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Investigating the depression-anxiety link in clients receiving Integrative Counselling

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Abstract

Objective: The aim of this paper was to investigate how anxiety and depression impact upon each other over the course of a counselling intervention.

Method: A single-group repeated measures quasi-experimental design was employed. Data were collected at four time points: at pre-therapy assessment and at first, third, and last sessions. The sample consisted of 562 predominantly white British clients receiving Integrative Counselling at North Kent Mind, UK. Two measures were used: the Generalised Anxiety Disorder Scale to measure anxiety and the Patient Health Questionnaire to measure depression.

Results: Clients improved in both dimensions at every measurement point. Path analysis suggested that anxiety and depression remained interlinked throughout treatment but they presented different effect profiles. They both appeared to have a premature effect on the other, but they did so in different ways.

Conclusions: The therapeutic relationship may be a crucial factor in understanding the premature effect observed and future research should utilise direct measures of the relationship.

Keywords: Anxiety, anxiety-depression comorbidity, depression, integrative counselling, path analysis, therapy outcome.

Key points

- Anxiety and depression exerted mutual effects during Integrative Counselling.
- Highly anxious clients appeared to improve in depression more than less anxious clients and highly depressed clients appear to improve in anxiety more than less depressed clients.
- However, such an effect was exerted in different ways by each dimension and it appeared to be premature, possibly implicating the therapeutic relationship.

According to epidemiological findings, 5-10% of the adult population has comorbid depression-anxiety in a 12-month period (Kessler, Chiu, Demler, & Walters, 2005). Research suggests that depressed individuals with comorbid anxiety tend to spend more time in depressive episodes compared to those without such comorbidity, although it is the number and severity of symptoms rather than the presence of an anxiety disorder itself that increase the risk (Coryel, Fiedorowicz, Solomon, Leon, Rice, & Keller, 2012). Similarly, individuals suffering from anxiety disorders with comorbid depressive symptoms are more likely to experience severe anxiety, report greater psycho-social impairment, and utilise health care resources more heavily compared to anxious individuals without comorbid depression (Ballenger, 1998). Although the dominant view is that these are two distinct types of pathology (American Psychiatric Association, 2013), some clinicians have argued that depression and anxiety are manifestations of a single clinical entity (Dealy, Ishiki, Avery, Wilson, & Dunner, 1981; Watson & Clark, 1984).

A number of theories have been proposed to capture the common elements between the two conditions. Authors utilising a two-component model of affective experience claim that while both disorders are strongly related to *negative affect*, only depression is related to *positive affect* (Jolly, Dyck, Kramer, & Wherry, 1994). On the other hand, Clark & Watson (1991) support a three-component, or tripartite, model suggesting that in addition to features of negative affectivity shared by both, each disorder is associated with specific negative emotional states: anxiety is related to hyperarousal and depression to anhedonia. A similar perspective is also adopted by Barlow, Allen, and Choate

(2004). These authors maintain that while both disorders share negative affectivity and the experience of general distress, anxiety is linked with autonomic arousal expressed in fear/panic and depression is related to anhedonia, low positive affect, and hopelessness. The three-component approach has been supported by most of the empirical evidence (Anderson & Hope, 2008; Watson, Clark, Weber, Assenheimer, Strauss, & McCormick, 1995). According to Werdenaar and colleagues (Werdenaar, Giltay, van Veen, Zitman, Penninx, 2012), each of the three components at baseline made specific predictions beyond the predictions of other established prognostic factors (e.g. diagnosis). In particular, while anxious arousal predicted panic disorder and anhedonic depression predicted depression over a two-year period, the shared elements between the two conditions captured by the construct of negative affectivity predicted depression-anxiety comorbidity. Moreover, utilising item response modelling, Krueger and Finger (2001) found that the comorbidity between unipolar mood and anxiety disorders could be adequately accounted for by a common factor, *internalising*. According to the authors, internalising was strongly correlated with number of hospitalizations and days of impaired functioning.

Although depression and anxiety have a distinct cognitive profile, as the *specificity hypothesis* indicates, they also share particular dysfunctional cognitions and information processing flaws, such as rumination, catastrophising, and excessive worry (Dozois & Beck, 2008). Moreover, similarities between the two conditions also exist at the level of neural functioning. For instance, both anxious and depressed individuals showed similar degree of amygdala activation in the presence of fear

stimuli, suggesting a common neural-circuitry dysfunction associated with the emotional modulation of perception and behaviour (Beesdo, Lau, Guyer, McClure-Tone, Monk, Nelson et al., 2009). In another study, both depression and anxiety were linked with an increased response to criticism in a region of the superior frontal gyrus involved in attentional gating (Hamilton, Chen, Waugh, Joormann, & Gotlib, 2015).

Most studies support the idea that anxiety precedes depression (de Graaf, Bijl, Spijker, Beekman, & Vollebergh, 2003; Wittchen, Kessler, Pfister, & Lieb, 2000), although a few report the reverse to be the case (e.g. Moffitt, Harrington, Caspi, Kim-Cohen, Goldberg, Gregory, Poulton, 2007). Nonetheless, while anxiety is a significant direct predictor of depression when anxiety appears first, when depression appears first the significant predictor of anxiety is not depression specifically but common aetiological factors (Mathew, Pettit, Lewinsohn, Seeley, & Roberts, 2011).

Both interpersonal and cognitive approaches have attempted to explain the temporal link between anxiety and depression. Anxious individuals often encounter interpersonal difficulties as a consequence of their increased anxiety. Research has shown that chronic social stress, interpersonal sensitivity, low sociability, and avoidance in expressing emotion are interpersonal problems that can lead to rejection, loss of social support, and eventually to depression (Starr, Hammen, Connolly, & Brennan, 2014). On the other hand, Alloy and colleagues (Alloy, Kelly, Mineka, & Clements, 1990) argue that the perceived inability of anxious individuals to control outcomes (helplessness expectancies) is often followed by the pessimistic expectation of negative events (negative outcome expectancies). Starr and

Davila (2012) have shown that hopeless cognition and ruminative thought can predispose anxious individuals towards depression as they infuse pessimistic thinking and interfere with adaptive coping.

Understanding the link between anxiety and depression is important in therapy. Barlow, Allen, and Choate (2004) argue that all emotional disorders should be treated utilising a single integrated therapeutic approach consisting of three main components: changing cognitive appraisals, averting emotional avoidance, and enabling behaviour unrelated to the problem emotion. However, some clinicians support the use of specialised interventions for comorbid anxiety and depression, due to the complexity of the underlying factors (e.g. Kush, 2004). A number of studies suggest that comorbid depression impedes change in the treatment of anxiety disorders, as individuals with strong depressiogenic cognitions are less likely to follow therapy instructions, expose themselves to anxiety-provoking situations, and fail to attend therapy appointments. These clients are also more likely to terminate therapy early (Ledley, Huppert, Foa, Davidson, Keefe, & Potts, 2005; Steketee, Chambless, & Tran, 2001). However, other research indicates no such a negative impact of depression on anxiety (Allen, White, Barlow, Shear, Gorman, & Woods, 2010).

Contradictory findings have also been reported regarding the role of anxiety in the treatment of depression. On the one hand, the presence of comorbid anxiety has been related with longer time to response and remission as well as greater treatment resistance to antidepressant medication (Howland, Rush, Wisniewski, Trivedi, Warden, Fava, et al., 2009). It has also been found to impede improvement in psychological therapy (Young, Makover,

Cohen, Mufson, Gallop, Benas, 2012). Nonetheless, other studies found either no such effects (Fournier et al., 2009) or a positive short-term impact of anxiety on both medication response and psychological therapy (Forand & DeRubeis, 2013; Kashdan & Roberts, 2011). According to Forand and DeRubeis (2013) such a counterintuitive positive impact disappeared in the second half of treatment and was reversed at follow-up as more anxious individuals tended to relapse more quickly. These authors argue that the rapid and transient positive effect of pre-treatment anxiety possibly suggested a quick response to therapist's warmth by highly distressed individuals. This type of premature and short-term change needs to be contrasted to the more genuine and long-lasting therapeutic gain clients often attain early in psychological therapy (Haas, Hill, Lambert, Morrell, & Morrell, 2002; Lutz, Hofmann, Rubel, Boswell, Shear, Gorman, et al., 2014).

A number of factors may have contributed to such contradictory findings regarding the role of the anxiety and depression link in therapy. Some studies have utilised categorical diagnoses, grouping together individuals with different severity levels on one or both disorders, thereby overlooking potentially important variability, while others have used dimensional measures of symptoms. On the other hand, some studies focus only on treatment outcome while others also investigate the process of change. Moreover, some studies have used small samples while others have excluded comorbid personality disorder and finally, cognitive-behavioural therapy tends to be the most frequent treatment of focus. In addition to presenting contradictory findings, studies also tend to identify a primary condition (either anxiety or

depression) and study the effects of the secondary condition on the primary one, rarely reporting their mutual impact in the same client sample. Finally, there is little information available on how the depression-anxiety link unfolds throughout the duration of therapy and to what extent the reported effects remain stable during the process.

The current study aimed to address some of the limitations of the existing literature and investigate the mutual effects of anxiety and depression scores as therapy unfolds. We treated anxiety and depression dimensionally as symptom scores rather than as categorical diagnoses and engaged clients with similar levels of severity in both conditions. Moreover participating clients received a type of treatment not yet included in studies exploring the anxiety-depression link - Integrative Counselling.

Integrative Counselling incorporates both cognitive and interpersonal elements in understanding and treating psychopathology, an integration that recognises the interconnections between different forms of distress (e.g. anxiety and depression) and different types of processes (i.e. interpersonal, emotional, cognitive, behavioural). Drawing on concepts and techniques from the humanistic, psychodynamic, and cognitive-behavioural perspectives, Integrative Counselling and Psychotherapy aim to reduce depression and anxiety by helping clients develop personal insight into the feelings, thoughts, and behaviours that maintain such difficulties (Gilbert & Orlans, 2011; O'Brien & Houston, 2007). Through attentive listening and non-judgemental response, the therapist facilitates the development of alternative ways of looking at and engaging with the world and the self, encouraging a more authentic and open experience. Although Integrative Counselling is

delivered in a number of mental health settings and is reported to successfully treat anxiety and depression (van Rijn & Wild, 2013), empirical research on its effectiveness is limited.

We formulated three research hypotheses. Based on research supporting the effectiveness of Integrative Counselling (van Rijn & Wild, 2013) and evidencing genuine early therapeutic gain (Haas et al., 2002; Lutz et al., 2014), firstly we predicted that anxiety and depression would be significantly reduced at every measurement point throughout treatment. Secondly, based on studies reporting a premature “facilitating” effect of anxiety on depression, we expected that relatively high anxiety scores at any given session would lead to relatively high anxiety but low depression scores at subsequent sessions. Thirdly, in the absence of previous evidence suggesting that depression exerts such a premature effect on anxiety, we hypothesised that relatively high depression scores at a session would lead to relatively high scores in both dimensions in subsequent sessions. In other words we expected that, overtime, high anxiety would be linked with relatively small improvement in anxiety but relatively large improvement in depression, while high depression would be linked with relatively small improvement in both dimensions.

Method

Design

A single-group repeated measures quasi-experimental design was employed, utilising questionnaire measurements at four time points during the therapeutic process: pre-therapy assessment, first session, third session, and last session. We felt these were appropriate measurement

points to focus on, given the brief duration of treatment.

Participants

The sample consisted of 562 clients receiving Integrative Counselling at the North Kent branch of the charitable mental health organisation Mind in the United Kingdom (formerly Dartford, Gravesham, and Swanley Mind). The aim of the intervention was to help clients with anxiety and depression. All clients were classified as “cases” based on their anxiety and depression scores at assessment and were identified as requiring a Step 3 level of care. In the UK, primary care for mental health problems consists of three steps: Step 1 involves the assessment and recognition of the problem, Step 2 entails the delivery of low intensity psychological therapy for mild problems, and Step 3 involves the delivery of high-intensity therapy for moderate to severe problems (National Institute for Health and Care Excellence, 2011). The average age of participants was 41.3 years ($sd=14.3$); 67% were female and 59% were already on psychotropic medication at assessment. Over 90% were white British, 3% were white non-British, 2.5% were of Asian and 1.5% of African origins. Seventy-two per cent were in employment, education, housework, or were retired, while 19.5% were on incapacity benefits.

Participating therapists either had already obtained a relevant counselling or psychotherapy qualification or were at their final year of training towards obtaining one. All therapist qualifications had been accredited by the British Association for Counselling & Psychotherapy.

Measures

Two brief but well-validated self-report questionnaires were used:

Generalised Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006). This is a seven-item instrument measuring generalised anxiety on a four-point scale (0-3). According to the authors, the measure has shown good reliability, as well as discriminant, criterion, construct, factorial, and procedural validity. The scale has been very widely used in the UK National Health Service as an efficient index of overall anxiety. Following NHS guidelines, we used total score 8 as the cut-off point for identifying caseness (IAPT, 2011).

Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002) This is a nine-item questionnaire measuring depression on a four-point scale (0-3). According to the authors, the instrument has evidenced excellent internal consistency, test-retest reliability, construct validity and sensitivity to change. Following NHS guidelines, we used total score 10 as the cut-off point for identifying caseness (IAPT, 2011).

Demographics Questionnaire. In addition to the above, a brief questionnaire was utilised to obtain information on clients' basic demographic variables.

Procedure

Data were collected at each session, as part of the clinic's routine. Clients received 8.6 therapy sessions on average ($sd=2.3$); therapy was not manualised. Permission for using the data and ethical clearance for this study were obtained by North Kent Mind and the Department of Psychology, University of Bedfordshire.

Results

To address the first hypothesis, we ran a repeated measures MANOVA, treating anxiety and depression as dependent variables and comparing their scores across the four time points. We controlled for the

effects of age, gender, number of sessions completed, and medication currently prescribed. According to the findings, our first hypothesis was confirmed, as both anxiety and depression scores were significantly reduced at every measurement point compared to the previous one (Pillai's trace = .76, $F_{6,551}=295.11$, $p<.001$, $\eta_p^2 = .75$). The Bonferroni test suggested that differences between all measurement points were statistically significant ($p<.001$) for both anxiety and depression. The overall effect size for anxiety was $\eta_p^2 = .43$ and for depression $\eta_p^2 = .45$.

To address the second and third hypotheses, we conducted path analysis. Path analysis enables us to test the direct effects of variables upon others, but also their indirect effects via third mediating variables (Klem, 1995). When path analysis is applied on longitudinal data, as in the present study, it yields information on how such effects develop overtime and provide a stronger basis for establishing a causal relationship between them. The multivariate analysis conducted tests whether the hypothesised set of effects (the hypothesised model) fits the data. A number of fit indices are used to assess model fit. Among the most important are the Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), Incremental Fit Index (IFI), Normed Fit Index (NFI), Root Mean Square Error of Approximation (RMSEA), and χ^2 . A good model fit is indicated when the value of CFI, IFI, TLI, and NFI are equal to or greater than .95, the value of RMSEA is equal to or lower than .05, and the value of χ^2 is as close to zero as possible.

We tested a pathway model linking depression and anxiety scores at each of the four points of measurement with anxiety and depression scores obtained at all subsequent points, as suggested in Hypothesis 1 (the AMOS 21 software was

used). The initial model did not attain a good fit (CFI=.48; IFI=.48; NFI=.48; RMSEA=.91; $\chi^2 = 1423.53$, $p < .001$, $df=3$) so we utilised modification indices to create additional meaningful links and trimmed off non-significant effects. In particular, we added three significant concurrent effects (Depression Session 1 on Anxiety Session 1, Depression Session 3 on Anxiety Session 3, and Anxiety Last Session on Depression Last Session) and we removed 7 non-significant paths (Anxiety Assessment on Anxiety Last Session and on depression at all subsequent points, Anxiety Session 1 on Anxiety Last

Session, Depression Assessment on Depression Last Session, Depression Session 3 on Anxiety Last Session). The final model presented excellent fit (CFI=1; TLI=1; IFI=1; NFI=.99; RMSEA=.00; $\chi^2 = 5.22$, $p = .633$, $df=7$).

According to the confirmed model, anxiety and depression presented quite different effect profiles throughout treatment. The two dimensions differed regarding the direction of their direct effects on each other. While the effects of anxiety obtained earlier in therapy on depression scores obtained later in

Variable	Assessment	Session 1	Session 3	Last Session
Anxiety (GAD-7)	M =16.71 (SD=3.06)	M=14.34 (SD= 5.77)	M= 10.28 (SD = 6.20)	M = 7.36 (SD = 5.97)
Depression (PHQ-9)	M = 19.19 (SD = 3.72)	M= 15.19 (SD = 6.91)	M = 11.53 (SD = 7.32)	M = 8.20 (SD = 6.93)

Table 1: Means and standard deviations of anxiety and depression scores at each measurement point.

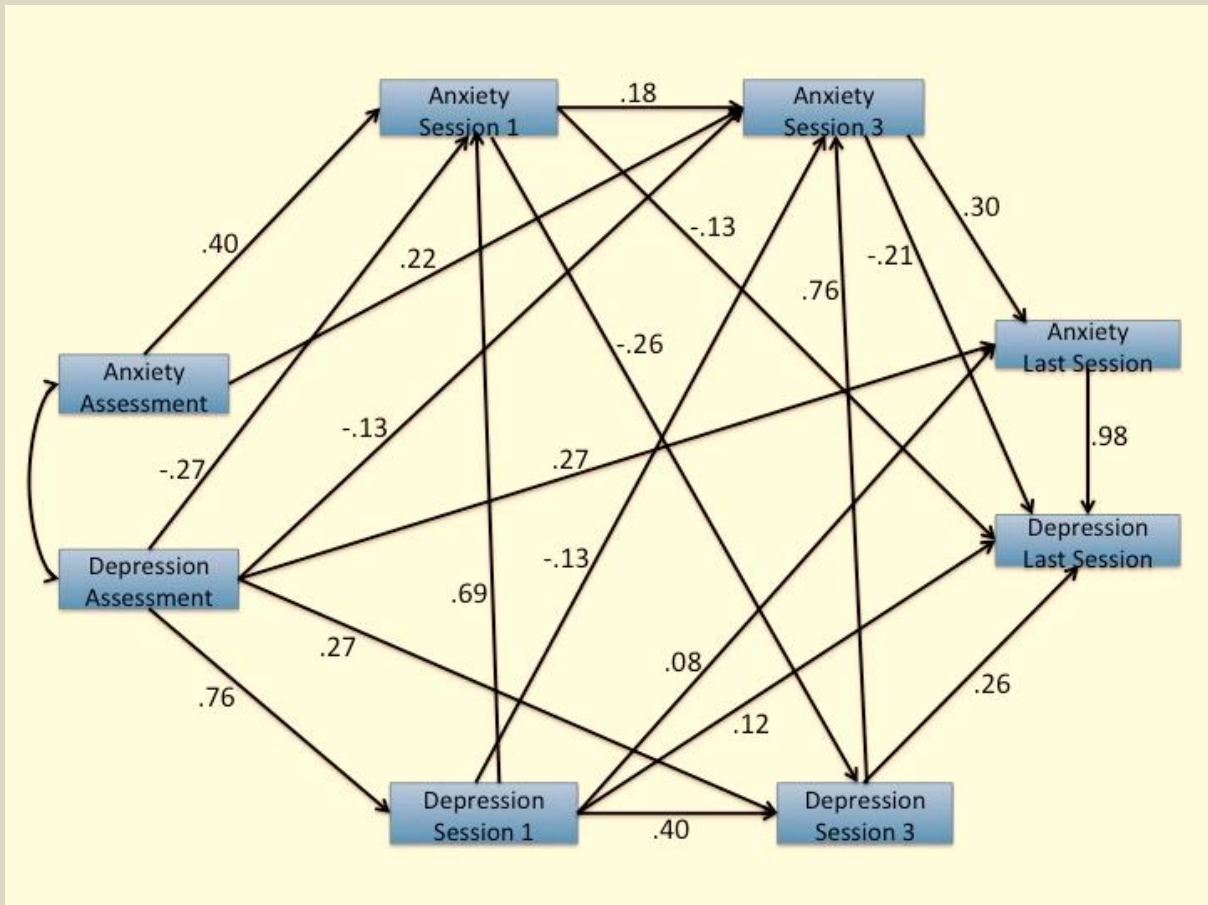


Figure: The hypothesised pathway model including the direct effects coefficients.

therapy suggested a negative association (that is, high anxiety in early sessions predicted low depression in later sessions), the effects of depression scores obtained early in therapy on anxiety scores obtained later in therapy was more complex. On the one hand, early depression scores were positively related with anxiety scores at the end of therapy; on the other hand, those scores were negatively related with anxiety scores in the more immediate subsequent sessions. More specifically, while depression scores obtained at

Assessment had a positive predictive association with anxiety scores obtained in the last session, they had a negative association with anxiety scores obtained in sessions 1 and 3. In other words, while relatively high depression at Assessment predicted relatively high anxiety at the end of treatment, it predicted relatively low anxiety in sessions 1 and 3. Similarly, depression in Session 1 was positively associated with anxiety in the last session but negatively associated with anxiety in Session 3.

Nonetheless, it should be noted that in addition to the negative direct effects, indirect effects suggesting a positive association between anxiety scores in early sessions and depression scores in subsequent sessions were found (see Table 2). In particular, depression at Assessment had positive indirect effects on anxiety in sessions 1 and 3 and depression at Session 1 had a similar effect on anxiety at Session 3. These effects seem to be mediated by the positive direct effects of depression on concurrent anxiety observed in Sessions 1 and 3. Finally, the direction of the effects of early scores on later scores of the same dimension was similar in both depression and anxiety: relatively high anxiety in the beginning of treatment predicted relatively high anxiety at the end of treatment and the same was true for depression.

Moreover, while anxiety and depression had a direct impact on each other during the course of treatment, as therapy progressed, that effect

seemed to change in opposite ways for the two dimensions: anxiety gradually increased its capacity to predict depression in later sessions, while depression gradually lost its initial capacity to predict anxiety. In other words, while depression at Assessment and at Session 1 predicted anxiety scores in all subsequent measurement points, depression at Session 3 did not. On the other hand, while anxiety at Assessment did not predict depression at any subsequent points, anxiety in Sessions 1 and 3 did. In addition, while depression scores tended to have an effect on anxiety scores obtained at the same session early in therapy (i.e. in sessions 1 and 3), anxiety scores had an effect on concurrent depression only in the last session (all concurrent effects indicated a positive association). Interestingly, depression at Assessment had only an indirect effect on last session depression while it did have a direct effect on last session anxiety.

Effect	Total Effect	Direct Effect	Indirect Effect
<i>On Anxiety at Session 1</i>			
From Anxiety at Assessment	.40	.40	.00
From Depression at Assessment	.27	-.27	.53
From Depression at Session 1	.69	.69	.00
<i>On Depression at Session 1</i>			
From Depression at Assessment	.76	.76	.00
<i>On Anxiety at Session 3</i>			
From Anxiety at Assessment	.21	.22	-.01
From Anxiety at Session 1	-.02	.18	-.20
From Depression at Assessment	.21	-.13	.33
From Depression at Session 1	.16	-.13	.29
From Depression at Session 3	.76	.76	.00
<i>On Depression at Session 3</i>			
From Depression at Assessment	.51	.27	.24
From Depression at Session 1	.22	.40	-.18
From Anxiety at Assessment	-.10	.00	-.10
From Anxiety at Session 1	-.26	-.26	.00
<i>On Anxiety at Last Session</i>			
From Anxiety at Assessment	.06	.00	-.06
From Anxiety at Session 1	-.01	.00	-.01
From Anxiety At Session 3	.30	.30	.00
From Depression at Assessment	.39	.27	.12

From Depression at Session 1	.13	.08	.05
From Depression At Session 3	.23	.00	.23
<i>On Depression at Last Session</i>			
From Anxiety at Assessment	-.06	.00	-.06
From Anxiety at Session 1	-.20	-.13	-.07
From Anxiety At Session 3	.08	-.21	.29
From Anxiety At Last Session	.98	.98	.00
From Depression at Assessment	.53	.00	.53
From Depression at Session 1	.18	.12	.06
From Depression At Session 3	.32	.26	.06

Table 2: Estimated unstandardised effects in the hypothesised model (no all-zero effects included).

Discussion

The present findings indicate that clients with comorbid depression and anxiety of medium to high severity improved substantially throughout treatment and from one measurement point to the next. Although findings should be considered with caution as no control group was included and no clinical effectiveness data was available, they do appear consistent with previous research evidencing the usefulness of Integrative Counselling in the treatment of depression and anxiety (van Rijn & Wild, 2013).

Moreover, the current findings are in agreement with previous studies reporting that relatively high anxiety is linked with greater reduction in depression over the course of psychological therapy (Forand & DeRubeis, 2013; Ledley et al., 2005). Our finding that such a “facilitating” effect did not appear at assessment but only after the completion of at least one therapy session, suggests that it did not simply derive from a pre-therapy client characteristic (i.e. high anxiety) but required an additional input, possibly an element introduced at the early stages of treatment. Although the current study cannot confidently identify such an element, the focus of Integrative Counselling on positive regard and a genuine client-therapist relationship is consistent with Forand and DeRubeis’s (2013) hypothesis that therapist’s warmth may lie behind such a premature client response.

Previous research suggests that interpersonal rejection and the reduction of social support mediate the link between anxiety and the onset of depression (Starr et al., 2014). It is possible therefore that the clients’ positive initial experience of the therapist temporarily reverses that process, resulting in a reduction in helplessness expectancies, hopeless cognition, and

ruminative, all anxiety related characteristics that can lead to depression (Alloy et al., 1990; Starr & Davila, 2012). However, as these highly distressed clients may tend to focus on immediate relief and be reluctant to fully engage with therapeutic work, the “facilitating” effect quickly weakens. Psychotherapists have long seen rapid therapeutic improvement with suspicion, as it often suggests the client’s non-conscious attempt to avoid the psychological pain that deeper therapeutic engagement and real change may bring (Train, 1953). Although the lack of follow-up data cannot confirm Forand and DeRubeis’s (2013) finding that such a premature effect largely disappears after therapy, the emergence of a positive association between anxiety and concurrent depression at the last session suggests that the weakening process may already be visible in the last phase of treatment.

Moreover, our findings show that clients with relatively high depression scores are also susceptible to such a premature effect on their anxiety. However, such an effect is partial and even more temporary than that exerted by anxiety on depression.

It is possible that negative thinking and depressive pessimism restrict clients’ positive feelings about the therapist and therefore limit their “flight into health” response. Research suggests that the difficulties depressed individuals often encounter in relating to others impacts on the satisfaction they experience in relation to goals and motives (Grosse Holtforth & Michalak, 2012) and that such relational problems are also manifested in the therapeutic alliance (Grosse Holtforth, Altenstein, Krieger, Flückiger, Wright, & Caspar, 2014).

The effect of assessment depression on last session anxiety in the

absence of a similar effect on last session depression was another noteworthy finding. This seems to suggest that while therapy fully mediated the negative influence of pre-therapy depression on depression outcome, it only partially affected that impact on anxiety outcome. It appears that therapy addressed the depression-perpetuating aspects of depression more adequately than its anxiety-provoking aspects. Previous research has recognised depression as a barrier in the treatment of anxiety due to lack of motivation and restricted engagement with therapy (Ledley et al., 2005). Our findings suggest that such characteristics may be particularly impeding for treatment elements addressing anxiety, for example preventing exposure to anxiety provoking situations. Perhaps the focus of Integrative Counselling on cognitive rather than behavioural aspects may also play a role, so that integrative therapists may need to utilise more often behavioural techniques that challenge anxious avoidance in this client group.

The present findings may also be useful to clinicians as they suggest that both anxious and depressed clients may form a very tentative therapeutic relationship. Initially introduced by psychoanalysis with the concepts of transference and counter-transference, the notion of behaving in current interpersonal contexts based on emotion-laden representations constructed in the past but not aligned with the present, is now recognised by many contemporary therapeutic approaches as a crucial factor in therapy (Elvins & Green, 2008). It is important that therapists identify and address as early as possible the tendency of these highly distressed clients to "fly into health".

The limitations of the present study need also to be considered. Anxiety and

depression scores do not in themselves suggest a particular psychiatric diagnosis and relevant clinical information such as comorbidity with personality disorder or substance abuse was not available. In addition, the measures used did not distinguish between the three components of the tripartite model so it was unclear to what extent shared and disorder-specific elements of distress were involved in each predictive association. Finally, the absence of follow-up data made it impossible to know the outcome of these clients in the medium and long term. Future research needs to address these issues and, very importantly, obtain more direct empirical evidence on the role of the client-therapist relationship by employing relevant measures (e.g. measures of therapeutic alliance or client and therapist attachment style).

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