Overview of the therapeutic relationship in psychiatric practice

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INTRODUCTION

The relationship between a clinician and a patient in psychotherapy plays a central role in alleviating symptoms and fostering character change [1]. The treatment relationship can be a potentially powerful vehicle for patient improvement, as it can provide a supportive environment for exploration, and because issues that come up in this context can be processed in a very immediate and instructive way. In addition, the treatment relationship can reflect issues in other relationships, especially relationships with other authority figures.

This topic describes common treatment issues, problems, and opportunities in the clinician-patient therapeutic relationship. Approaches to the therapeutic relationship in patients with personality disorders are described separately. The epidemiology, clinical manifestations, diagnosis, and treatment of specific personality disorders are also discussed separately.

- (See "Approaches to the therapeutic relationship in patients with personality disorders".)
- (See "Overview of personality disorders".)
- (See "Personality disorders: Overview of pharmacotherapy".)
- (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)
- (See "Antisocial personality disorder: Treatment overview".)
- (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)

- (See "Borderline personality disorder: Psychotherapy".)
- (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)
- (See "Narcissistic personality disorder: Treatment overview".)
- (See "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)
- (See "Schizotypal personality disorder: Psychotherapy".)

THERAPEUTIC RELATIONSHIP

Establishing a therapeutic relationship — Whenever an individual decides to undertake mental health treatment of any sort, a relationship is begun with the treating clinician. Several components of the relationship can influence the outcome of treatment:

- How the relationship is established and evolves
- How the patient experiences, reacts to and uses the relationship
- How the clinician engages in and manages the relationship

Most people seek help because they are having difficulties functioning, often with self-perception and interpersonal situations. Characteristic difficulties will likely manifest in the treatment relationship as well, and this provides a context in which the patients can learn how certain thought, behavioral, and emotional patterns may not be serving them well. The therapeutic relationship offers an opportunity for new interpersonal experiences with a clinician invested in being helpful and serving the patient's best interests. For some patients, mental health treatment provides a relatively rare opportunity to speak with someone who listens attentively and takes a genuine interest in them.

Clinicians need to be aware that many patients have difficulties that make it more challenging to engage in therapeutic work. The clinician's patience and skill will be necessary to engage these patients in a meaningful way.

A helpful component of the psychoanalytic definition of a therapeutic relationship suggests that there is a "split" in the patient's "ego," which allows the therapist to work with the patient's healthier aspects against resistance and pathology [2]. This definition acknowledges that there will be pathological parts of the patient's personality functioning that may interfere with the clinician's attempt to help, along with more adaptive aspects of the patient's character that may be available for the work of the treatment.

Therapeutic alliance — An important component of the treatment relationship between patient and therapist is the therapeutic or working alliance, a concept originating in psychoanalytic theory that has been operationalized and measured in research examining the relationship between the alliance and patient outcomes. A model of the therapeutic alliance identifies three interdependent components of a therapeutic alliance: bond, tasks, and goals. The bond is the quality of the relationship formed in the treatment dyad that mediates whether the patient will address the tasks inherent in working toward the goals of a particular treatment approach [3,4].

Forming an alliance may not be difficult with a relatively healthy patient. Establishing a therapeutic alliance with more disturbed patients may be one of the primary goals of treatment. There may be different phases in the development of an alliance as treatment progresses. Stages in alliance development have been observed in long-term psychotherapy of patients with borderline personality disorder [5] (see "Approaches to the therapeutic relationship in patients with personality disorders"):

- Contractual (behavioral) – An initial agreement between the patient and therapist on treatment goals and on each of their roles in achieving them.

- Relational (affective/empathic) – An emphasis on developing a relationship in which the patient experiences the therapist as caring, understanding, genuine, and likable.

- Working (cognitive/motivational) – The patient joins the therapist as a reliable collaborator to help the patient understand themselves.

A lengthy initial alliance-building period may be required with a significantly disturbed patient to reach a point at which work leading to substantive and enduring personality change can occur. Studies are emerging that demonstrate that neglecting the therapeutic relationship, and/or failing to collaboratively engage patients, can result not only in suboptimal treatment experiences [6-8], but at times result in significant harm [9].

A meta-analysis of 295 independent studies published between 1978 and 2017 included more than 30,000 patients who were engaged in in-person or internet-based psychotherapy [10]. A moderately strong relationship was found between the therapeutic alliance and treatment outcome of in person psychotherapy. Similar results were seen for internet-based psychotherapy. The results were consistent across assessors (ie, patient, therapist, observer), alliance and outcome measures, treatment approaches, patient characteristics, and countries. Nearly 70 percent of articles published between 2010 and 2017 used some version of the Working Alliance Inventory. Several other meta-analyses reported similar findings [11-13].

PROBLEMS IN THE THERAPEUTIC RELATIONSHIP

Research findings suggest that unaddressed problems in the therapeutic relationship may lead to premature treatment termination by a patient [14,15]. "Strains" are problems in the relationship that can undermine treatment effectiveness; "ruptures" are severe disruptions that threaten treatment continuity itself. Skillfully addressing ruptures may strengthen the relationship between a therapist and patient; the occurrence of rupture-repair episodes during treatment has been associated with better treatment outcomes [15-17].

Strains — Strains in the clinician-patient relationship are inevitable and occur more frequently than is apparent to clinicians [18]. One study found that patients frequently did not express negative thoughts and feelings that they had about their therapists. Even experienced therapists were aware of unarticulated negative material only 45 percent of the time [19]. Therapist awareness of patients' negative feelings towards them may also create problems if the therapist becomes defensive, negative, or more rigid in applying treatment techniques, rather than being open and flexible in response [15].

Ruptures — Clinicians should be alert to ruptures and adopt the attitude that these events may be excellent opportunities to engage a patient in a collaborative effort to observe and learn about themselves [20]. Two subtypes of ruptures in the therapeutic relationship have been described: withdrawal and confrontation [18].

- Withdrawal can be subtle. A patient may withhold important information because of lack of trust or for fear of feeling humiliated. They may intellectualize (eg, talking excessively about other people) or may repeatedly change the subject. Withdrawal behaviors may be more common in patients who are overly compliant, such as those with dependent or obsessive-compulsive personality traits or disorders, or those who are uncomfortable about interpersonal relations, such as those with avoidant personality traits or disorder. Patients who experience excessive shame, such as those with borderline personality disorder, may withhold information out of fear of being negatively judged by the therapist.

- Confrontations are more overt manifestations of relationship problems; they include direct complaints about various aspects of therapy or criticism of the therapist. Some confrontations may be dramatic, for example, a patient who storms out of session in a rage or leaves an angry message on a therapist's answering machine. Confrontation ruptures are more likely to occur in the treatment of severely interpersonally impaired patients, such as those with borderline, narcissistic, or paranoid personality traits or disorders.

COMMON TREATMENT ISSUES

Confidentiality — All patients must be afforded confidentiality in psychotherapy, however, there may be legal or clinical limits to its protection that the patient should be informed of at the outset of treatment. Examples include:

- Many jurisdictions require that therapists warn others when a patient makes a specific threat to harm someone and report instances of child abuse.

- If a patient tells a therapist that they are suicidal, the therapist may be obligated to enlist the help of family members or the police in having the patient hospitalized and will undoubtedly provide information about the patient's history and treatment to emergency room or hospital staff.

- Health insurers may require clinicians to provide information about the patient's symptoms and diagnosis to authorize or pay for the patient's treatment.

Any of these situations can result in a rupture in the clinician-patient relationship. The clinician should be mindful of this possibility and attempt to reach a mutually acceptable understanding of the meaning of the event.

Fee setting — In an individual therapist's private practice, particularly when the patient directly pays for therapy, the therapeutic situation is a transaction between the therapist and patient. The treatment provider typically charges the patient for their time. Fees should be discussed at the first visit and agreed upon. The timing of bills and the expected payment date should also be discussed. A therapist may elect to reduce their fees, based on the patient's financial circumstances, but should not inflate a usual fee because a patient can pay more. If fees are not paid on time, nonpayment and its significance should be brought up by the therapist and discussed. If nonpayment is due the patient's inability to pay for treatment, termination of treatment with a referral to an affordable treatment source is likely to be a better option than allowing a patient to become financially indebted to the therapist.

For patients who use health insurance and/or are treated in a clinic or hospital setting, matters may be somewhat more complicated by the policies of third-party payers and the provider organization. The organization's fee policies should be explained and the patient's insurance or personal resources should be determined.

It is common for patients to view the fee and the business part of therapy through the lens of their personalities. A patient with narcissistic tendencies may devalue a therapist who does not

have a fee commensurate with their inflated self-image. Some patients may experience the need to pay for treatment as an indication that the therapist is uncaring, while others may readily pay any amount, affordable or not, to assure the continuation of the relationship. An obsessive-compulsive patient may assume that paying their fee is sufficient evidence of active engagement in a treatment and not feel the need to pursue exploration or understanding of painful emotions.

A policy should be established regarding visits missed by a patient. Issues include:

- Under what circumstances would a patient be charged for a missed visit?
- How much advanced notice does a patient need to give for cancelling a visit?
- Will a make-up session be offered if a visit is cancelled or missed?

Personal disclosures — Therapists vary widely in the degree to which they are willing to disclose personal information to their patients. Some therapists choose not to answer any questions about their personal lives, while others engage in self-disclosure as if with a friend or colleague. For most patients, neither extreme is ideal [21,22]. For some patients, the refusal to answer personal questions may be viewed as rigid and withholding and drive a patient away. At the same time, being excessively revealing may be threatening and cause a patient intense fear or anxiety about the therapist's boundaries and ability to establish a safe environment. It is reasonable to answer questions relevant to the patient's seeking treatment, such as the therapist's training and the nature of the treatment to be provided. It is usually not justified for the therapist to reveal personal details of their life to patients such as:

- The therapist's family composition
- Living arrangements
- Income

Between these two extremes are many possibilities, which may vary depending on both the patient and the therapist. A well-trained therapist with a reasonable degree of self-understanding will ideally carefully consider the reasons for a patient's interest in obtaining details about the therapist's personal life and will have a specific rationale for disclosure that is within the patient's interests.

Gifts — Gifts are a common way of expressing gratitude to another person who has helped. Patients frequently want to give gifts to their therapists. Some therapists refrain from taking gifts, insisting that the fee paid is sufficient reward for their time and effort. Some patients may perceive this response as a rejection, but this can and should be addressed. Other therapists accept reasonable gifts from a patient when they conclude that it is therapeutically important for the patient to express themselves in this manner and have the gift be received. As with

disclosures, the important point is to try to understand the meaning of gift-giving for a particular patient and to attempt to have the patient understand it too.

Boundary crossings and violations — Psychotherapeutic treatment has specific rules guiding the appropriate behavior of therapists and of patients. These rules, often referred to as "boundaries," are necessary for a patient to feel safe in a very intimate environment and to protect both the patient and the therapist from exploitation. As examples, the therapeutic transaction usually takes place in a controlled environment, has a set time and duration, and involves discussing patient problems. These factors have been referred to as the "frame" of the treatment [23].

Certain rituals, such as whether to shake hands with a patient or not, vary by therapist, but can be appropriate if part of the therapist's standard practice. Other practices, such as those below, may differ by individual therapist or organizational policy, but may be helpful for certain patients if handled in a prudent and thoughtful fashion.

- Accepting text message communications
- Returning phone calls on weekends
- Offering a tissue to a patient who has been crying
- Helping an older adult patient put on a coat

There will be an occasional need to divert more extensively from the therapist's standard practice. As an example, a patient is stranded in a snowstorm with no access to transportation and needs a ride in the therapist's car.

These are called boundary "crossings" because they clearly deviate from standard procedure, but they may not be disruptive to treatment because they are necessary, have a clear purpose or rationale, and are understood by both the therapist and patient. Boundary crossings are ideally based on sound clinical judgment, are discussed afterward between a patient and a therapist, and are documented in the therapist's records [24]. In today's digital world, clinicians should also remain vigilant at maintaining boundaries in the face of information proliferation on the internet and avoid activities such as searching one's patient online if there is no good clinical reason to do so and the patient is unaware.

Boundary "violations" are more egregious deviations from protocol. As examples:

- A therapist inappropriately hugs a patient or allows her to sit on his lap
- A therapist sees a patient outside of the treatment for dinner

These violations are rarely if ever justified and undoubtedly do great damage to the relationship, the treatment, and the patient themselves. Boundary violations are by definition exploitative of the patient and serve to gratify needs of the therapist. Sexual involvement of any kind with a patient is an unjustifiable boundary violation that can result in a malpractice suit and loss of professional licensure. A study of 275 mental health professionals investigated self-reported inclinations toward boundary violations and associated predictors of their likelihood. Male treaters' boundary violation propensity was predicted by grandiose and vulnerable narcissism, self-centeredness traits, and low levels of empathy. Factors significant for female professionals were impulsivity, childhood adversity, self-sacrificing tendencies, and vulnerable narcissism. It is important to be cognizant of these tendencies in oneself and in situations with trainees and colleagues [25].

RELEVANCE ACROSS TREATMENT PARADIGMS

No matter what treatment paradigm a therapist uses, attention to the therapeutic relationship is critical. The therapist must monitor their thoughts and feelings closely, because interactions with difficult patients may often be provocative, inducing reactions that must be carefully managed. Although referred to as "countertransference" in the psychoanalytic/psychodynamic tradition, monitoring and understanding one's own thoughts and feelings about a patient is applicable across all treatments [26]. Clinician reactions to the patient have been shown to impact the quality of the therapeutic alliance [27].

Treatment approach and technique must be flexible so that interventions can be made appropriate to the individual patient's style. The relationship may otherwise be jeopardized and the patient will not benefit or may leave treatment altogether. As an example, a study of 78 patients with borderline personality disorder found that an interaction between the relationship and therapeutic techniques influenced patients' course and outcome [28]. (See "Approaches to the therapeutic relationship in patients with personality disorders".)

Psychodynamic/psychoanalytic psychotherapy — A mixture of supportive and expressive (interpretive) elements occurs in every analysis or psychodynamic psychotherapy [29]. The expressive, insight-oriented mode of assisting patients in uncovering unconscious conflicts, thoughts, or affects through interpretation or confrontation may be appropriate at times, whereas a more supportive approach of bolstering the patient's defenses and coping abilities is preferable in other circumstances. (See "Overview of psychotherapies", section on 'Psychodynamic psychotherapy' and "Unipolar depression in adults: Psychodynamic psychotherapy".)

Flexibility is recommended in adjusting between supportive and interpretive interventions according to the dynamics of a particular patient at a particular time given the patient's capacities and vulnerabilities. Interpretation of transference, long considered the heart of the psychoanalytic approach, can be counterproductive with more disturbed patients, most notably those with borderline and narcissistic tendencies, particularly in the initial phase of treatment [30,31].

It may be difficult to focus on more insight-oriented interventions with a patient with borderline impairments until that patient is assisted in achieving a safe, more stable relationship. The severely narcissistically impaired patient may similarly not be able to accept the analyst's interpretations of their unconscious motivations for quite some time, so that supportive, empathic communications may be more effective interventions in building a relationship by helping the patient feel heard and understood. Some obsessional patients may, conversely, benefit earlier in treatment by interpretations of the conflicts that may underlie the symptoms. A clinical trial of 100 outpatients seeking psychotherapy for depression, anxiety, and personality disorders found that the therapeutic alliance measured at week 7 was significantly associated with patients' psychological, social, and interpersonal functioning at three-year follow-up [32].

Cognitive-behavioral therapies — Most cognitive, behavioral, and cognitive-behavioral therapies are predicated on establishing a productive therapist-patient collaboration from very early in the treatment, which involves the patient's undertaking specific activities, perhaps including "homework." Patients' willingness and ability to participate constructively in these activities can vary significantly, depending upon personality style and severity of symptoms such as anxiety and depression. Patients with more severe personality psychopathology, such as borderline or narcissistic disturbances, are sometimes more difficult to engage in the therapeutic tasks [33]. To facilitate the therapeutic relationship when working with patients with personality disorders, work needs to directly address therapist-patient collaboration with clearly set boundaries, and to focus attention in treatment on the relationship itself when appropriate [33,34]. (See "Overview of psychotherapies", section on 'Cognitive and behavioral therapies' and "Approaches to the therapeutic relationship in patients with personality disorders".)

As an example, dialectical behavior therapy (DBT) is commonly employed for highly self-harming patients with borderline personality disorder. Although DBT is a manualized, structured treatment with particular skills training tasks, the therapist needs to explore problems that arise in treatment and maintain a great deal of flexibility within the paradigm to achieve and maintain a therapeutic relationship [35]. There may be frequent occurrences of patient behaviors interfering with treatment, ranging from missed sessions to multiple suicide

attempts. (See "Borderline personality disorder: Psychotherapy", section on 'Dialectical behavior therapy'.)

Several clinical trials have found outcomes of cognitive-behavior therapy (CBT) to be significantly associated with the strength of the treatment alliance during CBT [36-38]. As an example, a trial of 224 adult patients with chronic depression who did not fully remit with pharmacotherapy compared treatment augmentation with 16 to 20 sessions of cognitive-behavior therapy to augmentation with brief supportive therapy. The working alliance between patient and therapist was significantly associated with the reduction of symptom severity in both groups. The association was stronger in patients treated with CBT compared with brief supportive therapy [36].

Psychopharmacology — Research has found the therapeutic alliance to be associated with patient outcomes in pharmacotherapy as well as in psychotherapy. A study of 225 patients with depression treated with interpersonal psychotherapy, cognitive-behavioral therapy, imipramine, or placebo found that the quality of the therapeutic alliance was significantly related to patient outcome for all treatment groups [39]. Two additional studies of patients who took either antidepressants or placebo showed that therapeutic alliance predicted response [40,41].

These findings suggest that the prescribing clinician should make every effort to involve the patient as a collaborator who engages actively in goal-setting as well as observing and evaluating the course of treatment [42]. Such collaboration, like other therapeutic processes, may be affected by distortions in the patient's views of the clinician. Patients with paranoid tendencies may think the physician is trying to trick them, or to take control of their lives. Some patients who are prone to expressing their emotions through physical sensations or complaints, such as those with borderline or histrionic tendencies, might be hypersensitive to any possible side effects (real or imagined). They may argue with the prescriber about their competence. Some patients may become upset if the clinician decides that medication is not warranted, feeling slighted because they think their problems are not being taken seriously.

Psychiatric hospital settings — Inpatient psychiatric care almost always involves a treatment team of multiple clinicians and aides assigned to an individual patient. This circumstance can be stabilizing in that it offers more intensive care than outpatient therapy, but it can also be potentially fraught with conflict if problems are not anticipated and managed. As an example, inpatients with borderline personality disorder may cause "splitting" in their relationships with members of the inpatient treatment team. This type of patient's mental world is often organized into black/white, good/bad polarities. Through interactions with various staff members, this internal world can be replayed externally, dividing staff member against staff member. The patient will present one self-representation to one or several team members and a very

different representation to another [43]. One group of staff members may be viewed as the "good" one by the patient and the other as the "bad" one, although these designations can flip precipitously in the patient's mind. The split can be enacted among team members as they begin to compete and to work at cross purposes. Communication and close collaboration among members of the inpatient or day-program treatment team are vital during every phase of this treatment. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Interpersonal difficulties' and "Collaboration between prescribing physicians and psychotherapists in mental health care".)

The inpatient or day-program team also needs to productively collaborate with clinicians who provide the patient's outpatient treatment. Hospitalization may represent a significant rupture in the outpatient therapeutic relationship; however, the rupture does not necessarily indicate that the outpatient treatment was ineffective and must be terminated. Work may be needed to reestablish the continuity of the treatment relationship and to coordinate inpatient care with the patient's outpatient clinicians. A study of 3406 patients with Cluster B personality disorders examined the relationship between the working alliance of the inpatient treatment team and effects on depressive symptoms. More challenging borderline traits were significantly associated with lower working alliance scores. Improved team alliance across treatment, however, predicted lower depression scores at discharge, with patients feeling heard, connected, and sharing goals with the team as important factors [25].

SUMMARY

- **Therapeutic relationship** – The relationship between a clinician and a patient in psychotherapy plays a central role in alleviating symptoms or fostering character change. The therapeutic alliance is one of the most robust predictors of outcome in psychotherapy. Clinician skill and tact are necessary to build a productive relationship. (See 'Introduction' above.)

- **Establishing a therapeutic relationship** – Establishing a therapeutic relationship within any treatment paradigm requires empathy and acknowledgment of a patient's view of the treatment and the treatment relationship. (See 'Therapeutic relationship' above and 'Relevance across treatment paradigms' above.)

- **Problems in the therapeutic relationship** – Clinicians should be prepared to make adjustments in their approach to patients to avoid or to address various strains or ruptures in the alliance that may occur. (See 'Problems in the therapeutic relationship' above.)

Unaddressed problems in the therapeutic relationship may lead to premature treatment termination by a patient. "Strains" are problems in the relationship that can undermine treatment effectiveness; "ruptures" are severe disruptions that threaten treatment continuity itself. Skillfully addressing ruptures may strengthen the relationship between a therapist and patient; the occurrence of rupture-repair episodes during treatment has been associated with better treatment outcomes. (See 'Problems in the therapeutic relationship' above.)

Several common issues that may strain the therapeutic relationship, but also provide opportunities for a therapist and patient to observe and learn about the patient's interpersonal relationships, include confidentiality, fee setting, personal disclosure, and gifts. (See 'Common treatment issues' above.)

- **Relevance across treatment paradigms** – No matter what treatment paradigm a therapist uses, attention to the therapeutic relationship is critical. The therapist must monitor their thoughts and feelings closely, because interactions with difficult patients may often be provocative, inducing reactions that must be carefully managed. Although referred to as "countertransference" in the psychoanalytic/psychodynamic tradition, monitoring and understanding one's own thoughts and feelings about a patient is applicable across all treatments. (See 'Relevance across treatment paradigms' above.)

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