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Research Report

The relationship between interpersonal problems, therapeutic alliance, and outcomes following group and individual cognitive behaviour therapy

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ABSTRACT

Background: Cognitive behavioural therapy (CBT) is efficacious, but there remains individual variability in outcomes. Patient's interpersonal problems may affect treatment outcomes, either directly or through a relationship mediated by helping alliance. Interpersonal problems may affect alliance and outcomes differentially in individual and group (CBGT) treatments. The main aim of this study was to investigate the relationship between interpersonal problems, alliance, dropout and outcomes for a clinical sample receiving either individual or group CBT for anxiety or depression in a community clinic.
Methods: Patients receiving individual CBT ($N=84$) or CBGT ($N=115$) completed measures of interpersonal problems, alliance, and disorder specific symptoms at the commencement and completion of CBT.
Results: In CBGT higher pre-treatment interpersonal problems were associated with increased risk of dropout and poorer outcomes. This relationship was not mediated by alliance. In individual CBT those who reported higher alliance were more likely to complete treatment, although alliance was not associated with symptom change, and interpersonal problems were not related to attrition or outcome.
Limitations: Allocation to group and individual therapy was non-random, so selection bias may have influenced these results. Some analyses were only powered to detect large effects. Helping alliance ratings were high, so range restriction may have obscured the relationship between helping alliance, attrition and outcomes.
Conclusions: Pre-treatment interpersonal problems increase risk of dropout and predict poorer outcomes in CBGT, but not in individual CBT, and this relationship is not mediated by helping alliance. Stronger alliance is associated with treatment completion in individual, but not group CBT.

1. Introduction

Cognitive behavioural therapy (CBT) is an efficacious treatment for depression in both individual and group treatment formats (Morrison, 2001). However, there remains considerable individual variability in treatment adherence and treatment outcomes (Hamilton and Dobson, 2002). Psychological services operate in a climate where it is important that treatments are demonstrably evidence-based and cost-effective. In order to provide cost-effective services, and to ensure patients are accurately matched to treatments that provide the best chance of success, it is important to understand how, and for whom, CBT produces positive outcomes. One factor associated with the development and maintenance of psychological problems is interpersonal problems (Davies-Osterkamp et al., 1996), defined as dysfunctional patterns in social relationships with other people (Horowitz et al., 1993). Interpersonal problems include a wide range of potential difficulties (e.g. being too submissive or controlling) that have the potential to interfere with psychotherapy.

Individual and group therapies place differing interpersonal demands on patients, so unsurprisingly the influence of interpersonal problems on treatment outcome seems to vary according to treatment format. Individual therapy involves one-on-one interpersonal contact, and is likely to involve more verbal contributions from the patient than group therapy. Mohr and colleagues (1990) found that patients who report high levels of interpersonal suspiciousness and difficulties trusting others may respond negatively to therapy (i.e. symptoms become more severe). However, at least within the context of individual treatment, well trained clinicians can identify, manage, and, if necessary, help clients to modify interpersonal styles that may be contributing to the

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presenting problem. In contrast, group therapy involves interactions with a number of people, and patients need to share the opportunity to contribute to sessions. Within this context it may be more difficult to work with individuals' problematic interpersonal styles, especially when the group is not specifically targeting interpersonal skills and the patient's interpersonal problems interfere with their ability to contribute to group discussions. A recent study evaluating the contribution of interpersonal problems to outcomes in group CBT for depression found that difficulties being assertive and a tendency to subjugate one's own needs were associated with poorer outcomes, while difficulties supporting others or being open about one's problems were associated with higher attrition (McEvoy et al., 2013).

There is some evidence that the relationship between interpersonal problems and treatment outcome may be mediated by helping alliance (Hardy et al., 2001; Howard et al., 2006). While there is considerable diversity in the definition and measurement of alliance (Horvath and Luborsky, 1993), broadly speaking alliance refers to the perception of shared responsibility for working out treatment goals (Luborsky, 1976). Alliance can be measured by patient, therapist or observer report (or a combination of these); however evidence suggests that, of these, patient ratings are most predictive of treatment outcome (Bachelor, 1991). Therapy is an inherently interpersonal process (Andrews, 2001), and the ability to form a collaborative patient–therapist working relationship is seen as an essential component for effective psychotherapy across all treatment modalities and formats (Lambert and Barley, 2001). Helping alliance has been demonstrated to have a moderate but consistent relationship with outcome, with stronger alliance predicting more positive treatment outcomes (Martin et al., 2000). A recent meta-analysis indicated that patients reporting weaker helping alliance are more likely to drop out of therapy (Sharf et al., 2010). Importantly, patients reporting a greater number of interpersonal problems at pre-treatment may have an interpersonal style that diminishes their capacity to form a strong helping alliance which may, in turn, adversely impact on treatment outcomes (Horvath and Luborsky, 1993; Muran et al., 1994; Saunders, 2001; Taft et al., 2004).

The influence of helping alliance may vary according to treatment format and stage of treatment. Liber and colleagues (2010) found that stronger helping alliance was related to better treatment adherence and outcomes for anxious children receiving individual but not group CBT. With regard to alliance and treatment stage, Strauss et al. (2006) found that good alliance, followed by deterioration in alliance, followed by an improvement in alliance predicted improvements in symptoms of personality disorders and depression. Conversely, a meta-analysis of 79 studies evaluating the relationship between helping alliance and outcome indicated that alliance has a moderate, positive relationship with outcome, and that this relationship was consistent regardless of the time at which alliance was rated (e.g., early, middle or late in therapy; Martin et al., 2000).

Interpersonal problems have been shown to place patients at greater risk of poor alliance, treatment drop-out and poor outcomes. Howard et al. (2006) measured interpersonal problems, helping alliance and treatment outcomes in patients ($n=19$) receiving individual CBT for depression. They found that higher levels of pre-treatment interpersonal problems were associated with poorer outcomes on depression measures at post-treatment, and that the reduction in treatment efficacy associated with more severe interpersonal problems was largely explained by the impact of interpersonal problems on helping alliance. Hardy and colleagues (2001) evaluated the association between interpersonal problems and treatment outcomes for depressed patients receiving individual cognitive therapy. They found that patients who reported difficulties in becoming socially involved and having an avoidant interpersonal style were likely to have poorer outcomes. This relationship was mediated by helping alliance, such that under-involved, avoidant patients were typically less able to form a strong alliance, which in turn predicted depression outcomes.

The role of interpersonal problems in predicting therapy outcomes is clearly a complex but important one. There is a need to consider the relationship between interpersonal problems, treatment format (individual vs. group), and the mechanism through which interpersonal problems influence outcomes (directly, mediated by helping alliance, or both). Moreover, it is unclear whether helping alliance at different stages of treatment (i.e., early versus late) is differentially related to outcome. This naturalistic study aimed to examine the associations between pre-existing interpersonal problems, early versus late helping alliance, treatment adherence, and symptom change for patients receiving either individual or group CBT for emotional disorders. The first hypothesis was that poorer helping alliance early in therapy would be associated with higher treatment attrition in both individual and group therapy. The second hypothesis was that therapeutic alliance would mediate the relationship between interpersonal problems and symptom change. Specifically, it was expected that more severe pre-treatment interpersonal problems would result in poorer early and late helping alliance in individual and group therapy which, in turn, would result in higher post-treatment symptoms after controlling for pre-treatment symptoms. The third hypothesis was that interpersonal problems would have a greater adverse impact on attrition and outcomes for group therapy compared to individual therapy, where trained clinicians have more flexibility to address interpersonal issues compared to group sessions. In contrast, but consistent with Liber et al. (2010), it was expected that therapeutic alliance would have a weaker association with outcomes from group therapy compared to individual therapy, where the sole relationship with the therapist may wield greater influence than within a group context.

2. Method

2.1. Participants

Participants ($N=199$, 69.8% women) were referred to a community based specialist mental health clinic by health practitioners for a unipolar depressive disorder or anxiety disorder with a mean age of 37.25 years (SD=12.49, Range=18–73). Inclusion criteria for treatment and therefore this study were (a) a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 2000) unipolar depressive disorder or anxiety disorder, (b) no current active suicidal intent (suicidal ideation or history were not an exclusion criteria), and (c) no psychotic or bipolar affective disorder. DSM-IV diagnoses were determined using the Mini International Neuropsychiatric Interview (MINI, Lecrubier et al., 1997; Sheehan et al., 1997a,b, 1998). More patients received group ($n=115$) than individual ($n=84$) treatment. A majority of patients (70.5%) had a principal depressive disorder (major depressive disorder, $n=115$; dysthymia, $n=22$) with the remaining having a principal anxiety disorder. Principal anxiety disorders included generalized anxiety disorder ($n=26$), social phobia ($n=20$), panic disorder with or without agoraphobia ($n=11$), simple phobias ($n=3$), PTSD ($n=1$), and anxiety disorder not otherwise specified ($n=1$). A majority of patients met criteria for at least one comorbid disorder ($n=114$, 57.3%), with 37 (18.6%) meeting criteria for at least two additional disorders. The most common comorbid disorders were GAD ($n=43$), social phobia ($n=36$), dysthymia ($n=34$), major depressive disorder ($n=15$), and panic disorder/agoraphobia