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Institutional Therapeutic Alliance in Multi-Professional Treatments with Severely Disturbed Patients

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1. Introduction

In this paper I would like to show some relevant issues to consider in the alliance assessment of severely disturbed patients treated in institutional contexts by a multi disciplinary staff. I will start with a brief review of a few relevant researches about the therapeutic alliance in such settings and I will introduce the need to distinguish the classical psychotherapeutic one-to-one alliance, from the alliance between the patient and the staff conceived as a whole. After that I propose a methodology to assess it and finally, I will show some evidence that supports this distinction and suggests its clinical relevance.

The therapeutic alliance with severely disturbed patients has two main particular complexities that must be taken into account if we want to explore and understand it: on the one hand, these patients show important difficulties to establish a significant one-to-one relationship with another. And on the other, the treatment of these patients involves many professionals from different disciplines, whom are very relevant for the patient not only because of their technical expertise, but because of their personal engagement with the patient and his/her healing process. While the first complexity has been studied in many different ways, the second one has been almost neglected, at least from an empirical research point of view.

In the fifties and sixties some authors used the social and relational psychoanalysis theorization to reflect and propose new forms of treatment. Balint, Rapoport, Laing and Maxwell Jones are some of the most relevant example of this Anglo-Saxon movement that developed various therapeutic interventions based on an interpersonal conception of psychiatric diseases. According to these authors, since a major portion of psychic suffering comes from problems related to human relationships and social interaction processes, treatment must consist, in the first place, in living again experiences of social interaction in a new relationship characterized by its therapeutic and re-educative nature. Initially, only psychotherapists or analysts were called to enter this role, but quickly authors like Rapoport (1960) showed that other figures, with which the patient establishes meaningful interactions, could accomplish the same function. In the same direction, the pioneer Peplau (1952/1991) - from nursing field - has developed in the early fifties the Interpersonal Relationship Nursing Theory. According her, the nurse-patient relationship is the essence of the psychiatric nursing work and constitutes a significant factor for patient's insight and change.

Following these points of view, nurses, social workers, occupational therapists and also other patients, contribute to the "relational" and "social" healing process of the patient. Actually, there is empirical evidence that confirms these clinical observations. The first one is a study of Ferguson and Carney (1970), which demonstrated that in therapeutic settings, where informal and spontaneous interaction is possible and frequent, the patient potentially develops significant and therapeutic relationships not only with the doctors, but also with nurses and social workers. And more recently, Gallop et al. (1994) have reached a very similar conclusion exploring an in-patient eating disorder unit, in which the patients established equivalents levels of alliance with the various members of the therapeutic staff, no matter their professional role.

Thus from a clinical and empirical perspective, seriously disturbed patients treated in institutional settings by an interdisciplinary staff, can establish significant relationships not only with the psychiatrist or the psychotherapist, usually considered as the most relevant figure, but also with every member of the therapeutic staff. These are very interesting findings if we consider the crucial and so well documented role of the Therapeutic Alliance in psychotherapy outcomes. In other words, can we consider the multiple significant relationships available for the patient in terms of multiple potentially therapeutic alliances? And, is this distinction relevant for clinical practice and research? If yes, the patient establishes the alliance with only one professional, with many of them, with the staff as a whole? A few authors have inquired these questions and, as we will see, they have proposed many different methodologies to study them.

2. Alliance assessment within the institution

The first two researches that explore the Alliance in a psychiatric inpatient setting were done in the mid-eighties. In 1985, Allen and his colleagues (1985) conducted a longitudinal study to observe the relationship between Therapeutic Alliance and outcomes of 37 inpatients, almost all psychotics or personality disorder patients. They find a positive correlation between psychological improvement and a growing of the alliance perceived by the therapists, so they conclude that therapeutic alliance and therapeutic changes are concomitant and interdependent processes. Two years latter, Clarkin and his collaborators (1987), using a quite similar design, study 96 psychiatric inpatients, finding that better alliance at the end of the hospitalization is positively associated with the patient's better global functioning. Both research have many methodological limitations, but beyond that, they are among the firsts examples in which the alliance was assessed using every member of the staff as a source of observation; in fact, both conceive the alliance as the patient's collaboration and active engage in the treatment and assesses it by calculating a mean of the therapist's perception of patients' behavior related with their healing process.

3. Patient and case-manager alliance

Other groups of researches explore the relevance of a positive alliance between the patient and his/her case manager. There are three interesting studies from the nineties that highlight the need to consider the alliance in institutional settings as an interpersonal phenomenon instead of the patient's collaboration with the treatment. Using a more relational definition of the alliance, all of them show that a good alliance between patient and case manager helps considerably the patient's therapeutic course and process.

Nonetheless, these authors have used different constructs of the alliance. On the one hand, in Germany Priebe and Gruyters (1993), assess the alliance perception of 100 out-patients, almost all psychotics, based on Lester Lubosrky's Helping Alliance model; while from the other one, in Australia two studies use the Working Alliance proposed by Bordin to measure the relationships of several case manager-patient couples respectively (Solomon, Draine & Delaney, 1995); Neale & Rosenhec, 1995). Neglecting many methodological limitations of these studies, they report interesting relationships among better patient-case manager alliance and quality of life improvements, pharmacological compliance, treatment satisfaction and symptoms reduction.

4. The alliance between the patient and all the staff members

Another interesting research in terms of its methodological innovation is the study conducted by Priebe and Gruyters (1994). They examine many variables that influence the course of the treatment in 30 day hospital psychiatric inpatients, and they find a predictive value of the Therapeutic Rapport established with the patient form the staff's perspective. As we can see, this is another conception of the alliance that involves an additional way to assess it: the staff's vision agreed by all its members.

In the same direction, the work of Mona Eklund (1996) in Sweden are probably the first empirical studies in which there is an accurate reflection on the enormous complexity and multiple dimensions and levels of the rapport that patients and therapists establish in this kind of treatment. She proposes a novel method to compare the alliances that the patient establishes with a reference or main therapist in contrast with two other secondary co-therapists engaged in the treatment. The study explores the relationship between the alliance and many outcomes indexes in 20 patients of a psychiatric day-care unit based on occupational therapy. The results suggest that the more the patient becomes attached to his/her main therapist instead of his/her co-therapists, the more he/she experiments improvement in his/her global mental health and occupational functioning (like motor and interpersonal skills, will and habits).

5. Steps towards an alliance with the institution

Finally, there are a few types of researches that inquire how the ward atmosphere and the characteristics of the staff influence the treatment success. Various authors from the seventies related mostly to Ocupational Therapy, suggest the patient's perception of several emotional and organizational dimensions of the therapeutic staff and milieu, are associated with therapeutic process and outcome.

In this context, the study of Eklund and Hansson (1997) constitutes one of the first research that explores these variables with a longitudinal design. They assess the ward atmosphere perception of 20 patients in a psychiatric day-care and find that two aspects of these variables are consistent and early predictors of therapeutic success: after one month of treatment, low levels of anger and aggression and of staff control intensity, both perceived by patients, are positively associated with symptom improvement.

It is quite interesting to understand this result as an adequate bond between the patient and the therapeutic staff. But not an optimal bond among the patient and the various figures involved in the treatment, like the alliance with the main or the co therapists, but between the patient and the staff perceived as a whole, as a cohesive and unitary therapeutic system.

In fact, recently Johansson and Eklund (2004) offer support for this thesis correlating some dimensions of ward atmosphere and the helping alliance perceived by the patient. In this sense, ward atmosphere and therapeutic alliance can be two different ways to understand the same phenomenon. Psychological tradition, mostly influenced by psychoanalysis, has described it in terms of working, collaborative and faithful rapport, or as the therapeutic alliance; Occupational Therapy tradition, more used to work and deal with an interdisciplinary staff, conceives it as the milieu of emotional and organizational atmosphere. Both perspectives ignore some aspects: the first one, doesn't take into account the group dimension of the alliance that develops in institutional multidisciplinary settings and centers itself exclusively in the singular relationships between patient and therapists; the second one, neglects the reciprocal and relational nature of the phenomenon since the atmosphere is mainly understood as a characteristic of the institutional functioning itself and not as result of the inter-subjective encounter among specific staff and patients.

6. Therapeutic alliance with the institution

This brief and non exhaustive review of the main empirical research in the field of Therapeutic Alliance in institutional settings with seriously disturbed patients shows us the complexity of the phenomenon and the need to distinguish it from the alliance that occurs in the psychotherapy setting. However, conceptual and operational definition of the alliance and the source of assessment are very heterogeneous from one research to the other: in fact, sometimes the alliance has been understood simply as the patient's collaboration with the treatment, other times as the quality of the patient and therapist's bond; occasionally the source of measurement has been the staff as a whole and at times each therapist separately; from time to time authors have assessed it using one generic question and other times with a well validated scale derived from the psychotherapeutic field.

As we can see in table 1, almost all of these researches have conceived the alliance as a one-to-one rapport between a therapist and a patient. Nevertheless, and considering ward atmosphere studies, it becomes quite interesting to inquire, other than the alliances "within" the institution, the alliance "with" the institution. That requires a reflection on a new assessment focus: the patient-staff relationship or the therapeutic alliance established between a single patient and a therapeutic staff understood as a whole.

In a recent paper, along with my colleagues from Bologna University, I have proposed the term of "institutional therapeutic alliance" (ITA) as a way to distinguish the alliance developed among a patient and the whole staff involved in his/her treatment, from the classical alliance established between a patient and a single therapist (Pulido, Monari, Rossi, 2006). Paraphrasing Bordin's formulation (1994), the ITA could be defined as a mutual understanding and agreement about goals and the necessary task of moving toward these goals along with the establishment of bonds to maintain the collaborative work between the patient and the therapeutic staff as a whole. As you can see, the definition emphasizes the relational and reciprocal character of the phenomenon and implicates that patient and staff have to negotiate and renegotiate many aspects of the treatment, from expectations, specifics therapies and therapeutic strategies, to interpersonal distance, setting issues and the rules and norms of the institution (Monari et al., 2005).

In fact, many mental health units, like day-hospitals, day care units, therapeutic communities, etc., instead of imposing a regular treatment they try to propose treatment programs adequate to the patient reality, for example, by structuring the patient's daily

schedule and his/her specific activities according to his/her personal characteristics and concrete possibilities. Probably an institution that is able to be flexible to the patient's needs and at the same time maintain its own organization and identity, has better chances to establish positive therapeutic alliances with his clients. In contrast, more rigid institutions may have difficulties to establish adequate levels of Alliances, since in such places patients are treated in a very standardized way and the therapeutic tasks and goals are decided unilaterally by the staff or even only by a head doctor.

The concept of ITA does not constitute a theoretical reformulation of Bordin's model, but rather a clinical extension to treatments in which two or more therapists are engaged at the same time in the patient's therapeutic process. As we described elsewhere, the notion presuppose that "*the whole staff, on the one hand, can represent itself as a unitary object to the patient, and on the other, that can operate and rapport with the patient as a cohesive unity*" (Pulido, Monari & Rossi, 2008, p. 278).

There are many clinical observations that support this hypothesis. Authors from the psychoanalytic field have explored the way in which the patient interacts with the staff and vice versa, and suggest that many times the staff rapports with the patient as an organic whole and appears in the patient's mind as a cohesive unitary object. In other words, in institutional multi-professional treatment, many times a bi-directional relationship emerges between a subject (the patient) and a group (the staff) that operates and moves itself as a compact whole.

For example, Correale (1991) and Enriquez (1988), two of the most important European authors on institutional psychoanalysis, account for interesting examples that show the relationship between a patient and a staff as a whole. The first one describes clinical examples in which a single patient modifies in a very significant way the normal functioning of the therapeutic staff, and the second one analyzes different situations in which the internal conflicts within the staff influence considerably and negatively the patient's symptomatic condition.

Another good example is the concept of institutional transference. This phenomenon – described for the first time by Rider (1953), and further developed by Martin (1989) – is a well known paradigm about how some seriously disturbed patients tend to defend themselves from establishing significant one-to-one relationships, investing an impersonal, more permanent, predictable and stable object such as an institution or an institutional staff. Just as the transference and counter-transference phenomenon, that within the psychoanalytical framework were first considered as obstacles to the analytical process and second, as central aspects of the treatment, the institutional transference phenomenon, historically conceived as a patient's resistance to engage into an analytical relationship, can be viewed as a treatment resource instead of a defensive process.

According to Zetzel (1956) and Bordin (1994), severely disturbed patients have so many problems to enter a one-to-one close relationship that the sole development of a therapeutic alliance in a dyadic rapport could be a positive and primary outcome index and most of the time, when it happens, it is the result of a very "*critical, extended and painful process*" (Bordin, 1994, p 27.) for almost every psychotic, schizophrenic, and borderline patient. That is the case for the classical psychoanalytical or psychotherapeutic work, but when this process occurs together with other co-therapeutic processes and involving more than one or two professionals in the global treatment that the patient feels interrelated and coherently connected, the patient has a chance to form a positive alliance with the staff as a whole, which supports and holds a potential establishing of one-to-one close relationships in a lower anxious and painful way for the patient. In this sense there is a very stimulating phenomenological study coming form the

field of psychiatric nursing research, that shows that many patients have difficulties to distinguish nurses or other figures from other operators and tend to refer to the "*staff in the aggregate*" (Thomas, Shattell & Martin, 2002, p. 104).

Source / *Construct*	*Patient*	*Therapist*	*Therapeutic Staff as a whole*	*Each Therapist individually*
Patient's collaboration				Clarkin et al. 1987 (psychiatric in-patient; n=96) Allen et al . 1985 (psychiatric in-patient; n=37)
Therapeutic bond	Priebe & Gruyters 1994 (psychiatric day hospital; n=30)		Priebe & Gruyters 1994 (psychiatric day hospital; n=30)	
Helping Alliance (patinet-therapipst)	Solomon et al. 1995 (patient and case manager; n=90) Neale & Rosenheck 1995 (patient and case manager; n=143)	Solomon et al. 1995 (patient and case manager; n=90) Neale & Rosenheck 1995 (patient and case manager; n=143)		
Working Alliance (patient-therapist)	Eklund 1996 (psychiatric day-care unit based on occupational therapy; n=20) Priebe & Gruyters 1993 (patient and case manager; n=100) Johanson & Eklund 2004 (psychiatric in-patient n=61)	Priebe & Gruyters 1993 (patient and case manager; n=100)	-	Eklund 1996 (psychiatric day-care unit based on occupational therapy; n=20)
Ward Atmosphere	Eklund & Hansson 1997 (psychiatric day-care unit based on occupational therapy; n=20) Johanson & Eklund 2004 (psychiatric in-patient n=61)			

Table 1. Therapeutic Alliance assessment in institutional settings

Nonetheless, this notion of the patient-staff relationship does not preclude the establishment of significant rapport among the patient and single therapists, but rather suggests that in institutional multi-professional settings we can verify two different levels of alliance. In fact, not always do the patient and staff produce a clear subject-group relationship. Occasionally, the patient develops a significant bond with some therapist and perceives the other therapists of the staff as forming a "nebulous group" of operators. Other times, the staff appears mostly as a group of singular and separate therapists with whom the patient interacts in different and specific ways and level of intimacy, establishing, for instance, a positive relationships with someone(s) and negative interactions with other(s) (Pulido, Monari, Rossi, 2008). Precisely, regarding this aspect, Correale (1991) observes that "*the investment of the institution, together with or instead of the investment of the single therapist, is a very usual evidence, for some extent inevitable, and always significant*" in the institutional work (pp. 172). Thus, regularly the patient engages at one with the single(s) therapist(s) and at another level with the institution including the staff as whole. Figure 1 represents the way in which these two levels appear in the interaction between a patient and a single therapist. The rapport established among them is conditioned by their mental representation about the staff and the patient-staff relationship. At the same time, these two-levels could be dissociated or fused, coexist in contradiction or in harmony and forming a synergic or a conflictive rapport among each other.

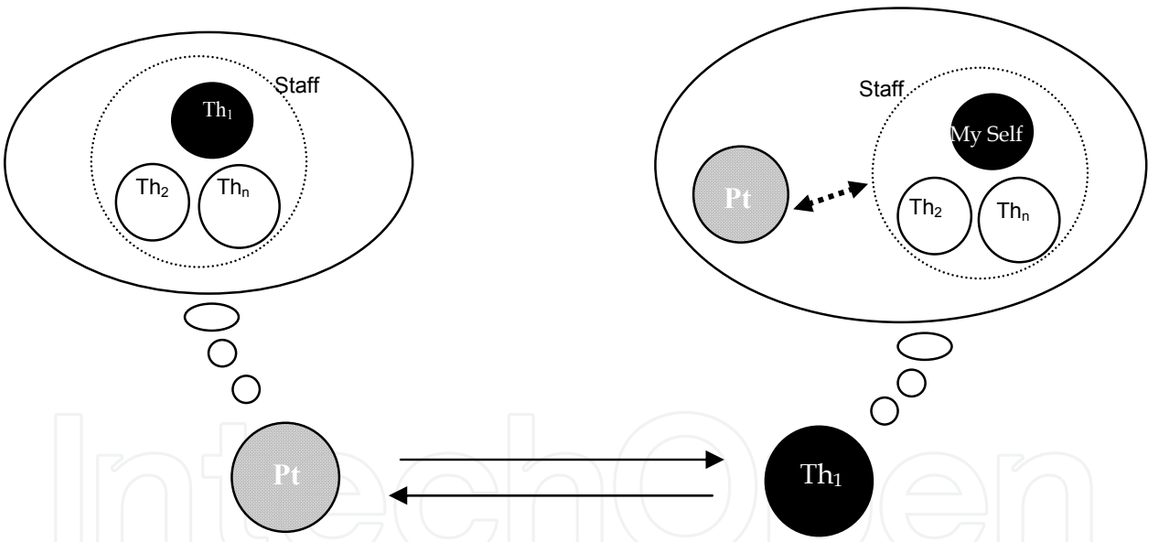


Fig. 1. Two relational levels within the patient-therapist interaction (*Note:* Pt = patient; Th = therapist)

7. Institutional therapeutic alliance assessment

We have collected some preliminary data that empirically sustain these hypotheses. We studied psychiatric patients from two day hospitals in Bologna, Italy, most of them with diagnosis of schizophrenia or personality disorder. Each therapeutic staff was conformed more or less by a head psychiatrist, four to six psychiatric nurses, a social worker, and a few postgraduate psychology students. They all maintained a direct, daily and continuous relationship with the patients. The institutions admit a maximum of 12 to 15 patients at the

same time and the length of the hospitalizations is around 6 weeks. The treatment consisted of pharmacotherapy and does not include any kind of psychotherapy. During the day, patients took their medicines and engaged in activities more or less organized, such as patients-staff meetings, socio-recreational activities and clinical interviews.

To assess the ITA we developed the Institutional Working Alliance Inventory – or IWAI – which has three main parts for patients and therapists:

1. The first part determines the presence of the two alliance levels (one-to-one and one-to-group) and the relationship between them. The patient answers the following general question: *In this staff there is a therapist (can be a doctor, a nurse, an occupational therapist, etc.) which is very close to me?* The patient answers YES or NO and then responds four items located under the YES or NO options. These four items explore the extent in which the presence or absence of a "close relationship" with one therapist coexists or does not coexist with a feeling that the rest of the staff is significant too. Total scores go from -4 to 4. Negatives values indicate absence or negative patient-staff alliance independently if there is or no an alliance with one particular therapist.

   In a pilot study with 39 patients (Pulido, 2010), we find that most part of the sample (54%) establishes high bonding with a single therapist and at the same time a positive relationship with the staff. Patients were consulted at discharge and as you can see in the table 2, only 10% does not perceive the staff as a source of contention and support, and many of the 90% that conceives it in a positive way does not establish a singular rapport with one of the therapists (14/35). This result suggests that we can describe three main patterns of therapeutic alliance within the institution: a) Alliance with one/therapist and the staff at the same time (64%); b) Alliance just with the staff (36%); and c) Alliance just with one-therapist (10%). And it seems that the first case is the most frequent, at least in our sample of day hospital psychiatric patient treated by a multidisciplinary staff.

Patient establish an…		… alliance with the staff as a whole?		
		Yes	***No***	***Total***
… alliance with one therapist?	***Yes***	21 (54%)	4 (10%)	25 (64%)
	No	14 (36%)	0 (0%)	4 (10%)
	Total	35 (90%)	4 (10%)	39 (100%)

Table 2. Two levels of therapeutic alliance (*Note. N=39)*

2. The second part assesses the quality of the therapeutic alliance with the focus on the patient-staff relationship. This part is an adaptation of the short form of the well-known Working Alliance Inventory developed by Horvath and Greenberg (1987). We transformed the original items in a way that they can account for a patient-staff relationship instead of a patient-single therapist rapport. There are 12 self-report parallel items for patients and therapists that they answer by using a 7-point Likert scale. It yields three 4-item added subscale scores – Task, Goal and Bond – as well as one overall score. Relative to the staff version, each therapist answers for himself. Then, overall and subscale scores correspond to the average of the staff members' values. In addition, a further index – the average of the item SD – indicates the internal agreement level of the staff's members, where lower scores indicate higher level of agreement. The

following is an example of an item in the patient and therapists version: *"I am confident in the staff's ability to help me"*; *"we are confident in the staff's ability to help (name of the patient) "*.

We tested the psychometric properties of the scale in a sample of 94 patients and two therapeutics staff (Pulido et al., 2010). Internal consistency and inter-rater reliability (for the staff version) reached adequate values: patient version shows an excellent reliability with a Cronbach's Alpha of .915, whereas the staff version shows adequate and significant reliability index between arbiters (ICC between .61 and .87; $p<.05$ in almost every item, except for two) and an ICC averages of .69 and .60 for each therapeutic staff. We also explored its factorial structure, and as many other authors, we did not confirm the classical three Working Alliance's dimensions of tasks, goals and bond. Instead of that, we found only one generic factor for the staff version which accounts for 79.8% of the variance, and three factors - one generic plus two secondary - for the patient form that account for 75% of the overall variance. The generic factor includes items about the quality of the professional relationships and the level of agreement with the treatment's goals and tasks, while the two secondary dimensions of the patient version refer, respectively, to negatives and meta-perceptive, or meta-communicative, aspects of the patient-staff relationships.

3. The third part verifies to what extent the patient answers the items of the II part thinking primarily at the staff as a whole, thinking in this or that therapist depending of the item, or having in mind just one specific therapist in almost all sentences. Our data shows that 78% of a total of 94 assessed patients at the end of the treatment, answered the scale actually considering the staff as a unitary and cohesive object and just few cases answered in the other two ways (Pulido, 2010).

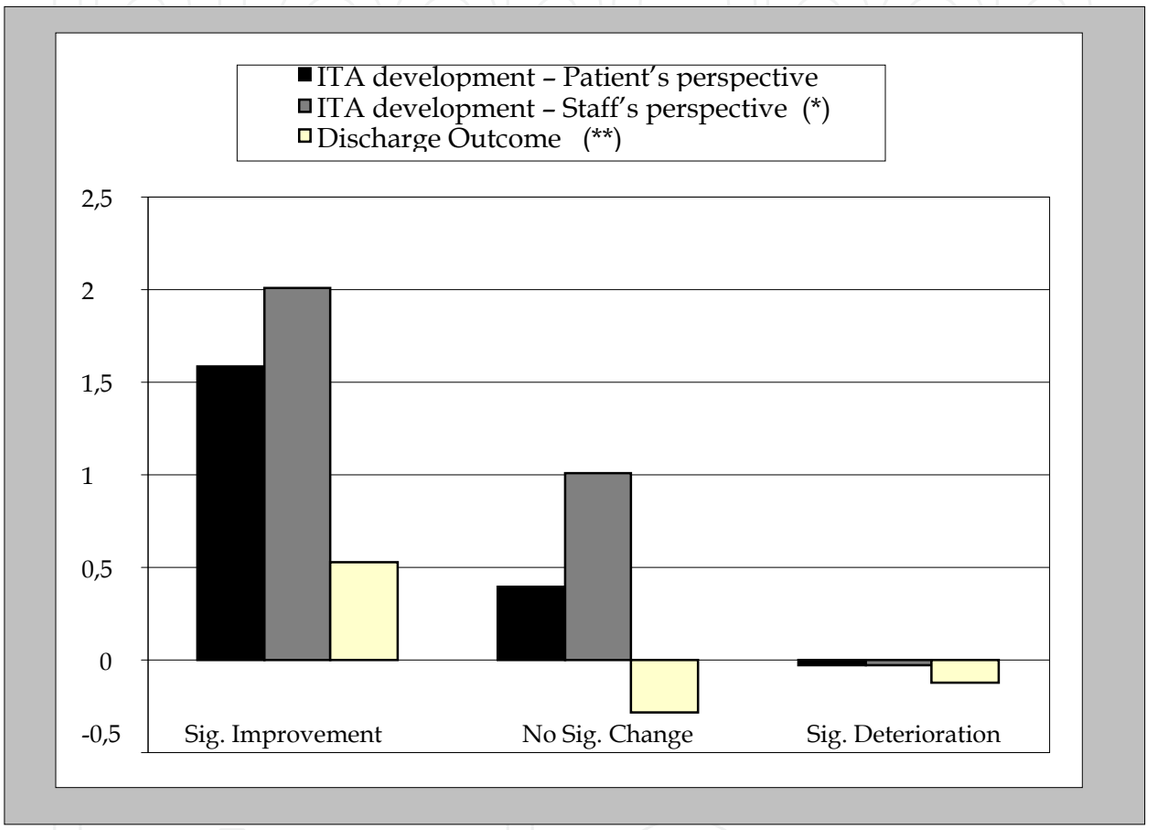
8. A longitudinal study

We conducted a longitudinal study to explore many aspects of the Institutional Therapeutic Alliance, like factors that influence its early formation and development, and its relationship with treatment outcomes (Pulido, Monari & Rossi, 2008). We assessed many variables in 55 patients in different steps of the partial hospitalization: admission, after one week, discharge and after 3-month from the end of the treatment. We found that initial ITA is not a good predictor of treatment success and that it is strongly influenced by the patient's feelings, expectations and attitudes toward several aspects of the treatment at admission. In fact, patients who began the treatment with a higher positive approach towards the treatment – that is more hope/trust and less fear/pessimism – in general report a higher perception of the alliance's quality with the staff after the first week of hospitalization ($r = .54$, $p < .01$).

The result suggests that early alliance would be strongly conditioned by several internal aspects of the patient that can obstruct the emergence of a real inter-subjective matching with the staff. In this sense, with severely disturbed patients the early alliance could be a sort of expectancy index toward the therapist(s) and the treatment, rather than an actual measure of the ITA. It is quite possible – considering the psychiatric severity of our sample and the complex dynamics of groups and institutions – that patients need more than one week of treatment to form a realistic image of the staff and to establish a relationship with its members.

In contrast with the low predictive value of the early ITA, we found that its positive growing during the treatment is a significant factor for therapeutic success and recidivism

prevention. Based on follow-up data of 31 patents, we formed 3 follow-up groups. 1) Patient with significant improvement; 2) patient with no significant change; and 3) patients who were re-hospitalized or presented significant deterioration after three month form discharge. As we can see in the graph 1, patients of the *significant deterioration* group, although they finished the treatment achieving symptomatic improvement similar to those of the *no significant change* group, show a poorer development of the alliance, which is statistically significant in the staff perspective.



Note. N=31. $^{**}p < .01$; $^{*}p < .05$. Numbers of the axis are Residual Gain Scores with pre-tests (symptoms and ITA) as baseline and post-test (symptoms and ITA) as dependent variable.

Graph 1. Discharge outcome and Variation of ITA in the 3-month follow-up groups (Pulido, Monari, & Rossi, 2008).

From a clinical point of view, this evidence suggests that the staff should consider its own perceptions of the in-treatment variations of the ITA and not exclusively the patient's symptomatic condition, in order to judge if the patient should be discharged or not. Usually, the alliance has been considered as a process variable that influences the treatment outcome, but it seems that in the case of severely disturbed patients – at least when they are treated in institutional settings – it would be important to consider it as an outcome variable by itself. The results, confirm some aspects of Peplau's intuition that what help to the patient recovery, more than an adequate early or initial patient-psychiatric nurse relationship, is the capacity to move form an orientation to a resolution phase of the relationship (Stockmann, 2005).

All together, this evidence shows us the relevance of studying the therapeutic alliance in institutional contexts and the need to differentiate it from the dyadic alliance studied in psychotherapy settings. The studies I just have presented have many methodological limitations like the heterogeneity of the sample and the outcome assessment (we used only a self-report measure from patient's perspective), but constitute the first empirical data to support the idea of two different levels of the alliance in multi-professional settings and the importance of the level of the patient-staff relationship, that we call Institutional Alliance, to reach good outcomes and to prevent re-hospitalization or deterioration of discharged severely disturbed patient.

9. Questions for further research

There are so many questions still open that need further empirical inquiry. First of all, we need to understand better the relationship between the two levels of alliance and the way in which they relate with treatment process and outcome. Are they independent processes? If they are, how they influence each other? At the same time, we should continue the developing process of the Institutional Working Alliance Inventory, using bigger samples to confirm its psychometric properties and generalize it to other settings and cultural contexts other than Italian day hospitals. And last, but not least, there is a very important issue, almost unexplored empirically, regarding the characteristics and dynamics of therapeutic staff that relate positively and negatively with fruitful negotiating institutional alliance processes. For example, in clinical practice we can distinguish different kinds of therapeutic staff that probably influence both of the alliance levels we are talking about: from pseudo-staffs in which the professionals are not bonded to each other in a collaborative, complementary and interrelated fashion to help the patient; to mature staffs in which the different professionals feel a relevant part of the therapeutic system and constantly reflect about their practice to become adaptable and flexible to the patients' needs without renouncing to the staff's own identity and coherence.

In synthesis, there are so many hypotheses to verify, methodological issues to improve and conceptual distinctions to do, but one thing is quite sure: the therapeutic staff is more than a sum of multi professionals' expertise and could become a significant therapeutic tool for the severely disturbed patient's healing process.

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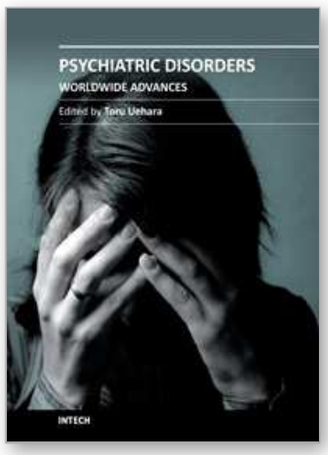
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A psychiatric disorder is defined as any complex condition that involves the impairment of cognitive, emotional, or behavioral functioning. Aside from knowing the physical organic factors, its causal pathology has remained a mystery. Regarding recent advances in psychiatry and neurosciences, psychiatric disorders have been closely associated with socio-cultural, psychological, biochemical, epigenetic or neural-networking factors. A need for diverse approaches or support strategies is present, which should serve as common knowledge, empathetic views or useful skills for specialists in the filed. This book contains multifarious and powerful papers from all over the world, addressing themes such as the neurosciences, psychosocial interventions, medical factors, possible vulnerability and traumatic events. Doubtlessly, this book will be fruitful for future development and collaboration in â€œworld psychiatryâ€.

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