The working alliance in supported employment for people with severe mental health problems

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Aims: This study examined the utility of the Working Alliance Inventory Short form (WAI-S) for measuring the working alliance between supported employment service providers and service users with severe mental health problems.

Methods: Service users ($n=32$) and their respective service providers ($n=17$, 32 pairs) from five supported employment services independently rated their working alliance using the WAI-S.

Findings: There was little correlation at item, factor, and total score levels, and low agreement between service users and service providers on 11 of 12 working alliance items of the WAI-S.

Conclusions: These findings challenge the validity of the working alliance construct in this context, suggesting that both the WAI and the WAI-S may not be optimal measures of the working alliance in supported employment. The contextual differences between psychotherapy and supported employment, and the greater divergence of user-provider perceptions, imply that the working alliance in supported employment may differ from the alliance in psychotherapy. Researchers are encouraged to investigate the nature of the working alliance in supported employment rather than project characteristics identified in other settings.

Key words: ■ working alliance ■ severe mental illness ■ psychiatric disability ■ employment

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Health professionals and therapists are aware of the importance of forming a professional working partnership with clients to ensure optimal engagement in treatment and to maximize health and rehabilitation outcomes. In psychiatry, psychology, and psychotherapy this is called the 'therapeutic alliance', whereas in rehabilitation it is more often referred to as the 'working alliance' or the 'rehabilitation alliance'. The working alliance is widely recognized as an important yet non-specific aspect of rehabilitation and therapy, capable of influencing health and rehabilitation outcomes. However, despite recognition of its potential importance, the working alliance has rarely been studied in supported employment programmes.

New interventions are urgently needed in supported employment for people with psychiatric disabilities. This is because even the best available programmes fail for on average 38% of volunteer clients (Bond et al, 2008). The best of these approaches to date is known as the Individual Placement and Support (IPS) approach which has been described

as a specialised 'place then train' method distinct from the 'train then place' approach often used in more traditional forms of vocational rehabilitation (Burns et al, 2007). IPS avoids pre-vocational training, closely coordinates health care with employment services, and explicitly focuses on rapid commencement of job searching and competitive employment. However, evidence for its effectiveness (Bond, 2004; Bond et al, 2008; Burns et al, 2007; Latimer et al, 2006) also reveals substantial room for improvement. For instance, in a recent review of 11 randomized controlled trials of the highest fidelity IPS approaches (Bond et al, 2008), 38% of IPS participants did not commence competitive employment. In addition, the mean waiting time to commencing the first job was 144.5 days and the mean duration worked in the longest competitive job held was 22 weeks.

The therapeutic and working alliances

Most research on the therapeutic alliance has taken place in psychotherapy settings where clients typically have depression or anxiety disorders and are not being treated for severe mental illness (Priebe

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and McCabe, 2006). In this context, the therapeutic alliance is described as an open, collaborative and trusting relationship formed between the client and the therapist. Evidence shows that the therapeutic alliance is an important but non-specific contributor to therapy outcomes (Horvath and Symonds, 1991; Martin et al, 2000). The importance of the working alliance in psychotherapy inspired the idea that the working alliance may be a similarly strong non-specific factor capable of enhancing employment outcomes for people with severe mental illness participating in supported employment programmes. The proposed mechanism is that a stronger working alliance will reduce attrition by facilitating client engagement and by facilitating more active client participation in the jointly agreed individual employment plan.

Bordin (1979) conceived the working alliance within a general theory of change rather than as a construct dependent on the different contexts in which change is sought. He proposed that the working alliance that develops between the person who seeks change and the person acting as the change agent is a necessary aspect of the change process. The change mechanism is expected to involve the principle that stronger relationships enable better engagement in the service being provided and lead to better communication to more effectively identify service users' needs (Wasylenki, 1992). Consistent with this conception, characteristics of the therapeutic alliance studied in psychotherapy are expected to generalize to the working alliances formed in other contexts, such as in community psychiatry, psychiatric rehabilitation and supported employment.

However, contextual differences may be important because, unlike psychotherapy, different power gradients can coexist in community psychiatry. For instance, a community psychiatrist may have to impose involuntary treatment as well as provide voluntary supportive therapy. More subtle power gradients are found in supported employment. In this setting, employment specialists can often influence which clients are accepted into the programme, and they can also influence which clients obtain employment by how they allocate their time and energy across the caseload. For example, the employment specialist may lose confidence in a particular client's success prospects and then inadvertently hinder progress by reducing assistance intensity to a level below that required for success. The potential differences in this context contrast with the views of Bordin (1979) who proposed a single general alliance consisting of collaboration and agreement between the person and therapist on three sub-components, namely goals, tasks and bond.

In psychotherapy, the failure of the therapist to develop a working alliance has been found to predict poor therapy outcomes (Horvath and Greenberg, 1986). Frank and Gunderson (1990) reported that a positive working alliance in the first 6 months, as rated by the therapist, predicted successful psychotherapy. Horvath (1994) found that service users' ratings of the working alliance were more closely associated with psychotherapy outcomes, indicating a need to consider alliance ratings by both service users and therapists. Hersoug et al (2001) found that patients and therapists had divergent perspectives on the working alliance. Training and skill of therapists were positively associated with the alliance as rated by therapists, but not by clients. Interpersonal relationships assessed as warm on the cold-warm dimension were found to be positively associated with client perceptions of the alliance. In a recent study of supportive therapy for opioid users, Bethea et al (2008) found that patients' and therapists' scores were consistent during sessions focused on emotional bonds but divergent during sessions that demanded behaviour change.

Measuring the working alliance

Before the working alliance in supported employment can be investigated, a valid and reliable measure for this context is needed that can be used by researchers and practitioners with minimal training. In community psychiatry, measuring the working alliance has helped improve the quality of treatment and care. Several suitable measures are now available for this domain. Catty et al (2007) reviewed measures of the working alliance and found 15 measures from which they recommended four. Examples of the psychiatry specific measures include the Helping Alliance Scale (Priebe and Gruyters, 1993) and the Working Alliance Survey (Donnell et al, 2006). Strauss and Johnson (2006) found that a stronger working alliance contributed to better management of manic symptoms in bipolar affective disorder. Johansson and Eklund (2006) found that negative client perceptions, more than provider perceptions, of the helping alliance predicted early dropout from psychiatric treatment. Calsyn et al (2006) found that client characteristics, particularly motivation to change, explained more of the client's rating of the alliance, whereas treatment variables and actual client change explained more of the case manager's alliance ratings. In psychiatric rehabilitation, Gehrs and Goering (1994) found that rehabilitation therapist perceptions rather than client perceptions had the strongest relationship to rehabilitation outcomes. Rehabilitation therapist and client perceptions, as measured by the Working Alliance Inventory (WAI), showed moderately high congruence.

In psychiatric vocational rehabilitation, Goldberg et al (2004) used a short version of the Working Alliance Inventory (WAI-S) with minimal individual and provider modifications. These authors found that both versions had fair to moderate test-retest reliability and modest internal consistency. However, marked user-provider discrepancies were found in perceptions of the working alliance.

AIMS

This exploratory study was conducted with the immediate aim to test the utility of an existing measure of the working alliance for use in supported employment for people with psychiatric disabilities. Rather than design a new measure for this context, we accepted Bordin's view of the context-independent nature of the working alliance, and tested an established measure which could be readily applied to the working alliance in supported employment. The longer-term aim was to determine the extent that measuring and strengthening the working alliance can increase competitive employment outcomes in supported employment for people with psychiatric disabilities.

The WAI-S was selected because of the volume of information published on its psychometric properties. The initial focus was on assessing the extent of agreement on ratings of the working alliance between employment service users and employment service providers. Correlates of working alliance agreement were examined to test Bordin's (1979) assertion that user-provider agreement underpins a strong working alliance.

METHOD

Ethics approval was obtained from the Behaviour and Social Science Research Ethics Committee of the University of Queensland. The potential risks associated with research involving vulnerable participants were reviewed. An example of such a risk is the potential for vulnerable participants (e.g. people with psychotic disorders) to feel obligated to participate perhaps because of the fear that if they decline, employment services will not be provided, or will not be provided as intensively as needed. Before commencing the investigation, a minimum sample size was calculated at 29 service user-provider pairs (alpha 0.05—two tailed with 80% power) to detect a minimum correlation of 0.5 (Cohen, 1988: p86). This strength of effect was selected because of the relative clarity of the concrete tasks and goals in a joint activity focused on attaining a person's employment preferences,

in comparison to the more abstract goals of psychotherapy. A sample of service-provider and service-user pairs was recruited from supported employment services in the greater Brisbane metropolitan region.

Recruitment

Managers of five Australian government-funded disability employment services (Department of Employment, Education and Workplace Relations (DEEWR), 2006) in the Brisbane metropolitan area were approached and invited to participate. Disability employment services provide the most intensive and continuous assistance compared to other Australian employment services. Disability employment services are designed specifically to help people with disabilities and severe health conditions to obtain and keep employment. Researchers requested support for the project from volunteer service provider staff from each of these five organizations. Service provider staff inclusion criteria were:

- The staff member is currently employed by a participating organization
- The staff member had met with each service user four times or more
- The staff member provided written informed consent to participate.

Service user recruitment began through discussions initiated by their respective provider staff. Interested service users were then invited to contact the researchers directly. Coercion was prevented by having the researchers re-explain the project to service users and emphasize the voluntary nature of participation before obtaining written informed consent. The following inclusion criteria applied to each service user volunteering to participate:

- Primary diagnosis is a psychiatric disorder
- Registered with the disability employment service provider at least 4 weeks
- Aged 18 to 64 years
- Can communicate sufficiently well in English to not require assistance
- Written informed consent is provided.

Secondary diagnoses such as an intellectual disability, substance misuse, or physical health conditions did not trigger exclusion.

Participants

Written informed consent was obtained from 33 service user and provider pairs involving 17 provider staff. One service user-provider pair was excluded because the service user did not meet the diagnostic inclusion criterion. Service user and service provider characteristics are shown in Table 1.

Procedures

The service user interview consisted of a structured interview incorporating a standardized user version of the WAI-S. The balance of the structured interview questions covered the service user's age, sex, psychiatric diagnosis, medical conditions, work history, employment goals, illness severity and level of psychological distress, number of contacts, duration since first contact, contact intensity, user employment status, and perceived comfort of interviewing facilities. The remaining interview consisted of questions about the amount of contact with the service user, service user's psychiatric diagnosis, medical history, work history, employment goals, and service user prospects for success. Provider responsiveness towards the study was assessed by the interviewer in terms of signs of positive or negative attitudes towards participation. Separate interviews with the service users and their respective providers were held in a room provided by the disability employment service provider on the same day or consecutive days.

Measures

The working alliance was measured by the minimally modified 12 items of the WAI-S (Table 2), rated on a seven-point scale (1=never, to 7=always). Sub-scales of the WAI-S included:

■ Goal: items 4, 6, 10, 11

■ Task: items 1, 2, 8, 12

■ Bond: items 3, 5, 7, 9.

The full scale score represents the general alliance. Prior research found the WAI-S to have good internal consistency for the three factors and the total score. Coefficient alphas ranged from 0.90 to 0.98 (user version) and 0.83 to 0.95 (provider version) (Tracey and Kokotovic, 1989). The WAI-S was developed for greater utility in applied settings. It has similar construct validity to the longer version with a similar factor structure to the original WAI (Horvath and Greenberg, 1986), and with good internal consistency for goal, bond and task factors, as well as the full scale. The brevity of the WAI-S appears to have contributed to its increasing use in psychotherapy research (Busseri and Tyler, 2003; Hatcher and Gillaspay, 2006).

Psychological distress was measured by the Kessler Psychological Distress scale (K10, Kessler et al, 2002) for the previous 4 weeks, rated from 1=none of the time, to 5=all of the time. This scale is widely used in population surveys owing to concurrent validity in terms of probable diagnoses of anxiety and depressive disorders (Andrews and Slade, 2001), its brevity and good internal consistency (Cronbach's alpha 0.87, Kessler et al 2002). Illness severity was measured by the interviewer-rated Clinical Global Impressions (CGI) severity item (0=normal, not at all ill, to 6=among most extremely ill). Dahlke et al (1992) found the CGI severity item had good inter-rater agreement (0.91) with acute patients (Spearing et al, 1997).

Service user and service provider expectations of employment success were rated by each party to three levels (low, medium or high) in response to the question: 'How do you rate (your or 'insert name') employment prospects in the next 6 months?'. Service provider responsiveness towards the study was categorized into one of three levels (below average to above average) by the interviewer on completion of the service provider interviewer. The behaviours taken into account were eye contact, attention, degree of interest, openness to ideas and willingness to share time. The quality of interview facilities was also interviewer-rated to three levels (below average to above average) based on noise level, privacy, comfort of furniture, facilities available, and general appearance of the waiting area.

TABLE 1.
Participant and provider characteristics

Service users (n=32)		n (%)
Age (years)	Mean (SD)	36.3 (9.3)
Sex	Male	19 (59.4)
	Female	13 (40.6)
Psychiatric diagnosis*	Schizophrenia	9 (28.1)
	Schizoaffective disorder	4 (12.5)
	Bipolar affective disorder	6 (18.8)
	Depression	9 (28.1)
	Anxiety disorder	4 (12.5)
Programme type†	Disability employment	29 (90.6)
	PSP	3 (9.4)
Current job-stage‡	Job-preparation	21 (40.4)
	Job-seeking	10 (19.2)
	Employment	16 (30.8)
	Education§	5 (9.6)
Provider staff (n=17)		
Age (years)	Mean (SD)	38.5 (9.2)
Sex	Male	7 (41.2)
	Female	10 (58.8)

* Psychiatric disorders were identified by medical report (n=24) and self-report (n=8). Self-reported diagnoses were considered confirmed by the necessary existence of medical reports held by the referring organization.

† Service users were involved in one of two labour market programmes: Personal Support Program (PSP) and Disability Employment Program (Department of Employment, Education and Workplace Relations, 2006).

‡ Service users may have been involved in more than one of these activities. Job-preparation includes addressing issues such as non-vocational barriers (e.g. homelessness).

§ Education as a current activity means seeking enrolment, or enrolled in a formal course of vocational or higher education.

Comparing provider and service user perceptions of the working alliance

Candidate correlates included user and provider age and sex, user illness severity and psychological distress, number of contacts, duration since first contact, contact intensity, user employment status, comfort of interviewing facilities, and interviewer perceptions of provider responsiveness towards the study. Provider responsiveness was included to check the possibility that only service providers who valued research volunteered for the study.

The extent of WAI-S item agreement was assessed by correlations and by subtracting provider ratings from service user ratings. Rating differences were converted into a category of agreement: moderate-high (± 1 point); low (± 2 points); and no agreement (± 3 or more points). The total number of WAI-S items that fell into the moderate-high agreement category were totalled and divided by 12 to produce an average 'extent of agreement' variable that was further defined by three categories: no agreement ($n=6$; 0–49%); low agreement ($n=12$; 50–79%); and moderate-high agreement ($n=14$; 80–100%). This variable was then correlated with service user and provider characteristics including age, gender, number of times met with the service user or provider, length of contact (months), intensity of contacts (number of contacts per month), employment status, psychological distress, illness severity.

Analyses

Analyses were conducted in SPSS 15.0 (SPSS, 2006). Cronbach's coefficient alpha was used to assess internal consistency of the WAI-S service user and provider versions and the factor subscales. Comparisons of interest were examined via frequency tables (mean, standard deviation, sample size), plots, cross tabulations, Pearson correlations, and paired samples *t*-tests.

FINDINGS

Utility and internal consistency of WAI-S

The WAI-S was minimally adapted to service user and service provider versions, and had good face validity for both service users and service providers. No participants commented negatively on the scale or its items for this purpose. The good face validity and the short time required for administration suggest that the scale has utility in supported employment. The full scale internal consistency of the service user version (coefficient alpha=0.87) exceeded that for the service provider version (alpha=0.79). The alpha values for goal, task, and bond factors on the service user version were 0.87, 0.76 and 0.82 respectively, compared to 0.69, 0.87 and 0.67 for the service provider version. The smaller number of service

TABLE 2.
The service user version* of the Working Alliance Inventory-Short (WAI-S†)

Item
1. _____ and I agree about the things I will need to do to help improve my situation
2. What I am doing with _____ gives me new ways to look at my problem
3. I believe _____ likes me
4. _____ does not understand what I am trying to accomplish
5. I am confident in _____'s ability to help me
6. _____ and I are working toward mutually agreed upon goals
7. I feel that _____ appreciates me
8. We agree on what is important for me to work on
9. _____ and I trust each other
10. _____ and I have different ideas on what my problems are
11. We have established a good understanding of the kind of changes that would be good for me
12. I believe the way we are working with my problem is correct

*Service users rated their working alliance with their service provider on a 7-point Likert scale (never, rarely, occasionally, sometimes, often, very often, always).

†This version is identical to the original WAI-S (Tracey and Kokotovic, 1989) except that the term 'therapist' and the associated grammar were replaced by a blank line so that the interviewer could insert the actual name of the service provider. The service provider version was similarly minimally amended so that the interviewer could insert the actual name of the service user.

providers in the sample compared to service users may account for these differences.

Strength of the working alliance

Mean scores of service user and provider ratings of the working alliance were used to assess the strength of the working alliance for each of the extent of agreement categories. Mean scores in the moderate-high agreement category were found to be significantly different from the grand mean in a paired samples *t*-test ($n=14$, $T=2.15$, $P<0.05$). Service user-provider pairs with higher agreement on working alliance ratings also had higher working alliance ratings indicating a stronger working alliance.

Service user and provider agreement on strength of the working alliance

Service user-provider ratings of the working alliance were uncorrelated at the full scale, factor and item levels. At the item level, all paired ratings were uncorrelated except item one ('_____ and I agree about the things I will need to do to help improve my situation') ($r=0.39$; $P=0.03$). Service users rated aspects of the alliance more positively than providers on items 3 ($T=2.96$; $P=0.01$), 5 ($T=5.19$; $P=0.00$), 7 ($T=2.13$; $P=0.04$), 9 ($T=2.09$; $P<0.05$) and 12 ($T=2.52$; $P=0.02$). Service users rated the full scale score ($T=2.98$; $P=0.01$), task ($T=2.31$; $P=0.03$), and bond factors ($T=4.62$; $p=0.00$) more positively than provider staff, by paired samples *t*-tests.

Correlates of perceptions of strength of the working alliance

Some service user characteristics were correlated with service user ratings of the working alliance. Higher levels of psychological distress ($r=-0.43$; $P=0.01$) were associated with lower service user ratings of the working alliance. Service provider characteristics were not correlated with service provider ratings of the working alliance.

Service user and service provider goal factor scores were uncorrelated, even when the sample was restricted to service users in the job-seeking or employment stages of vocational progress. Similarly, service user and service provider bond factor scores did not correlate with the number of previous contacts, gender match, or age. Nor did service user and provider ratings of the working alliance correlate with service user or service provider expectations of employment outcomes. Neither service user nor service provider expectations of employment success correlated with the extent of agreement on the working alliance.

Correlates of extent of agreement on ratings of the working alliance

The extent of agreement on service user-provider working alliance ratings was significantly correlated with period of contact ($r=0.37$; $P=0.04$), employment status ($r=0.43$; $P=0.01$), and interviewer ratings of interviewing facilities on comfort

of service users ($r=0.36$; $P=0.04$). Greater period of contact, service users becoming employed, and above average interview facilities, were associated with higher agreement between service user-provider ratings of the working alliance (Table 3).

DISCUSSION

Utility of the WAI-S

Based on this trial of the WAI-S, the authors recommend its further modification for use in supported employment by positively scoring all items, and by introducing work-related terms to substitute for more general descriptors. General terms such as 'situation' (item 1) can be reworded to 'work situation' as suggested by Goldberg et al (2004). Similarly, the term 'problem' (items 2, 10 and 12) can be changed to 'barriers to obtaining employment' to provide a more specific context for measuring the working alliance. Service users, and occasionally providers, sometimes misinterpreted two negatively worded WAI-S items (4 and 10). A recent study of the WAI-S factor structure (Hatcher and Gillaspay, 2006) found negatively worded items did not correlate well to Bordin's (1979) proposed structure. Hatcher and Gillaspay developed a revised version with all items positively worded on a 5-point scale. Their version achieved higher internal consistency than the original WAI-S. These minor changes to each minimally amended version used in this study are recommended to strengthen the utility and face validity of the WAI-S in supported employment settings.

Construct validity

Although the WAI-S appears to have good face validity and promising utility in supported employment, the low user-provider agreement on most WAI-S items challenges Bordin's conception of the working alliance, and challenges the validity of the construct in this context. An exception was item 1 ('_____ and I agree about the things I will need to do to help improve my situation'). The moderate agreement ($r=0.39$, $P=0.03$) on this item is notable because it captures the client's agreed and immediate action plan, a feature which may be particularly important in supported employment where the first milestone is to commence competitive employment as soon as possible. The lack of significant agreement on the other 11 items suggests that agreement on these items may not be as essential to the working alliance in supported employment as in psychotherapy. This finding is consistent with the divergence previously reported by Hersoug et al (2001), Calsyn et al (2006), Gehrs and Goering (1994), Goldberg et al (2004), and by Bethea et al (2008) when sessions focus on behaviour change rather than on emotional

TABLE 3.
Correlates of agreement on the working alliance[§]

Correlates of working alliance agreement	<i>r</i>	<i>P</i>
1. Age of service user (years)	0.05	0.81
2. Age of provider staff (years)	0.19	0.30
3. Gender of service user	-0.28	0.11
4. Gender of provider staff	-0.04	0.81
5. Number of contacts since first contact	0.11	0.57
6. Period since first contact (months)	0.37	*0.04
7. Intensity of contacts (number of contacts per month)	0.24	0.20
8. Employment status	0.43	*0.01
9. Psychological distress [†]	0.09	0.63
10. Illness severity [‡]	-0.26	0.15
11. Interviewer rating of interviewing facilities on comfort of service user	0.36	*0.04
12. Interviewer rating of provider's responsiveness towards the study	0.15	0.41

[§]Extent of agreement on WAI-S ratings between 32 service user-provider pairs.

* $P<0.05$ indicating a statistically significant correlation at the 95% confidence level.

[†]As measured by the total Kessler Psychological Distress scale score of service user's level of psychological distress in the last four weeks (10–19=low; 20–24=moderate; 25–29=high; 30–50=very high), where mean K10 score was 23.7 (SD=7.59).

[‡]As measured by the interviewer-rated Clinical Global Impressions severity score.

bonds. This divergence also highlights the issue identified by Bethea et al (2008), namely whose perspective of the working alliance is most important, for what purposes, and under what circumstances?

Service user perceptions of the working alliance

Service users consistently rated some items, the task and bond factors, and the full scale, higher than service providers. However, service user perceptions of the working alliance were negatively related to psychological distress, indicating that mental health status negatively moderates service user perceptions of the working alliance. This finding has important implications for service providers because just as psychiatric disorders fluctuate over time, so might clients' perceptions of the working alliance. This means that clients' ability to engage in a supported employment programme may also fluctuate in unexpected ways with the severity of their psychiatric symptoms.

Correlates of user-provider agreement

Studies in other contexts have identified the potential importance of developing a strong working alliance within the first 6 months (Frank and Gunderson, 1990). This may not be as applicable in supported employment because it was found that the period since first contact, not the number of contacts or intensity of contacts, was positively related to user-provider agreement. This suggests that perceptions of the working alliance in supported employment may gradually converge over a longer period.

Service users who were employed at the time of the study were more likely to report a stronger working alliance than those who were unemployed. This is consistent with findings by Donnell et al (2006) and suggests that success in attaining behaviour change milestones may be an important contributor to a working alliance in supported employment. The positive association between service user perceptions of the working alliance and interviewer ratings of the quality of interviewing facilities may indicate that the physical environment also influences service user perceptions of the working alliance.

Limitations

The authors found the working alliance challenging to investigate because of the difficulty recruiting sufficient user-provider pairs from currently operating disability employment services. In Australia, these are typically non-government services, funded exclusively by case-based funding for outcome attainment. Hence, service providers had strong financial incentives to avoid any distracting activities such as research, which can divert time and energy away from the immediate service delivery goals.

The small sample size and the cross-sectional nature of this sample limited this exploratory investigation to a small number of the possible attributes of the working alliance. Based on previous research in psychotherapy, moderate to high agreement on all WAI-S items with correlations of 0.5 or greater was anticipated. However, actual agreement was more often in the low to moderate range, indicating a need for a larger sample size to detect smaller effect sizes.

Not all potentially important service provider attributes, such as emotional warmth toward the service user, social skills, expertise, or years of experience, could be included. It is possible that these attributes also influence both service user engagement and service user perceptions of the working alliance. Service user attributes, such as self-esteem, educational attainment, ethnicity, homelessness, and psychiatric history, also warrant investigation in future studies.

The non-availability of measures developed in supported employment with known psychometric properties was also a limitation. Bordin's (1979) conceptualization of the working alliance, as not being context-dependent, was followed. However, the findings and a re-examination of the literature revealed evidence for the counter assumption: namely that some features of the working alliance may be context-dependent and the working alliance in supported employment may be different in important ways from that in psychotherapy.

CONCLUSIONS

The findings challenge the validity of the working alliance construct in this context, suggesting that both the WAI and the WAI-S may not be optimal measures of the working alliance in supported employment. The contextual differences between psychotherapy and supported employment, and the greater divergence of user-provider perceptions, imply that the working alliance in supported employment may differ from the alliance in psychotherapy. This construct validity issue needs to be resolved before the next critical question is examined, that is whether an explicit focus on the working alliance can increase employment outcomes among service users with psychiatric disabilities.

Supported employment service providers should remain cautious about the applicability of working alliance research not based on a supported employment-specific measure with known psychometric properties. In the meantime, supported employment service providers can expect service users to have more positive perceptions of the alliance when well, with more divergent views of aspects of the alliance not related to their current

action plan. Researchers are encouraged to build on this work by investigating the nature of the working alliance in supported employment using a context-specific measure rather than projecting characteristics identified in other settings. **III**

Conflict of interest: none

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KEY POINTS

- The working alliance has been successfully measured in psychotherapy and in psychiatry, and doing so has contributed to improved treatment and care.
- This study examined the utility of the Working Alliance Inventory Short form (WAI-S) to measure the working alliance between supported employment service providers and service users with severe mental health problems.
- Results showed little correlation at item, factor, and total score levels on the WAI-S, and low agreement between service users and service providers.
- Contextual differences and greater divergence of user-provider perceptions may characterize supported employment.
- Existing measures developed in other contexts do not seem to capture the nature of the working alliance in supported employment. A context-specific measure of the working alliance may be needed in supported employment for people with psychiatric disabilities.

With their study, Waghorn and colleagues address a very important issue in psychiatric rehabilitation. In psychotherapy, a sustainable therapeutic alliance between client and therapist is an essential treatment mechanism. In psychiatric rehabilitation, the working alliance between service user and service provider has not been studied explicitly before.

However, in rehabilitation in general the concept of goal setting is considered a fundamental component of the intervention and a core skill of rehabilitation practitioners (Wade and de Jong, 2000). Goal setting is defined as the collaborative process of identification of and agreement on behavioural targets which the patient, therapist or team will work towards over a specified period of time (Scobbie et al, 2009). The working alliance can be characterized as an open, collaborative and trusting relationship between service user and service provider, which involves shared ideas on the client's problems, a general agreement on important rehabilitation goals and an agreement about the things to do to achieve these goals. With these definitions it becomes clear that both concepts share a substantial proportion of their theoretical background.

Whereas goal setting focuses on the translation of the client's general goals (e.g. 'I want to live independently again') into specific, achievable behavioural goals (e.g. 'I want to apply for a job'), the working alliance provides the relational basis for the mutual and trusting cooperation between client and service provider to achieve these goals.

To achieve both a high agreement on realistic behavioural targets as well as a high agreement on the working alliance, the rehabilitation setting must involve an interactional process of cooperative negotiation of the rehabilitation goals according to the individual needs of the service user and the service spectrum of the rehabilitation programme.

However, Waghorn and colleagues find little correlation between, and low agreement in, assessment of the working alliance rated by service users and by service providers. This result can be interpreted as a challenge of the validity of the working alliance construct and their method of operationalizing it. But, beyond this interpretation, the results may stem from differing expectations of the rehabilitation goals and divergent needs and capabilities of the service users.

In supported employment,

service users are placed in competitive work places as soon as possible with respect to their choices and capabilities. According to an 'individual placement and support model' they receive continued and indefinite support to maintain their position (Bond et al, 2003). Still, employment rather than occupation is the central focus of this approach. Psychiatric rehabilitation that focuses on recovery—independently whether seen from the user's or the service perspective (Schränk and Slade, 2007)—should take into account the fact that employment is only one facet of a successful reintegration into social life. We know that not all service users equally benefit from vocational rehabilitation and that reintegration success is predicted by individual capabilities and learning potential (Watzke et al, 2008).

Programmes that follow a flexible approach using a detailed and individual-centred rehabilitation planning system can address rehabilitation targets beyond rapid integration into competitive employment (Watzke et al, 2009). These programmes involve training in social communication and competence, concentration and memory, management of daily activities, and offer medical and

psychotherapeutic treatments as well as social support. Future research is needed to investigate whether these programmes are capable of reflecting a broader range of the service users' needs and thus, result in a better agreement on rehabilitation targets and finally in a higher agreement on the working alliance.

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