Investigating the anatomy of the helping relationship in the context of psychiatric rehabilitation: The relation between working alliance, providers’ recovery competencies and personal recovery

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\textbf{A B S T R A C T}

Professional helping relationships established with mental health consumers are vital in mental health recovery processes. However, little is known about how the constructs of alliance building and providers’ recovery promoting strategies relate to each other and play a role in supporting recovery. To this end, we examined associations between consumer-reported working alliance, perceived providers’ recovery competencies, and personal recovery. In a cross-sectional study design, 72 mental health consumers who established relationships with providers through a psycho-educational intervention over a period of 10 months in hourly weekly sessions were examined as part of a larger study conducted in mental health community settings in Israel. Participants filled in the Working Alliance Inventory (Tracey and Kokotovic, 1989), the Recovery Promoting Relationships Scale (Russinova et al., 2013), and Recovery Assessment Scale (Corrigan et al., 2004). Pearson correlations and linear regression analysis showed positive correlations between relational variables and recovery. A mediating model was identified whereby providers’ recovery strategies positively impact the working alliance, which, in turn, positively impact consumers’ recovery. Implications of the current study for future research and clinical practice are discussed, emphasizing the importance of examining recovery strategies and the working alliance with regard to the process of mental health recovery.

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1. Introduction

In recent decades a shift towards a more optimistic view about the possibility of recovery of people with serious mental illnesses has gained prominence around the world (Andresen et al., 2010; Anthony, 1993; Moran et al., 2012; Morrison et al., 2013; Slade et al., 2012). A necessary building block on the road to recovery is a supportive relationship, often developed with practitioners (Angell and Mahoney, 2007; Deegan, 2001; Farkas and Anthony, 2010; Moran et al., 2014; Slade, 2009). Such relationships involve not just “what” clinicians do, but first and foremost “how” they do it; that is, the interpersonal context itself (Davidson et al., 2009; Slade, 2012).

Given the multi-layered challenges mental health consumers often face, it is not surprising that having a connection with someone who supports and provides hope is essential and often crucial (Deegan, 2001; Farkas et al., 2005; Slade, 2009). These challenges include the debilitating effects of impairment and disability due to mental illnesses (Deegan, 1988; Onken et al., 2007; Russinova, 1999); psycho-social consequences, economic and social disadvantages, deficient state of health care, and low quality of life (e.g. Thornicroft, 2006), as well as loneliness, reduced self-esteem, self-efficacy, and stigma (Hinshaw, 2007; Moran et al., 2012a; Rusch et al., 2010; West et al., 2011). Thus, consumers often experience deep and prolonged periods of despair. Such a state leaves recipients of services disempowered and discouraged when facing the daily tasks involved in acquiring skills and competencies as part of their rehabilitation processes. Having someone who is sensitive to one’s multiple life challenges, acknowledges one’s personhood, provides hope, and supports a self-determined approach helps alleviate some of these emotional burdens (Bedregal et al., 2006; Borg and Kristiansen, 2004; Deegan, 1993; Moran et al., 2012; Onken et al., 2007; Russinova, 1999).

Yet, establishing a professional and effective helping relationship with mental health consumers is easier said than done. Marrelli et al.
(2005) highlight the complexity of psychiatric rehabilitation practitioner competencies as requiring an amalgam of knowledge, skills, abilities, and personal characteristics. In contrast to more traditional helping relationships (e.g., treatment/psychotherapeutic relations); here, the roles, tasks, and goals of providers vary considerably in terms of their focus, location, and duration. Perhaps what lies at the core of this complexity is the somewhat loose connection between rehabilitation and recovery. Recovery is an internal subjective and non-linear process, rather than the end target of a particular rehabilitation service. However rehabilitation often involves a focus on attainment of tangible goals (Anthony, 1993; Deegan, 1988; Slade, 2009). As a result of this loose connection, providers may experience recovery and rehabilitation needs as conflicting: attaining concrete goals within a realistic timeframe can be experienced as competing with time invested in forming a relationship that supports recovery. Such a relationship often involves being there for the person and attending to their feelings in support of their personal recovery process.

In recent years, the working alliance has emerged as a central relational concept, well known from the field of psychotherapy, which is comprised of the sense of bonding between client and therapist and their agreement on the tasks and goals of treatment (Horvath, 1994). The working alliance was found to positively impact processes and outcomes of therapies, irrespective of the type of treatment modality (Horvath, 2005; Horvath and Symonds, 1991; Lambert and Barley, 2001). More specifically, the working alliance was identified as important for people in psychiatric care relationships (Crowe et al., 2006; Priebe and McCabe, 2008). For example, a positive association was found between therapist working alliance ratings and outcomes in the treatment of depression (Weiss et al., 1997), schizophrenia, psychosis, and major affective disorders (McCabe and Priebe, 2003; Neale and Rosenheck, 1995). In addition, poorer alliance at admission to hospital predicted violent behavior during the first week of hospitalization (Beaurord et al., 1997). In recent years the working alliance was specifically identified as relevant to promoting client engagement, overcoming disagreements, and enabling delivery of complex treatment programs in psychiatric practices (McCabe and Priebe, 2004).

More novel is the conceptual model and scale of Russinova et al. (2013), which address the perceptions of the consumer regarding the provider’s use of recovery promoting competencies. They describe two components comprising such competencies: a. providers’ core interpersonal skills, which involve a humanistic, empathic, and respectful approach; and, b. provider utilization of a set of specific recovery-promoting strategies (i.e., empowering, enhancing hope, and self-acceptance). Beyond conceptual development, their study demonstrates the feasibility of identifying specific provider competencies relevant to the population of people with serious mental illnesses.

1.1. The present study

The accumulating knowledge about the relational construct of alliance and consumer perceptions of provider’s use of recovery promoting competencies suggest they may be, and that both are important for recovery. However, little is known about how recovery promoting competencies and alliance building relate to each other and play a role in supporting recovery. Thus, the purpose of the present study was to examine the relationship between working alliance (Horvath, 2005) and consumer perceptions of recovery promoting relationships (Russinova et al., 2013), as well as to examine how these variables relate to self-reported recovery. Such an examination was expected to broaden the knowledge about the characteristics of recovery promoting consumer-provider relationships.

Specifically, we hypothesized that:

1) There will be a positive relationship between consumers’ experiences of the working alliance and their perceptions of providers’ use of recovery promoting competencies.
2) There will be a positive relationship between the working alliance, perceptions of providers’ use of recovery promoting competencies and consumers’ self-reported recovery.
3) The working alliance will moderate the relationship between perceptions of recovery promoting competencies and consumers’ self-reported recovery.
4) The working alliance will mediate the relationship between perceptions of recovery promoting competencies and consumers’ self-reported recovery.

2. Methods

2.1. Research setting

This study was part of a larger research project conducted between October 2010 and September 2011 aimed to assess the effectiveness of illness management and recovery (IMR) (Gingerich and Mueser, 2005). It was administered over a 10 month period across 43 psychiatric rehabilitation community service agencies. The current study focused on 14 residential community services in the southern part of Israel. IMR intervention was conducted in small group format with trained providers in 10 weekly sessions. Participants were administered three self-report scales upon completion of the intervention (Working Alliance, Recovery Promoting Relationships, and Recovery Assessment). Ethical approval for the study was obtained by the Helsinki Ethics Committee. After receiving a detailed description of the study, study participants provided written informed consent.

2.2. Participants

Seventy-two people with serious mental illnesses whose ages ranged from 20 to 60 years (M = 43.2, S.D. = 10.6) participated in the study. All had at least a 40% psychiatric disability, which indicates substantial reduced work capacity and difficulties in social adaptation, as determined by a professional medical committee. This committee included a psychiatrist and was recognized by the Israeli National Insurance Institute. Participants were diagnosed with schizophrenia, schizoaffective, bipolar, and/or depressive disorders, and were living in supported residential facilities. Inclusion criteria were fluency in Hebrew and providing informed consent. About half were women (51%, n = 37) and more than half had never been married (61%, n = 44). Almost two-thirds had at least high school level education (65%, n = 47).

2.3. Measures

The questionnaire includes three measures: Recovery Assessment Scale (RAS), Recovery Promoting Relationships Scale (RPRS), and Working Alliance Inventory (WA).

2.3.1. Recovery Assessment Scale

The RAS (Corrigan et al., 2004; Roe et al., 2012b) is a 41-item scale that assesses perceptions of recovery from severe mental illness. Participants endorse items (e.g., “I have a desire to succeed”) on a 5-point Likert scale (1 = do not agree at all, and 5 = very much agree). The RAS has good psychometric properties and is correlated with measures of self-esteem, empowerment and quality of life (Corrigan and Phelan, 2004). The current study used a short Hebrew 20-item version and analysis was performed on 12 items that supported four out of the five factors originally identified (Roe et al., 2012a). A confirmatory factor analysis (Roe et al., 2012a) yielded four factors: personal confidence and hope with three items (Cronbach’s alpha = 0.72), willingness to ask for help with three items (Cronbach’s alpha = 0.91), reliance on others with three items (Cronbach’s alpha = 0.66), and no domination by symptoms with three items (Cronbach’s alpha = 0.70). In the present study, Cronbach’s alphas were 0.83, 0.93, 0.68 and 0.75 for personal confidence and hope, willingness to ask for help, reliance on others, and no domination by symptoms, respectively.

2.3.2. Recovery Promoting Relationships Scale

The RPRS (Russinova et al., 2011; Russinova et al., 2013) is a 24-item scale with each item ranging from 0 “disagree” to 3 “agree” (e.g., “My provider helps me recognize my strengths”). All items are phrased positively, so that greater scores represent higher provider competencies. For each item participants may also choose the option “not applicable”. In previous assessments the RPRS demonstrated a high level of internal consistency with alphas ranging from 0.88 to 0.98 for the total scale. The RPRS has perspective norms for an acceptable level of practitioners’ recovery promoting competence (Russinova et al., 2006).
The RPRS was translated to Hebrew in consultation with the developers of the scale employing forward-backward translation and sensitivity to cultural-linguistic discrepancies approaches (Morgan et al., 2014; Russinova et al., 2013). Its psychometric properties were assessed based on administration to 216 mental health consumers in mental health community settings. The RPRS-Heb yielded a 23-item RPRS-Heb version with a psychometrically sound factor structure, satisfactory reliability, and concurrent validity tested against the Hope, Alliance, and Recovery Assessment Scales. The emerging two-factor structure of the RPRS-Heb includes a 15-item Recovery Strategies Index (RPRS-RI) (Cronbach’s alpha = 0.91), which relates to providers’ empowering, hope giving, and enhancement of self-acceptance, and an 8-item Core interpersonal skills index (Cronbach’s alpha = 0.72), which relates to qualities of the relationship (i.e., caring, understanding, respect, trust, etc.) (Morgan et al., 2014).

In the current study, for the purpose of processing the data, we addressed only the RPRS-RI factor because the core interpersonal skills factor had a low dispersion (M = 2.90, S.D. = 0.19). The reason for not addressing the core interpersonal index was that in a state where a variable has a low variance, it leads to underestimation of the correlation coefficients with the other variables.

2.3.3. Working Alliance Inventory

The Working Alliance Inventory (Horvath and Greenberg, 1989; Tracey and Kokotovic, 1989), originally developed by Horvath and Greenberg (1989), was measured by participants in its short version (WAI-S; Tracey and Kokotovic, 1989). It is one of the most researched and utilized measures of working alliance (Busseri and Tyler, 2003; Martin et al., 2000). The WAI-S is a 12-item instrument (e.g., “My provider and I respect each other”) scored on a 7-point Likert scale (1 = do not agree at all, and 7 = very much agree), and assesses one general scale (General Alliance or Total). The total score for the WAI-S ranges from 1 (low working alliance) to 7 (high working alliance). The WAI-S has strong internal consistency of alpha = 0.90 to alpha = 0.95 for the total score (Busseri and Tyler, 2003; Tracey and Kokotovic, 1989). The WAI-S has acceptable test re-test reliability over an average interval of two weeks (0.83; Horvath, 1994), while a meta-analytic review conducted by Martin et al. estimated that the test-retest reliability was approximately 0.73. Research has also shown the WAI-S to have sound predictive and concurrent validity (Busseri and Tyler, 2003). The WAI-S was translated to Hebrew using forward-backward translators. In the present study, internal consistency (Cronbach’s alpha) was 0.73.

2.4. Statistical analysis

Analyses were computed using the Predictive Analytics SoftWare (PASW, Version 21.0). The analysis was calculated on 72 responses. Analyses were performed in four steps. First, we performed Pearson correlations between the variables (RAS, Recovery-strategies, and WAI). In addition, we assessed multicollinearity by examining tolerance and the Variance Inflation Factor (VIF). Tolerance is defined as the amount of variability of the selected independent variable not explained by the other independent variables and VIF is calculated as the inverse of the tolerance value (Hair et al., 2006). Multicollinearity exists when at least one of the input variables is an exact linear combination of the other input variables, which suggests that multicollinearity is not likely to present an issue in the analysis (Hair et al., 2006).

3. Results

3.1. Relationships between variables

Correlations between all the variables (RAS, RPRS-RS, and WAI), were explored and are reported in Table 1. As can be seen, there was a significant positive correlation between RPRS-RS and WAI (r = 0.55, p < 0.001). In addition, there was a significant positive correlation between RPRS-RS and RAS (r = 0.42, p < 0.001) and between WAI and RAS (r = 0.59, p < 0.001). Analysis of the subscales revealed a positive correlation between RPRS-RS and different subscales of RAS. Of these, two had a medium effect size; r = 0.36 (p < 0.01) for ‘willingness to ask for help’, and r = 0.40 (p < 0.001) for ‘reliance on others’. Two had small effect sizes; r = 0.24 (p < 0.05) for ‘no domination by symptoms’ and r = 0.22 (p > 0.05) for ‘personal confidence and hope’ sub-scale. Furthermore, there was a significant positive correlation between WAI and all the sub-scales of RAS.

To detect the potential problem of multicollinearity, we checked the tolerance and the variance inflation factor (VIF) for each independent variable (RPRS-RS and WAI) and found that the tolerance value was 0.70 and the VIF value was 1.4 for both variables, which suggests that multicollinearity is not likely to present an issue in the analysis (Hair et al., 2006).

3.2. Multiple regression analysis

To further examine the association between the relationship variables and the consumer’s perceived recovery, we performed multiple regression analysis, with total RAS scores as the dependent variable and the RPRS-RS and WAI as independent variables. We found that WAI significantly predicted RAS scores in the model; F(2,69) = 19.48, p < 0.001, R squared = 0.36. RPRS-RS was not a significant predictor of RAS. The results of the regression analysis are presented in Table 2.

3.3. WAI as moderating between RPRS-RS and RAS

To test the moderation model we used hierarchical regression analysis (Jaccard et al., 1999). In this analysis RPRS-RS and WAI were the independent variables and RAS was the dependent variable. The interaction effect of RPRS-RS and WAI was estimated by the product of these variables. The analysis was carried out in two steps. RPRS-RS and WAI were entered into the regression at step 1 and the product term variable was entered at step 2. The analysis did not reveal significant interaction (β = −0.043, p = 0.728), which suggests that WAI does not moderate these relationships.

Table 1

<table>
<thead>
<tr>
<th>Pearson correlations, Cronbach α, Means, S.D.s, and possible ranges of the variables.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>α</th>
<th>M (S.D.)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RAS – Total scale</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.84</td>
<td>3.91 (0.69)</td>
</tr>
<tr>
<td>2. RAS – Hope</td>
<td>0.81***</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.83</td>
<td>3.94 (0.98)</td>
<td>1–5</td>
</tr>
<tr>
<td>3. RAS – Help</td>
<td>0.63***</td>
<td>0.24*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>0.93</td>
<td>4.17 (0.93)</td>
<td>1–5</td>
</tr>
<tr>
<td>4. RAS – Others</td>
<td>0.61***</td>
<td>0.37***</td>
<td>0.33***</td>
<td>1</td>
<td></td>
<td></td>
<td>0.68</td>
<td>4.14 (0.81)</td>
<td>1–5</td>
</tr>
<tr>
<td>5. RAS – Symptoms</td>
<td>0.78***</td>
<td>0.64***</td>
<td>0.27</td>
<td>0.17</td>
<td>1</td>
<td></td>
<td>0.75</td>
<td>3.38 (1.16)</td>
<td>1–5</td>
</tr>
<tr>
<td>6. RPRS – RS</td>
<td>0.42***</td>
<td>0.22</td>
<td>0.36***</td>
<td>0.40***</td>
<td>0.24***</td>
<td>1</td>
<td>0.91</td>
<td>2.61 (0.48)</td>
<td>0–3</td>
</tr>
<tr>
<td>7. WAI</td>
<td>0.59***</td>
<td>0.50***</td>
<td>0.35***</td>
<td>0.37***</td>
<td>0.45***</td>
<td>0.55***</td>
<td>0.73</td>
<td>5.64 (0.75)</td>
<td>1–7</td>
</tr>
</tbody>
</table>

M=mean; S.D.—standard deviation. RAS—Recovery Assessment Scale; RPRS-RS—Recovery Promoting Relationships Scale-Recovery Strategies; WAI—Working Alliance Inventory.

* p < 0.05.
** p < 0.01.
*** p < 0.001.

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A signiﬁcant positive correlation was found between these two variables ($\beta = 0.42$, $p < 0.001$). We then conducted a regression analysis to test whether RPRS-RS predicts WAI. A signiﬁcant positive correlation was found ($\beta = 0.55$, $p < 0.001$). Further, we performed linear regression analysis to test whether RPRS-RS and WAI predict RAS (see Table 2). Results of the regression revealed a signiﬁcant positive correlation between WAI and RAS when controlling for RPRS-RS ($\beta = 0.52$, $p < 0.001$) but did not reveal a signiﬁcant correlation between RPRS-RS and RAS when controlling for WAI ($\beta = 0.13$, $p > 0.05$). As can be seen, the correlation between RPRS-RS and RAS decreased from $\beta = 0.42$ to $\beta = 0.13$ when controlling for WAI. The Sobel test (Sobel, 1982) revealed that this difference is signiﬁcant ($Z = 3.49$, $p < 0.001$). These results indicate that WAI mediated the relationship between RPRS-RS and RAS (see Fig. 1).

### Table 2

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>$B$</th>
<th>S.E.</th>
<th>$\beta$</th>
<th>$t$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>0.74</td>
<td>0.51</td>
<td>1.44</td>
<td>0.16</td>
<td></td>
</tr>
<tr>
<td>RPRS-RS</td>
<td>0.19</td>
<td>0.17</td>
<td>0.13</td>
<td>1.15</td>
<td>0.25</td>
</tr>
<tr>
<td>WAI</td>
<td>0.48</td>
<td>0.11</td>
<td>0.52</td>
<td>4.48</td>
<td>0.00</td>
</tr>
</tbody>
</table>

RAS = Recovery Assessment Scale; RPRS-RS = Recovery Promoting Relationships Scale-Recovery Strategies; WAI = Working Alliance Inventory.

Fig. 1. Results for linear regression analyses and Sobel tests for the mediation hypothesis $p < 0.001$.

### 3.4. WAI as mediating between RPRS-RS and RAS

To test the mediation model we used linear regression analysis (Baron and Kenny, 1986). First, we investigated the direct effect of RPRS-RS on RAS. A signiﬁcant positive correlation was found between these two variables ($\beta = 0.42$, $p < 0.001$). We then conducted a regression analysis to test whether RPRS-RS predicts WAI. A signiﬁcant positive correlation was found ($\beta = 0.55$, $p < 0.001$). Further, we performed linear regression analysis to test whether RPRS-RS and WAI predict RAS (see Table 2). Results of the regression revealed a signiﬁcant positive correlation between WAI and RAS when controlling for RPRS-RS ($\beta = 0.52$, $p < 0.001$) but did not reveal a signiﬁcant correlation between RPRS-RS and RAS when controlling for WAI ($\beta = 0.13$, $p > 0.05$). As can be seen, the correlation between RPRS-RS and RAS decreased from $\beta = 0.42$ to $\beta = 0.13$ when controlling for WAI. The Sobel test (Sobel, 1982) revealed that this difference is signiﬁcant ($Z = 3.49$, $p < 0.001$). These results indicate that WAI mediated the relationship between RPRS-RS and RAS (see Fig. 1).

### 4. Discussion

Given a growing interest in the role of consumer-provider relationships on recovery processes (Angell and Mahoney, 2007; Farkas et al., 2005; Slade, 2012; Russinova et al., 2013), the current study aimed to identify the relations between consumer reports on the working alliance, their perceptions of provider recovery-promoting competencies, and self-reported recovery. The study ﬁndings provide initial insights suggesting the existence of a complex net of positive associations that empirically validate the value of the working alliance across various types of life problems and less severe symptom conditions (e.g., Lambert and Barley, 2001).

In addition, the ﬁndings highlight the potential positive contribution of recovery strategies (RPRS-RS) to consumer-provider relationships and mental health recovery. This is in accord with a previous study identifying similar associations and acknowledging the value of empowerment, self-acceptance, and hope-giving strategies by mental health consumers’ perspectives (Russinova et al., 2013). Thus, assessing consumers’ perceptions of their providers’ use of recovery strategies can add valuable knowledge about critical processes in recovery-supporting consumer-provider dynamics in psychiatric care and rehabilitation.

The current outcomes also revealed a stronger correlation (medium effect size) between perceptions of the provider’s recovery strategies and the interpersonal sub-scales of recovery measured by RAS (i.e., ‘willingness to ask for help’, and ‘reliance on others’) in comparison to a smaller effect size of intrapersonal subscales of recovery (‘no domination by symptoms’ and ‘personal conﬁdence and hope’). This ﬁnding may signify a more direct linkage between consumer-provider relationships and participants’ relational processes reﬂected in one’s willingness to rely on others and ability to ask for help. A plausible explanation may be that positive experiences of providers’ recovery strategies are associated with more reaching out to relationships outside the professional settings. This may suggest that recovery promoting strategies can be valuable in particular to one’s interpersonal aspects of recovery. This possibility highlights the challenge related to the loose association between recovery and rehabilitation: while often, providers in psychiatric rehabilitation are focused on functional/“doing” aspects with recipients of services (e.g., attaining tangible rehabilitation goals) (Eini-Finaret and Shor, 2006; Nath et al., 2012), this ﬁnding raises awareness about the potential of consumer-provider relationships in themselves for supporting social recovery, which often might go unnoticed alongside the practical aspects of rehabilitation.

The ﬁndings need to be considered with caution for several reasons. First, the study’s cross-sectional design limits the ability to ascertain cause-and-effect relationships with an evident direction. For example, perhaps higher level of recovery is associated with better being able to develop relationships and respond to providers’ recovery strategies. Otherwise, the current outcomes may be associated with yet a third variable that was not measured. Thus, additional experimental and/or longitudinal naturalistic designs are needed to ascertain causality among relationship variables and personal recovery. Second, the study is limited in generalization due to the speciﬁc illness management and recovery intervention context that may have inﬂuenced the extent that providers endorsed recovery strategies (Gingerich and Mueser, 2005). Examination of alliance and recovery strategies in diverse populations is needed to consider the potential effects of these factors on the results.
service delivery contexts is advised. Finally, additional outcome measures of recovery and relationships may be used (Leamy et al., 2011; McCabe and Priebe, 2004; Mcguire-snieckus et al., 2007) as well as incorporating providers’ perspectives into the study design (Le Boutillier et al., 2011).

5. Conclusion

This study examined how mental health consumers’ relationship and perceptions of providers’ recovery promoting strategies relate to each other and play a role in supporting personal recovery. Using a cross-sectional design we examined reports of mental health consumers engaged in relationships with providers over a 10 month period. Positive associations among relationship variables and recovery were found. A mediating model whereby the alliance explained the relationship between provider recovery strategies and personal recovery was confirmed. These outcomes highlight the consumer-provider relationship as a foundation of therapeutic change in the context of recovery from serious mental illnesses. Specifically they reveal the dynamics between empowering/hopeful/self-accepting provider strategies and the therapeutic alliance in supporting recovery. Clinically, the study brings attention to the role of recovery strategies and alliance building in promoting recovery processes in psychiatric rehabilitation in addition to rehabilitation practitioners’ customary tasks and goals. Further studies are needed to elucidate the architecture of recovery promoting relationships.

References

Eini-Finaret, A.E., Shor, R., 2006. Perceptions of professionals about the nature of rehabilitation relationships with persons with mental illness and the dilemmas and conflicts that characterize these relationships. Qualitative Social Work 5, 151–166.


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