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ORIGINAL ARTICLE

Structured Questionnaire To Measure Therapeutic Relationship

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Abstract:

The study attempts to develop and validate a new instrument to measure therapeutic relationship for use with high hospital principals and hospital employees. By using the three domains of therapeutic relationship, namely Patient factor, Therapist factors and Environmental factors, a primary questionnaire with 142 – item was developed and tested based on a sample of 250 hospital employees drawn from 4 hospitals representing in Iran. KMO Measure of Sampling Adequacy (.832) and Bartlett's Test of Sphericity (1345.32) and Analysis of Scree Plot have shown that the properties of sample are appropriate for factor analysis. Factor analysis for the final items items were made from which 64 items were extracted which had factor loading of >0.5 on the four domains. The properties of reliability and validity have borne significant results which show this instrument can be considered suitable to determine the position of therapeutic relationship in hospital employees.

KEYWORDS:,

Therapeutic relationship, structured Questionnaire, Reliability & Validity.

INTRODUCTION:

The implication of the therapeutic relationship has historical roots in the field of psychology. As theories evolved in mental health, a direct link between the therapeutic relationship and client change has been established (Sprenkle & Blow, 2004; Hardy & Barkham (2007); Werner-Wilson, Michaels, Thomas & Thiesen, 2003). The literature on the therapeutic relationship is almost exclusively within the context of individual therapy but has a few references to relational therapy. One of the most important questions in this area is that how research on the therapeutic relationship can be expanded to include a systemic focus. Thus, in order to understand the systemic nature of the therapeutic relationship, it is important to understand the historical viewpoint from the foundation of psychoanalytic, person centered, and alliance theories. These theories highlight the importance of the relationship in therapy. The literature recognizes at least three aspects of a sound therapeutic relationship:

1) The importance of clients' role as active and collaborative participants in the therapeutic process; 2) the value of client's investment in therapeutic activities forming the core of therapy (i.e. interpretation, homework, two-chair exercise, etc.); and 3) the crucial nature of the early phases of therapy from the perspective of relationship development (Horvath, 2000). These aspects have been inherited from psychoanalysis and client-centered theories and subsequently formulated the basis for alliance theory. These “aspects” have also provided the framework to shift the focus of the therapeutic alliance from an individualistic perspective to a systemic perspective.

Bordin (1979) identified three aspects of the therapeutic relationship: the development of bonds between therapist and client, the assignment of tasks, and agreement on goals. The affective aspects of the

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alliance consist of the relational bonds established between the therapist and the client. Qualities such as trust, respect and caring devise the relational foundation for building the therapeutic alliance. The second aspect of the alliance pertains to the distribution of tasks. This domain is comprised of the collaboration between therapists and clients surrounding activities engaged in during therapy. The therapists suggest specific interventions/activities to augment the clients' therapeutic experience. While the therapists make suggestions, the clients, on some level, must agree with the activity. The clients' agreement and collaboration around the task, along with the timing or pacing of the suggested activities are vital in the therapeutic relationship due to the fact that the clients' participation in treatment signifies their commitment to change. Bordin (1979) suggested that such collaboration relies heavily on the therapists' ability to help their clients.

The final aspect of the therapeutic relationship focuses the therapists' and clients' ability to mutually create and invest in goals for treatment. This feature of the alliance reflects the need for collaboration between the clients and therapists. These three parts of the therapeutic relationship formulate the therapeutic alliance, which expands the conceptualization of the relationship between therapists and clients. Although Bordin acknowledged the importance of the relationship, he did not address issues of counter transference.

Research suggests that therapists also believe that the therapeutic relationship is a healing, yet changing entity where clients can receive a “corrective emotional experience” (Marziali, 1984; Tallman & Bohart, 1999). This experience comes about from relationships where the therapist's position as a supportive and non-judgmental listener helps repair damage done by previous relationships. It also provides an environment that is more conducive to healing and positive reinforcing behaviors that leads the client toward change.

In cognitive behavior therapy (CBT), however, the therapist, in collaboration with clients, applies techniques such as evidence testing and new learning to help clients manage their psychological difficulties, sometimes instead of focusing on the therapeutic relationship itself (Pierson and Hayes 2007). The preferred order of importance of the three parts of the therapeutic alliance are goal, task and bond (Bordin 1979). Cognitive behaviour therapy can be thought of as a family of differing evidence-based psychotherapeutic approaches. Specific interventions for a range of psychological disorders (Beck et al 1979) have developed from these approaches and there is growing interest in how the therapeutic relationship contributes to outcomes (Safran 1998, Gilbert 2000, Hardy et al 2007).

People receive therapy as they would with any form of care, with varying expectations, motivations, presentations and experiences. Similarly, the therapists people see differ in skill, sensitivity and empathy. All these factors influence the bond formed between therapist and client (Leahy 2008), and breakdowns in the collaborative process, known as 'ruptures', can be important points for intervention (Katzow and Safran 2007).

Muran et al (2009) found that a lower intensity of rupture is associated with higher quality of sessions and outcomes, and that higher resolution of ruptures is a predictor of greater client retention. If ruptures are not discussed frankly in or outside formal therapy, their resolution may be blocked. Consequently, such discussion with clients can be an important feature of the work of mental health professionals. Generally, CBT therapists report less rupture and provide more positive assessments of the therapy process than their peers (Aspland et al 2008), although this finding does not necessarily indicate that there are fewer relational incidents during CBT, but may be the product of the greater emphasis on technique in CBT than in other forms of therapy.

Inevitably, some methodological difficulties arise in researching fluid concepts like the therapeutic relationship. Robust results are rare due to variations in CBT technique, client history and therapist competence, and in the quality of published studies.

Elvins and Green (2008) point out that, although the evidence for the effect of the working relationship on treatment outcomes is impressive, much less is known about its components and measurement. They conclude that there is no single instrument that can measure the complexity of the alliance and that there is much more to do before a universal measure has been accepted as valid in therapy and supervision.

While a positive therapeutic relationship is a necessary prerequisite for a successful therapeutic outcome, it remains a largely unmeasured phenomenon that is not well understood. A review of the theoretical and empirical literature indicates that the elements of the therapeutic relationship in relation to interactive, subjective and dynamic components have been largely ignored (L. M. Weibe, University of Toronto, Toronto, unpublished dissertation). This study aims to provide empirical evidence in relation to understanding a fundamental aspect of the psychiatric nurses' role, namely what constitutes the therapeutic relationship. Psychiatric nurses intuitively form relationships with patients and these relationships invariably are stated to be therapeutic. Exploration of this phenomenon in a scientific sense is fundamental

to understanding how and why the psychiatric nurse performs his or her role.

A review of clinical social work outcome literature reveals a lack of process– outcome research in the evaluation of clinical social work practice. Russell, in a comprehensive review of clinical social work research, which included studies undertaken between 1970 and 1988, argues that, 'In social work studies. these (therapy specific) characteristics have been studied infrequently in relation to outcome' (Russell, 1990). She could cite only one study that has included a discussion of the importance of the therapeutic alliance in social work (Marziali, 1984). More recent studies (Coady, 1991; Young & Poulin, 1998) have directly explored the link between the worker–client relationship and the outcomes of counselling practice. They both identified the therapeutic relationship as predictive of positive outcomes. In general there has been a failure on the part of researchers and social work clinicians to actively enter a phase of research aimed at understanding more completely the nature of social work intervention processes and how its components impact upon outcomes. The importance of this relationship in nursing adolescents diagnosed with anorexic is also well established but there is still insufficient research to provide an in-depth understanding of these difficulties and why they develop or of how nurses believe therapeutic relationships might be improved.

Over the last 30 years the therapeutic relationship in psychotherapy has been researched using a number of different measurement tools (Bambling & King, 2001). Of these tools, the Working Alliance Inventory (WAI) developed by Horvath and Greenberg (1989) was considered the most relevant, usable and reliable to replicate in the present study. The one measurement tool that had recently been developed to assess the relationship in social work practice by Young and Poulin (1998), the Helping Alliance Inventory, was not used in the study as it was developed as a tool to indicate the quality of the relationship within sessions, whereas the evaluation study was aimed at a retrospective analysis of clients' experience of the service as a whole.

The development of the WAI emerged out of the work of Edward Bordin who developed the notion of the therapeutic working alliance originally identified by psychoanalyst Ralph Greenson as one of three distinct components comprising the therapeutic relationship in psychotherapy (Gelso & Carter, 1985). Bordin's development of the concept was based on the formulation of the working alliance between the client seeking change and the therapist offering to act as a change agent, as incorporating a mutual understanding and agreement about change goals and the necessary tasks to move towards these goals along with the establishment of bonds to maintain the partners' work. The working alliance was defined by Bordin as consisting of three dimensions:

bond, tasks and goals. The bond dimension concerns a complex network of positive personal attachments between the client and the counsellor that includes mutual trust, acceptance and confidence. The task dimension concerns in-counselling behaviours and cognitions that form the substance of the counselling process. In a well-functioning relationship participants perceive these tasks as relevant and efficacious and accept responsibility for performing these acts. The goal dimension refers to the target of interventions which are mutually endorsed and valued by the counsellor and client. Using Bordin's theoretical framework, Horvath and Greenberg (1989) developed the Working Alliance Inventory, a 36-item inventory aimed at measuring its overall strength. On the basis of the results of the studies conducted by the authors, they argue that the WAI provides a reliable and valid basis for the development of a scale to measure the therapeutic relationship as a working alliance

(Horvath & Greenberg, 1989). Other studies have explored the complexity of the therapeutic alliance, particularly from the viewpoint of the client and noted that the alliance is not only multi-dimensional in terms of major foci (alliance as client– therapist bond; as improved self-understanding; and as ollaboration) but that this focus can change over the course of the therapeutic relationship (Bachelor, 1995).

Despite the abundance of research exploring the dimension of therapeutic relationship in developed countries, relatively little attention has been paid in their counterparts. The current study proposes to investigate the various dimensions of therapeutic relationship and is aimed towards eliciting it in a group of hospital principals & hospital employees in Iran. Therapeutic relationship comprises of three dimensions. First is Patient factor, the second dimension, Therapist factors and third, dimension is Environmental factors.

Recognizing the need for an instrument that addresses the diversity of Iran academic population, Therapeutic relationship Questionnaire (TRQ) was developed for their specific use. Due to the above reason the two questions in this study are:

Does TRQ items generated reflect previously identified domains factors?
Does the TRQ evidence satisfy reliability and validity?

2.0 METHOD:

2.1 Sample Characteristics

The sample for factor analysis was 250 hospital employees representing 4 hospitals. These samples were cluster randomly selected and grouped on the basis of their sex, age, experience, academic levels, status of hospital, etc.

2.3 Procedure:

This study was carried out in four interconnected but separate phases. Planning, Construction, Quantitative evaluation and Psychometric properties. Summary of this study are in Table 2.

Table 2, Scale Development Procedure:

Phase	Scale Development Procedure
Phase 1 "Planning"	Identify the purpose of (TRQ), Identify the audience that the results of the (TRQ) study will be most important to: Principals, Hospital employees, Counselors & Students. Conducting a literature review in which all of the theories of Therapeutic relationship are united. Conducting a pilot study to tryout different potential items. Conducting two sets of interviews with hospital employees.
Phase 2 "Construction"	Determining and defining domains by linking visual illustration of various theories related to therapeutic relationship. Generating item pool with items that are distinguishable both by domain and level of agreeability. Conducting expert reviews of all items for content validation.
Phase 3 "Quantitative Evaluation"	Administering the item pool on the hospital employees. Reducing item pool to only the most valid and reliable items and factors by using factor analysis.
Phase 4 "Psychometric Properties"	Assessing the validity of the scale (concurrent validity). Assessing the reliability by internal consistency (alpha chronbach).

3.0 RESULTS & DISCUSSION

3.1 Developing item pool questionnaire

By using all aspects of therapeutic relationship, an item pool with 142 items was initially developed. These 142 items reduced to 93 appropriate items and again were corrected by 3 experts and 4 interviews with hospital employees. Finally, 29 items were removed from the main questionnaire and retained only those 64 items which was then administered on the hospital employees. They were asked to respond using a 5- point likert – type scale .The scale ranged from 1 to 5. (1 = Never) (5 = Always).

3.2 Factor extraction

The 65 itemed instrument on Therapeutic relationship was administered to the 350 hospital employees and their scores were subjected to factor analysis using principal component and varimax rotation to verify the factorial composition of the instrument as well as define the common measure. Kaiser-Meyer-Olkin Measure of Sampling Adequacy (.832) and Bartlett's Test of Sphericity (1345.32), has shown that the properties of sample are appropriate for factor analysis it has shown in table 3.

Table 3, KMO and Bartlett's Test:

Kind of test	Aims	Result
Kaiser-Meyer-Olkin	Measure of Sampling Adequacy	.832**
Bartlett's Test	Measure The Sphericity	1345.32**

Note: ** p <0.01

More over the number of factors was determined by contrasting the results of a parallel analysis with an analysis of the Scree plot below

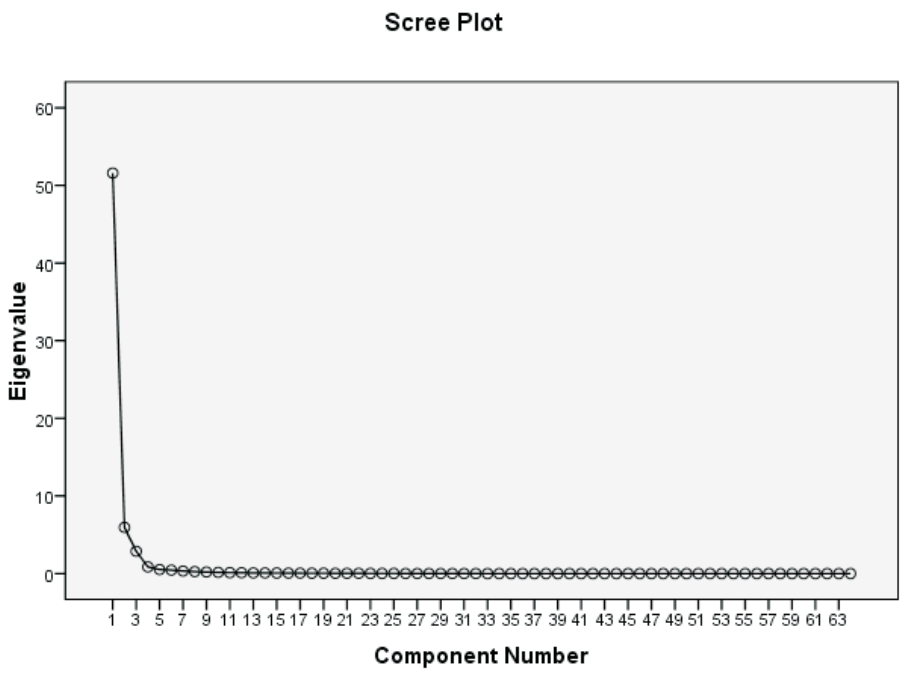

Figure 1: Scree plot to determine the number of factors.

3.3 FACTOR INTERPRETATION

Results of the factor analysis indicate that out of the 65 items of the TRQ subjected to factor analysis with varimax rotation; only 24 items attained the minimum loading of 0.50 and was accepted as valid. As it is shown in appendix 1, factor 1 is comprised of 8 items associated with personal influences

(Idealized Influence). Factor 2 comprises 3 items associated with motivational aspects (Inspirational motivation), factor 3 contains 5 items associated with cognition and thinking aspects (Intellectual stimulation) and factor 4 contains 9 items associated with individual concern (Individual Consideration).Together, these four factors accounted for 88.26 percent of the variance. Their quasi-orthogonal nature suggests that each factor is measuring something unique.

3.4 Reliability And Validity:

Reliability: The indices of internal consistency associated with each sub-scale has shown that all of four subscales exceed 0.73 ; which is often regarded as the benchmark for claiming that a scale is sufficiently reliable to be used in applied settings.

Table 4: Subscale Means, Standard Deviations, and Cronbach Alpha Coefficients of TRQ

N	factor	M	SD	@	sig
1	Patient factor	2.1	.92	.82	.01
2	Therapist factors	1.22	.83	.72	.01
3	Environmental factors	2.13	.92	.830	.01

Note. N = 450

Validity: concurrent validity has showed the relationship between total score on each subscale of the TRQ items and the score on TRS (Therapeutic relationship scale). As expected, all subscales on the TRQ were positively correlated with TRS (Therapeutic relationship scale).

Table 5: Inter-correlations between subscales of TRQ and TRS.

Scale		1	2	3
Subscales of TRQ	**Patient factor**	-		
	Therapist factors	.39*	-	
	Environmental factors	.36*	.54**	-
TRS		.57**	.64	.31*

Note: N = 350. All of this correlation is significant at. * p <0.05 and ** p <0.01.

3.5 CONCLUSIONS

The purpose of this study was to investigate the nature of therapeutic relationship and develop an instrument to assess therapeutic relationship for use specifically with high hospital principals & hospital employees.

Analysis of data in this study has shown that there is support for the inclusion of four factors namely idealized influence, inspirational motivation, intellectual stimulation & individualized consideration in therapeutic relationship with factor loading of >0.5 on the four domains. KMO Measure of Sampling Adequacy (.832) and Bartlett's Test of Sphericity (1345.32) and Analysis of Scree Plot has shown that the properties of sample are appropriate for factor analysis.

The quasi-orthogonal nature suggests that each factor is measuring something unique. Factors associated with personal influences, motivation, cognition and thinking & individual concern are reliable & valid. The indices of internal consistency show that the scale is sufficiently reliable. There exists a positive co-relation between TRQ and TRS. Similarly, a number of previous studies (Bass & Avolio, 1992 and Avolio, et al., 2003) show support for the four factors.

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Appendix:

Summary of factor loading for the surviving 64 items on the three valid factors (final questionnaire):

	Patient factor					
1	patient`s perception of the problem	Nothing	very less	less	much	Very Much
2	patient`s experience of therapeutic relationship	1	2	3	4	5
3	level of problem and needs	1	2	3	4	5
4	quality of patient`s participation in therapeutic relationship	1	2	3	4	5
5	level of trust	1	2	3	4	5
6	level of adaptive skills in patients	1	2	3	4	5
7	patient`s attitude to therapeutic relationship	1	2	3	4	5
8	patient`s ability for coping with conditions	1	2	3	4	5
9	diagnose	1	2	3	4	5
10	patients age	1	2	3	4	5
11	congruency of gender	1	2	3	4	5
12	economical status of patient	1	2	3	4	5
13	educational status (patients)	1	2	3	4	5
14	patients personality	1	2	3	4	5
	Therapist factor					
1	nurse`s ability for trust creation	1	2	3	4	5
2	nurse`s ability for coping	1	2	3	4	5
3	nurse`s manner to build trust	1	2	3	4	5
4	nurses empathy	1	2	3	4	5
5	nurses perception	1	2	3	4	5
6	nurses previous experience of t.r	1	2	3	4	5
7	non-judgmental attitude in nurses	1	2	3	4	5
8	listening skills in nurses	1	2	3	4	5
9	nurse`s creativity in T.R	1	2	3	4	5
10	expertise skills in caring	1	2	3	4	5
11	communication skills in nurses	1	2	3	4	5
12	nurse`s commitment to patients	1	2	3	4	5
13	sharing emotions	1	2	3	4	5
14	considering the whole condition	1	2	3	4	5
15	nurse`s expertise knowledge of caring	1	2	3	4	5
16	verbal and non-verbal communication	1	2	3	4	5
17	senility to patient`s needs	1	2	3	4	5
18	attention to first encounter	1	2	3	4	5
19	nurse`s self-awareness	1	2	3	4	5
20	ability of thinking and reflection in nurses	1	2	3	4	5
21	monitoring of patient`s progress	1	2	3	4	5
22	power imbalance	1	2	3	4	5
23	nurse`s knowledge about communication	1	2	3	4	5

24	standard development and specifying boundaries	1	2	3	4	5
25	considering patient's value system	1	2	3	4	5
26	nurse`s flexibility	1	2	3	4	5
27	involving the patient into decision making	1	2	3	4	5
28	perfectionism in nurses	1	2	3	4	5
29	ready for all sessions	1	2	3	4	5
30	nurse`s honesty	1	2	3	4	5
31	nurse`s kindness	1	2	3	4	5
32	observation skills in nurses	1	2	3	4	5
33	taking history	1	2	3	4	5
34	nurse`s ability for risk assessment	1	2	3	4	5
35	nurse`s composure	1	2	3	4	5
36	nurses responsibility	1	2	3	4	5
37	good reaction to challenges in nurses	1	2	3	4	5
38	nurse`s confidentiality	1	2	3	4	5
	Environmental factors					
1	appropriate place	1	2	3	4	5
2	good equipment	1	2	3	4	5
3	predict of conditions and possibilities	1	2	3	4	5
4	ethical considerations	1	2	3	4	5
5	cultural consideration	1	2	3	4	5
6	period of hospitalization	1	2	3	4	5
7	location of admission	1	2	3	4	5
8	name and fame of hospital	1	2	3	4	5
9	name and fame of doctors	1	2	3	4	5
10	number of staffing	1	2	3	4	5
11	economical statuse	1	2	3	4	5
12	supportive systems	1	2	3	4	5