Journal of Affective Disorders 174 (2015) 549–555

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Premature termination from psychotherapy and internalizing psychopathology: The role of demoralization

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ARTICLE INFO

Article history:
Received 3 December 2014
Accepted 4 December 2014
Available online 13 December 2014

Keywords:
Premature termination
Psychotherapy
MMPI-2-RF

ABSTRACT

Background: Some research suggests that higher levels of depression and anxiety-related symptoms at intake are associated with premature termination from psychotherapy, but findings are mixed. However, theoretical and measurement considerations – introduced by a common mood factor – might complicate literature synthesis. Tellegen (1985) demonstrated that demoralization causes multicollinearity between measures of depression and anxiety, and other lines of research have converged to indicate that this construct is an important non-specific factor to consider when assessing mood pathology.
Methods: We utilized a sample of 557 community mental health center outpatients (188 males, 265 females; 80% Caucasian) with an average age of 32.2 years ($SD = 10.2$). We used self-report indicators to model latent low positive emotionality and negative emotionality constructs, which are temperament markers of core depressive and anxiety symptoms. We further specified a latent demoralization bifactor from these indicators.
Results: As hypothesized, the bifactor model yielded significantly better fit than competing one-factor and two-factor models. Furthermore, the bifactor was substantially correlated with a demoralization measure ($r = .96$). As expected, low positive emotionality and negative emotionality were significant predictors of therapist ratings of premature termination. Though demoralization was a non-significant predictor, the structural paths from the other two internalizing constructs markedly increased in the bifactor model relative to the two-factor model.
Limitations: Replications with other, more diverse clinical populations using multi-method indicators of premature termination are needed.
Conclusions: This research indicates that after accounting for demoralization patients presenting with core mood disorder symptoms are at substantially increased risk for premature termination.
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1. Introduction

Premature termination from psychotherapy is common. Wierzbicki and Pekarik (1993) conducted a seminal meta-analysis of 147 studies and found that average premature termination rates ranged from 36 to 48%, depending on how premature termination was operationalized. Swift and Greenberg (2012) conducted an updated meta-analysis of over 600 studies published between 1990 and 2010 and found that the average premature termination rate was approximately 20%. Because of these high rates of premature termination from psychotherapy, researchers have sought to identify predictors of this construct for at least the past forty years (Baekeland and Lundwall, 1975; Swift and Greenberg, 2012; Wierzbicki and Pekarik, 1993).

One promising line of research concerns the association between initial depression and anxiety severity and premature termination, though these research findings are mixed. For example, several studies report that higher levels of pre-treatment depressive symptoms are associated with premature termination (Persons et al., 1988; Shappell-Lewis, 2007; Shepherd, 1997), though other studies have supported the opposite association (Baekeland and Lundwall, 1975; Conte et al., 1988; Walters et al., 1982). Similarly, some research has identified initial anxiety symptoms as a predictor of premature termination (Arnow et al., 2007; Chisholm et al., 1997; Shepherd, 1997), whereas other authors find that lower levels of initial anxiety are predictive of premature termination (Baekeland and Lundwall, 1975; Conte et al., 1988; Walters et al., 1982).

One reason for mixed findings on the association between mood symptoms and premature termination is measurement overlap across and within anxiety and depression scales, which are regularly used to assess these symptoms. Tellegen (1985) considered this issue in light

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http://dx.doi.org/10.1016/j.jad.2014.12.018
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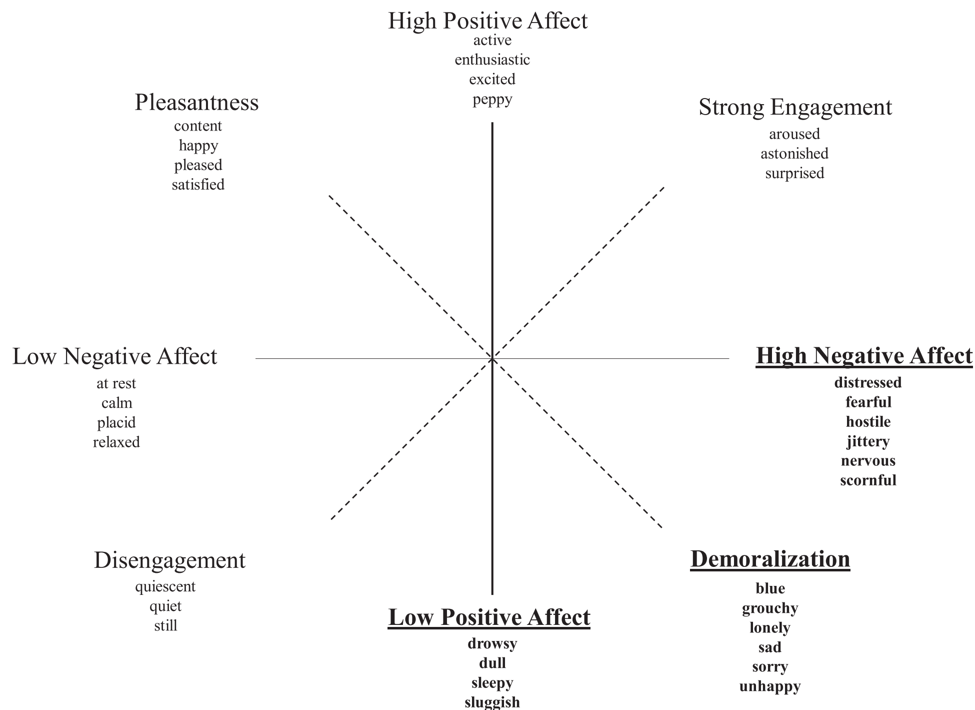

Fig. 1. Tellegen's (1985) Theory of Mood.
Note: Bolded constructs are associated with mood and anxiety disorders.

of his and Watson's theory on the structure of affect (Watson and Tellegen, 1985). Based on reanalysis of several existing mood studies, these authors identified two primary orthogonal mood factors: negative affect and positive affect. The negative affect construct was characterized by descriptors such as *distressed*, *fearful*, *hostile*, *jittery*, *nervous*, and *scornful* at the high end and *at rest*, *calm*, *placid*, and *relaxed* at the low end. The positive affect construct was characterized by such descriptors as *active*, *elated*, *enthusiastic*, *excited*, *peppy*, and *strong* at the high end and *drowsy*, *dull*, *sleepy*, and *sluggish* at the low end (see Fig. 1 for model).

Tellegen (1985) observed that anxiety is associated with high negative affect, whereas depression is associated with low positive affect. However, he also demonstrated that anxiety and depression measures were highly correlated with each other, as well as with a common mood factor that he labeled demoralization (see Fig. 2). This demoralization factor was characterized by *blue*, *grouchy*, *lonely*, *sad*, *sorry*, and *unhappy* at the high end and by *content*, *happy*, *pleased*, *satisfied*, and *warmhearted* at the low end. Not coincidentally, this factor emerged from a 45 degree rotation of the negative affect/positive affect results (along with an "arousal" factor), such that high demoralization reflects a combination of low positive affect and high negative affect. Based on his findings, Tellegen (1985) concluded that demoralization needed to be isolated and measured, so its common variance could be removed from measures of depression and anxiety. This process should yield improved measures of low positive affect and high negative affect, respectively.

Subsequent research has supported Tellegen's (1985) suggestion that positive affect, negative affect, and demoralization are important constructs in the structure of mood disorders. Building upon research by Watson (2005), who proposed a hierarchical structure of mood disorders (similar to one previously described by Krueger, 1999), Watson et al. (2006) developed a revised theory on the association between the temperament markers of negative affect and positive affect (henceforth referred to as *negative emotionality* and *positive emotionality*, respectively) and the mood and anxiety disorders. Specifically, Watson and colleagues (2006) hypothesized that negative emotionality was broadly associated with *internalizing disorders*, which were comprised of *distress disorders* (major depressive disorder, dysthymia, generalized anxiety disorder, and post-traumatic stress disorder) as well as *fear disorders* (social phobia, panic disorder, agoraphobia, and specific phobia), whereas low positive emotionality was associated with major depressive disorder and social phobia in particular.

Sellbom et al. (2008) replicated Watson's (2005) proposed hierarchical structure of internalizing disorders using self-report measures and expanded on Watson and colleagues (2006) hypotheses regarding the association between negative emotionality and positive emotionality with the distress and fear disorders. Based on Tellegen's (1985) proposal, Sellbom and colleagues elaborated on the two-factor model's association with internalizing disorders by incorporating demoralization in the model and analyses. They tested competing structural models and found that the best-fitting one included demoralization as the primary marker of the distress disorders, negative emotionality as the primary marker of the fear disorders, and low positive emotionality as a specific marker of depression and social phobia. Sellbom et al. (2008) concluded that demoralization was a significant factor to consider when assessing – and describing the structure of – mood and anxiety disorders, and they noted that prior research from a variety of perspectives had also emphasized the importance of this construct, particularly in psychological treatment (Barlow et al., 2004; Frank, 1974, 1985).

Though the effect of demoralization on premature termination has been examined relatively less than anxiety and depression, some research indicates that higher levels of demoralization may lead to premature termination. Howard et al. (1993) described an empirically supported theory that therapy progresses through three consecutive phases: remoralization, symptomatic recovery, and functional improvement. During the remoralization process, therapy leads to increases in subjective well-being, which mobilizes the individual's coping resources for symptom reduction and the acquisition of long-term functional coping mechanisms. Because the authors demonstrated that the stages are consecutive, individuals who drop out of treatment before the end of the remoralization stage (perhaps because of the severity of their demoralization) will

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