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Social support as a predictor of the outcome of depressive and anxiety disorder in short-term and long-term psychotherapy

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ABSTRACT

Social support is known to be important for well-being of individuals, but it is not clear how it predicts psychotherapy outcome in patients suffering from depressive or anxiety disorders. The aim of the present study was to study the prediction of social support on the outcome of short-term and long-term psychotherapy. In the Helsinki Psychotherapy Study, 326 psychiatric outpatients, aged 20–46 years, and suffering from depressive or anxiety disorders, were randomly assigned to short-term psychotherapy (short-term psychodynamic or solution-focused) or long-term psychodynamic psychotherapy. The level of social support at baseline was assessed using the Brief Inventory of Social Support and Integration (BISSI). Psychiatric symptoms were assessed with the Symptom Check List, Global Severity Index (SCL-90-GSI) at baseline and four times during a 3-year follow-up. Patients with a high level of social support before treatment benefitted more from long-term than short-term therapy at the 3-year follow-up, whereas patients with a low level of social support experienced no such benefit.

Pretreatment social support seems to predict differentially short- and long-term psychotherapy and thus needs to be acknowledged when evaluating patient's resources and treatment options. More research is needed to verify these findings.

1. Introduction

Social support is a meta-concept which encompasses different dimensions of perceived and functionally realized social exchange, such as satisfaction with the quality and quantity of support, feeling cared for, respected and being connected in one's social network (Chronister et al., 2006). Social support has in a large variety of populations been reliably linked to maintenance of both physical (Berkman et al., 2000) and psychological health (Cohen and Wills, 1985; Monroe and Steiner, 1986; Kawachi and Berkman, 2001) and the lack of social support, i.e. smaller social networks, fewer close relationships, and lower perceived adequacy of social support, has been linked to psychological distress and especially depressive symptoms (Turner, 1981; Cohen and Wills, 1985; Barnett and Gotlib, 1988). It is evident that social support has significance for the well-being of individuals, and there are a number of different hypotheses on how this influence occurs (Cohen and Wills, 1985; Thoits, 1986; Bergeman et al., 1990). Accordingly, social support may be helpful for patients during psychotherapeutic treatment by toning down and buffering their responses to stressful events, thus preventing a vicious circle of negative emotional and behavioral reactions (Cohen and Wills, 1985). Additionally, a sufficient and functional social network may support help-seeking behavior, and in itself produce positive mental health effects, such as a sense of purpose, belonging, security and a feeling of self-worth. However, it remains unclear whether the effect of social support on depressive and anxiety disorders after treatment with different modalities of psychotherapy, differs.

To the authors' knowledge the prediction of the level of social support on individual psychotherapy outcome has been examined in only two studies, both involving short-term psychotherapies. In a study by Marziali (1987), psychiatric outpatients selected on the basis of their suitability for the treatment, were treated with psychodynamically oriented short-term therapy with a follow-up at 12 months after the end of treatment. Baseline social support was not significantly associated with the patients' psychiatric symptoms at follow-up after controlling for the pre-treatment symptom level. However, social support was significantly associated with social adjustment at follow-up. Another study (Eurelings-Bontekoe et al., 1995; Eurelings-Bontekoe et al., 1996) investigated how qualitative and quantitative social support variables and social support seeking predicted psychological distress after brief behavioral therapy in mainly depressive and anxiety disorder patients. The results indicated that none of the variables predicted the level of distress at neither the 6-month nor the 18-month follow-up, suggesting that social support had no long-term

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prognostic significance (Eurelings-Bontekoe et al., 1996). Based on this limited information from these two studies, no firm conclusions can be drawn on that social support would have any significance in the prediction of psychotherapy outcome. Controversially, social support seems to be a fairly consistent significant predictor in the recovery of depressive outpatients in general psychiatric treatment (Brugha et al., 1990; Moos, 1990; Lara et al., 1997). The inconsistency on the issue is further demonstrated by a meta-analytic review of social support as a predictor of other, heterogeneous therapeutic interventions (Roehrle and Strouse, 2008), showing no statistically significant effects. Thus, there is an apparent need for comprehensive studies on the relation between social support and psychotherapy outcome. We hypothesized that patients with good social support would gain more early benefits from short-term than from long-term therapy, and that patients in long-term therapy would have better long-term symptomatic outcome irrespective of the level of social support.

The present study investigates the prediction of social support on the outcome of short-term (solution-focused and psychodynamic) and long-term psychodynamic psychotherapy during a 3-year follow-up.

2. Population and methods

2.1. Study population

This study was part of the Helsinki Psychotherapy Study, a randomized clinical trial on the effectiveness, sufficiency and suitability of short- and long-term psychotherapies (Knekt and Lindfors, 2004; Knekt et al., 2008). Patients gave written informed consent and the study was approved by the Helsinki University Central Hospital's ethics council.

Patients considered eligible were required to be 20–45 years of age and to have either anxiety or mood disorder, according to DSM-IV (American Psychiatric Association, 1994) and to suffer from dysfunction in work ability. Patients were excluded from the study if any of the following criteria were met: psychotic disorder or severe personality disorder (DSM-IV cluster A personality disorder and/or lower level borderline personality organization (Kernberg, 1996)), adjustment disorder, substance-related disorder, organic brain disease or other diagnosed severe organic disease, and mental retardation. Individuals treated with psychotherapy within the previous 2 years and psychiatric health employees were also excluded.

Of 459 eligible patients 133 declined to participate. The remaining 326 patients were randomly assigned to solution-focused therapy ($N=97$), short-term psychodynamic psychotherapy ($N=101$) or long-term psychodynamic psychotherapy ($N=128$). The two short-term therapy groups were combined as one group ($N=198$) in order to bring more statistical power to the analyses and to clarify the presentation. Combining the groups as a single homogenous group was possible since no notable differences in the outcome of solution-focused therapy and short-term psychodynamic psychotherapy were found during the 3-year follow-up (Knekt et al., 2008), and neither no difference in the prediction of a suitability score on their 3-year outcome were observed (Laaksonen et al., 2013).

Of the patients randomized, 33 (7 from short-term and 26 from long-term therapies) declined to participate and 42 of those starting the treatment (21 in both short- and long-term therapies) discontinued prematurely.

2.2. Treatments

Patients were provided either with short-term therapy (solution-focused or psychodynamic) followed by no treatment or long-term psychodynamic therapy during a 3-year follow-up.

2.2.1. The therapies

The therapies have been described in more detail elsewhere (Knekt et al., 2011a). Solution-focused therapy usually included one session every second or third week, with a limit of 12 sessions over no more than 8 months. Short-term psychodynamic psychotherapy was scheduled for 20 weekly treatment sessions over 5–6 months. The frequency of sessions in long-term psychodynamic psychotherapy was 2–3 a week and the duration up to 3 years.

Solution-focused therapy is a brief resource-oriented and goal-focused therapeutic approach which helps clients change by constructing solutions (De Shazer et al., 1986; Johnson and Miller, 1994). The technique includes the search for pre-session change, miracle and scaling questions, exploration of exceptions, use of a one-way mirror and consulting break, positive feedback and home assignments.

Short-term psychodynamic psychotherapy is a brief, focal, transference-based therapeutic approach which helps patients by exploring and working through specific intrapsychic and interpersonal conflicts (Malan, 1976; Sifneos, 1978). Short-term psychodynamic psychotherapy is characterized by the exploration of a focus, identified by both the therapist and the patient. Current and past interpersonal and intrapsychic conflicts are explored by using confrontation, clarification and interpretation in a process where the therapist is active in creating the alliance and ensuring the time-limited focus.

Long-term psychodynamic psychotherapy is an open-ended, intensive, transference-based therapeutic approach which helps patients by exploring and working through a broad area of intrapsychic and interpersonal conflicts, expressed as unconscious conflicts, developmental deficits, and distortions of intrapsychic structures (Gabbard, 2004). Confrontation, clarification and interpretation are major elements, as well as the therapist's actions in ensuring the alliance and facilitating the working through process.

2.2.2. The therapists

The therapies were conducted by a total of 55 therapists of whom six provided solution-focused therapy, 12 short-term psychodynamic psychotherapy, and 41 long-term psychodynamic psychotherapy (Knekt and Lindfors, 2004; Heinonen et al., 2012). All the therapists were professionally qualified to provide the specific therapy modality. The mean number of years of experience of those providing short-term therapy was 9 (range 2–20) and of those providing long-term therapy 18 (range 6–30).

2.3. Study design

The design of this study was a cohort study with assessments at baseline and at follow-up 7, 12, 24 and 36 months after baseline examination.

2.4. Assessments at baseline

The baseline assessment methods are described in more detail elsewhere (Knekt and Lindfors, 2004) and are only briefly summarized here.

Social support was assessed using a self-reported 10-item Brief Inventory of Social Support and Integration (BISSI) questionnaire (Appendix A). The global BISSI index as well as four subscales, network size, satisfaction in social support and social relations, perceived availability of emotional support from family, and perceived availability of emotional support from friends, were used as predictor variables. The size of the social network was assessed by a 6-point scale from 0 ("none") to 5 ("5 or more"). Satisfaction in social support and social relations was rated by two