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Original article

Changes in lifestyle for psychiatric patients three years after the start of short- and long-term psychodynamic psychotherapy and solution-focused therapy

P. Knekt [a,b,*], M.A. Laaksonen [b], R. Raitasalo [a], P. Haaramo [c], O. Lindfors [c]

[a] *Social Insurance Institution, P.O. Box 450, 00101 Helsinki, Finland*
[b] *National Institute for Health and Welfare (THL), Mannerheimintie 166, P.O. Box 30, 00271 Helsinki, Finland*
[c] *Biomedicum Helsinki, Helsinki, Finland*

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Abstract

Objectives: Lifestyle is less favourable among individuals suffering from psychiatric disorders. We studied whether psychotherapy brings along changes in lifestyle and whether these changes differ between short-term and long-term psychodynamic psychotherapy (SPP and LPP) and solution-focused therapy (SFT).
Methods: A total of 326 outpatients, 20–46 years of age, with mood or anxiety disorder were randomly assigned to LPP, SPP and SFT. The lifestyle variables considered were alcohol consumption, smoking, body mass index (BMI), leisure time exercise and serum cholesterol. The patients were monitored for three years from the start of treatment.
Results: During the three-year follow-up, BMI and serum cholesterol rose statistically significantly although no statistically significant trends were shown for alcohol consumption, smoking or exercise. SPP showed a disadvantage of increased alcohol consumption and serum cholesterol level when compared with LPP. SFT showed an advantage of reduced smoking in comparison with SPP.
Discussion: Small therapy-specific changes in lifestyle may be a result from psychotherapy treatment. These lifestyle changes are apparently more common in short-term therapy. More studies are needed to verify these findings.

Keywords: Unipolar depression; Anxiety disorder; Psychotherapy; Lifestyle; Randomization; Trial

1. Introduction

The risk of chronic diseases and mortality is elevated in persons suffering from psychiatric disorders [5,18,23]. These associations may be due to biological mechanisms [20] and treatment side effects [18,19] but they may also be due to lifestyle [10]. Individuals who are depressed [40] or suffer from anxiety disorder [13] also have a poorer lifestyle. It has been shown that depressive individuals consume more alcohol [36], are more often smokers [10], exercise less during their leisure time [23], and are more often obese [33] or underweight [23] than non-depressive individuals. Similar associations have also been found in anxiety-related disorders, implying that negative coping behavior is associated with a poor health behavior [13,35].

Individuals with psychiatric disorders tend to have lowered self-esteem and may find the pressure to change their lifestyle too demanding [1]. Negative affectivity or activation, which is common in depressive and anxiety disorders [9], may restrict the ability to stop smoking [16], increase cigarette or alcohol consumption, and decrease physical activity [40]. The simultaneous effect of a poor lifestyle and an unstable mental status may induce an increased biologically-mediated risk for somatic disease [31], which underlines the importance of acknowledging lifestyle changes in psychotherapy. The evidence from studies on behavioral interventions, ranging from a very brief [7,24,25] to more comprehensive psychological counseling and therapeutic interventions [32,34,37],

* Corresponding author. Tel.: +358 20 610 8774; fax: +358 020 610 8760.
E-mail address: paul.knekt@thl.fi (P. Knekt).

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support this hypothesis by generally indicating small to moderate positive changes when the focus of the treatment has been a specific lifestyle problem.

Both short- and long-term psychotherapy have been shown to be effective in the treatment of psychiatric symptoms [22], thus improving the conditions for implementing lifestyle changes. Although it has been suggested that an individualized psychotherapy relationship would be the most effective and safe environment to facilitate lifestyle changes [42], there is, as far as the authors know, no information on the effect of different psychotherapies on the lifestyle of depressive or anxiety patients. This presentation is based on data from the Helsinki Psychotherapy Study and it studies whether patients suffering from depression or anxiety disorder spontaneously changed their lifestyle during and after treatment with long- and short-term therapy, aimed at reducing depression and anxiety, and whether there were differences in the changes due to the form or length of therapy.

2. Subjects and methods

2.1. Patients and settings

A total of 459 outpatients were referred to the project from psychiatric services in the Helsinki region from June 1994 to June 2000 [21]. Patients considered eligible for this study had to be 20–45 years of age and suffer from a long-standing disorder causing dysfunction in work ability. They were required to meet DSM-IV criteria [2] for anxiety or mood disorders. Patients were excluded from the study if any of the following criteria was met:

- psychotic disorder or severe personality disorder;
- adjustment disorder;
- substance-related disorder;
- organic brain disease or other diagnosed severe organic disease;
- mental retardation.

Individuals treated with psychotherapy within the previous two years were also excluded. Of the 459 patients referred to the project, 381 satisfied the eligibility criteria and were willing to participate in the study. During the waiting time from the assessment of eligibility to baseline examination, 55 of these patients decided not to participate.

Of the remaining 326 patients, 128 were randomly assigned to long-term psychodynamic psychotherapy (LPP), 101 to short-term psychodynamic psychotherapy (SPP) and 97 to solution-focused therapy (SFT). Altogether 26 patients who were randomized to long-term psychotherapy and seven patients who were randomized to short-term therapies refused to participate after they were assigned to the treatment group, mainly because they were dissatisfied with the type of therapy. Of the patients starting the assigned therapy, 42 discontinued the treatment prematurely; mostly due to a life-change in life situation or disappointment with the treatment. The patients discontinuing SFT had more symptoms than those continuing treatment [21].

The project follows the Helsinki Declaration and was approved by the ethics council of the Helsinki University Central Hospital. The patients gave written informed consent.

2.2. Methods

2.2.1. The therapies and therapists

SFT is a brief resource-oriented and goal-focused therapeutic approach, which helps clients change by constructing solutions [11,12]. The frequency of SFT sessions was flexible, usually one session every second or third week, up to a maximum of 12 sessions, over no more than eight months. SPP is a brief, focal, transference-based therapeutic approach, which helps patients by exploring and working through specific intrapsychic and interpersonal conflicts [29,39]. SPP consisted of 20 treatment sessions, one session per week, over five to six months. LPP 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 [15]. The frequency of LPP sessions was two to three times a week and the duration of therapy was up to three years.

A total of 55 therapists participated in the study; six provided SFT, 12 SPP and 41 LPP. The therapists' average experience in administering the respective therapies was nine years on average for both SFT (range 3–15) and SPP (range 2–20) and 18 years (range 6–30) on average for LPP [22].

2.2.2. Outcome measures

The lifestyle factors considered as outcome variables were alcohol consumption, smoking, body mass index (BMI), leisure time exercise, and serum cholesterol (total and HDL) [3]. They were measured first at baseline and then again 7, 12, 24 and 36 months from baseline.

2.2.3. Other variables

Psychiatric diagnosis on axes I and II were assessed using a semi-structured interview [2,21]. General psychiatric symptoms were assessed with the Symptom Checklist Global Severity Index (SCL-90-GSI), anxiety symptoms with the Symptom Checklist Anxiety Scale (SCL-90-Anx) [14], and depressive symptoms using the Beck Depression Inventory (BDI) [6]. Socioeconomic factors (sex, age, marital status, education and employment status) and psychiatric history data (age at onset of first psychiatric symptoms, number of previous episodes, duration of symptoms, and separation experiences) were assessed at baseline with questionnaires and interviews. The use of auxiliary psychotherapy, psychotropic medication, and psychiatric hospitalization during the three-year follow-up was continuously assessed with questionnaires and using nationwide public health registers [21].

2.3. Statistical methods

The statistical methods have been presented in more detail elsewhere [22] and will be described only briefly here. Linear mixed models were applied for continuous response variables [41] and logistic regression models for binary responses [28].