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The working alliance and Clinician-assisted Emotional Disclosure for rheumatoid arthritis

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ABSTRACT

Objectives: The working alliance predicts improvement following general psychotherapy, but how it operates in brief interventions conducted with medically ill patients is unknown. Also, the role of the working alliance may differ in emotion-focused versus educational interventions.

Methods: We report secondary analyses of a randomized clinical trial (Keefe et al.) [35], in which patients with rheumatoid arthritis (RA) received four nurse-provided sessions of either a) Clinician-assisted Emotional Disclosure (CAED), which emphasized the disclosure, expression, and processing of emotions related to stressful events; or b) Arthritis Education (AE), which provided basic education about RA. The Working Alliance Inventory was completed by both patient and nurse after each session. Patients were evaluated on multiple health measures at baseline and 1, 3, and 12 months post-treatment.

Results: Analyses compared the alliance between interventions and related the alliance to outcomes within interventions. Patients in CAED reported a lower alliance than patients in AE. Interestingly, in CAED, lower alliance ratings predicted better outcomes (improved functioning, lower pain behaviors, lower inflammation, lower daily stress), whereas in AE, the working alliance was largely not predictive of outcomes.

Conclusion: Having nurses encourage emotional disclosure among patients with RA reduced the patients' working alliance, but a lower alliance nonetheless predicted better patient outcomes, perhaps reflecting successful engagement in an intervention that is emotionally and relationally challenging. The level and predictive validity of the working alliance likely depends on patient, provider, and intervention factors, and further study of the working alliance in psychosocial interventions in the medical context is needed.

1. Introduction

The doctor-patient relationship has long been acknowledged as the cornerstone of quality medical care [1]. Empathy, trust, and collaborative decision-making are all thought to strengthen the quality of the provider-patient relationship [2,3]. The call for relationship-based medical practice, however, has far outpaced the evidence base to guide it; as such, providers are often left to their own devices regarding how to promote successful working relationships.

In contrast, substantial research on relational factors has informed the field of psychotherapy. Researchers have studied the relational and contextual factors that build rapport, facilitate a trusting environment, and promote patient disclosure. One of the most robust predictors of positive outcomes is the working alliance [4]. Bordin's [5] pan-theoretical model defines three components of the working alliance: collaboration between patient and therapist on goals, collaboration on tasks, and quality of emotional bond. The bond component is thought to be most emotion-based, and hence is most characterized by the emotional-interpersonal processes that occur between the patient and therapist when working collaboratively [6]. The working alliance is a common factor, exerting its effects across treatment approaches and patient populations [7]. It is the most consistent process-based predictor in psychotherapy, predicting better outcomes at small to medium effect sizes (r = 0.22–0.26) [4].

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1.1. The working alliance in medical settings

The extent to which the working alliance extends *beyond* psychotherapy and into other health-delivery services is less clear. Very little research, for example, has examined the working alliance in psychosocial interventions of medical or physical health problems. There are reasons to believe that the working alliance may operate differently in medical settings than it does in psychotherapy. Outpatient medical visits are fewer and briefer than psychotherapy. Moreover, medical patients usually present with chronic and comorbid illnesses, such as obesity, diabetes, arthritis, and chronic pain, and treatment goals often differ from psychotherapy, as symptom management is more realistic than remittance or cure. Perhaps most importantly, medical patients likely do not expect to be asked to disclose and discuss private psychosocial issues, especially if such issues are not seen as clearly linked to their physical health problems.

Several authors have reported that the working alliance is an important issue in the treatment of chronic pain. For example, a difficult alliance is a top concern of health care providers when working with patients with chronic pain [8], and patients' negative emotions can impair the working alliance [9,10]. Positive patient-provider relations in general appear to predict better healthcare outcomes in patients with chronic pain [11,12], but almost no research has been conducted on the working alliance specifically in chronic pain treatment. Ferreira et al. [11] found that the therapeutic alliance predicted improved outcomes of physical therapy for chronic back pain. We know of only one study that examined the working alliance as a predictor of outcomes for a psychosocial treatment for chronic pain, finding that the working alliance was unrelated to outcomes [13].

1.2. Rhematoid arthritis

Rheumatoid arthritis (RA) is a chronic and often debilitating autoimmune disease marked by cycles of inflammation in the synovial areas. Characterized by chronic joint and muscle pain and stiffness, patients with RA may be particularly prone to emotional or psychological distress. Moreover, several large-scale studies have found links between a history of psychosocial adversity or posttraumatic stress disorder and subsequent RA [14,15]. Negative emotions are thought to exacerbate the stress response, and people with RA report elevated levels of interpersonal stress [16,17]. Thus, patients with RA are particularly prone to negative affect, but they may have a difficult time engaging in treatments designed to ameliorate negative emotions. Traditionally, psychosocial interventions for patients with RA have involved self-management educational approaches and training in cognitive-behavioral coping skills [18–21]. These interventions have been effective, although with small effect sizes and inconsistent long-term maintenance of effects. There is increasing interest in targeting stress and emotions [16,22–24], how interpersonal relationships are used for coping [25,26], and the roles played by emotions and relationships in psychosocial treatments of RA.

Emotional disclosure approaches have been tested for patients with various health problems, and many studies report some benefits following emotional disclosure of stressful or traumatic events [27–30]. Studies of emotional disclosure among people with RA, however, have reported mixed, often null findings [31–33]. Yet, the experimental protocol in almost all emotional disclosure studies involves only private or solitary disclosure; thus, little is known about how interpersonal processes might influence emotional disclosure's effects on health. Whether disclosure occurs privately or to another person is important because some patients with chronic pain, particularly RA, inhibit their negative emotions and have particular difficulty describing their feelings to others [23]. Thus, encouraging patients with RA to disclose personal stressors and express their emotions may negatively impact the working alliance with the provider working with them, even though it might be healthy for such patients to do so.

1.3. The present study

Given the links among RA, emotions, and interpersonal stress, an important area for research is to understand how interpersonal emotional disclosure might influence the working alliance, and how the working alliance might affect health responses to emotional disclosure. We developed Clinician-assisted Emotional Disclosure (CAED), in part, because the nature of emotional disclosure likely fits well with a warm, caring human relationship, and in part, because patients may need help identifying, labeling, and describing their emotions. CAED has been tested and found to be helpful in one study of college women who were symptomatic after experiencing a sexual assault [34]. In a prior randomized trial for RA, the current research team compared CAED to Arthritis Education (AE), both provided by nurses, and to private emotional disclosure and no-treatment control. The trial found no clear pattern of differences in health outcomes among the conditions [35]. The present report is a process-level analysis of working alliance assessed during CAED and AE, and its relation to outcomes from that trial. The trial was unique not only because it assessed therapeutic alliance in a study of chronic pain, but also because it: a) compared the working alliance in CAED to a very different approach, AE, in a randomized design; b) examined the validity of the working alliance to predict health changes after both CAED and AE at 1, 3, and 12 months; and c) assessed working alliance from two perspectives: patient and therapist, which is important because these ratings often differ, and patients' ratings tend to be more predictive than therapists' ratings of psychotherapy outcomes [4].

We examined the possibility that CAED, which is emotionally and perhaps interpersonally challenging, would create a lower working alliance than a supportive and educational comparison intervention (AE). We also explored whether the working alliance would predict health outcomes differently for CAED than AE, including the possibility that a poorer alliance in CAED would predict better outcomes, perhaps because a relatively poor alliance could indicate that the therapist has successfully encouraged the patient to disclose and process negative experiences.

2. Methods

2.1. Participants

Participants were 60 patients who met the 1987 American College of Rheumatology criteria for the diagnosis of RA, and were recruited from rheumatology clinics affiliated with the Duke University Medical School (65.0%) or the Ohio University College of Osteopathic Medicine (35.0%). Patients were excluded if they also had other serious diseases (e.g., COPD, lupus), severe personality disorders, substance abuse problems, or who were involved in current psychiatric treatment. In the original trial [35], patients were randomized to four conditions (CAED, AE, private disclosure, or standard medical care only); however, the working alliance was assessed only in the two conditions that included a therapist. Thus, the current analyses included only CAED or AE. The sample of 60 patients was 75% female, 91.7% Caucasian, had a mean age of 54.7 years (SD = 10.94), had been diagnosed with RA for an average of 13.45 years (SD = 8.25), and had, on average, mild to moderate RA as determined by rheumatologist rating of disease activity. Further data on the sample is provided in Keefe et al. [35].

2.2. Procedure

Patients came to four assessments over the study: (a) baseline, which was 1 month prior to treatment; (b) 1 month post-treatment; (c) 3 months post-treatment; and (d) 12 months post-treatment. At each assessment, a rheumatologist conducted a physical exam including grip strength and inflammation assessment of the patient. Patients also had a structured assessment of pain behavior and completed self-report