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Therapist–client relationships in a psychological therapy trial for psychosis and substance misuse

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ABSTRACT

Background: This study aimed to explore factors associated with outcomes in a randomised controlled trial of integrated motivational interviewing and cognitive behavioural therapy for psychosis and substance misuse.
Method: Clients and therapists completed self-report measures of alliance and clients completed a self-report measure of adult attachment. Trial therapists were also asked to identify challenges in therapy, client strengths and reasons for client making and not making changes in relation to substance misuse.
Results: Neither therapist-rated nor client-rated alliance was significantly related to objective outcomes. Client insecure attachment avoidance was associated with poorer symptoms and functioning at 12 and 24 months; although not changes in substance misuse. Therapists' perceptions of therapeutic processes (e.g., challenges to therapy, client strengths, client reasons for change and alliance) were consistent with previous literature. Therapists' perceptions of client improvement were associated with reductions in substance use at the end of treatment and their ratings of therapeutic alliance.
Conclusion: Insecure adult attachment styles may be a potentially important predictor of symptom outcomes for people with psychosis and substance misuse. Trial therapists may also provide an important source of information about therapeutic processes and factors associated with outcome.
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1. Introduction

Often people with a dual diagnosis of psychosis and substance misuse have low motivation to reduce their use and there are obstacles to delivering therapy to this group (Barrowclough et al., 2007). A recent Cochrane paper reviewed 32 trials comparing psychosocial interventions for substance misuse with standard care in people with serious mental illness and concluded that there was no evidence that any existing treatments were effective (Hunt et al., 2013). Randomised controlled trials (RCTs) of complex interventions have been criticised as it is often difficult to know why interventions worked or not (Oakley et al., 2006). The current study explores a number of different contextual factors which influence outcomes for individual patients in the largest trial for people with a dual diagnosis of psychosis and substance misuse to date (Barrowclough et al., 2010a). This RCT involved 327 participants and compared MI integrated with cognitive behavioural therapy (CBT) and treatment as usual only. The authors found a significant effect of therapy on amount of substance used per substance using day which was maintained over two year follow-ups; although the therapy had no effect on hospital admissions or symptoms. Identifying factors which contribute to these outcomes has important treatment implications as it can help future researchers and therapists to modify therapies to maximise benefit (Webb et al., 2010).

One process factor that is frequently investigated to help explain outcomes is therapeutic alliance. Good alliance has been shown to predict outcomes across a range of different therapeutic modalities and client groups (Martin et al., 2000), including people with substance misuse (Meier et al., 2005) and in CBT for psychosis (Dunn and Bentall, 2007). The strength of the association between alliance and outcome has been questioned due to the relatively small nature of its magnitude and the possibility of third variables confounding the relationship (Crits-Christoph et al., 2006). However, there is some evidence from research evaluating interpersonal psychotherapy for depression that alliance remains significantly associated with changes in symptoms even after controlling for a wide range of patient-related confounding variables including prior improvement (Klein et al., 2003). This suggests that alliance is still

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a potentially important variable to consider in therapy process-outcome research.

Given the potentially important role of alliance in predicting outcomes it is beneficial to identify factors that are associated with alliance. Identifying such factors may inform interventions to improve alliance and, ultimately, outcomes. Barrowclough and colleagues (2010b) previously reported baseline predictors of therapist-rated and client-rated alliance from the trial. Client baseline variables that were associated with therapist perceptions of better alliance included: White race, living with others, positive attitude towards medication, greater insight, lower levels of depression and lower levels of dysphoria. Poorer insight at baseline was related to poorer client-rated alliance.

Other studies investigating predictors of alliance in therapy for people with psychosis have identified a range of predictors of therapist-rated alliance, but therapist and client perceptions of alliance are not highly correlated and there is relatively little consensus regarding determinants of client-rated alliance (Couture et al., 2006; Svensson and Hansson, 1999). One consistent finding in the general psychotherapy literature is that the quality of clients' current or past attachment relationships predicts the quality of therapeutic relationships. A number of studies have found that clients who have secure attachment styles and are comfortable with close emotional relationships develop better alliances (Diener and Monroe, 2011; Smith et al., 2010). Attachment styles may be related to improved therapy outcomes as a result of their associations with therapeutic alliance; a recent study involving people with early psychosis found associations between insecure attachment and poorer recovery from symptoms 12 months later (Gumley et al., 2014). It is also possible that interpersonal factors, such as attachment style, act as a 'third' variable which explains previous associations between alliance and outcomes (Crits-Christoph et al., 2006). Client attachment style is associated with both therapist- and client-rated alliance in the context of relationships between people with psychosis and psychiatric nurses (Berry et al., 2008), but to our knowledge there are no studies investigating associations between attachment and alliance and attachment and outcomes in psychological therapy for people with psychosis.

One important perspective that has the potential to offer insight into factors influencing alliance and therapy outcome, but which has been neglected by previous research, is that of the trial therapists. Trial therapists have direct experience in therapy delivery and, thus, provide a useful source of information about therapeutic processes influencing outcomes, such as barriers to treatment engagement, client strengths and reasons for change/no change (McGowan et al., 2005). They have insight into factors that facilitated or impeded change, which may not be captured by outcome measures. A number of studies involving people with a diagnosis of psychosis have found that both case managers and therapists report more difficulties in engaging those with insecure attachment patterns (Berry et al., 2007). However, to our knowledge, no previous studies have investigated how therapists' perceptions of a range of different aspects of client presentations relate to alliance or actual outcomes. Indeed, we do not even know if trial therapists are able to provide accurate inferences about clients' objective level of improvement.

The first aim of this study was to investigate associations between alliance, attachment and outcomes. We hypothesised positive associations between attachment and alliance and between both attachment and alliance and outcomes. Our secondary aim was to describe trial therapists' perceptions of challenges and obstacles in delivering MI and CBT for clients with dual diagnoses and therapists' perceptions of clients' strengths and resources that facilitated change. In addition, we aimed to describe therapists' perceptions of reasons for clients making and not making changes in relation to their substance misuse. Finally, we aimed to investigate therapists' perceptions of how much each client improved as a result of therapy and whether therapists' perceptions were related to actual outcomes and alliance. We hypothesised positive associations between therapist perceptions of outcomes and actual outcomes and alliance.

2. Method

2.1. Participants and procedure

The sample comprised participants in the treatment arm of the MIDAS trial (Motivational Interventions for Drug and Alcohol misuse in Schizophrenia or psychosis) (Barrowclough et al., 2010a) and the five therapists. Patients were randomised into the intervention arm of the trial, or the monitoring and assessment arm, and followed up at 12 months (end of treatment for those in the treatment arm of the trial) and 24 months.

2.2. Measures

2.2.1. End of therapy forms. At the end of treatment sessions, trial therapists completed forms about their experiences of carrying out therapy with each patient. The first part of the form asked for an open-ended list of: (a) challenges and obstacles; (b) strengths and resources; (c) the patient's reasons for reducing substance use; and (d) the patient's reasons for not reducing substance use. A system for coding responses in relation to each domain was devised following an initial content analysis of the data and responses were categorised by a trained rater. An independent trained rater double coded 20% of codings. Percentage of agreement between the two raters ranged from 91.11% to 100%. Discrepancies in categories were resolved via discussion with the first author. Descriptions of categories for each domain are listed in Table 2.

At the end of therapy, therapists were also asked to rate their impression of the patient's improvement in terms of substance use and symptoms. Rating scales ranged from none to substantial (1–5) and therapists were asked to rate improvement at the end of treatment and their projections about the likely level of improvement at the 24-month follow up.

2.2.2. Working Alliance Inventory. The 12-item Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) assesses agreement on therapeutic goals and tasks and emotional bond, and has both patient and therapist versions. A global rating of alliance is derived by summing scores for individual items, with high scores indicating a good therapeutic alliance. Therapists aimed to complete their questionnaire at the same time as clients (after session 3). We assessed alliance at session as opposed to later on in therapy in order to minimise early improvements in symptoms confounding any associations between alliance and later outcomes. Questionnaires were given to the research co-ordinator in a sealed envelope.

2.2.3. Attachment. We measured adult attachment using the Psychosis Attachment Measure (PAM; Berry et al., 2008) which assesses attachment in terms of the two dimensions of attachment anxiety and avoidance with higher scores reflecting more insecure attachment. The PAM has been shown to have good reliability and validity.

2.2.4. Substance misuse. Patients were assessed for alcohol and drug abuse and dependence in the past three months using DSM-IV criteria. The patient's most problematic substance was recorded. This was defined as the substance that the patient perceived to be most problematic, or if the person did not make the distinction, the most frequently used. Most problematic substances were coded as alcohol, cannabis or other substances (including cocaine, heroin and ecstasy). Frequency and quantity of substance misuse were assessed using the timeline follow back method which has good reliability and validity in dual diagnosis populations (Hjorthøj et al., 2012). The timeline follow back involves asking patients to report all substance use per day during the previous 90 days. We used the timeline follow back data to calculate average daily use followed by changes in average daily use of most problematic substance and all substances (referring to all substances including most problematic substance). In order to assess changes in most problematic and other substances, alcoholic drinks were translated into standard UK units (1 unit = 10 ml pure ethanol) and drugs were recorded by weight and cost or by number of tablets and costs, as appropriate. Self-reported drug misuse was validated by hair samples and informant-report (see Barrowclough et al., 2010b).

2.2.5. Symptoms. The Positive and Negative Syndrome Scale (PANSS) was used to assess psychiatric symptoms (Kay et al., 1987). The Global Assessment of Functional Scale (GAF) is an observer-rated measure which has two subscales assessing severity of symptoms and deficits in functioning (Hall, 1995). Both subscales range from 0 (severe symptoms and severe lack of functioning) to 100 (no symptoms and extremely high level of functioning). The lowest out of the two scores is used as the overall total GAF score. High levels of inter-rater reliability were obtained with experienced raters on all symptom measures throughout the study (all ICC > .70).

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