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Relapses in recurrent depression 1 year after psychoeducational treatment: The role of therapist adherence and competence, and the therapeutic alliance

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ABSTRACT

Psychoeducation has proved to be an effective treatment method for the prevention of relapse in recurrent depression. However, little is known about the processes which could account for the effects of psychoeducational treatment. In this study, patients with recurrent depression (currently remitted) received, over a period of 8 months, 16 sessions of psychoeducational treatment, in order to prevent relapse. Therapist adherence and competence, and the therapeutic alliance, were investigated as predictors of reducing the recurrence risk in depression. Videotapes of 43 participants in a psychoeducational treatment for depression were analyzed, in order to evaluate therapist adherence and competence. Additionally, the therapeutic alliance was assessed by means of a questionnaire. One year after treatment, no associations were found between therapist adherence or competence and the risk of relapse. The patients' view of the therapeutic alliance was moderately associated with the time to relapse. However, the correlation disappeared when controlled for the number of previous depressive episodes. The latter was the most important predictor of time to relapse, explaining 15% of variance.

1. Introduction

Depressive disorders are highly recurrent, and the risk of a further episode increases with each additional episode. At least 60% of individuals with one depressive episode can be expected to have a second. With two episodes, the likelihood of developing a third is 70%, and with three episodes, the likelihood of a fourth is 90% (American Psychiatric Association, 2000). Accordingly, the number of previous episodes is one of the most important predictors of recurrence (Burcusa and Iacono, 2007).

Reducing the frequency of recurrences is a central aim of treatment. Apart from antidepressants (Geddes et al., 2003) and psychological treatments (e.g., Jerrett et al., 2001), psychoeducation has proved to be an effective intervention for preventing further depressive episodes (Cuijpers et al., 2009). Psychoeducational interventions for depression are those in which education is offered to patients. Psychoeducation can vary from passive material (e.g. information websites) to active multisession interventions with exercises and therapist-guidance (see Donker et al., 2009). Clinical management, by contrast, only includes minimal supportive therapy which flanks antidepressant medication. However, little is known about the mechanisms through which psychoeducational treatment exerts its beneficial effects.

Therapist behavior is considered a promising predictor of treatment outcome (Beutler et al., 2004). Therapist adherence and competence, however, are therapist variables that have rarely been researched (Perepletchikova et al., 2007). *Adherence* describes the extent to which a therapist uses interventions and approaches dictated by a treatment manual, and *competence* is defined as the extent to which the therapist implements interventions in a skillful manner (Waltz et al., 1993). Although it seems obvious that therapist adherence and competence are important for the treatment outcome, a recent meta-analysis did not support this hypothesis. No significant correlations were found between adherence and outcome or between competence and outcome (Webb et al., 2010). However, the meta-analysis was based on only a small number of studies and therefore has limited power. In addition, no studies were included which investigated the role of therapist adherence and competence in psychoeducational treatment.

These issues are thus very rarely investigated, although one study indicates that therapist adherence plays an important role in the outcome of psychoeducational interventions (Zobel et al., 2008). Patients with depressive disorders received 15 sessions of manualized psychoeducation and improved more if the therapists were more adherent. To our knowledge, no studies have so far explored the influence of therapist competence on the outcome of psychoeducational treatments.

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Aside from adherence and competence, other *common factors* could be important for the outcome of psychoeducational treatment. Such factors include those dimensions of the treatment setting that are not specific to any particular technique (Lambert and Ogles, 2004). The *therapeutic alliance* – defined as the collaborative and affective bond between therapist and patient – is just such a common factor, which has been found to be important for treatment outcome. In a meta-analysis, a moderate overall relationship between the therapeutic alliance in psychotherapeutic treatment and outcome was indeed found (Martin et al., 2000).

In psychoeducational treatment, the therapeutic alliance has also rarely been investigated. One study demonstrated that the therapeutic relationship is important for a psychoeducational group treatment of schizophrenia and schizoaffective disorders. A better therapeutic relationship, as perceived by patients, was moderately to highly correlated with treatment success (Fries et al., 2003).

Another study analyzed the role of the therapeutic alliance in the clinical management of bipolar disorders (Strauss and Johnson, 2006). The authors found that the therapeutic alliance was a protective factor in the clinical management of bipolar disorders. A stronger alliance, as perceived by patients, yields fewer manic symptoms 6 months later, even if the results are controlled for baseline manic symptoms. However, for the prediction of depressive symptoms, only the baseline depressive symptoms strongly predict depression scores 6 months later. The alliance scores are not a significant predictor of depression levels, after controlling for baseline depressive symptoms. Even though the investigation focused on the role of alliance in clinical management, the results could also be important in the context of psychoeducation.

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 depression (Stangier, et al., 2010). The main objective of the study was to compare the long-term outcome of *cognitive-behavioral maintenance therapy* (CBMT) with that of *manualized active psychoeducation* (MAPE). In addition to the therapy, patients in both groups continued pharmacological treatment (treatment as usual) if they were already receiving such treatment. The patients were recruited through the participating clinics, outpatient departments, and newspaper advertiesments; they had to have been diagnosed with recurrent depression, with at least three previous episodes; and they had to be in remission at the time of selection, for participation in the study. The selection was based on the *Hamilton Rating Scale for Depression* (HRSD-17; Hamilton, 1960). The cut-off criterion for selection was a score of nine or less (≤ 9), 8 weeks prior to treatment. Exclusion criteria were organic mental disorders, those caused by psychotropic substances, schizophrenia or schizoaffective disorder, bipolar disorders, borderline personality disorders, mental retardation and acute suicidality. A total of 90 patients participated in each trial. Both treatments contained 16 sessions which were applied over a period of 8 months. The patients were randomly assigned to the MAPE or CBMT. The treatment setting for both treatments was ambulatory. With regard to our research questions, only the MAPE trial was used for the data analysis. Therapists were instructed to videotape the sessions, but a video camera was not available in all cases. Altogether, 43 (47.8%) of the 90 MAPE treatments were videotaped and could be considered.

2.2. Manualized active psychoeducation (MAPE)

All 16 MAPE-treatment sessions lasted 20 minutes and were applied by a therapist in individual treatment sessions. Psychoeducation was standardized by means of a treatment manual and included two weekly, 10 biweekly and four monthly contacts. Therapists followed a manual in supporting patients, giving advice, providing psychoeducation and maintaining compliance (see Hautzinger et al., 2006). Patients were informed about symptoms, causes and the course of depression, as well as given information on early indicators and risk factors triggering relapse. Each session included a patient-specific component, during which current problems and changes were explored. The second component focused on a core psychoeducational topic. The session content included the exploration of symptoms and previous treatments (1st and 2nd sessions), symptoms, frequency and course of depression, basic information on the treatment (3rd session), bio-psychological model of depression (4th session), individual model of the disorder (5th session), effect mechanisms of antidepressant medication (6th and 7th session), side effects of antidepressant medication (8th session), attitude towards medicinal therapy (9th session), compliance (10th session), early detection and early interventions (11th session), prevention of depression (12th session), crisis management (13th and 14th session), refreshment of medicinal effect mechanisms (15th session) and closing session (16th session).

Drop-outs during the intervention time and follow-up period were defined as relapses. In the sample of the 43 patients who were analyzed in the current study, altogether eight (18.6%) participants dropped out: four (9.3%) during the intervention time and four (9.3%) during the follow-up period. One year after treatment, 18 (41.9%) patients had no recurrence of depressive episodes in the MAPE treatment. These recurrence rates were not significantly different for patients who received CBMT, which had recurrence rates of 34 (47.8%). There was no significant interaction between the treatment condition (MAPE vs. CBMT) and antidepressant medication use (Stangier et al., 2010).

2.3. Participants

2.3.1. Patients

Therapist adherence and competence were evaluated with respect to the treatment of 43 patients. Thirty-two of the patients were female (74.4%) and 11 were male, 23 (53.5%) were married and 25 (58.1%) were employed. On average, patients were 47.9 years old (S.D. = 12.5 years; range = 25–69 years). They had suffered from a minimum of 3 to a maximum of 25 previous depressive episodes (mean = 6.5; S.D. = 5.0). Twenty (46.5%) of the patients had a comorbid disorder, of which eight (18.6%) had a personality disorder. Twenty-seven (62.8%) of the patients received antidepressant medication.

2.3.2. Therapists

The 43 patients were treated by 30 (75.0%) female and 10 male therapists. Three therapists were physicians and the others were clinical psychologists (92.5%). On average, the therapists were 32.9 years old (S.D. = 4.9 years; range 26–44 years) and their clinical experience was 1.3 years (S.D. = 1.8; range 0–5 years) when treatment began. All therapists were trained in implementing the psychoeducational treatment.

2.3.3. Judges

Four judges evaluated therapist adherence and competence. Two (Raters 1 and 2) were clinical psychologists with 2 and 7 years of clinical experience, respectively. Two further judges (Raters 3 and 4) were graduate students. All judges were familiar with the therapy manuals for this study and had completed a 10-h training course on applying the adherence and competence scale. During the training, the judges practiced the rating of therapy sessions by using the two scales. Only therapy sessions which were not part of the current study were rated during training. For each of the 43 patients, one videotape was selected randomly, in order to evaluate the adherence and competence of the therapists. The first 30 videotapes were rated by all four judges. Because of the high interrater reliability of the ratings, the last 13 videos were evaluated by Raters 1 and 3 only.

2.4. Measures

2.4.1. Primary outcome

The primary outcome measure of the study was the time to the first relapse, which was evaluated with the *Structured Clinical Interview for DSM-IV* (SCID; First et al., 1997). The SCID was conducted every 3 months since the beginning of the treatment to the 1-year follow-up. If patients were free of relapse 1 year after treatment, the time to relapse was set at 609 days (treatment time plus 1-year follow-up).

2.4.2. Adherence

For the assessment of therapist adherence, the Manualized Active Psychoeducation-Adherence Scale (MAPE-AS; Weigel et al., 2009) was used. The MAPE-AS was developed to assess the level of therapist adherence to the treatment manual of relapse prevention therapy for recurrent depression (Hautzinger et al., 2006). The items in the MAPE-AS are aimed at evaluating whether or not specific interventions described in the manual had been applied during the treatment sessions. Therefore, the treatment manual served as a basis for selecting important interventions and developing the MAPE-AS items. The MAPE-AS contains 12 items which refer to therapist adherence to the manual. These are the agenda, time management, use of materials, listening and responding to questions and problems of understanding, recognizability of the treatment module, adherence to session structure, role allocation, reference to the biopsychological model, focus on medication intake, working on current problems, information gathering, and psychoeducative approach. The response format is a three-point rating scale (0 = not adherent, 1 = partly adherent, and 2 = adherent). The first 30 videotapes were evaluated by all four judges. For the mean adherence measure (items 1–12), an excellent interrater reliability was found ($ICC_{(2,4)} = 0.93$; $P<0.001$). Because of the high level of consensus between the judges, the evaluation of the next 13 videotapes was carried out by only two of the original judges. These two judges also yielded a good interrater reliability for the 43 judgments on the mean adherence measure ($ICC_{(2,2)} = 0.85$; $P<0.001$).

2.4.3. Competence

Therapist competence was assessed with the Competence Scale for Psychoeducation (CS-P; Weck et al., 2011). The CS-P was developed to assess the level of therapist competence in conducting psychoeducative treatment for depression. The CS-P