborative care to produce the best health outcomes makes it imperative that nurses in practice and education focus on the therapeutic benefits of relationship with these clients. The therapeutic relationship in nursing has historically been important but is being challenged now by the rise of pharmacological intervention and other health care system demands, potentially leaving clients without optimal care, particularly for managing complex comorbidities and life situations. This review of the literature represents a first step in a program of study to draw attention back to the benefits of therapeutic relationship for this population and to provide resources for practitioners and educators to maximize the potential in the therapeutic relationship.

#### Conflict of Interest

The authors declare that there is no conflict of interest.

#### References

- Baker, J. A., Sanderson, A., Challen, K., & Price, O. (2014). Acute inpatient care in the UK. Part 1: Recovery-oriented wards. *Mental Health Practice, 17*(10), 18–24.
- Barrowclough, B., Meier, P., Beardmore, R., & Emsley, R. (2010). Predicting therapeutic

- alliance in clients with psychosis and substance abuse. *The Journal of Nervous and Mental Disease*, 198(5), 373–377.
- Berry, C., & Greenwood, K. (2015). Hope-inspiring therapeutic relationships, professional expectations and social inclusion for young people with psychosis. *Schizophrenia Research*, 168(1-2), 153–160. <https://doi.org/10.1016/j.schres.2015.07.032>.
- Berry, K., Gregg, L., Lobhan, F., & Barrowclough, C. (2016). Therapeutic alliance in psychological therapy for people with recent onset psychosis who use cannabis. *Comprehensive Psychiatry*, 67, 73–80.
- Boyd, M. (2017). *Essentials of psychiatric nursing*. Philadelphia, PA: Wolters Kluwer.
- Catty, J., Cowan, N., Poole, Z., Ellis, G., Geyer, C., Lissouba, P., ... Burns, T. (2011). Attachment to the clinical team and its association with therapeutic relationships, social networks, and clinical well-being. *Psychology and Psychotherapy: Theory, Research and Practice*, 85(1), 17–35. <https://doi.org/10.1111/j.2044-8341.2010.02011.x>.
- Cavelti, M., Homan, P., & Vauth, R. (2016). The impact of thought disorder on therapeutic alliance and personal recovery in schizophrenia and schizoaffective disorder: An exploratory study. *Psychiatry Research*, 239, 92–98.
- Crawford, C. L., & Rondinelli, J. L. (2013). The integrative review process: Yes you can!! (Powerpoint slides). Retrieved from [https://outlook.depaul.edu/owa/redir.aspx?C=Df5j\\_W7hV15S0EgAx5BhOf5FesdNhusQ5dpXROO8muCFQBWFydzUCA.&URL=http%3a%2f%2fwww.academyebp.org%2fsystem%2ffiles%2fprivate%2feducation%2fintegrative-review-process%2fhow-to-conduct-an-integrative-review.pdf%3fdownload%3d1](https://outlook.depaul.edu/owa/redir.aspx?C=Df5j_W7hV15S0EgAx5BhOf5FesdNhusQ5dpXROO8muCFQBWFydzUCA.&URL=http%3a%2f%2fwww.academyebp.org%2fsystem%2ffiles%2fprivate%2feducation%2fintegrative-review-process%2fhow-to-conduct-an-integrative-review.pdf%3fdownload%3d1).
- Easter, A., Pollock, M., Pope, L. G., Wisdom, J. P., & Smith, T. E. (2015). Perspectives of treatment providers and clients with serious mental illness regarding effective therapeutic relationships. *The Journal of Behavioral Health Services & Research*, 341–353.
- Farrelly, S., Lester, H., Rose, D., Birchwood, M., Marshall, M., Waheed, ... Thornicroft, G. (2015). Improving therapeutic relationships: Joint crisis planning for individuals with psychotic disorders. *Qualitative Health Research*, 25(12), 1637–1647.
- Frost, B. G., Turrell, M., Sly, K. A., Lewin, T. J., Conrad, A. M., Johnston, S., ... Sadanand, R. (2017). Implementation of a recovery-oriented model in a sub-acute Intermediate Stay Mental Health Unit (ISMHU). *BMC Health Care Services Journal*, 17(2), 2–12. Retrieved 01/31/18 <https://doi.org/10.1186/s12913-016-1939-8>.
- Gaillard, L. M., Shattell, M. M., & Thomas, S. P. (2009). Mental health patients' experiences of being misunderstood. *Journal of the American Psychiatric Nurses Association*, 15, 191–199.
- Glasper, A. (2016). The new task force that wants to improve the nations mental health. *The British Journal of Nursing*, 25(5), 272–273.
- Goldsmith, L. P., Lewis, S. W., Dunn, G., & Bentall, R. (2015). Psychological treatments for early psychosis can be beneficial or harmful, depending on the therapeutic alliance: An instrumental variable analysis. *Psychological Medicine*, 45(11), 2365–2373.
- Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of Advanced Nursing*, 52(5), 561–570.
- Johansen, R., Iversen, V. C., Melle, I., & Hestad, K. A. (2013). Therapeutic alliance in early schizophrenia spectrum disorders: A cross-sectional study. *Annals of General Psychiatry*, 12(1), 14–23. <https://doi.org/10.1186/1744-859X-12-14>.
- Johansen, R., Melle, I., Iversen, V. C., & Hestad, K. (2013). Personality traits, interpersonal problems and therapeutic alliance in early schizophrenia spectrum disorders. *Comprehensive Psychiatry*, 54, 1169–1176.
- Kondrat, D. C., & Early, T. J. (2010). An exploration of the working alliance in mental health case management. *Social Work Research*, 34(4), 201–211.
- Kvrgic, S., Cavelti, M., Beck, E., Rusch, N., & Vauth, R. (2013). Therapeutic alliance in schizophrenia: The role of recovery orientation, self-stigma, and insight. *Psychiatry Research*, 209, 15–20.
- McCabe, R., Bullenkamp, J., Hansson, L., Lauber, C., Martinez-Leal, R., Rossler, W., ... Priebe, S. (2012). The therapeutic relationship and adherence to antipsychotic medication in schizophrenia. *PLoS One*, 7(4), e36080. <https://doi.org/10.1371/journal.pone.0036080>.
- McCabe, R., John, P., Dooley, J., Healey, P., Cushing, A., Kingdon, D., ... Priebe, S. (2016). Training to enhance psychiatrist communication with patients with psychosis (TEMPO): Cluster randomized controlled trial. *The British Journal of Psychiatry*, 209, 517–524.
- van Meijel, B., Megens, Y., Koekoek, B., de Vogel, W., Kruitwagen, C., & Grypdonck, M. (2009). Effective interaction with patients with schizophrenia: Qualitative evaluation of the interaction skills training programme. *Perspectives in Psychiatric Care*, 45(4), 254–261. <https://doi.org/10.1111/j.1744-6163.2009.00228.x>.
- Melrose, S. (2009). Schizophrenia: A brief review of what nurses can do and say to help. *The Journal of Practical Nursing*, 59(2), 3–4.
- Moreno-Poyato, A. R., Delgado-Hito, P., Suarez-Perez, R., Leyva-Moral, J. M., Acena-Dominguez, R., Carreras-Salvador, R., ... Montoso-Curto, P. (2017). Implementation of evidence on the nurse-patient relationship in psychiatric wards through a mixed method design: Study protocol. *BMC Nursing*, 16(1) 10.1186/s12912-016-0197-8.
- Nemade, R., & Dombeck, M. (2009, July 10). Mentalhelp.net. Retrieved from schizophrenia symptoms, patterns and statistics and patterns <https://www.mentalhelp.net/articles/schizophrenia-symptoms-patterns-and-statistics-and-patterns/>.
- Perraud, S., Delaney, K. R., Carlson-Sabelli, L., & Johnson, M. E. (2006). Advanced practice psychiatric mental health nursing, finding our core: The therapeutic relationship in the 21st century. *Perspectives in Psychiatric Care*, 42(4), 215–226.
- Pitkanen, A., Hatonen, H., Kuosmanen, L., & Valimaki, M. (2008). Patients' descriptions of nursing interventions supporting quality of life in acute psychiatric wards: A qualitative study. *International Journal of Nursing Studies*, 45, 1598–1606.
- Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods* (7th ed.). Philadelphia, PA: Lippincott, Williams, & Wilkins.
- Reed, P., & Crawford Shearer, N. (2006). *Perspectives on nursing theory* (6th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Reitan, A. (2014, October 12). Poor social judgment—An aspect of schizophrenia. Retrieved from BrainBlogger <http://brainblogger.com/2014/10/12/poor-social-judgment-an-aspect-of-schizophrenia/>.
- Ruchlewska, A., Kamperman, A. M., van der Gaag, M., Wiersma, A. I., & Mulder, N. C. L. (2016). Working alliance in patients with severe mental illness who need a crisis intervention plan. *Community Mental Health Journal*, 52, 102–108.
- Schizophrenia Statistics (2017). Retrieved from: <http://www.schizophrenic.com/content/schizophrenia/schizophrenia-statistics>.
- Shattell, M. M., Harris, B., Beavers, J., Tomlinson, S. K., Prasek, L., Geervarghese, S., ... Heyland, M. (2014). A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: “The Living Room”. *Issues in Mental Health Nursing*, 35, 5–12.
- Sheehan, K. A., & Burns, T. (2011). Perceived coercion and the therapeutic relationship: A neglected association? *Psychiatric Services*, 62(5), 471–476.
- Shives, L. R. (2002). *Basic concepts of psychiatric-mental health nursing* (5th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Silverstein, C. M. (2006). Therapeutic interpersonal interactions: The sacrificial lamb? *Perspectives in Psychiatric Care*, 42(1), 33–41.
- Thibeault, C. (2016). An interpretation of nurse–patient relationships in inpatient psychiatry: Understanding the mindful approach. *Global Qualitative Nursing Research*, 3, 1–10.
- Tingle, J. (2012). Schizophrenia care: Failings and recommendations. *The British Journal of Nursing*, 21(22), 1350–1351.
- Tranter, S. (2013). Cardiovascular health in mental health practice. In E. Collins, M. Drake, & M. Deacon (Eds.). *The physical care of people with mental health problems*. London, England: Sage Publications.
- Videbeck, S. (2017). *Psychiatric-mental health nursing* (7th ed.). Philadelphia, PA: Wolters Kluwer.
- Whitmore, R., & Knafl, K. (2015). The integrative review: updated methodology. *Methodological Issues in Nursing Research*, 52(5), 546–553.
- Wittorf, A., Jakobi, U., Bannert, K., Bechdorf, A., Muller, B., Sartory, G., ... Klingberg, S. (2010). Does the cognitive dispute of psychotic symptoms do harm to the therapeutic alliance? *The Journal of Nervous and Mental Disease*, 198(7), 478–485.