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A randomized controlled trial of brief psychoanalytic psychotherapy in patients with functional dyspepsia☆,☆☆

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ABSTRACT

Functional dyspepsia (FD) is a common cause of upper gastrointestinal symptoms and discomfort. The present study aimed to assess the effectiveness of brief core conflictual relationship theme (CCRT) psychoanalytic psychotherapy on changing gastrointestinal symptoms, alexithymia, and defense mechanisms in patients with FD. In a randomized controlled trial study, 49 patients with FD were randomly assigned to medical treatment with brief psychodynamic therapy (24 subjects) or medical treatment alone (25 subjects). Gastrointestinal symptoms, defense mechanisms, and alexithymia were assessed before the trial, after treatment, and at 1- and 12-month follow-ups. The results showed that brief psychodynamic therapy improved all of the gastrointestinal symptoms, including heartburn, nausea, fullness, bloating, upper abdominal pain, and lower abdominal pain, after treatment and at two follow-ups. The CCRT therapy significantly improved many psychological symptoms, including mature defenses, neurotic defenses, immature defenses, difficulties in identifying feelings, difficulties in describing feelings, and total alexithymia score. In conclusion, brief psychodynamic therapy is a reliable method to improve gastrointestinal symptoms, mature defenses, and alexithymia scores in patients with functional dyspepsia.

1. Introduction

Functional dyspepsia (FD) is defined by the Rome II consensus as persistent or recurrent pain or discomfort centered in the upper abdomen, without evidence of organic disease (Talley et al., 1999). The upper abdominal discomfort is often described as fullness, bloating or early satiety accompanied by belching, nausea, and vomiting.

Community studies reveal that FD has an annual prevalence of 17–29% in developed countries (Shaib and EI-Serag, 2004; Okumura et al., 2010). Although only approximately 25% of dyspeptic subjects present to a physician (Jones et al., 1990), dyspepsia impairs quality of life (Talley et al., 1995) and influences absenteeism and direct and indirect healthcare costs (Brook et al., 2010). Unfortunately, the treatment of FD remains a major challenge. The symptomatic improvement of patients with FD after pharmacological interventions remains controversial (Holtmann and Gapasin, 2008). Some research has shown that selective serotonin and norepinephrine reuptake inhibitors are no more effective as treatment than placebos in patients with functional gastrointestinal disorders (Van Kerkhoven et al., 2008; Talley et al., 2008).

Research has demonstrated the influence of psychological processes on gastrointestinal sensorimotor functions and symptoms (Van Oudenhove et al., 2004). Negative correlations have been demonstrated between state anxiety levels and both gastric sensitivity and compliance in FD patients (Van Oudenhove et al., 2007). It has been established for some time that comorbidity of mood and anxiety disorders in functional gastrointestinal disorder patients is higher than in the general population (Henningsen et al., 2003), with rates up to 50% or more, depending on the population studied (Van Oudenhove et al., 2004; Lydiard, 2005).

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Little research is available regarding the role of psychotherapy in dyspeptic syndromes. Haug (2002) found that cognitive therapy may be effective in patients with FD, and Hamilton et al. (2000) reported the same findings for psychodynamic-interpersonal psychotherapy. Short-term psychodynamic psychotherapies (STPP) are a group of brief therapeutic techniques that aim to acquire insight into various unconscious phenomena and any difficulties in identifying and experiencing emotions (Abbass et al., 2009). A systematic review of randomized controlled trials of manual-guided psychodynamic psychotherapy revealed that STPP is superior to control conditions and, on the whole, as effective as already established treatments (e.g. cognitive-behavioral therapy) in specific psychiatric disorders (Leichsenring and Leibing, 2007). The core conflictual relationship theme (CCRT) is one the most widely employed of these short-term psychoanalytic psychotherapy methods for changing or assessing relationship patterns (Book, 2007). Previous studies have shown that prevalence of alexithymia, depression, anxiety, somatization, and interpersonal sensitivity is high among FD patients (Porcelli et al., 1999), that many alexithymic patients also have relationship disturbances (Vanheul et al., 2010), and that there is a strong association between alexithymia and maladaptive ego defense style (Parker et al., 1998). Consequently, we hypothesized that the CCRT therapy may improve interpersonal function, alexithymic disturbances, ego defense mechanisms, and FD symptoms. The CCRT psychotherapy focuses on interpersonal conflicts and emotional changes. It seems that a release from interpersonal conflicts will improve the regulation of emotional affect and alexithymia. When relationship conflicts are resolved, interpersonal sensitivity will decrease, and social functioning will be improved.

In the present study, we compared the outcome of combined CCRT psychotherapy and medical therapy with the outcome of medical therapy alone in patients with FD. The effects of CCRT psychotherapy on FD symptoms, alexithymia symptoms and defense mechanisms were investigated.

2. Methods

2.1. Participants

The trial is registered at the Iranian Registry of Clinical Trials, number IRCT 201102285931N1. The patients were recruited from the gastroenterology clinics in two teaching hospitals at the Babol University of Medical Sciences (Babol, northern Iran) from April 2010 to September 2011. The case notes of all the clinic patients were screened by a researcher associated with the study to determine their recruitment eligibility. Any patients experiencing recurrent or persistent upper abdominal pain or discomfort more than 2–3 days per week for at least 3 months were considered to have FD. All of the patients were 20–40 years old and had earned high school diplomas or university degrees. Table 1 shows the characteristics of the study sample. There were no significant differences in the variables between the groups.

2.2. Procedure

After assessing the inclusion criteria (dyspeptic symptoms, age, and education), the patients were referred to two gastroenterologists to confirm their FD diagnosis. Rome III criteria were applied to identify subjects with dyspepsia (Tack et al., 2006). Biochemical, ultrasonographic, and endoscopic examinations were performed to exclude any structural organic gastrointestinal diseases. Exclusion criteria were: peptic ulcer, gastroesoghageal reflux, biliary tract disease, and gastric cancer. Then, all of the subjects with diagnosis of FD were interviewed by a female psychoanalytic psychotherapist who had sufficient experience in long-term psychoanalysis and the CCRT psychotherapy to assess the inclusion and exclusion criteria for the therapy. The therapist was trained in the CCRT psychotherapy before starting the trial by a supervisor (H.E. Book) through face-to-face distance learning with Skype software. Therefore, patients with diagnosed psychosis, borderline, dependent personality, schizoid or paranoid personalities were excluded from the study (Luborsky et al., 1993; Crist-Christoph & Connolly, 1993). At the end of the interview session, if the patient agreed to participate, she/he was randomly assigned on a paper list, which was used to assign her/him to either a medical therapy (control group) or CCRT-based psychoanalytic therapy in combination with medical therapy (experimental group). The block randomization was by a paper list (random numbers supplied from 1 to 49 by the trial statistician) prepared by an investigator with no clinical involvement in the trial (odd numbers were assigned to the control group, and even numbers to the experimental group). Fig. 1 shows flow diagram in the patients.

At the beginning of the study, all of the participants in both groups were asked to complete the Patient Assessment of Upper Gastrointestinal Symptom Severity Index (PAGI-SYM), 40-item Defense Style (DSQ-40), and 20-item Toronto Alexithymia Scale (TAS-20). As the duration of the interventions in the two groups was not equivalent (for the medical therapy the duration was 4–6 weeks, and for the CCRT psychotherapy the duration was 18 weeks,

Table 1
Baseline demographic and characteristics of study sample.

	CCRT		Control	
	Women ($n=17$) *N* (%)	Men ($n=7$) *N* (%)	Women ($n=17$) *N* (%)	Men ($n=8$) *N* (%)
Age (mean, SD)	31.6 (7.0)	32.7(7.6)	32.8 (5.7)	34.1(4.5)
Education				
High school	9.0 (18.4)	3.0 (6.1)	11.0 (22.5)	5.0 (10.2)
College degree	8.0 (16.3)	4.0 (8.2)	6.0 (12.2)	3.0 (6.1)
Occupational status				
Employed	6.0 (12.2)	7.0 (14.3)	10.0 (20.4)	7.0 (14.3)
Unemployed	11.0 (22.5)	0.0 (0.0)	7.0 (14.3)	1.0 (2.0)
Marital status				
Single	5.0 (10.2)	1.0 (2.0)	3.0 (6.1)	1.0 (2.0)
Married	12.0 (24.6)	6.0 (12.2)	14.0 (28.6)	7.0 (14.3)
Helicobacter status				
Positive	11.0 (22.5)	4.0 (8.2)	11.0 (22.5)	5.0 (10.2)
Negative	6.0 (12.2)	3.0 (6.1)	6.0 (12.2)	3.0 (6.1)
Duration of symptoms				
≤2 years	3.0 (6.1)	2.0 (4.1)	4.0 (8.2)	1.0 (2.0)
>2 years	14.0 (28.6)	5.0 (10.2)	13.0 (26.5)	7.0 (14.3)

Abbreviation: CCRT, Core conflictual relationship theme.