Metacognition as a predictor of therapeutic alliance over 26 weeks of psychotherapy in schizophrenia

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A B S T R A C T

Research to identify client factors that impact treatment outcome has found that deficits in metacognitive abilities and weaker therapeutic alliance are both associated with poorer treatment outcomes for schizophrenia. However, it is unknown if metacognition and therapeutic alliance are related in any way, in particular, if metacognitive abilities predict therapeutic alliance. This study explored whether differing capacities for mastery, a domain of metacognition that involves the ability to use knowledge about mental states to respond to psychological challenges, predicted client perceptions of therapeutic alliance assessed by the Working Alliance Inventory – Short Form (WAI-S). Participants were 63 adults with schizophrenia or schizoaffective disorder enrolled in a 6-month program of cognitive behavioral or supportive therapy, placed into a high, intermediate or minimal mastery group as measured by the Metacognitive Assessment Scale (MAS). Repeated measures ANOVA found group effects for the total WAI-S score, with the high and intermediate mastery groups having better alliance scores than the minimal mastery group. The group effects approached significance when neurocognition was controlled for. Results suggest that greater capacity for mastery predict stronger therapeutic alliance, but do not predict its development over time.

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1. Introduction

Recent studies have found that deficits in metacognitive abilities (e.g. Lysaker et al., 2010a; Lysaker et al., 2010c) and weaker therapeutic alliance (e.g. Davis and Lysaker, 2007) are both associated with poorer treatment outcomes for persons who have schizophrenia. However, it is unknown if metacognition and working alliance are related in any way for persons with schizophrenia. For instance, might the ability to “think about thinking” be associated with the ability to form a stronger therapeutic alliance? And, might limitations in metacognitive abilities impede the development of a working relationship in therapy? We anticipated that metacognitive abilities would be related to therapeutic alliance since the ability to conceptualize a psychological problem and think about it flexibly would seem to be a prerequisite for clients to develop a shared treatment focus and approach with their therapists. In studies of individuals with personality disorders, Dimaggio et al. (2010) suggest that metacognitive deficits are an impediment to development of therapeutic alliance, while Fonagy et al. (2002) propose that therapeutic alliance is a vehicle for developing metacognitive abilities in this population. Perhaps a clearer understanding of the metacognitive correlates of therapeutic alliance in schizophrenia may help to identify persons at risk for forming a poor alliance as well as point to the need for innovation in therapies for persons with schizophrenia. For example, perhaps treatment outcomes of individuals who have metacognitive deficits may be enhanced by an initial therapy focus on interventions that improve metacognition thereby improving alliance versus an immediate focus on the presenting problem.

Therapeutic alliance is frequently defined as a collaborative relationship between patient and therapist consisting of a therapeutic bond and agreement on the goals and tasks of therapy (Bordin, 1979). Therapeutic alliance has consistently predicted treatment outcome across a variety of treatment approaches and patient populations, with effect sizes ranging from 0.22 to 0.26 (Horvath and Symonds, 1991; Martin et al., 2000), including schizophrenia (Svensson and Hansson, 1999). In schizophrenia treatment research, the strength of the alliance has been linked with reduced symptoms, improved quality of life, as well as performance in rehabilitation (Frank and Gunderson, 1990; Neal and Rosenheck, 1995; Solomon et al., 1995; Lacro et al., 2002; Donnell et al., 2004; Davis and Lysaker, 2007; Smerud and Rosenfarb, 2008). Thus, therapeutic alliance is of particular concern in the treatment of those who have schizophrenia due to the wide array of associated difficulties that may create barriers to developing interpersonal relationships, such as anxiety and confusion about interpersonal boundaries, (Weiden and Havens, 1994; Lysaker and Gumley, 2010).

Although research examining therapeutic alliance in the treatment of persons with schizophrenia has focused on its correlates, recently the therapeutic alliance has been viewed as a component of a more broadly
defined therapeutic relationship that may interact with other interper-
sonal constructs, e.g. therapist empathy, client and therapist attachment
style (Castonguay et al., 2006). According to Semerari et al. (2003),
metacognition, or thinking about thinking, may describe a wide range of
internal and socially driven cognitive acts that include the ability to
recognize and understand one’s own mental states as well as the mental
states of others. Lysaker et al. (in press) describe how metacognitive
capacities function interpersonally as an ability to hypothesize about the
wishes and intentions of others and to identify social cues that trigger
psychological pain, thereby enabling coping with social dilemmas such as
negotiating between one’s own wishes and the demands of relevant
others. It has been widely documented that metacognitive dysfunction
is a feature of schizophrenia (e.g. Frith, 1992; Brune, 2005; Lysaker
and Lysaker, 2008; Lysaker et al., 2010b) which is linked to both concurrent
and prospective deficits in functioning (Bora et al., 2006; Brune et al.,
2007; Horton and Silverstein, 2008; Lysaker et al., 2010a). Further,
metacognition may mediate the impact of other clinical characteristics
such as neurocognition on social and vocational outcome (McGlade
et al., 2008; Bell et al., 2009; Lysaker et al., 2010c). Given that both
therapeutic alliance and metacognition function in an interpersonal
context, understanding the mechanisms of their interplay within
therapy may provide intervention opportunities that enhance both and in
turn, enhance treatment outcome.

For the purpose of this study we chose to explore a particular aspect
of metacognition — mastery — which can be thought of as an awareness
of one’s and others’ thoughts and feelings that enables coping with a
variety of subjectively distressing and challenging psychological
experiences, such as those commonly encountered in interpersonal
relationships. For persons with schizophrenia, mastery has been
operationalized as a dimensional construct adapted by Lysaker et al.
(2005) from the work of Semerari et al. (2003). Specifically, individuals
can differ in their capacity to perform increasingly complex acts of
metacognitive mastery. Some, who are incapable of even the least
complex forms of metacognitive mastery, are unable to provide plausible
descriptions of psychological problems. Persons who are capable
of mastery in the intermediate range of complexity can describe
psychological problems plausibly, but cope with these problems through
avoidance and non-cognitive strategies (e.g. sleeping, drinking or
physically withdrawing from conflict). Persons capable of the highest
levels of mastery are those who can plausibly describe psychological
problems and respond to them by utilizing knowledge about their own
mental states and the mental states of others and modifying their own
thought patterns. We hypothesized that mastery would be linked to
better alliance as it represents a fundamental capacity that is needed for
most forms of cognitive therapy. Specifically, we reasoned that with a
greater capacity to use metacognitive knowledge to respond to distress,
persons might be better able to deal with distress that arose in session
and to join the therapist in thinking about themselves as someone whose
responses to difficulties could be the subject of reasoning and thought.
Evidence that mastery is broadly linked to functioning can be found in
studies correlating it with quality of life (Lysaker et al., 2005), the
complexity of social schema (Lysaker et al., 2010b), and in structural
equation models supporting its role as a mediator of the impact of
neurocognition on quality and quantity of social functioning (Lysaker
et al., 2010c).

In order to explore the possible link between mastery and therapeutic
alliance, the current study examined alliance ratings of 63 clients who were engaged in a 26-week course of cognitive behavioral
therapy or supportive therapy for a vocational rehabilitation research
study. We made two primary predictions. First, we hypothesized that
stronger metacognitive ability, specifically mastery, would be linked
with stronger client-rated alliance. Second, we entertained two
hypotheses about the development of alliance over time. We predicted
that persons who had a greater capacity for mastery would perceive
greater improvement in their alliance with their individual counselor
over the course of therapy relative to those who had weaker mastery.

We also predicted that persons who had weaker mastery would
perceive a decline in their alliance with their individual counselor over
the course of therapy relative to those who had a greater capacity for
mastery. Finally, to rule out the possibility that neurocognitive factors
might influence client alliance ratings, we included measures of
memory and visual–spatial reasoning, which have been reported to be
linked to therapeutic alliance in a previous study (Davis and Lysaker,
2004). This study found that higher client ratings of therapeutic alliance
were linked to poorer memory function in those clients, whereas better
performance on tests of visual spatial reasoning was related to therapist
report of stronger alliance.

2. Methods

2.1. Participants

Participants were 63 adults who received outpatient services from a
VA Medical Center outpatient psychiatry service (n = 43) or Community
Mental Health Center (n = 20) and were enrolled in a larger study of
the effects of cognitive behavior therapy on work outcomes in schizophre
nia. All had been randomized to receive cognitive behavioral therapy or
supportive therapy from an original sample of 100 and had a SCID-I
confirmed diagnosis of schizophrenia (n = 41) or schizoaffective
disorder (n = 22). Participants were included in the larger study if
they indicated a willingness to engage in vocational rehabilitation and
were in a post-acute phase of illness as defined by having no psychiatric
hospitalizations, change in type of psychotropic medication, or change
in housing during the month before entering the study. Other exclusion
criteria were a chart documented diagnosis of mental retardation or
active substance abuse/dependence. A total of 130 people began the
consent process for this study. Of those, 2 people did not finish the
consent process, 2 people finished consenting but did not qualify for the
study and 26 people consented and passed the screening but did not
start the study for various reasons.

The 63 participants were included in the present analyses because
they had attended at least 7 individual cognitive behavioral or
supportive psychotherapy sessions and completed alliance ratings for
at least 3 of these sessions. On average, participants were 46.89 years
old (SD = 8.10) and had 12.73 years of education (SD = 2.25). Participants had a mean of 6.51 lifetime psychiatric hospitalizations
(SD = 8.14). This sample included 53 males and 10 females; 38 were
African American, 24 were Caucasian, and 1 identified as “other”.

2.2. Instruments

The Working Alliance Inventory — Short Version — Client Form
(WAI-S-C; Tracey and Kokotovic, 1989) is a 12-item self-report measure
based on Bordin’s (1979) transtheoretical conceptualization of therapeu
tic alliance (TA) as comprised of three components: the therapeutic
bond, agreement between client and therapist on goals, and agreement
on tasks. While many measures of TA focus on what the client and
therapist may contribute separately to the alliance, this measure
emphasizes the mutuality of the relationship between client and
therapist in terms of both affective attachment and willingness to
invest in the therapy process (Martin et al., 2000). The WAI short version
is composed of the four items with the highest factor loadings for each of
the three subscales (goal, bond, and task) of the 36-item Working
Alliance Inventory (Horvath and Greenberg, 1989). Participants are asked
to rate these items on a 7-point scale ranging from “never” to
“always.” This measure has previously been utilized in studies of
participants with schizophrenia (i.e. Davis and Lysaker, 2004; Davis and
Lysaker, 2007). As an indicator of reliability, coefficient alpha for the
total client scores in the current sample was 0.95. Regarding the
individual scales for this version of the WAI, acceptable internal
consistency was reported, ranging from 0.80 to 0.54 (Busseri and
Tyler, 2003).
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