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The therapeutic alliance and therapist adherence as predictors of dropout from cognitive therapy for depression when combined with antidepressant medication



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ABSTRACT

Background: Previous psychotherapy research has examined the therapeutic alliance and therapist adherence as correlates or predictors of symptom change. While some initial evidence suggests the alliance is associated with risk of dropout in cognitive behavioral treatment for depression, evidence of such relations has been limited to date. We examined the relation of these psychotherapy process variables and dropout in the context of cognitive therapy for depression when provided in combination with pharmacotherapy.

Methods: Patients were randomized to the CT plus pharmacotherapy condition of a clinical trial for chronic or recurrent depression. Consistent with the spirit of personalized medicine, patients were treated until they met remission and recovery criteria (or reached the maximum allowable time in the study). In a sample of 176 patients, we examined observer-rated alliance and therapist adherence in the first three CT sessions as potential predictors of treatment dropout.

Results: The therapeutic alliance and one facet of therapist adherence (i.e., Behavioral Methods/Home-work) predicted reduced odds of dropout. Therapist use of Negotiating/Structuring predicted greater likelihood of dropout, but only when other variables were included in the model.

Limitations: Process ratings were not available for concurrent pharmacotherapy sessions. A minority of patients did not have session recordings available.

Conclusions: Results are consistent with the possibility that the therapeutic alliance and therapists' focus on homework and behavioral methods promote treatment retention in combined treatment for depression.

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The therapeutic alliance and therapist adherence are among the most frequently studied psychotherapy process variables. While the relation of process variables to symptom change has been the focus of hundreds of investigations (Horvath, Del Re, Flückiger, & Symonds, 2011; Webb, DeRubeis, & Barber, 2010), in many fewer studies have researchers examined the relation between process variables and treatment dropout. As dropout is an important therapeutic outcome, there is a need to identify its predictors, as

well as intervention strategies that reduce the risk of dropout (Cooper & Conklin, 2015; Swift & Greenberg, 2012; Swift, Greenberg, Whipple, & Kominiak, 2012).

In a meta-analysis of 11 studies across a very wide variety of contexts and treatment populations, Sharf, Primavera, and Diener (2011) reported a significant association between the therapeutic alliance and lower risk of dropout. In cognitive-behavioral therapies for depression specifically, there has been limited study of psychotherapy process variables as predictors of dropout. Perhaps the most revealing examination of these relations was Arnou et al.'s (2007) analysis of a large trial involving the Cognitive Behavioral Analysis System of Psychotherapy (CBASP) for chronic

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depression. In that study, alliance scores assessed during the second week of treatment were associated with lower risk of dropout across both the CBASP alone and the CBASP combined with medication conditions. As the authors noted, the observed relation of alliance and dropout could be due to the direct effect of the alliance on patients' commitment to treatment, or might have been mediated by the promotion of patients' medication adherence and their willingness to tolerate bothersome side effects. Consistent with this latter possibility, relative to patients in the medication alone condition, patients in the combined condition were less likely to cite side effects of medications as a reason for discontinuing treatment (Arnou et al., 2007).

Researchers have examined the alliance more often than therapist adherence; in fact, unlike the alliance, we know of no published studies examining the relation of therapist adherence and dropout in cognitive behavioral treatments for depression. However, a number of studies have examined the relation of therapist adherence and symptom improvement in CT for depression specifically. Four studies have reported that one or more facets of adherence predict subsequent symptom change in CT for depression (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999; Strunk, Brotman & DeRubeis, 2010; Strunk, Cooper, Ryan, DeRubeis, & Hollon, 2012). While the evidence is indirect, these studies provide some reason to suspect that a relation may exist between adherence and dropout. Thus, we evaluate both therapist adherence and the alliance as predictors of dropout.

We investigate these psychotherapy process variables in patients randomized to CT combined with antidepressant medication (ADM) in a clinical trial of chronic or recurrent depression (Hollon et al., 2014). In this trial, the provision of treatment was intended to capture the spirit of personalized medicine by allowing for flexibility in treatment duration. Compared to clinical trials that provide a fixed duration treatment for all patients, a design in which patients are treated until achieving an outcome better reflects high quality, personalized care. Accordingly, patients in this trial were treated until they met criteria for remission (normalization of symptoms) and recovery (presumed resolution of the underlying episode). In cases where therapeutic outcomes were not achieved, the duration of treatment was capped at a maximum of 42 months of treatment. Relative to most fixed-duration clinical trials, patients in this study were treated for a longer period over which they might have dropped out. In addition, the length of this period was not independent of whether patients experienced remission and recovery.

Even among studies of treatments provided for shorter fixed durations, there is evidence that variability in how dropout is defined substantively influences dropout estimates (Barrett et al., 2008; Swift & Greenberg, 2012). In the Hollon et al. (2014) trial, dropouts were defined as patients who were randomized to treatment, but then left the study. Patients who were administratively withdrawn (e.g., due to experiencing a manic episode) are considered separately in this paper, as we suspect their outcomes are best regarded as distinct from dropout. Dropout in this study may differ from dropout studied in the context of relatively brief, fixed duration treatments. While studies of dropout in both contexts are informative, dropout in a context such as Hollon and colleagues' trial has the key advantage of reflecting state of the art in high quality personalized medicine.

Our analyses focus on early psychotherapy process ratings for several reasons. First, therapeutic gains tend to occur disproportionately in early sessions of psychotherapy, including CT (Feeley et al., 1999; Sasso, Strunk, Braun, DeRubeis, & Brotman, 2015). This could be due in part to psychotherapy process variables being particularly important early in the course of treatment (DeRubeis & Feeley, 1990). Second, to examine the relation of psychotherapy

process variables and risk of dropout, examining later sessions when some or even many patients have dropped out would be difficult due to missing process data for these patients.

In keeping with the meta-analytic results reported by Sharf et al. (2011), we hypothesized that observer ratings of the therapeutic alliance would predict reduced odds of dropout. As we are not aware of any previous studies examining therapist adherence to CT as a predictor of dropout risk, we simply hypothesized that adherence ratings would be associated with reduced dropout risk and planned to explore whether these associations were specific to particular facets of therapist adherence.

1. Method

1.1. Participants and trial information

1.1.1. Patients

Patients were 176 of 227 patients (78%) in the combined condition of a multi-site, randomized trial of CT combined with ADM versus ADM alone; institutional review boards at all three sites approved the study. All patients received a primary current diagnosis of Major Depressive Disorder per DSM-IV criteria; details of the additional inclusion and exclusion criteria, informed consent procedures and the pharmacotherapy regimen can be found in Hollon et al. (2014). Randomization at each of three sites was stratified by recurrence/chronicity, depression severity, presence of a comorbid personality disorder, sex, and whether patients were married or cohabitating. Across the entire sample of 227 patients treated with CT and ADM, 39 people were classified as dropouts (17%). For this paper, the sample was limited necessarily to those combined treatment patients with a video recording available from at least one of the first three CT sessions; largely due to missing recordings, 51 patients could not be included. Of the 176 patients included in the sample, 58% were women. The average age was 43.3 (SD = 13.2; range of 18–80). With regard to race, 85% of patients were Caucasian, 9% were African American, 2% were Asian, 1% were American Indian or Native Alaskan, and 2% self-identified as "other".

1.1.2. Study implementation

Treatment was provided in a manner intended to capture the spirit of personalized medicine by allowing for flexibility in treatment duration according to clinical need, with the aim of having all patients achieve recovery (see Hollon et al., 2014). Patients progressed through an acute phase and a continuation phase. In the acute phase, patients were treated until they met remission criteria (i.e., 4 consecutive weeks of minimal symptoms). Following acute treatment, patients remained in the continuation phase until they met recovery criteria (i.e., 26 consecutive weeks without relapse). During the continuation phase, patients who relapsed needed to again achieve remission criteria before being eligible to achieve recovery criteria. There were maximum periods allowed for achieving remission (18 months) and recovery (36 months), after which patients who did not meet criteria were removed from the study and referred for other treatment (see Hollon et al. for additional details). If patients met the symptomatic criteria at the end of a phase, they were followed to determine if they would ultimately meet the duration criteria. Thus, patients could be treated for up to 19 months for remission, and up to 42 months for recovery.

Remission and recovery were defined on the basis of scores from the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) and Longitudinal Interval Follow-up Evaluation (LIFE; Keller et al., 1987) combined with duration criteria. Specifically, remission was defined as scores of eight or lower on the HRSD, and scores of two

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