Relapses in recurrent depression 1 year after maintenance cognitive-behavioral therapy: The role of therapist adherence, competence, and the therapeutic alliance

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ABSTRACT

The prevention of relapse in recurrent depression is considered a central aim in cognitive-behavioral therapy, given the high risk of relapse. In this study, patients with recurrent major depressive disorder (currently remitted) received 16 sessions of Maintenance Cognitive-Behavioral Therapy (M-CBT) over a period of 8 months, in order to prevent relapse. Therapist adherence and competence, as well as the therapeutic alliance, were investigated as predictors for reducing the risk of recurrence in depression. Videotapes of 80 participants were analyzed in order to evaluate therapist adherence and competence. Additionally, the therapeutic alliance was assessed by questionnaire. No associations were found between therapist adherence or competence, and the risk of relapse 1 year after treatment. By contrast, the therapeutic alliance was a significant predictor of the time to relapse. Moreover, we found that the number of previous depressive episodes (≥5 vs. ≤4) was a significant moderator variable. This indicates that the alliance-outcome relationship was particularly important when patients with five or more previous depressive episodes were taken into account, in comparison to patients with four or fewer episodes. For the psychotherapeutic treatment of recurrent depression and the prevention of relapse, sufficient attention should be paid to the therapeutic alliance.

1. Introduction

Depressive disorders are highly recurrent, and with each additional episode, the risk of a further episode increases still further (e.g., ten Doesschate et al., 2010). Therefore, reducing the frequency of recurrences is a central aim of treatment. Cognitive-behavioral therapy has proven to be effective in preventing further depressive episodes (see Paykel, 2007).

In several studies, it has been found that cognitive-behavioral treatments are more effective for patients with three or more previous depressive episodes, than for those with fewer episodes. Teasdale et al. (2000) found that Mindfulness-Based Cognitive Therapy (MBCT) reduces the risk of relapse only for patients with three or more previous episodes of depression, but not for those with only two previous episodes. In a further study, MBCT was again more effective in preventing relapses for patients with three or more previous depressive episodes than for those with only two (Ma and Teasdale, 2004). Two studies applying cognitive-behavioral therapy (Conradi et al., 2008) and cognitive group therapy (Bockting et al., 2005) found that patients with four or five or more previous depressive episodes, respectively, had a lower risk of relapse than those with fewer episodes. Another study, which is also the basis for the current one, investigated patients with a considerably increased risk of relapse and focused on patients with a minimum of three previous depressive episodes (Stangier et al., 2013). In this study, Maintenance Cognitive-Behavioral Therapy (M-CBT) and psychoeducation were compared, with respect to their efficacy in reducing the risk of relapse in recurrent depression. M-CBT was more effective than psychoeducation, but only for patients with five or more previous depressive episodes. It can be argued that particularly those high-risk patients, may have benefitted from specific ingredients of M-CBT, by reducing cognitive vulnerability factors for recurrent depression, such as ruminating, negative attributions and memories or dysfunctional beliefs, or by maintaining positive emotions when

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experiencing stress (see Stangier et al., 2013). Therefore, the therapeutic processes are also expected to differ in their importance for the success of treatment and prevention of relapse for the sample of patients with five or more previous depressive episodes, in comparison to patients with four or fewer episodes.

In order to understand the processes needed for cognitive-behavioral therapy to exhibit its beneficial effects, therapist adherence and competence, as well as the therapeutic alliance, have been gaining increasing attention (Chatoor and Krupnick, 2001). Therapist adherence describes the extent to which a therapist uses interventions and approaches dictated by a treatment manual, and therapist competence is defined as the extent to which the therapist implements interventions skillfully (Waltz et al., 1993). Even though these therapist behaviors have generally been considered as promising predictors of treatment outcome, a recent meta-analysis did not support this hypothesis. Neither the adherence-outcome $(r=0.02)$ nor the competence-outcome $(r=0.07)$ effect size estimates were found to be significantly different from zero. However, additional analyses have demonstrated a differing result for studies targeting clinical depression and yielded a significant correlation between therapist competence and outcome for this disorder $(r=0.28; p<0.01)$, but not between therapist adherence and outcome (Webb et al., 2010). One possible explanation for the divergent values of adherence and competence for predicting outcome might be that adherence is more important for predicting outcome when the time lag between therapist activities and the prediction of outcome is short (Strunk et al., 2010). Altogether, the meta-analysis was based on only 36 studies. Of these, only 10 investigated the adherence-outcome relationship for the treatment of depressive disorders (only five of the 36 studies calculated the competence-outcome relationship). Moreover, no study focused on the role of therapist adherence and competence in preventing relapses in the treatment of recurrent depression. Even though earlier studies found only a significant relationship between treatment outcome and competence, and not between adherence and competence, it is reasonable to assume that therapist adherence and competence are both important variables in preventive treatments for recurrent depression, because those variables are considered to contribute to patients' learning effective strategies for preventing relapses. Therefore, further studies are necessary to evaluate the role of therapist adherence and competence in the success of cognitive behavioral-therapy for recurrent depressive disorders.

The therapeutic alliance is defined as the collaborative and affective bond between therapist and patient (Luborsky, 1984). A recent meta-analysis included 190 independent data sources and overall, found a moderate but consistent relationship between the therapeutic alliance in psychotherapeutic treatment and outcome $(r=0.28;$ Horvath et al., 2011). Furthermore, the strength of relationship between the therapeutic alliance and outcome proved to be robust regarding several aspects of treatment and research design (Flückiger et al., 2012). However, only one recent study investigated the relationship between the therapeutic alliance and the risk of relapse in 84 patients with recurrent major depressive disorder (Vittengl et al., 2010). The authors found no relationship between the Working Alliance Inventory (WAI) (Horvarth and Greenberg, 1989) and the risk of relapse. However, the therapeutic alliance was assessed only in one late treatment session and it is questionable whether this single session is representative of the whole therapy. A good therapeutic alliance can be considered an important precondition for the willingness to report intimate problems and try "new ways". These positive preconditions can also be considered as beneficial in preventive treatment for relapse prevention. Therefore, further studies should investigate the relationship between the therapeutic alliance and the risk of relapse in recurrent depression with respect to preventive psychological

treatment based on a more representative assessment of the therapeutic alliance.

In our study, we investigated whether therapist adherence, competence, and the therapeutic alliance are associated with patient risk of a further depressive episode in recurrent major depressive disorder, 1 year after treatment. We hypothesized: (1) that therapist competence and adherence in a psychotherapeutic treatment for relapse prevention are significant predictors of the relapse risk, and (2) that the therapeutic alliance is also a significant predictor of the risk. Moreover, in line with Bockting et al. (2005) and Stangier et al. (2013), we hypothesized that (3) therapist competence and adherence, as well as the therapeutic alliance, are stronger predictors of the risk of relapse when patients had many previous depressive episodes (≥5), in comparison to fewer depressive episodes (≤4).

2. Methods

2.1. Design

We assessed therapist adherence, competence, and the therapeutic alliance in the context of a multicenter study (including 14 research centers at two research sites in Germany) of relapse prevention in recurrent depression (Stangier et al., 2013; registered under ISRCTN 81212636). The main objective of the study was to compare the long-term outcome of Maintenance Cognitive-Behavioral Therapy (M-CBT) (Risch et al., 2012) with that of Manualized Psychoeducation (M-PE) (Hautzinger et al., 2006). In addition to the therapy, patients in both groups continued pharmacological maintenance treatment (treatment as usual). The patients had to have been diagnosed with recurrent major depressive disorder (according to the Structured Clinical Interview for DSM-IV; First et al., 1997), with at least three previous episodes, and they had to be in remission at the time of selection, for inclusion in the study. The stability of remission was ensured with the Hamilton Rating Scale for Depression (HRSD-17) (Hamilton, 1960) which was conducted eight weeks prior to treatment and directly before treatment commenced. Only patients who had a score of nine or less (≤9) at both assessment times were included. Exclusion criteria of the treatment study were organic mental disorders, disorders caused by psychotropic substances, schizophrenia or schizoaffective disorder, bipolar disorders, borderline personality disorders, mental retardation and acute suicidality. A total of 180 patients participated in the study, 90 in each treatment condition. Both treatments contained 16 sessions which were applied over a period of 8 months. Patients were randomly assigned to M-PE or M-CBT. Relapse rates 1 year after treatment were not significantly different for both treatments (60% for M-PE and 51% for M-CBT), although, if only patients with five or more depressive episodes were considered, patients in M-CBT had significantly fewer relapses than in M-PE (50% vs. 73% relapses). With regard to our research questions, only the M-CBT-trial was used for the data analysis. Process analysis in the M-PE-trial, from which data were not included in the current study, was part of a previous publication (see Weck et al., 2012).

2.2. Maintenance Cognitive-Behavioral Therapy (M-CBT)

The M-CBT involved 16 individual 1-h sessions within 8 months (4 weekly, 10 every two weeks, and 2 monthly sessions) aiming at preventing recurrences of depressive episodes. The M-CBT were based on cognitive-behavioral approaches and included interventions from Continuation Phase Cognitive Therapy, Mindfulness-Based Cognitive Therapy, and Well-Being Therapy. M-CBT comprises the following main ingredients: cognitive case conceptualization (assessment of individual psychological risk factor for former relapses, deriving a psychological model of recurrent depression), mindfulness mediation exercises, modification of dysfunctional cognitions and beliefs, behavioral activation, behavioral experiments and stress testing, and enhancement of cognitions and reinforcement of behaviors that increase psychological well-being. All interventions were described in a treatment manual (Risch et al., 2012).

2.3. Participants

2.3.1. Patients

For 80 (88.9%) of the 90 patient-therapist dyads, videotapes were available and could be considered for the analysis. Fifty-five (68.8%) of the 80 patients were female, 38 (47.5%) were married and 45 (56.3%) were employed. On average, patients were 48.3 years old (S.D.=11.6 years; range=22–72 years). They had suffered from a minimum of three to a maximum of 50 previous depressive episodes ($M=6.9$; S.D.=7.3; median=5). Fifty-two (65.0%) of the patients received antidepressant medication.