Interpersonal Problems Predict Differential Response to Cognitive Versus Behavioral Treatment in a Randomized Controlled Trial

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Objective: We examined dimensional interpersonal problems as moderators of cognitive behavioral therapy (CBT) versus its components (cognitive therapy [CT] and behavioral therapy [BT]). We predicted that people with generalized anxiety disorder (GAD) whose interpersonal problems reflected more dominance and intrusiveness would respond best to a relaxation-based BT compared to CT or CBT, based on studies showing that people with personality features associated with a need for autonomy respond best to treatments that are more experiential, concrete, and self-directed compared to therapies involving abstract analysis of one’s problems (e.g., containing CT). Method: This was a secondary analysis of Borkovec, Newman, Pincus, and Lytle (2002). Forty-seven participants with principal diagnoses of GAD were assigned randomly to combined CBT (n = 16), CT (n = 15), or BT (n = 16). Results: As predicted, compared to participants with less intrusiveness, those with dimensionally more intrusiveness responded with greater GAD symptom reduction to BT than to CBT at posttreatment and greater change to BT than to CT or CBT across all follow-up points. Similarly, those with more dominance responded better to BT compared to CT and CBT at all follow-up points. Additionally, being overly nurturant at baseline was associated with GAD symptoms at baseline, post, and all follow-up time-points regardless of therapy condition. Conclusions: Generally anxious individuals with domineering and intrusive problems associated with higher need for control may respond better to experiential behavioral interventions than to cognitive interventions, which may be perceived as a direct challenge of their perceptions.

Keywords: GAD; interpersonal problems; CBT; cognitive therapy; behavioral therapy

An important focus of psychotherapy research has been which treatments work for whom (Paul, 1967), which is the core theme of “personalized medicine” (Simon & Perlis, 2010). Although studies are beginning to emerge on this topic, there has been limited research with respect to cognitive behavioral therapy (CBT) for generalized anxiety disorder (GAD; Newman, Castonguay, Jacobson, & Moore, 2015; Newman & Fisher, 2013). Such research is important because even though CBT works for many people, it does not work equally for everyone. Elucidation of moderators of therapy outcomes might lead to more individualized treatments.
Interpersonal problems are likely candidates as moderators of therapy given that individuals with the same diagnosis are often heterogeneous in terms of their predominant interpersonal difficulties (e.g., Kachin, Newman, & Pincus, 2001; Przeworski et al., 2011). A relevant, well-developed framework for measuring such problems is the interpersonal circumplex (IPC), which assesses a wide variety of interpersonal characteristics and behaviors (Gurtman, 2009). The interpersonal problems IPC consists of “octant” scales representing underlying dysfunctions of affiliation/warmth (e.g., needing to take care of others) vs. coldness (e.g., seeking distance from others) and dominance (e.g., difficulty considering others’ point of view) vs. submission (e.g., excessively deferring to others). Interpersonal problems can be studied at the level of overall problems or more specific types of problems via octant scales (e.g., being “socially avoidant” is defined as being both cold and submissive, whereas “intrusiveness” is a warm and dominant problem; see Figure 1). Such problems are relatively stable over time, suggesting they are trait-like characteristics (Horowitz, Rosenberg, Baer, Ureno, & Vilasenor, 1988; Vittengl, Clark, & Jarrett, 2003).

Knowledge about such problems might facilitate individualized treatment planning, given that interpersonal problems have predicted treatment response to both CBT and other therapies (e.g., psychodynamic therapy). For example, clients’ overall pretreatment interpersonal problems predicted less improvement or greater rates of dropout across individual or group CBT for depression or anxiety as well as individual CBT or interpersonal therapy for binge eating disorder, suggesting that interpersonal problems are relevant to treatment response (Hilbert et al., 2007; McEvoy, Burgess, & Nathan, 2014; Renner et al., 2012). Second, overall interpersonal problems predicted differential response to interventions. Higher overall problems predicted less improvement in depression or anxiety from group CBT, but not from individual CBT (McEvoy et al., 2014), and predicted greater attendance in supportive, but not interpretive, group therapy for personality disorders (Ogrodniczuk, Piper, & Joyce, 2006). Lastly, sub-types of interpersonal problems may predict stronger responses to specific therapies. For example, those with avoidant personality disorder who had interpersonal problems related to being cold-avoidant benefited from graduated exposure, but not from skills training (Alden & Capreol, 1993). Also, those with more dominant problems (i.e., being too controlling) responded more to a nonmanualized community psychodynamic therapy for personality disorders, but not to manualized supportive-expressive dynamic therapy (Vinnars et al., 2007). Such findings suggest the possibility that the effects of interpersonal problems may depend on specific features of the psychotherapy. However, effects found in non-CBT interventions may not generalize to CBT, and there is no prior research that might be used to predict how interpersonal problems may shape differential response to cognitive versus behavioral therapies.

Despite a lack of direct data on interpersonal moderators of cognitive versus behavioral therapies, hypotheses may be informed by theory and research on internalizing/externalizing coping styles (Beutler & Mitchell, 1981; Welsh, 1952). Those who “internalize” are relatively passive and withdrawn and tend to be more interested in thinking, whereas those with an “externalizing” style are characteristically more active and assertive and more interested in doing. Internalizers had greater symptom reduction from interventions emphasizing intellectual insight, whereas externalizers fared better with more concrete, experiential, and action-oriented therapies (Beutler, 1979; Beutler & Mitchell, 1981; Beutler, Mohr, Grawe, Engle, & MacDonald, 1991; Calvert, Beutler, & Crago, 1988; Cooney, Kadden, Litt, & Getter, 1991). For example, alcoholic patients with higher levels of externalizing coping styles did better in response to behaviorally focused skills training compared to a more insight-oriented treatment (Cooney et al., 1991; Kadden, Cooney, Getter, & Litt, 1989). Such findings are relevant to interpersonal problems because passivity maps onto cold-submissive and submissive octants whereas tendencies to be active and assertive map onto the dominant and friendly-dominant octants of the circumplex (i.e. dominant, and intrusive interpersonal problems; Gurtman, 2009).

FIGURE 1 The interpersonal circumplex with eight octants representing combinations of the dimensions of dominance and affiliation. Interpersonal problem types, which reflect rigid or extreme versions of normal social behavior, are superposed on these octants.

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