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Working alliance and competence as predictors of outcome in cognitive behavioral therapy for social anxiety and panic disorder in adults

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A B S T R A C T

Objective: The research on the association between the working alliance and therapist competence/adherence and outcome from cognitive behavioral therapy (CBT) is limited and characterized by inconclusive findings. This study investigates the working alliance and competence/adherence as predictors of outcome of CBT for social anxiety disorder (SAD) and panic disorder (PD).
Method: Eighty-two clinically referred patients (58.5% female; age: $M = 33.6$ years, $SD = 10.3$) with PD ($n = 31$) or SAD ($n = 51$) were treated with 12 sessions of manualized CBT by 22 clinicians with limited CBT experience in a randomized controlled effectiveness trial. Independent assessors rated the CBT competence/adherence of the therapists using a revised version of the Cognitive Therapy Adherence and Competence Scale, and the patients rated the quality of the working alliance using the Working Alliance Inventory-short form in therapy sessions 3 and 8. The outcome was assessed by independent assessors as well as by patients self-report. A total of 20.7% of the patients (27.5% SAD, 9.7% PD) dropped out during treatment. The association between the alliance, competence/adherence, outcome and dropout was investigated using multiple regression analyses.
Results: Higher therapist' competence/adherence early in the therapy was associated with a better outcome among PD patients, lower competence/adherence was associated with dropout among SAD patients. Higher rating of the alliance late in the therapy was associated with a better outcome, whereas lower alliance rating late in the therapy was associated with dropout.
Conclusion: The findings indicate that the therapist competence/adherence and the working alliance have independent contributions to the outcome from CBT for anxiety disorders, but in different phases of the treatment.

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1. Introduction

The effect of cognitive behavioral therapy (CBT) for anxiety disorders has been documented in recent decades in a large number of randomized controlled trials and meta-analyses (Hofmann & Smits, 2008; Norton & Price, 2007; Olatunji, Cisler, & Deacon, 2010). However, there is less knowledge from research on the relationship between process factors and treatment outcome.

Research on process factors in psychotherapy can be divided into two traditions, one emphasizing specific and unique factors for a specific treatment orientation, and the other emphasizing trans-theoretical mechanisms, frequently termed common factors (Ahn & Wampold, 2001; Messer & Wampold, 2002). Researchers emphasizing the specific factors in the treatment hypothesize that

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the therapist's adherence to and competence in delivering treatment in accordance with the specified theoretical and technical model are important in explaining psychotherapy outcomes. However, this assumption has so far received limited support from research findings. A meta-analysis indicated very small summary effect sizes for the association between the outcome and adherence- (r = .03, ns), as well as competence (r = .07, ns) when aggregated across different treatment modalities for various conditions (Webb, DeRubeis, & Barber, 2010). Some evidence suggest that higher therapist competence is related to better treatment outcomes in cognitive therapy of depression (Kuyken & Tsivrikos, 2009; Shaw et al., 1999; Strunk, Brotman, DeRubeis, & Hollon, 2010); however, research on this relationship in CBT of anxiety disorders is limited. Some recent studies have indicated a positive competence–outcome association in CBT for mixed anxiety and social anxiety disorder whereas other studies have indicated no- or even a negative - association between competence/adherence and the outcome in the treatment of panic disorder (Boswell et al., 2013; Huppert, Barlow, Gorman, Shear, & Woods, 2006).

Advocates of the common factors perspective argues in general that treatment outcomes in CBT, as in other therapies, are predominantly regulated by trans-theoretical mechanisms (Ahn & Wampold, 2001; Messer & Wampold, 2002). In this tradition, the concept of working alliance (Bordin, 1994) has a central position. Several meta-analyses, the last one including 190 separate studies (Horvath, Del Re, Flückiger, & Symonds, 2011), indicate a consistent positive association between the quality of the working alliance and the treatment outcome. No apparent moderators have so far been identified for this association, indicating that the alliance is of similar importance for different types of disorders, and across different theoretical models, treatment formats, study designs, and outcome measures (Del Re, Horvath, Flückiger, Symonds, & Wampold, 2012; Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath et al., 2011). However, the quality of the alliance explains only a moderate part of the total variance in the outcome, approximately 5–7%, according to major meta-analyses (Horvath et al., 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Moreover, most studies on this association have not controlled for temporal confound or other potential confounding factors (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Barber, Sharpless, Klostermann, & McCarthy, 2007; Webb et al., 2010).

A common perspective among CBT researchers is that the alliance primarily operates as an auxiliary factor that facilitates the utility of specific CBT techniques. Aggregated research findings indicate that a stronger alliance is associated with a better treatment outcome, also in CBT (Castonguay et al., 2010; Waddington, 2002). However, the assumed causal alliance-outcome relationship has been questioned. Several studies have reported a non-significant alliance–outcome association in cognitive therapy when the improvement of the patients prior to the alliance ratings is taken into account (DeRubeis, Brotman, & Gibbons, 2005; Derubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999; Webb, Beard, Auerbach, Menninger, & Björgvinsson, 2014). This suggests that the quality of the alliance may rather be a consequence than an antecedent of improvement from therapy. In comparison to depression, however; relatively few studies have investigated the alliance–outcome association in CBT for anxiety disorders, and the findings are more mixed (Newman & Stiles, 2006). While some studies have indicated a positive alliance–outcome association (Huppert et al., 2014), others report non-significant findings in CBT for panic disorder and social anxiety disorder (Mörtberg, 2014; Ramnerö & Öst, 2007; Woody & Adessky, 2002). Taken together, the current research on therapist competence/adherence and the working alliance as predictors of outcome from CBT for anxiety disorders is inconclusive.

High rates of dropout are a common problem in clinical trials on CBT for anxiety disorders (Taylor, Abramowitz, & McKay, 2012). Assuming that patients who terminate treatment prematurely fare less well than those who complete treatment, it is important to also identify factors that are associated with dropout. There are some studies indicating that poorer alliance (Taylor et al., 2012) and lower therapist competence (Brown et al., 2013) is associated with dropout from treatment, but the research is limited also on this issue.

Alliance and the therapist' competence and adherence are frequently conceptualized as stable characteristics within a therapist and within a treatment. This is reflected in the design of the majority of studies in this field as competence/adherence and/or alliance are assessed at one single time-point, typically early in the therapy (Horvath et al., 2011; Webb et al., 2010). Alliance and competence might, however, vary between sessions for the same patient as well as across different patients of the same therapist (Boswell et al., 2013). Obtaining ratings from more than one time point and across treatments has been recommended to investigate the stability of these constructs (Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Dobson & Mintz, 2006).

Relatively few studies have simultaneously investigated the association between competence and alliance, and outcome from psychotherapy (Barber et al., 2008, 2006; Hoffart, Sexton, Nordahl, & Stiles, 2005; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004). The findings from these studies are inconclusive; however, there are some indications that the alliance and therapist competence overlap to some degree and explain some shared variance (Webb et al., 2010). It is therefore important to investigate alliance and competence simultaneously, and to control for other potential confounding factors such as early treatment gain and patient characteristics at baseline (Barber, 2009; Feeley et al., 1999; Kazdin & Whitley, 2006). Finally, most studies on the relationship between therapist adherence/competence and the treatment outcome have used data from efficacy trials with strictly selected, intensively trained, and frequently supervised therapists, resulting in very high competence ratings with little variation in scores (Roth, Pilling, & Turner, 2010). This restriction of the range limits the possibility of detecting potential associations between competence and outcome. Therefore it has been recommended to study this relationships in samples with greater variability in therapists' competence (Crits-Christoph, Gibbons, & Mukherjee, 2013).

This study investigated therapist competence/adherence and alliance as predictors of outcome from an effectiveness trial on CBT of panic disorder (PD) and social anxiety disorder (SAD). With therapists less experienced in CBT, we expected a larger variation in therapist competence/adherence than what is typically reported from efficacy trials. Moreover, it was controlled for temporal confound and other potential confounding factors. The primary objectives were as follows: 1) to examine whether the therapists' competence/adherence and the patients ratings of the working alliance were overlapping and interrelated concepts; 2) to examine whether competence/adherence and alliance ratings were stable across sessions 3 and 8 in the treatment; 3) to investigate the associations between working alliance, therapist competence/adherence, and treatment outcome while controlling for prior symptom improvement and other potential confounding factors; 4) to examine whether the associations between alliance, competence/adherence, and outcome were the same in the early and late phases of the treatment, and if they were similar for PD and SAD; and 5) to investigate the associations between working alliance, therapist competence/adherence and dropout.

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