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Best Practices of Building Therapeutic Alliances with Clients Living with Psychotic Disorders

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Best Practices of Building Therapeutic Alliances with Clients Living with
Psychotic Disorders

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a single semester time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This systematic narrative review examined best practices for developing therapeutic alliances with clients living with psychotic disorders. A systematic narrative literature review resulted in eight articles included in this research. A narrative review of the articles presented three main findings: practitioner's utilization of psychotherapeutic theories in order to conceptualize psychotic symptoms and build relationships, recovery-focused collaborative models of care, and what clients say they want in relationships from practitioners. Results indicated that there may be a disconnect between theory and practice, as data speaking to the process of building a therapeutic alliance with this population was limited. Further implications recommend that mental health practitioners gain knowledge and skills in the evidence-based models of Feedback-Informed Treatment (FIT) and Cognitive Behavioral Therapy for Psychosis (CBTp).

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Introduction

The purpose of this study was to identify best practice guidelines for mental health practitioners in building therapeutic alliances with clients living with psychotic disorders. This study systematically examined current peer-reviewed literature, then synthesized findings into a narrative review. As the therapeutic alliance is considered a vital component to psychotherapeutic interventions, it is imperative that mental health practitioners have a working understanding of best practices while working with this population.

Background

The therapeutic alliance

The National Association of Social Workers *Code of Ethics* (2008) has defined the core values of social work practice as: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. Social work values, particularly the value of human relationships, is actively encompassed within the therapeutic alliance that is built between practitioners and clients. The therapeutic alliance is composed of the emotional bond, sense of partnership, consensus of goals regarding treatment, and is an ongoing relationship between client and clinician (University of Sheffield Centre for Psychological Services Research, 2017). *The Handbook of Psychology Integration* has stated that 30% of improvement in psychotherapy patients comes from the therapeutic relationship, while only 15% of improvement is attributed to therapeutic techniques employed, the remaining 55% of factors are attributed to internal and external client factors which clinicians have little to no control over (Lambert, 1992, p.97).

A clinician may represent a psychotherapist, but the therapeutic alliance may be formed between any helping professional and the clients whom they serve. The therapeutic alliance has been present in all forms of treatment spanning multiple paradigms, and the term has commonly been referred to as the therapeutic relationship, working relationship, therapeutic bond, alliance, as well as other terms specific to different scopes of practice and theoretical viewpoints (University of Sheffield Centre for Psychological Services Research, 2017). In social work practice, this alliance has been referred to as the professional partnership, and has been represented as a combination of professional skills, personal characteristics and responses filled with genuineness, acceptance, respect, trustworthiness, empathy, cultural sensitivity, and

purposefulness (Miley et al., 2011). Within this study, the term practitioner encompassed the roles of mental health practitioners, mental health professionals, mental health workers, psychotherapists, mental health case managers, and other helping professionals within the mental health field, positions commonly held by social workers.

Engagement skills

An essential building block of forming a therapeutic, or working, alliance between practitioners and clients has been through the use of engagement skills. *Generalist Social Work Practice: An Empowering Approach* illustrated how social workers have engaged their clients through use of empowering speech, active listening skills, proactive responding, and eliciting the client's reality (Miley et al., 2011). Eliciting the client's reality has required that the social worker, "withhold their views in favor of eliciting the client's perspective...as a learner with respect to the client's construction of reality, the worker responds reflectively with interest and curiosity until achieving a mutual understanding" (Miley et al., 2011). By effectively engaging clients, social workers have historically aimed to "meet the client where they are" in order to collaboratively problem solve, navigate systems, and meet goals. Social workers, as well as other helping professionals, have found the engagement and alliance building process challenging while working with clients experiencing psychosis, a mental health symptom which has been defined as "a loss of contact with reality" (National Institute of Mental Health [NIMH], 2017). Eliciting the reality of a person experiencing psychosis can therefore become less straightforward, and warranted further research to ensure ethical, compassionate, and competent practice.

Psychosis defined

Psychosis has been conceptualized as primarily affecting a person's mind, including their ability to tell what is real or not real, their speech and communication, and it may cause them to act inappropriately in response to their altered sense of reality (NIMH, 2017). Another common symptom of disordered thought and speech has been illustrated as jumping between unrelated topics, speech that does not make sense to others, as well as pressured speech (National Alliance on Mental Illness [NAMI], 2014). Psychosis was formally defined as "a loss of contact with reality that is not part of the person's cultural or religious beliefs" (NIMH, 2017). The National Alliance on Mental Illness (2014) further clarified that, "psychosis is a symptom of an illness. It is not an illness itself."

Psychotic disorders were categorized by the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association [APA], 2013) as schizophrenia spectrum and other psychotic disorders, representing a total of thirteen diagnoses encompassing varying degrees and combinations of symptoms. These disorders were conceptualized in terms of positive, negative, and cognitive symptoms (APA, 2013). Positive symptoms (APA, 2013) included delusions, auditory, visual, and/or olfactory, and/or tactile hallucinations, disorganized thinking and/or speech, as well as varying degrees of disorganized or abnormal motor behavior. Delusional beliefs, or delusions, were defined as fixed false beliefs (NAMI, 2014) and commonly fell under categories of: delusions of paranoia, or that someone or something was out to get the person; delusions of reference, where an item or event held special meaning for the person; delusions of grandeur in oneself; and delusions of control in which the person experiencing symptoms believes that their mind was being controlled by outside forces. Negative symptoms (APA, 2013, p. 87-88) included diminished emotional expression, decreased

motivation and self-initiation, diminished speech output, decreased ability to experience pleasure, and lack of interest in social interactions. The *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2013) also listed disorders including bipolar, depression, personality disorders, and substance use disorders, which were also given added specifiers of “psychotic symptoms” when psychotic symptoms were not considered a primary diagnosis (APA, 2013).

Recent research (McGrath et al., 2016) suggested that nearly one in every 13 people worldwide have had at least one psychotic experience by the time they were 75 years old. Though not every person who experienced psychotic symptoms met the full diagnostic criteria for schizophrenia, the disorder recently affected about 21 million people worldwide, half of whom did not receive medical or mental health treatment (World Health Organization [WHO], 2017). In the United States, about 1% of the population had a diagnosis of schizophrenia in 2001, yet the disorder accounted for over 30% of all mental health treatment spending resulting in roughly 34 billion dollars (Mark et al., 2005). Due to the high health costs, as well as other disabling effects of schizophrenia and other psychotic disorders, increased performance of treatment modalities has been an especially important public health and social justice concern.

Current and emerging best practice treatment models

Social Work: A Casebook on Diagnosis and Strengths Based Assessment listed currently accepted treatment modalities for people living with schizophrenia as: antipsychotic medications, hospitalization, individual psychotherapy, group interventions, family interventions, Assertive Community Treatment (ACT), case management, and vocational rehabilitations (Corcoran & Walsh, 2015). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2017) explained that treatment for schizophrenia has often included elements of multiple treatment modalities working together to manage symptoms, improve quality of life, increase

functionality, and support the person's recovery goals, rather than cure disorder. Evidence-based practices of psychotherapy for psychotic disorders, such as cognitive behavioral therapy for psychosis and cognitive remediation therapy (SAMHSA, 2017), also helped people cope with symptoms and learn skills to manage their day-to-day life stressors in recovery.

In response to the complex nature and treatment of psychotic disorders, recent efforts have been made to focus on early interventions for people experiencing a first episode of psychosis. Coordinated Specialty Care (CSC) treatment models combined medical, psychosocial therapy, case management, family and social supports, as well as supported employment and education services in order to improve clients' quality of life and reduce the long-term effects of the disorder (NIMH, 2017). Research (NIMH, 2017) showed that such CSC models were more effective in treating clients with first episode psychosis than usual treatments, and clients felt that this model of care helped them live fuller lives. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP, 2017) identified, NAVIGATE for First Episode Psychosis, as a current evidence based CSC treatment model. NAVIGATE, a program designed for adolescents and young adults aged 15-40 (NREPP, 2017), emphasized the importance of practitioners' focus on recognizing and fostering client strengths, abilities, recovery and resiliency instead of disability, which complimented social work values (NASW, 2008).

Social workers and clients living with psychotic disorders

The National Association of Social Workers *Code of Ethics* (2008) has mandated social workers to serve all clients with dignity, integrity, and competence while valuing the importance of the human relationship. It was therefore vital that social workers, and all helping professionals, had a working knowledge of best practices for forming and maintaining therapeutic alliances with clients living with psychotic disorders. In order to effectively engage

clients living with psychotic disorders and build solid therapeutic alliances, social workers have been made to decide on meaningful ways to elicit a client's reality while taking into account that the client's reality may have been composed of magical and/or delusional thinking, hallucinations, disorganized speech, and disorganized thought patterns. Social workers have been given the unique opportunity to engage, support, and build rapport with clients living with psychotic disorders in multiple different treatment avenues. Corcoran and Walsh (2015) listed interventions performed by social workers for people living with schizophrenia as: case managers, residential treatment program employees, therapists, out-patient and day programming, amongst other roles. Social workers have commonly been employed in both medical and psychosocial categories of intervention, and have played a critical role in providing care and creating positive relationships and alliances with these clients as they utilized social, medical, and psychological services.

Need for best practice guidelines

Recent research showed that clients living with schizophrenia and other psychotic disorders commonly experienced negative feelings regarding their relationships with clinicians, and suggested that nurturing of the therapeutic alliance was needed. A 2016 systematic review and meta-synthesis (Walsh, Hochbrueckner, Corcoran, & Spence) examined 27 qualitative studies of inpatient clients diagnosed with psychotic disorders from multiple countries, and found that clients identifying their treatment experiences as a common theme. Within 12 of the 27 studies, clients identified having negative contact with clinical staff, for reasons such as lack of staff understanding, lack of staff education about schizophrenia, and staff invalidating clients' positive symptoms and psychotic episodes (Walsh et al., 2016). Clients also identified negative issues of control during clinical visits, particularly non-volunteer placements, but also with

consideration to lack of control over taking medication, as well as lack of involvement in treatment options, treatment planning, and discharge planning (Walsh et al., 2016).

Research question

This research aimed to systematically examine current literature and compile a narrative review of best practices of building therapeutic alliances with people living with psychotic disorders. A systematic narrative review was conducted in order to examine literature from multiple modalities in order to answer an overarching research question. The research question for this research was conceptualized as ‘what are best practices for building therapeutic alliances with clients living with psychotic disorders?’

Methods

Research Design

This research systematically examined current literature on the therapeutic alliance between practitioners and clients diagnosed with, and also receiving mental health services for psychotic disorders. Themes, findings, and highlighted information was compiled into a narrative review in order to serve as best practice guidelines for clinicians. A systematic narrative review was utilized in order to view, assess, and combine multiple forms of literature including qualitative research, case studies, and personal accounts from clients in order to represent all bodies of knowledge meeting search criteria. Just as effective best practice guidelines encompass multiple viewpoints, so does this body of knowledge, by gathering data from clients, clinicians, and theorists in order to identify overarching factors.

Evaluated studies included quantitative and exploratory studies, qualitative research findings, mixed method studies, case studies and interviews, and first-person narratives. Historical and theoretical peer-reviewed literature was also systematically searched. It was important to incorporate reports from practitioners, and also important to take great care to include client experiences and perceptions of the therapeutic alliance.

Literature Search

A systematic literature search was completed through use of databases PsycNET/INFO and SocIndex, both accessible through the University of St. Thomas library system. Literature was searched within the parameters of being published after the year 2000, was accessible through the library system, and was peer-reviewed. Search terms utilized for PsycNET/INFO included “psychoses”, “schizophrenia”, and “therapeutic alliance”, resulting in 96 data sources. After an initial screening of title and abstracts, results were narrowed

down to 38 possible data sources. A further review of full articles resulted in eight viable data sources. SocIndex search terms utilized were “psychoses” and “therapeutic alliance or working alliance” resulting in 20 possible data sources. Following title and abstract review, no viable data sources were available for purpose of this study.

Criteria

Results from the literature search were subjected to an initial screening of title and abstract against the inclusion and exclusion data. After the first round of screening, a fuller review was conducted by analyzing full articles of remaining literature against inclusion and exclusion criteria (see Table 1).

Table 1. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Peer-reviewed	Not available in English
Psychotic disorders defined by DSM 4 and 5	Mood disorders and other diagnoses with psychotic features
Terms similar to therapeutic alliance such as working alliance, therapeutic relationship, and others	Studies measuring alliance outcomes on external measures
Evidence based practices, case studies, theoretical literature, books, client reports	Electronic and non-face-to-face interactions between client and practitioner

Studies examining, and explaining practice of developing a therapeutic alliance in a mental health setting	Studies measuring effects on alliance, but not speaking to alliance process
All mental health backgrounds: social work, psychology, psychiatry, and others	Studies conducted in non-mental health settings
	Clients under age 18
	Graduate Theses

Data Analysis

The data was analyzed utilizing a data extraction form (See Figure 1). This form was used to collect common information from each source. Once these data were extracted, the data was analyzed and synthesized into a narrative review organized by major findings.

Category	Content
Reference	
Setting	
Population	
Duration of care	
Treatment modality	
Philosophy of care and/or theoretical perspective	
Intervention techniques specific to TA	
Method	
Results	

Figure 1. Data extraction form

Findings*Table 2. Data findings*

Author	Title	Theoretical perspective	Population and Setting	Key elements
Brent (2014)	A mentalization-based approach to the development of the therapeutic alliance in the treatment of schizophrenia	Mentalization-based approach to reduce disturbances of mental states	Outpatient therapy with 20-year-old man living with early course schizophrenia with paranoid features	Used to increase client's knowledge of their own internal states with a goal of creating a collaborative mentalizing process between practitioner and client
Buck & Alexander (2006)	Neglected voices: Consumers with serious mental illness speak about intensive case management	Person-centered	67 clients living with schizophrenia or schizoaffective disorder and their intensive case managers in Pennsylvania	Clients identify that they want and appreciate connection from, and connection to the outside world through their case managers
Hoass et al. (2011)	The therapeutic alliance in cognitive behavioral therapy for psychosis	Cognitive Behavioral Therapy for Psychosis (CBTp)	N/A	Practitioner and client are equal collaborators in the therapeutic process and relationship. Specific outline for establishing therapeutic alliance: empathy, positive regard, goal consensus, collaboration, appropriate self-disclosure, stages of change and motivation, normalization
Knafo & Selzer (2015)	"Don't step on Tony!" the importance of symptoms when working with psychosis	Psychoanalysis	In and out-patient therapy with one woman living with schizophrenia	The way to understand a person, and create a relationship, is to understand their

				psychotic symptoms
McNamara (2011)	Can we sit and talk? Poems, stories and some words of advice	First-person narrative	First-person perspective from author, who has received treatment for psychosis	List of ways for practitioners to treat clients with dignity
Melton & Taylor (2017)	Feedback-informed treatment for adolescents and young adults with early-onset psychotic disorders	FIT can be incorporated into any psychotherapeutic theory or model	Early intervention for ages 15-25 in Oregon experiencing schizophrenia or schizophrenia-related disorders	Systematically and informally track and honor clients feedback on interventions, clinicians help clients reach their own definition of recovery
Rosenbaum (2002)	Interviewing the patient with schizophrenia	Psychodynamic	Ideas supported through use of 5 vignettes	List of tips for interviewers (of clients): symptoms have meaning and interviewers can understand them similar to a dream, befriending clients without endorsing symptoms, establishing rapport, care with introductions to work against fear and paranoia, agree with feelings, not with symptoms
Zapparoli et al. (2002)	Delusional, cognitive and emotional aspects of communication with the psychotic patient	Psychoanalysis and cognitive therapy	Presented hypothesis based in authors' past clinical experiences with vignette to demonstrate	Clients communicate through their own "psychotic language"; language can be understood by analyzing the delusion, the cognition, and the emotion presented; The only way to make an alliance is

				to understand the delusion
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The data findings showcased multiple theories of psychotherapy and models of treatment to utilize while building a therapeutic alliance with clients living with psychotic disorders (see Table 2). Much of the data came from the point of view of mental health practitioners, while some findings honored the voices of clients receiving services. The data was synthesized into three main findings representing: practitioner’s utilization of psychotherapeutic theories in order to conceptualize psychotic symptoms and build relationships, recovery-focused collaborative models of care, and what clients say they want in relationships from practitioners.

Finding 1: Theoretical viewpoints used by practitioners to conceptualize symptoms and build alliance

The initial finding, represented in half of the data, utilized psychotherapeutic theories for practitioners to utilize in order to conceptualize symptoms of psychosis, then interact with patients accordingly. Within the data, specific theories conceptualized symptoms of psychosis and gave guidelines for establishing the therapeutic alliance while providing psychotherapy. All data represented within this finding were rooted in psychoanalytic theory. (Knafo & Selzer, 2015; Zapparoli, Gislón, & De Luca, 2002; Rosenbaum, 2002; Brent, 2014).

Citing a psychoanalytic viewpoint, Rosenbaum (2002) provided recommendations and instructions for practitioners to utilize while interviewing clients diagnosed with schizophrenia, based in past clinical experience. As “the seeds of a potential therapeutic alliance are often sown during the first interviews” (Rosenbaum, 2002, p. 12), such recommendations included taking care with introductions, clearly explaining the purpose of meetings with clients in order to work against paranoia, respecting ego boundaries and the client’s need for privacy, avoiding

“exaggerated sweetness”, and starting the sessions off with a “business-like manner” to allow natural warmth to enter the relationship (p. 26). It was noted that though Sigmund Freud did not work with people with psychosis due to the belief that they could not experience transference for analysis (Rosenbaum, 2002), the current data stated that special attention should be paid to clients’ high likelihood of intense transference in response to their poor ego separation. In order to maintain a therapeutic alliance, it was recommended that such disruptions be addressed immediately within the session and continuously throughout therapy (Rosenbaum, 2002).

In regard to building rapport with clients to enrich the alliance, it was further advised to focus on working on problems or distress the client was experiencing, rather than focusing on diagnostic criteria or disagreeing with the truthfulness of delusions (Rosenbaum, 2002). It was also noted that practitioners should take care in reflecting the client’s feelings, to work against delusions of mind-reading (Rosenbaum, 2002). For example, rather than interpreting a client’s body language and stating that the client was feeling an emotion, it was recommended to verbally reflect the client’s change in body language and ask them if they are experiencing a new emotion (Rosenbaum, 2002).

Rosenbaum (2002), stated that by focusing on what the client thought of their current life situation, many concerns would present themselves, such as sleep disturbances, interpersonal conflict, disorganization, and pressure from others to receive treatment. Rosenbaum (2002) further stated that working from a psychoanalytic theoretical perspective, symptoms of psychosis could be partially understandable, similar to dream-work. This acceptance of understanding could help practitioners interpret what their clients were experiencing, though it was important to never “collude with delusions” (Rosenbaum, 2002, p. 26). It was suggested that by relating to the

client's feelings and current concerns, the practitioner could build trust and increase the strength of the therapeutic alliance.

Working with symptoms of psychosis from a framework of psychoanalysis was additionally represented throughout the findings as Knafo and Selzer (2015) identified that positive symptoms of psychosis offered a meaningful and vital window into the client's struggles, simultaneously presenting an opportunity for practitioners to build a working relationship. Knafo and Selzer (2015) further suggested working with symptoms with respect and curiosity, especially considering that most clients with psychotic disorders were not treated with enough respect while receiving treatment in the past. Based on an individual case study of a hospitalized client, Knafo and Selzer (2015) stated that positive symptoms, such as delusions and hallucinations, were a representation of the person. Knafo and Selzer (2015) argued that these symptoms were a valid attempt at meaning-making, driven by logic and intelligence, and that they ultimately communicated and were credible. Similar to focusing on the patient's concerns (Rosenbaum, 2002), Knafo and Selzer (2015) stated that symptoms could provide practitioners with further information on major concerns in the client's life. Within this data, positive symptoms were to be explored before they were eliminated by medication. From this perspective, the mutual exploration of positive symptoms could improve the clinician's understanding of the client's situation and further strengthen the therapeutic alliance.

Expanding on a psychoanalysis model, Zapparoli, Gislón, and De Luca (2002) proposed incorporating aspects of cognitive models into therapy with clients with symptoms of psychosis. Based in clinical experience and a vignette from a case study, the authors proposed focusing on "psychotic language and communication" from the client, and also analyzing the delusion, emotion, and cognition presented (Zapparoli et al., 2002, p.75). In congruence with Knafo and

Selzer (2015), Zapparoli et al. (2002) expressed the importance of understanding the client's delusions before attempting to remove them through medication. Zapparoli et al. (2002) also conceptualized positive symptoms as a means by which the client was expressing their needs and requests from others. Zapparoli et al. (2002) further stated that therapeutic alliance was constantly maintained by the practitioner in their conceptualization and response to the client's delusion, emotion, and cognition. Zapparoli et al. (2002) additionally proposed that based on the practitioner's conceptualization of these three factors forming the "psychotic language and communication" (p. 75), the practitioner could determine appropriate psychotherapeutic interventions, such as psychodynamic therapy to increase awareness of unconscious feelings, and/or cognitive therapy to repair faulty cognitive models. From this perspective, the therapeutic alliance was built by practitioners interpreting the client's "psychotic language and communication" (Zapparoli et al., 2002, p.75), and providing reactions to the client's cognitions, emotions, and delusions.

The final psychotherapeutic theory found in the data was a mentalization-based approach (Brent, 2014), a concept based in psychoanalytic theory. This mentalization-based approach (MBT) operated within the framework that people with symptoms of psychosis presented with hindered mentalization processes, defined as the ability to "think about states of mind in the self and others, such as thoughts, feelings, or intentions" (Brent, 2014, p. 146). According to Brent (2014), these hindered mentalization processes interfered with psychotherapeutic treatment and the therapeutic alliance. Within this viewpoint, it was proposed that the practitioner utilize mentalization-based interventions in order to help the client understand their mental states, and subsequently decrease symptoms that negatively interfered with the therapeutic relationship (Brent, 2014).

Based on a case example of a young man with early-onset schizophrenia symptoms including paranoia, Brent (2014) proposed mentalization-based techniques to create a safe relationship between practitioner and client. The author noted that the basic MBT stance to build and maintain a therapeutic alliance with a person experiencing symptoms of psychosis, was based on constant focus and attention to the patient's mind while trying to understand things from their point of view (Bateman and Fonagy, 2006, as cited in Brent, 2014). Through the MBT therapeutic stance, practitioners were to take an open-minded and curious approach to the patient's mental processes, and to engage the patient's curiosity towards their own mind during moments that mentalization was jeopardized by symptoms (Bateman and Fonagy, 2006, as cited in Brent, 2014).

Brent (2014) proposed that by creating a safe, supportive, and organizing framework, practitioners could help alleviate stress that patients experienced from symptoms of paranoia and other delusions. Specific techniques to foster a therapeutic alliance, also referred to as a collaborative mentalizing process (Brent, 2014), used by practitioners from this viewpoint included keeping observations simple, and focusing on current states of mind, rather than behaviors or external focuses. Additionally, it was encouraged to use open and nonjudgmental listening, active listening and asking questions that revolved around states of mind in clients and others, and using the therapist's mind as an example (Brent, 2014). Furthermore, it was emphasized that practitioners praise positive mentalizing, stop and explore with the client when mentalization had disrupted, and avoid complex interpretations of unconscious motivations (Bateman and Fonagy, 2006, as cited in Brent, 2014).

Finding 2: Collaborative models of care to foster therapeutic alliances

The second finding highlighted models of care that prioritized collaboration between clients and clinicians in order to build and maintain the therapeutic alliance. Utilizing a model of Cognitive Behavioral Theory for Psychosis (CBTp), Hoass, Lindholm, Berge, & Hagen (2011, p. 69) explained, that the goal of collaboration within CBTp was, “to meet the other wherever he/she is in life, and try to see and understand their problems from their standpoint”. In this literature, it was emphasized that a CBTp approach was built “on a view of humanity characterized by respect, individualization, normalizing, and inclusion” and it was “fundamental” that therapists and patients were “equal and active collaborators” to the process (Hoas et al., 2011, p. 74).

From this viewpoint, it was also problematic to divide the alliance into separate parts such as therapist factors, patient factors, common-factors and techniques (Hoas et al., 2011), though guidelines were illustrated for practitioners to use in order to build an alliance collaboratively with the client. Some guidelines suggested for building an alliance included: expressing therapeutic empathy, holding positive regard and congruence, goal consensus and collaboration, using appropriate self-disclosure, honoring stages of change and motivation, repairing alliance ruptures, maintaining flexible organization of structure in therapy, encouraging engagement, and expressing normalization of symptoms (Hoas et al., 2011). Also differing from the first finding, rather than conceptualizing symptoms, Hoas et al. (2011) emphasized that case conceptualization of the client and their presenting concerns was to be formed in collaboration with the client, although noting it could be difficult due to symptoms the client may be experiencing (Hoas et al., 2011).

Another viewpoint within the second finding that encompassed collaboration between clients and practitioners was presented by Melton and Taylor (2017), who examined the role of Feedback Informed Treatment (FIT). FIT was used in the context of the Early Assessment and Support Alliance (EASA), an early-intervention program for people age 15-25 in Oregon over the course of two years (Melton and Taylor, 2017). By utilizing the Outcome Rating Scale and the Session Rating Scale, FIT practitioners established a “culture of feedback” where recovery was defined in broad terms, such as individual, interpersonal, social factors, and recovery was not focused solely on symptom reduction (Melton & Taylor, 2017, p. 284).

From this stance, the therapeutic alliance was maintained by empowering clients, and practitioners responding to clients’ stated needs. According to research (Grealish, Tai, Hunter & Morrison, 2013, as cited in Melton & Taylor, 2017), teenagers experiencing psychosis placed the highest importance on being listened to, being understood, taking control, and receiving enough psychoeducation and information to make their own decisions. The FIT model incorporated these age-appropriate goals into treatment through discussion, rating scales, and utilizing a multi-disciplinary team approach (Melton & Taylor, 2017). Practitioners and clients reviewed rating scales together, and practitioners then adapted their therapeutic style, delivery, and treatment to mirror the client’s wants and needs in order to maintain an alliance based in serving the client’s conceptualization of recovery (Melton & Taylor, 2017).

Similar to CBTp (Hoass et al., 2011) the FIT model (Melton & Taylor, 2017) stressed the importance of understanding between practitioner and client to foster an alliance. While utilizing FIT within an EASA model, the authors emphasized that the understanding of treatment is constantly measured against what the client states they want, and practitioners can use a

multitude of psychotherapeutic theories to accommodate the client's expressed needs (Melton & Taylor, 2017).

Finding 3: The client's voice in what they want from their relationship with practitioners

The third finding of the data was shown through use of the client's voice expressing what they wanted in relationships with practitioners. Within a largely quantitative exploratory study that examined the relationship between clients diagnosed with schizophrenia or schizoaffective disorder and their intensive case managers, Buck and Alexander (2006) revealed that clients mainly wanted social connection with, and through, their case managers. While using a grounded theory technique to code client reports (Buck & Alexander, 2006, p. 474), three main findings emerged as 'getting services', 'being social', and 'being there for me'. Clients reported that they wanted, and appreciated, both instrumental and affective support from their case managers, in terms of their social relationship (Buck & Alexander, 2006). Specific requests clients made were that they wanted to spend more time with their case managers in the form of outings that represented everyday social functioning, such as shopping trips, going to the movies, or eating meals together, in order to create a feeling of being connected (Buck & Alexander, 2006).

Writing from her own treatment experiences where social connections were not emphasized, McNamara (2011) shared her own personal stories, poems, and advice to practitioners. McNamara (2011, p. 170) specified what she wanted from practitioners in order to create a therapeutic alliance; requesting to be treated like a human being and looked in the eye, being given all of the information on her case as available, being spoken to in "plain talk" without jargon or case studies of past clients, privacy and quiet physical space for discussions and personal information, ample time with the practitioner, full information for her to make her own choices for her care, and to be treated within her own community.

All of McNamara's (2011) specific requests fell under her overarching therapeutic alliance guideline to practitioners, which highlighted, "In working alongside somebody in distress, never let go of the fact that this is a partnership; that you are working together. I ask you to hold onto that person's dignity" (p. 168). Tying in with previous findings, McNamara (2011) expressed the importance of practitioners listening to their client's stories, which are often "desperate metaphors of unspeakable experiences" (p.167).

Discussion

The findings showcase an overlap in ideas and possible best practices for establishing therapeutic alliances with clients living with psychotic disorders. The practice of focusing on the client's current stressors or concerns was presented across multiple theories and models of care (Rosenbaum, 2002; Knafo and Selzer, 2015, Hoass, Lindholm, Berge, Hagen, 2011; Melton and Taylor, 2017). It was also repeatedly emphasized that positive symptoms do hold meaning and value and should be explored with varying degree of openness (Rosenbaum, 2002; Knafo and Selzer, 2015; Zapparoli et al., 2002; Hoass et al., 2011; McNamara, 2011). Though aspects of the findings overlap in content and ideas presented, the perspectives expressed within the findings greatly differ in how clients are treated and how cases of people experiencing psychosis are conceptualized.

The first finding, representing half of the data sources, came from case-studies and vignettes of practitioners writing from a psychoanalytic theoretical point of view. Within this research, this theoretical framework indicated that practitioners should independently conceptualize clients and their symptoms in order to theoretically understand the meaning of symptoms, thereby indicating their therapeutic stance in building a therapeutic alliance (Knafo & Selzer, 2015; Zapparoli et al., 2002; Rosenbaum, 2002, Brent, 2014; Brent, 2014). Rosenbaum (2002, p. 25) writes, that if practitioners view their clients as “an eccentric cousin from Kanakee” the practitioner can “befriend the patient without endorsing his psychosis”, illustrating how this viewpoint is not necessarily endorsing collaboration and joining with the client.

While endorsing the same idea of building a relationship without endorsing psychotic symptoms, the CBTp model (Hoass et al., 2011, p.69) explains that, “the therapist can be empathetic with the patient's anger and experience, without affirming all of the patient's

conceptions”. Within the findings, psychodynamic perspectives, CBTp, and the FIT model all agree that practitioners should not encourage symptoms by outright agreeing with delusions, though the way in which the clients are conceptualized, vary from “an eccentric cousin” (Rosenbaum, 2002, p. 25), an equally important half of the relationship (Hooas et al., 2011), or the definer of their own recovery (Melton and Taylor, 2017).

The collaborative evidence-based models of FIT and CBTp also align with social work values (NASW, 2008), particularly values of dignity and worth of the person, the importance of human relationships, and competence. Though all findings emphasize the importance of the relationship between practitioners and clients, not all explicitly do so while maintaining the dignity of the person and giving them power in the relationship. McNamara (2011, p.168) writes of her own experiences while being treated for psychotic symptoms, “If they lose a sense of it for themselves in their expression of psychic pain, in their chaos and confusion, do not forget that person’s dignity”. When anonymously asked what was enjoyed about their treatment in FIT (Melton and Taylor, 2017, p. 285) a client voiced that, “Instead of being worked *on*, I was worked *with*”, highlighting the importance for practitioners to join their clients and give them power in the relationship. Overall, the lack of data on this topic indicates that there may be a consensus on the values and skills that practitioners can utilize, but the process of how to build an alliance is lacking. Of the data found, two findings represented evidence-based interventions for this population (Hooas et al., 2011; Melton and Taylor, 2017).

Implications

Based on this research, evidence based models of care that may apply to all clients living with a psychotic disorder cognitive behavioral therapy for psychosis (Hooas et al., 2011) and

feedback informed treatment (Melton and Taylor, 2017). This overall finding emphasizes the need for practitioners to have exposure and competence in CBTp and FIT, as they directly align with the social work value of competence (NASW, 2008). The NASW *Code of Ethics* (2008, Ethical Standard 4) further explains that social workers have an ethical obligation as professionals, “social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics”. In connection to this research, social workers may find theoretical perspectives helpful in understanding psychosis from a clinical stance, but evidence based models of care must be available for our clients.

The lack of research in this area of putting theory into practice with this population also invites working practitioners to collect, teach, and publish their experiences in the field with this population. Our ethical responsibility to the profession dictates that we “should promote and facilitate evaluation and research to contribute to the development of knowledge” (NASW, 2008, Ethical Standard 5). As there is limited knowledge of best practices for establishing a therapeutic alliance with clients living with psychotic disorders, we are called to add knowledge to this lacking pool.

The lack of research on this subject also calls into question the reason behind the missing data. Psychotic disorders, including schizophrenia, are commonly seen as incurable brain diseases and do not fit well into the typical medical-model of assessment, diagnosis, treatment, and removal of symptoms. Social stigma, misconceptions, and cultural biases towards this population may also play a role in the lack of data, and hesitation for mental health practitioners to routinely interact with this population. Rosenbaum (2002, p.25) offers that most inexperienced practitioners are “often afraid of schizophrenia patients”, reflecting how our society at large may regard these clients living with psychotic disorders. Within this

apprehensive viewpoint of this population, perhaps it aligns that little research is conducted on how to create relationships with these clients.

Limitations

Due to the nature of this single-semester research and limited access to all published material on the subject matter, this research may not represent the full spectrum of published literature. Utilizing two databases, PsycNET/INFO and SocIndex, only PsycNET/INFO produced any viable peer-reviewed data, indicating that the field of sociology may have little to offer on this subject. Had the researcher utilized all relevant databases, the findings could have been more robust.

Conclusion

This systematic narrative review examining best practices of creating a therapeutic alliance with people living with psychotic disorders shows that current research is compiled of multiple theoretical viewpoints, client voices, and collaborative models of care. In line with social work values, this research indicates that cognitive behavioral therapy for psychosis (CBTp) and feedback informed treatment (FIT) present evidence-based approaches to working with, and building alliances with, people living with psychotic disorders. Further research is needed in this subject matter to add to the sparse current literature. Working practitioners could benefit from education, training, and implementation of elements of cognitive behavioral therapy for psychosis and feedback informed treatment to enhance collaborative alliances with our clients.

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