Journal of Affective Disorders 167 (2014) 112–117

Contents lists available at ScienceDirect

Journal of Affective Disorders

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

Research report

The effect of core clinician interpersonal behaviours on depression

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ARTICLE INFO

Article history:
Received 20 January 2014
Received in revised form
27 May 2014
Accepted 29 May 2014
Available online 6 June 2014

Keywords:
Depression
Psychotherapy
Cognitive behaviour therapy
Interpersonal psychotherapy
Therapy process research
Outcome predictors

ABSTRACT

Background: It is well-established that core clinician interpersonal behaviours are important when treating depression, but few studies have evaluated whether outcome is determined by clinicians' general behaviour rather than by the perception of the individual being treated.
Methods: In the NIMH TDCRP, 157 patients rated their clinician's genuineness, positive regard, empathy and unconditional regard during cognitive behavioural therapy, interpersonal therapy or clinical management with placebo. The association between averaged ratings for each of 27 clinicians and their patients' self- and observer-rated depression outcomes was evaluated, adjusting for the deviation of individual patient ratings from the average for their clinician and other potential confounders.
Results: Clinicians in the clinical management condition were rated on average as less genuine and less empathic than those in the psychotherapy conditions. Clinicians' average genuineness, positive regard and empathy were significantly associated with lower depression severity during treatment, but not with recovery from depression, after adjusting for the deviation of the individual patient's rating of their clinician from the average for that clinician, treatment condition and baseline depression severity. Clinician unconditional regard was not significantly associated with outcome.
Limitations: Using averaged ratings of clinician behaviour likely reduced statistical power.
Conclusions: Clinicians' ability to demonstrate genuineness, positive regard and empathy may represent a stable personal characteristic that influences the treatment of depression beyond the individual clinician–patient relationship or an individual patient's perception of their clinician. However, clinicians' ability to demonstrate these behaviours may be poorer when delivering an intervention without a specific rationale or treatment techniques.

1. Introduction

It is a well-established finding that, regardless of the particular therapeutic model followed or the particular patients they see, some clinicians achieve better outcomes than others (Baldwin and Imel, 2013; Wampold, 2001). It has been estimated that this 'therapist effect' explains between 6% and 9% of the variance in outcomes (Blatt et al., 1996a; Crits-Christoph and Mintz, 1991; Luborsky et al., 1997; Project MATCH Research Group, 1998;) with a meta-analysis of 46 studies placing the average variance explained at 7% (Baldwin and Imel, 2013). In the dataset used in this paper, the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIHR TDCRP), although one analysis failed to find any evidence of therapist effects (Elkin et al. 2006), further analysis using improved statistical methodology found that 8% of the variance in depression outcomes was due to therapist effects (Kim et al., 2006). Thus it seems that therapist effects are an important determinant of outcome with potential implications for clinician selection, training, and quality assurance. However, there is a scarcity of high quality evidence on how and why this effect occurs, and on what makes some clinicians more effective than others.

Carl Rogers' theory of the core clinician behaviours necessary for good patient outcomes has been highly influential. He suggested that effective clinicians should be genuine (integrated and genuine within the therapeutic encounter, without front or façade, and expressing his/her true feelings and attitudes), display positive regard (caring for and valuing the client and showing warmth towards them), be empathic (communicating an understanding of what the patient's experiences and emotions feel like to them), and show unconditional regard (the attitude of the clinician towards the client does not fluctuate regardless of what they say or do) (Rogers, 1957; Rogers, 1961;

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http://dx.doi.org/10.1016/j.jad.2014.05.064
0165-0327/

Lietaer, 1987). Over 100 studies of this theory have been conducted to date, and meta-analyses and systematic reviews have concluded that, overall, patients achieve better outcomes if they rate their clinicians as higher on these core behaviours (Bozarth et al., 2002; Elliott et al., 2011, Klein et al., 2001; Orlinsky et al., 1994). However, it is not clear from these studies to what extent the association between patient ratings of clinician behaviour and outcome is driven by the capacities of the clinician to provide the core conditions to various patients, rather than by the characteristics of the individual patient, who might have the characteristics that elicit such behaviour from the clinician (e.g., not interpersonally aggressive, see Boswell et al., 2013), or by the characteristics of the particular patient–clinician dyads involved. It is important to determine this in order to understand better how clinician behaviour affects outcome and therefore how it can potentially be harnessed to improve outcomes. Baldwin et al. (Baldwin et al., 2007) were the first to show that clinician variability in patient-rated alliance is related to outcome, whereas patient variability in alliance ratings is not – suggesting that alliance-outcome associations primarily relate to the clinician's rather than the patient's ability to establish an alliance. There is only one analysis to date that has disaggregated the effect of the core conditions on outcome into the portion of variance explained by the clinician and the portion explained by the patient (Zuroff et al., 2010). They showed that clinicians who were rated on average as higher on a composite measure of genuineness, positive regard and empathy achieved better outcomes, and that this effect was twice the size of the effect of within-clinician differences in individual patients' ratings. This study showed for the first time that the association between patient ratings of clinician behaviour and outcomes is largely driven by the general behaviour of clinicians, regardless of the particular individual patients making the rating.

However, this analysis did not examine the individual effects of genuineness, positive regard, unconditional regard and empathy and thus it is unclear whether all four of these characteristics are important. Furthermore, the analysis focused on outcomes not commonly used in everyday clinical practice (global maladjustment and self-critical perfectionism).The present analysis therefore aimed to determine the individual effects of clinicians' mean genuineness, positive regard, empathy and unconditional regard on a clinically relevant outcome (severity of and recovery from depression).

2. Methods

2.1. Design

A prospective analysis of the effect of clinician genuineness, positive regard, empathy and unconditional regard on depression, using data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) (Elkin et al., 1985).

2.2. Participants

The present analysis was based on 157 patients allocated to 27 clinicians from the TDCRP study, comprising those who were randomly allocated to receive cognitive behaviour therapy, interpersonal therapy or clinical management with placebo, who completed the Barrett Leonard Relationship Inventory at session two, and whose clinicians had more than one patient. Clinical management with placebo was included in the analysis because this condition was designed to provide a supportive therapeutic relationship (Elkin et al., 1985). Furthermore, variables related to the relationship have been shown to be comparable between this condition and the psychotherapy conditions whilst some clinicians have been shown to be more effective than others (Blatt et al., 1996b, McKay et al., 2006, Zuroff et al. 2000), and another research has found that providing a therapeutic relationship in conjunction with a placebo can be an effective treatment (Kaptchuk et al., 2014). All participants had a diagnosis of major depression and did not have comorbid bipolar or psychotic disorders. Inclusion and exclusion criteria, sample characteristics, treatment procedures, and assessment procedures have been described previously (Elkin et al., 1985; Elkin et al., 1989). All participants underwent a thorough informed consent procedure.

2.3. Measures

2.3.1. Clinician genuineness, positive regard, empathy and unconditional regard

These were assessed using the patient-rated Barrett Lennard Relationship Inventory (BLRI) (Barrett-Lennard, 1962, 1986). This 64 item questionnaire has a separate sub-scale for each of these four behaviours, including both positively and negatively valenced items, and patients rate their clinicians on each on a scale from −3 (Strongly not true) to++3 (Strongly true). The possible total scores for each subscale range from −48 to++48. Patients completed this at their second treatment session and for each clinician an average score was calculated for each sub-scale by averaging across the ratings made by each of their patients.

2.3.2. Outcome measures

2.3.2.1. Patient-rated depression. Patients rated their depression severity on the Beck Depression Inventory (BDI) (Beck et al., 1961) at weeks 0, 4, 8, 12 and 16 of treatment. A score of 9 or less at week 16 was taken to indicate recovery.

2.3.2.2. Observer-rated depression. A trained PhD level researcher assessed patients' depression severity on using the 17 item Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1967), at weeks 0, 4, 8, 12 and 16 of treatment. A score of 6 or less at week 16 was taken to indicate recovery.

2.4. Statistical analysis

Clinicians' mean genuineness, positive regard, empathy and unconditional regard were treated as continuous variables in order to assess the effect of these behaviours across their full continuum. Logistic regression was used to evaluate the association between these behaviours and recovery from self and observer -rated depression at week 16. Multilevel random effects linear regression was used to evaluate the association between these behaviours and depression severity at weeks 4, 8, 12 and 16 of treatment, with the patient at Level 2 and repeated measures of depression at Level 1, thus accounting for autocorrelation between repeated measures of depression in the same patient. The depression scores did not conform to a normal distribution and so robust standard errors were used. All models adjusted for pre-treatment depression severity at week 0, for treatment condition, and for the difference between an individual patient's rating of their clinician and the average for their clinician. This enabled us to separate out the variance in outcome explained by the general behaviour of that clinician from that explained by the characteristics of the individual patient making the rating.