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Patients' pre-treatment interpersonal problems as predictors of therapeutic alliance in long-term psychodynamic psychotherapy



Pekka Ollila^a, Paul Knekt^{a,b}, Erkki Heinonen^a, Olavi Lindfors^{a,*}

^a National Institute for Health and Welfare, Helsinki, Finland

^b Biomedicum Helsinki, Helsinki, Finland

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ABSTRACT

Information on how the patient's interpersonal problems predict alliance development during long-term therapy is lacking. The aim of this study was to explore how the patient's pre-treatment interpersonal problems predict the development of alliance in long-term psychotherapy. Altogether 128 adult outpatients experiencing mood or anxiety disorder were assigned to long-term psychodynamic psychotherapy in the Helsinki Psychotherapy Study. The Inventory of Interpersonal Problems (IIP) total score and the eight octant scores, assessed at baseline, were used as predictors. The trajectories of change in patient- and therapist-rated Working Alliance Inventory (WAI) were used as outcome measures at 7, 12, and 36 months of follow-up after baseline. Study of the changes by time showed that the patient-rated alliance was significantly improved by the 36-month follow-up, i.e. the most usual end-point of therapy, in persons with higher pre-treatment level of the IIP total score. Low total IIP score and low to moderate level of hostile type problems showed no slope of improvement of patient-rated alliance during follow-up. The therapist-rated alliance showed a similar course as the patient-rated alliance with the exception of a faster improvement for higher IIP scores. In conclusion, a higher level of patients' interpersonal problems predicted favorable alliance development.

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1. Introduction

Development of a good therapeutic alliance between the patient and the therapist is one of the most reliable known predictors of better psychotherapy outcomes (Fluckiger et al., 2012; Horvath et al., 2011; Norcross and Wampold, 2011). Accordingly, efforts have been made to identify factors endangering or enhancing the quality of the patient-therapist relationship (Del Re, 2012; Horvath et al., 2011). Given both that the patient-rated alliance predicts outcome most strongly (Horvath et al., 2011) and that the patient-attributable factors appear to make the single biggest contribution to the outcome (Bohart and Wade, 2013; Wampold, 2001), it is particularly important to identify the patient-related predictors of the working relationship.

Several single factors in respect to the patient's personality and psychological dysfunction, such as avoidant problem-solving style (Gaston, 1988) and maladaptive defense mechanisms (Bond and Perry, 2004; Gaston et al., 1988; Kramer et al., 2009), have frequently, but not consistently (Hersoug et al., 2002b), been shown to predict poorer alliance. In turn, being assigned to a preferred

treatment and good overall psychological suitability, are to a greater extent known to enhance alliance (Connolly Gibbons et al., 2003; Elkin et al., 1999; Iacoviello et al., 2007; Valbak et al., 2004).

Beyond the personality factors, the patient's characteristic style of relating to others and the quality of his or her interpersonal relationships are expected to have an impact on the alliance, as its formation is built on a positive emotional bond, over and above merely agreeing on mutual tasks and goals in the therapeutic relationship (Bordin, 1979). Thus the patient's relational history, interpersonal styles and problems in relating to others are likely to influence negotiating the alliance (Safran and Muran, 2000). In line with this, patients' positive representations of early social experiences in the form of secure attachment style and more mature object relations (Diener and Monroe, 2011; Eames and Roth, 2000; Hilliard et al., 2000; Joyce and Piper, 1998) as well as fewer current interpersonal problems (Hersoug et al., 2002a; Kokotovic and Tracey, 1990; Mallinckrodt, 1991; Moras and Strupp, 1982) have been shown to contribute to a better alliance. It should be noted that these studies have mostly focused on short-term therapy and the assessment of alliance rather early in the treatment. Similar studies have also shown that a higher amount of interpersonal problems (Connolly Gibbons et al., 2003; Paivio and Bahr, 1998) and certain types of interpersonal problems, such as those of the under-involved (Hardy et al., 2001), the detached

* Corresponding author.

E-mail address: olavi.lindfors@thl.fi (O. Lindfors).

(Saunders, 2001) and the hostile-dominant variety (Connolly Gibbons et al., 2003; Paivio and Bahr, 1998; Renner et al., 2012) quite consistently predict poor alliance. However, certain other types of interpersonal problems such as those of the affiliative-submissive type have more inconsistently predicted either poorer alliances (Paivio and Bahr, 1998) better alliances (Beretta et al., 2005; Muran et al., 1994; Renner et al., 2012) or indicated no association (Connolly Gibbons et al., 2003; Muran et al., 1994).

An important issue, with only a few available studies, concerns how the patient's pre-treatment interpersonal problems predict alliance development in long-term therapies. In a study on mostly open-ended psychodynamic therapies, Hersoug et al. (2002a) showed that between the third and twelfth session only the higher level of cold/hostile type interpersonal problems predicted poorer patient- and therapist rated alliances throughout the early phase of treatment, unlike avoidant type problems which were associated only with only the third session alliance ratings. Consequent analyses from the same study (Hersoug et al., 2009) but now covering up to 120 sessions showed that the alliance was rated better throughout therapy by patients who reported better quality of current interpersonal relationships. Interestingly, patients' interpersonal tendencies toward "coldness" and detachment predicted poorer alliance at session 20, but not anymore at sessions 60 or 120. This finding might be explained by a continuing process of corrective, remedial emotional experience and learning in long-term psychotherapy (Hersoug et al., 2002a). Also, in another study of long-term psychotherapy the amount of interpersonal problems did not predict alliance 18 months after the start of treatment, although it did at the early phase of treatment (Puschner et al., 2005).

In sum, the few studies on long-term therapy suggest that the effect of patients' pre-treatment interpersonal problems on the therapeutic alliance may be modified by ongoing therapy as the treatment progresses, indicating the need to further explore both patients' overall and specific interpersonal problems as predictors of the working alliance over the course of a long time-frame. The aim of this study was to determine how the patient's pre-treatment interpersonal problems predict the development of the therapeutic alliance during a 3-year follow-up in long-term psychodynamic psychotherapy for patients with depressive or anxiety disorder. We hypothesized that the potentially poorer early alliance of patients with high level of interpersonal problems would be improved during the course of long-term therapy.

2. Methods

This study is based on the Helsinki Psychotherapy Study (HPS) data. The methods used have been described in detail elsewhere (Knekt and Lindfors, 2004; Knekt et al., 2008a) and are summarized briefly here. Patients gave written informed consent. The study's protocol was approved by the Helsinki University Central Hospital's ethics council.

2.1. Study Design and Patients

Eligible patients were 20–45 years of age, from the Helsinki region plus they had to have a long-standing (> 1 year) disorder causing dysfunction in work ability. They also had to meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria (American Psychiatric Association, 1994) for an anxiety or depressive disorder and to be estimated on a psychodynamic scale, the Level of Personality Organization (LPO, Valkonen et al., 2012), to have a neurotic to higher level borderline personality organization (Kernberg, 1996). Patients suffering from severe personality disorder, bipolar I disorder, psychotic disorder, adjustment disorder, substance-related disorder, organic brain disease, or mental retardation were excluded from the study. Additional exclusion criteria consisted of patients treated with psychotherapy within the previous 2 years, psychiatric health care employees and persons known to the research team members. A total of 326 outpatients, eligible and willing to participate, were randomly allocated to solution-focused therapy (N=97), short-term psychodynamic psychotherapy (N=101), and long-term psychodynamic therapy (N=128). The present study is based on the 128

patients assigned to the long-term psychodynamic therapy group, of whom, a total of 102 started therapy. The reasons for not starting therapy were objections to type of therapy (15 patients), difficulties in co-operation (5 patients), life situation and other reasons (6 patients). The patients were followed-up for 3 years after the baseline.

2.2. Therapy and therapists

The definition of the general treatment guidelines for long-term psychodynamic psychotherapy was agreed with eligible therapists for the study (Heinonen et al., 2012; Knekt et al., 2008a). Long-term psychodynamic psychotherapy is an open-ended, intensive, transference-based therapeutic approach which helps patients by exploring and working through a broad range of intrapsychic and interpersonal conflicts. Long-term psychodynamic psychotherapy is characterized by a framework in which the central elements are exploration of unconscious conflicts, developmental deficits, and distortions of intrapsychic structures. Confrontation, clarification and interpretation are major elements, as well as the therapist's actions in ensuring the alliance and working through the therapeutic relationship to attain conflict resolution and greater self-awareness. Therapy includes both expressive and supportive elements, the use of which depends on patient needs. The orientation follows the clinical principles of long-term psychodynamic psychotherapy (Gabbard, 2004). The frequency of sessions was 2–3 times a week, and the mean duration of therapy was 31.3 months (SD=11.9).

A total of 41 therapists were involved in the present study. Their mean age was 49.9 (SD 5.5) years and 22.5% of them were male. Altogether 82.5% of the therapists were psychologists, 5% psychiatrists and 12.5% from other professions. The therapists had a mean of 17.8 years (SD 5.6) of experience in practicing long-term psychodynamic psychotherapy. All the therapists had received standard training (3–6 years) in psychoanalytically oriented psychotherapy (psychoanalysis or long-term psychotherapy) that was approved by one of the psychoanalytic or psychodynamic training institutes in Finland (Heinonen et al., 2012). Clinical principles of psychodynamic orientation and technique were adhered to in each basic training course although the emphasis of different theoretical models varied (e.g. ego psychological, object-relations, self-psychological and attachment models) (Gabbard, 2004). The therapies were conducted in accordance with clinical practice, where the interventions might be modified according to patients' needs within the psychodynamic framework. Accordingly, no manuals were used and no adherence monitoring was organized.

2.3. Assessments

2.3.1. Predictor variable

The Inventory of Interpersonal Problems (IIP) (Horowitz et al., 2000) was measured prior to allocation to treatment, and was used as the predictor variable. The circumplex version of the IIP is a 64-item self-report inventory designed to measure interpersonal problems in eight different domains across two dimensions representing affiliation (friendly-unfriendly) and control (dominant-submissive). The questions are of two forms, "it is hard for me to..." (39 items) or "things I do too much" (25 items). Each item is rated at a 5-point scale to reflect the respondent's position, ranging from 0 (=not at all) to 4 (=very much). The eight octant scores, Dominant/Controlling, Vindictive/Self-Centered, Cold/Distant, Socially Inhibited, Nonassertive, Overly Accommodating, Self-Sacrificing, and Intrusive/Needy, are each based on a sum score of the respective eight items. Also a total sum score, reflecting the overall level of distress from interpersonal problems, and covering all the 64 items, was calculated.

2.3.2. Other baseline measures

Patients' socio-economic (sex, age, marital status, and education) data and psychiatric diagnoses according to the DSM-IV diagnostic criteria (Axes I and II) (American Psychiatric Association, 1994) were assessed at baseline using questionnaires and interviews. Psychiatric symptoms were assessed with the Symptom Check List 90 Global Severity Index (SCL-90-GSI) (Derogatis et al., 1973) and by the Hamilton Rating Scale for Depression (HDRS) (Hamilton, 1960) and the Hamilton Anxiety Rating Scale (HARS) (Hamilton, 1959). Previous psychiatric treatment (psychotherapy, psychopharmacological treatment, and hospitalization) data were obtained by questionnaire and linking the study population to nationwide health registers (Knekt and Lindfors, 2004).

2.3.3. Outcome measures

The Working Alliance Inventory (WAI) (Horvath and Greenberg, 1989) was used as the outcome measure. The questionnaire includes 36 items addressing the therapeutic relationship, divided in three subscales according to each dimension (goal, task, and bond). Items are statements (i. e. "I believe my therapist likes me", "we agree on what is important for me to work on") and are answered on 7-point ordinal scale (1=never; 7=always). In this study the total score was used as the indicator of the patient- (WAI-P) and therapist-rated (WAI-T) alliance, assessed at 7, 12 and 36 months of follow-up from start of therapy.

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