



**CENTER for  
PSYCHIATRIC  
REHABILITATION**

Boston University

College of Health & Rehabilitation  
Sciences: Sargent College

RECOVERY & REHABILITATION

June 2010

**Volume 7 - Number 2**

Drew Johnson, Editor

940 Commonwealth Ave.  
Boston, MA 02215

*The Center for Psychiatric  
Rehabilitation is funded by the  
National Institute on Disability  
and Rehabilitation Research and  
the Center for Mental Health  
Services, Substance Abuse  
and Mental Health Services  
Administration.*

## The Recovery Promoting Relationships Scale (RPRS)

at the Center for Psychiatric Rehabilitation

### Introduction

Mental health and rehabilitation professionals can either facilitate or hinder the recovery process of people with psychiatric disabilities. Practitioners can inspire hope and empower mental health consumers in their efforts to overcome the disabling effects of a mental illness or they can instill hopelessness, dependence, and helplessness.

*"Mental health providers can play a very important role in promoting the recovery process. We need to be able to capture in measurable terms their impact on the people they serve." - Zlatka Russinova, Senior Research Associate, BU Center for Psychiatric Rehabilitation*

Numerous first-person accounts by consumers describe interactions with mental health professionals that have left them feeling disrespected, discouraged, and hopeless. These accounts provide significant anecdotal evidence about the detrimental impact that practitioners' negative attitudes can have on people with psychiatric disabilities. Deegan (1990) eloquently describes this phenomenon of "spirit breaking": "the experience of breaking occurs as a result of those cumulative experiences in which we are humiliated and made to feel less than human, in which our will to live is deeply shaken or broken, in which our hopes are shattered and in which giving up, apathy, and indifference become a way of surviving and protecting the last vestiges of the wounded self" (p. 352). This phenomenon also explains the development of learned helplessness among mental health consumers that has been identified as one of the major barriers to recovery (Deegan, 1992; Kramer & Gagne, 1997; Weingarten, 1994).

At the same time, people in recovery and practitioners have both emphasized the invaluable role that practitioners can have in influencing the recovery process (Deegan, 1997; Minkoff, 1987; Orrin, 1996). There is also a considerable body of research on how the therapeutic relationship (e.g., Horvath, 2005; McCabe & Priebe, 2004; Strupp, 1996; Watson & Geller, 2005), the core conditions of the helping relationship (e.g., Aubry et al., 2005; Barrett-Leonard, 1986), and empowering medical practices (Ellison, 1996), all have an important effect on the outcomes experienced by people in recovery. Based on a survey conducted with persons with psychiatric disabilities, Coursey and his colleagues (1995) observed a positive correlation between the extent clients felt empowered by their therapist and the process of their recovery: clients who felt more empowered in therapy spent less time in hospitals, expected a shorter stay in therapy, and knew more about their problems.

The recovery paradigm, which has become the guiding principle in the delivery of services to people with psychiatric disabilities (New Freedom Commission on

Mental Health, 2003), requires an understanding of the impact practitioners can have on their clients (Coursey et al., 2000a; Coursey et al., 2000b; Hoge, Tondora, & Marrelli, 2005; Young, Forquer, Tran, Starzynski, & Shatkin, 2000). From this perspective, the professional competence of mental health and rehabilitation providers needs to be reexamined in the context of the current understanding about the nature and the dimensions of the process of recovery. There have been a few recent attempts to define the core competencies of mental health providers working with persons in recovery (Coursey et al., 2000a; Coursey et al., 2000b; Hoge et al., 2005; Young et al., 2000).

The Boston University Center for Psychiatric Rehabilitation has developed a new instrument designed to assess the recovery promoting competence of mental health and rehabilitation providers serving clients with serious mental illnesses (Russinova, Rogers, & Ellison, 2006). Components of the scale measure providers' skills that promote clients' hopefulness, empowerment, self-acceptance and personhood.

The RPRS is a 24-item scale that assesses providers' recovery promoting competence from the point of view of clients served. This competence is measured in the context of a specific client-provider relationship, however can be aggregated across the caseload of a given provider. In addition, the RPRS instrument can be used to assess clients' perceived helpfulness of a specific therapeutic relationship.

The development of the RPRS instrument was supported by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration.

### Concepts behind the Development of the RPRS Instrument

The development of the RPRS instrument focused on identifying and reliably measuring the competencies of mental health providers that have a particular impact on the recovery process beyond the management of psychiatric symptoms. Its development was informed by a new conceptual model about the structure of providers' competencies titled "the pyramid model of recovery promoting professional competence" (Rusinova, Rogers, & Ellison, 2006).

This conceptual model examines providers' recovery-promoting competence as a complex set of attitudes, skills and strategies that facilitate the recovery process of persons with serious mental illnesses. It identifies three key components in the structure of mental health providers' professional competence.

1) The first component is represented by the provider's core interpersonal skills necessary to acknowledge the client's personhood and maintain an ongoing positive regard toward this person. In addition to the skills that have been traditionally acknowledged as essential in establishing and maintaining a therapeutic alliance with the client, this component also includes skills that are specific to working with individuals who have been affected by the most disabling mental illnesses, including the provider's ability to identify and relate to the core personhood of a client who might be overwhelmed by psychiatric symptoms and ability to maintain and convey a personal confidence in the potential for a given client to pursue and achieve recovery.

2) The second component includes the competencies that are specific to the different modalities of services provided to persons with serious mental illnesses such as psychopharmacological management, psychotherapy, case management, rehabilitation counseling, peer support, etc. These competencies are developed in the context of the discipline-specific training of mental health providers. They are also acquired through undergraduate and post-graduate training in specific discipline-related interventions.

3) The third component of mental health providers' professional competencies is comprised of a complex set of skills that specifically target the recovery process of clients with serious mental illnesses. These skills determine providers' ability to use a variety of strategies that promote clients' hopefulness, empowerment and self-acceptance. The development of providers' skills in utilizing various recovery-promoting strategies is a relatively new trend in defining and assessing the professional qualifications of mental health professionals while the professional skills relevant to the first two components of the presented conceptual model have been all along part of the traditional state-of-the art mental health education.

Although all three components of mental health providers' professional competence are essential for the effective delivery of services to persons with serious mental illnesses, their relative importance to the optimal unfolding of the treatment process can be presented in a hierarchical way (Figure 1). Providers' core interpersonal skills constitute the basis for the effective delivery of any mental health intervention specific to a given treatment modality. At the same time, the delivery of specific interventions needs to be permeated by the use of relevant strategies that enhance the hopefulness, empowerment and sense of self-acceptance of clients. Without the provider's ability to acknowledge the personhood of the client and establish a solid therapeutic alliance, treatment would be severely compromised especially in services for which the provider-client relationship is essential. Without the use of recovery-promoting strategies, treatment would be less than optimal. Providers' skills in acknowledging the client's personhood and in promoting his/her hope, empowerment and self-acceptance should constitute the fabric of any intervention delivered to persons with serious mental illnesses. They may be incorporated in the context of newer recovery-oriented interventions or may need to be added as an adjustable module to established services.

## Pyramid Model of Recovery-Oriented Professional Competencies

*The first and third components of this model which the RPRS specifically measures represent the generic components of mental health providers' recovery-promoting competence that need to be integrated with the professional skills relevant to different treatment modalities or specific clinical or rehabilitative interventions. Although the frequency and intensity of the use of specific recovery-promoting strategies may vary across different treatment modalities and interventions, the enhancement of clients' hopefulness, empowerment and self-acceptance is essential for achieving desired treatment outcomes and ultimately for promoting the recovery process of clients with serious mental illnesses.*

*The RPRS instrument was developed based on findings from an anonymous Internet survey inquiring about mental health providers' attitudes, skills and techniques that have a particular relevance to the recovery process of clients with serious mental illnesses. Quantitative and qualitative data about the professional competencies that enhance the recovery process beyond symptom management were collected from 603 consumers, 153 consumer-providers and 239 providers of mental health and rehabilitation services (Roussinova, Rogers, Ellison & Lyass, in press). These findings informed the development of the initial pool of items for the RPRS instrument. Consequently, these items were tested and reduced through several rounds of cognitive interviews conducted with persons with serious mental illnesses.*

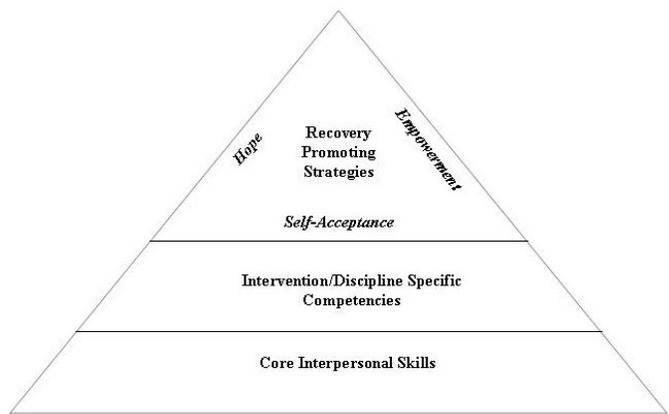
### Structure of the RPRS

Items are assessed based on a 4-point Agree/Disagree Likert scale. The scale allows for a "Not Applicable" response to allow for adjustment of the instrument to the specificity of different treatment modalities and interventions. Conceptually, the "Not Applicable Response" is not relevant to the items of the Core Relationship Index. Higher occurrence of "Not Applicable" responses across the subscales of the Recovery-Promoting Strategies Index might invalidate the use of certain subscales or the whole index since such responses are counted as missing values.

Since the RPRS instrument measures the generic components of mental health providers' recovery-promoting competence, it can be administered in the context of any treatment modality or specific clinical intervention. The instrument provides a template of administration instructions that can be flexibly modified based on the specific context and purposes for which the instrument is used. The administration of the RPRS instrument needs to account for the duration of the provider-client relationship in which context the practitioner's recovery-promoting competence is assessed. The items constituting the Core Relationship Index can be administered at any time-point during service delivery, including after the first encounter with the client, since providers' core interpersonal skills are essential for any segment of the treatment process. At the same time, the score for the Recovery-Promoting Strategies Index is sensitive to the duration of the provider client relationship. A certain "dose" or duration of treatment intervention is necessary to allow for the optimal utilization of various recovery-promoting strategies. The minimum treatment dose allowing the use of hopefulness, empowerment and self-acceptance enhancing strategies needs to be determined based on the specificity of the intervention in which context the RPRS instrument is administered.

### Conclusion

This study highlighted the crucial role mental health and rehabilitation practitioners play in promoting the recovery of individuals with serious mental illnesses through the acknowledgement of clients' personhood and clients' equipping with strategies that foster hope, empowerment, acceptance and efficient illness management. It also provided evidence that the client-provider therapeutic relationship constitutes the foundation on which any evidence-based and recovery-oriented promising practices need to be built. Thus, it emphasizes the need of aligning the training of mental health professionals with established recovery-promoting competencies as well as of developing sound measures to evaluate the manifestations of these competencies in everyday clinical practice.



### Most Important RPC Ingredients – Consumers' Perspective

- *Having genuine respect for clients*
- *Helping clients develop skills to cope and manage symptoms*
- *Seeing clients as persons apart from diagnosis and symptoms*
- *Helping clients accept and value themselves*
- *Listening to clients without judgment*
- *Believing in clients' potential to recover*
- *Trusting the authenticity of clients' experiences and accounts*
- *Caring about clients*
- *Being accessible to clients when they need help*
- *Understanding clients*

## Bibliography

- Aubry, T. D., Flynn, R. J., Gerber, G., & Dostaler, T. (2005). Identifying the core competencies of community support providers working with people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 28(4), 346-353.
- Barrett-Lenard, G. T. (1986). The relationship inventory now: Issues and advances in theory, method, and use. In L. S. Greenberg & W. M. Pincus (Eds.), *Psychotherapeutic process: A research handbook* (pp. 439-476). New York: The Guilford Press.
- Coursey, R. D., Curtis, L., Marsh, D. T., Campbell, J., Harding, C., Spaniol, L., Lucksted, A., McKenna, J., Kelley, M., Paulson, R., & Zahniser, J. (2000). Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems. *Psychiatric Rehabilitation Journal*, 23(4), 370-377.
- Coursey, R. D., Curtis, L., Marsh, D. T., Campbell, J., Harding, C., Spaniol, L., Lucksted, A., McKenna, J., Kelley, M., Paulson, R., & Zahniser, J. (2000). Competencies for direct service staff members who work with adults with severe mental illnesses: Specific knowledge, attitudes, skills, and bibliography. *Psychiatric Rehabilitation Journal*, 23(4), 378-392.
- Coursey, R. D., Keller, A. B., & Farrell, E. W. (1995). Individual psychotherapy and persons with serious mental illness: The clients' perspective. *Schizophrenia Bulletin*, 21(2), 283-301.
- Deegan, P. (1990). Spirit breaking: When the helping professions hurt. *Humanistic Psychologist*, 18(3), 301-313.
- Deegan, P. (1997). Spirit breaking: When the helping professions hurt. In L. Spaniol, C. Gagne & M. Koehler (Eds.), *Psychological and social aspects of psychiatric disability* (pp. 348-357). Boston: Boston University, Center for Psychiatric Rehabilitation.
- Deegan, P. E. (1992). The Independent Living Movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychosocial Rehabilitation Journal*, 15(3), 3-19.
- Ellison, M. L. (1996). Empowerment and demedicalization in mental health case management: Meaning and measurement. Boston University, USA.
- Hoge, M. A., Tondora, J., & Marrelli, A. F. (2005). The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health*, 32(5-6), 509-531.
- Horvath, A. O. (2005). The therapeutic relationship: Research and theory-An introduction to the Special Issue. *Psychotherapy Research*, 15(1-2), 3-7.
- Kramer, P. J., & Gagne, C. (1997). Barriers to recovery and empowerment for people with psychiatric disabilities. In L. Spaniol, C. Gagne & M. Koehler (Eds.), *Psychological and social aspects of psychiatric disability*. Boston: Boston University, Center for Psychiatric Rehabilitation.
- McCabe, R., & Priebe, S. (2004). The therapeutic relationship in the treatment of severe mental illness: A review of methods and findings. *International Journal of Social Psychiatry*, 50(2), 115-128.
- Minkoff, K. (1987). Resistance of mental health professionals to working with the chronic mentally ill. *New Directions for Mental Health Services*(33), 3-20.
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America*. Final report. DHHS Pub. No. SMA-03-3832 Rockville, MD.
- Orrin, D. (1996). Recovering from mental illness: Vignettes of the benefits of psychotherapy. *Psychiatric Rehabilitation Journal*, 19(4), 89-91.
- Russinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation outcomes. *Journal of Rehabilitation*, 65(4), 50-57.
- Russinova, Z., Rogers, E.S., & Ellison, M.L. (2006). Conceptualization and measurement of providers' recovery-promoting competence. Paper presented at the 16th Annual Conference on State Mental Health Agency Services Research, Baltimore, Maryland, February 12-14.
- Russinova, Z., Rogers, E. S., Ellison, M.E., & Lyass, A. (in press). Recovery-Promoting Professional Competencies: Perspectives of Mental Health Consumers, Consumer-Providers and Providers, *Psychiatric Rehabilitation Journal*.
- Strupp, H. H. (1996). The tripartite model and the Consumer Reports study. *American Psychologist*, 51(10), 1017-1024.
- Watson, J. C., & Geller, S. M. (2005). The relation among the relationship conditions, working alliance, and outcome in both process-experiential and cognitive-behavioral psychotherapy. *Psychotherapy Research*, 15(1-2), 25-33.
- Weingarten, R. (1994). Despair, learned helplessness and recovery. *Innovations & Research*, 3(2).
- Young, A. S., Forquer, S. L., Tran, A., Starzynski, M., & Shatkin, J. (2000). Identifying clinical competencies that support rehabilitation and empowerment in individuals with severe mental illness. *Journal of Behavioral Health Services & Research*, 27(3), 321-333.

*The final 24-item version of the RPRS instrument was developed with a mixed approach combining Classical Test Theory and Item Response Theory of instrument development. The RPRS instrument, including indices and subscales, has acceptable fit statistics established based on the Item Response Theory principles. The scale has demonstrated a high level of internal consistency (0.981, 0.976 and 0.953 for the total scale and respectively two indices), good test-retest reliability (inter-class correlation coefficients of 0.72, 0.72 and 0.75 for the total scale and two indices) and acceptable concurrent, criterion and known groups validity. The internal consistency coefficients for the three subscales were 0.945 for the Hope Subscale, 0.925 for the Empowerment Subscale, and 0.885 for the Self-Acceptance Subscale. The intra-class correlation coefficients for the test-retest reliability of the three subscales were respectively 0.69 for the Hope Subscale, 0.72 for the Empowerment Subscale, and 0.61 for the Acceptance Subscale.*