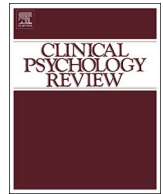




ELSEVIER

Contents lists available at ScienceDirect

Clinical Psychology Review

journal homepage: www.elsevier.com/locate/clinspsychrev

Review

For whom does interpersonal psychotherapy work? A systematic review

Samantha L. Bernecker^{a,*}, Alice E. Coyne^a, Michael J. Constantino^a, Paula Ravitz^b^a Department of Psychological and Brain Sciences, University of Massachusetts, Tobin Hall, 135 Hicks Way, Amherst, MA 01003-9271, USA^b Department of Psychiatry, University of Toronto, Mount Sinai Hospital, 600 University Ave., Toronto, ON M5G 1X5, Canada

HIGHLIGHTS

- Interpersonal psychotherapy (IPT) effectively treats depression and other disorders.
- It remains unknown which patients will benefit from IPT versus another treatment.
- Relatively few moderators have replicated across trials of IPT.
- A handful of patient characteristics may predict better or worse response to IPT.
- Obstacles to identifying moderators and possible remedies are discussed.

ARTICLE INFO

Keywords:

Interpersonal psychotherapy
Moderator
Aptitude-treatment interaction
Personalized medicine

ABSTRACT

The efficacy of interpersonal psychotherapy (IPT) to treat depression and other disorders is well established, yet it remains unknown which patients will benefit more from IPT than another treatment. This review summarizes 46 years of clinical trial research on patient characteristics that moderate the relative efficacy of IPT vs. different treatments. Across 57 studies from 33 trials comparing IPT to pharmacotherapy, another psychotherapy, or control, there were few consistent indicators of when IPT would be more or less effective than another treatment. However, IPT may be superior to school counseling for adolescents with elevated interpersonal conflict, and to minimal controls for patients with severe depression. Cognitive-behavioral therapy may outpace IPT for patients with avoidant personality disorder symptoms. There was some preliminary evidence that IPT is more beneficial than alternatives for patients in some age groups, African-American patients, and patients in an index episode of depression. The included studies suffered from several limitations and high risk of Type I and II error. Obstacles that may explain the difficulty in identifying consistent moderators, including low statistical power and heterogeneity in samples and treatments, are discussed. Possible remedies include within-subjects designs, manipulation of single treatment ingredients, and strategies for increasing power such as improving measurement.

Assigning patients to mental health interventions is presently more guesswork than science. Although numerous psychological and pharmacological treatments show comparable efficacy, healthcare stakeholders have little information about which treatments will be more effective for a specific patient (Simon & Perlis, 2010). Because improvement rates in both psychotherapy and pharmacotherapy are sobering (with as many as 40% of patients failing show clinically significant response; e.g., Stiles, Barkham, Connell, & Mellor-Clark, 2008; Thase et al., 2005; Westen & Morrison, 2001), generalizable knowledge

about “what treatment works best for whom” is sorely needed so that patients can be matched to optimal treatments for them.

One means to produce such knowledge is by investigating patient characteristics as moderators of comparative treatment efficacy, or patient characteristics that predict when one treatment will be more effective than another (Kraemer, Wilson, Fairburn, & Agras, 2002). However, moderation effects are often small and therefore may not, on their own, provide a strong basis for treatment decision-making (Wallace, Frank, & Kraemer, 2013), especially when a patient displays

Abbreviations: AVPD, avoidant personality disorder; BED, binge eating disorder; BWL, behavioral weight loss; CBT, cognitive-behavioral therapy; CBTgsh, CBT guided self-help; CGT, complicated grief treatment; CM, clinical management; CT, cognitive therapy; ED, eating disorder; IPC, interpersonal counseling; IPT, interpersonal psychotherapy; IPSRT, interpersonal and social rhythm therapy; OCPD, obsessive-compulsive personality disorder; PE, prolonged exposure; PD, personality disorder; PTSD, post-traumatic stress disorder; RT, relaxation training; SP, supportive psychotherapy; SSRI, selective serotonin reuptake inhibitor

* Corresponding author at: Department of Psychology, Harvard University, 33 Kirkland St., Cambridge, MA 02138, USA.

E-mail addresses: sbernecker@fas.harvard.edu (S.L. Bernecker), acoyn@umass.edu (A.E. Coyne), mconstantino@psych.umass.edu (M.J. Constantino), paula.ravitz@sinaihealthsystem.ca (P. Ravitz).

¹ Samantha L. Bernecker is now at Department of Psychology, Harvard University.

<http://dx.doi.org/10.1016/j.cpr.2017.07.001>

Received 10 January 2017; Received in revised form 8 June 2017; Accepted 3 July 2017

Available online 08 July 2017

0272-7358/ © 2017 Elsevier Ltd. All rights reserved.

moderating characteristics that make contradictory predictions. Addressing this limitation, several research groups have, with some success, combined multiple moderators into a single predictive index (e.g., DeRubeis et al., 2014; Wallace et al., 2013; also see Kraemer, 2013, for a tutorial). However, these algorithms may not generalize beyond specific samples. To fully realize the promise of this approach, it is important to identify, with a wide net, moderators that emerge consistently across samples and with different treatment comparisons.

To this end, the present review organizes the knowledge base about moderators of one well-established, widely researched intervention: interpersonal psychotherapy (IPT). IPT is based on the premise that symptoms are linked to interpersonal stressors, so resolving these problems will lead to symptom amelioration. Initially developed to treat depression, IPT addresses an interpersonal problem area (i.e., grief, relational disputes, social role transitions, or interpersonal deficits) that is hypothesized to be most tied to the patient's symptoms (Weissman, Markowitz, & Klerman, 2000). Treatment strategies include psychoeducation, assessment of the patient's relationships, and, most centrally, efforts to improve interpersonal functioning in the targeted problem area. IPT has repeatedly proven effective in clinical trials (Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016), and several professional and governmental organizations (e.g., National Institutes of Health, 2011; National Institute for Health and Clinical Excellence, 2009; Parikh et al., 2016) recommend it as a first-line treatment.

Since the first major randomized controlled trial (RCT) of IPT (i.e., the National Institute of Mental Health Treatment of Depression Collaborative Research Program; TDCRP), much research on IPT has ensued (Ravitz et al., under review), and adaptations of IPT have been developed for other disorders (e.g., panic, bipolar) and for specific populations (e.g., adolescents, mothers). Yet, despite IPT demonstrating equivalent efficacy to cognitive-behavioral therapy (CBT) for depression, it has been much less widely disseminated (Cuijpers et al., 2016). This relative lack of dissemination is problematic in that IPT is comparably effective, and in that CBT may be a poorer fit for some patients. Identifying moderators of IPT's efficacy, compared to CBT and other approaches, will aid in determining where greater efforts should be made to disseminate IPT and for whom specifically it should be offered.

Though investigations of moderators of IPT's comparative efficacy have been amassing for decades, this research has never been compiled in one place, making it difficult for clinicians to know when to deliver IPT and impeding researchers' development of treatment assignment algorithms. By synthesizing all extant research on moderators in trials comparing IPT to one or more psychotherapies or pharmacotherapies, we hoped to clarify, to the current extent possible, when IPT should be the treatment of choice and when IPT is not indicated. Additionally, this synthesis constitutes an opportunity to take stock of what has been accomplished in IPT moderator research to date and to make recommendations for future empirical directions.

1. Method

1.1. Identification of studies

We conducted the initial electronic database search in May 2014 in the PsycINFO and PubMed databases using the terms “*interpersonal psychotherapy*” or “*interpersonal therapy*” in combination with one of the following: *moderat**, *interac**, or *differential**. We identified additional candidate articles in the reference sections of review articles and communication with IPT researchers. A final search of Google Scholar was conducted in September 2016.

Articles needed to meet several inclusion criteria. First, participants had to be randomly assigned to IPT or at least one other treatment condition. A psychotherapy was considered IPT if it was a derivative of Klerman, Weissman, Rounsaville, and Chevron's (1984) initial operationalization, with similar techniques and interpersonal foci. Second, the study needed to include a statistical test of whether a pretreatment

patient-level variable was differentially associated with outcome in each treatment (typically a test of an interaction; Kraemer et al., 2002). Studies that investigated the same patient-level predictor of outcome separately within each treatment, but lacked a statistical test of moderation, were excluded. Additionally, articles were excluded if they tested only a composite or block of moderators rather than individual variables. Third, any pretreatment variable was accepted as a moderator, except when the only moderator was the use of medication, which we considered to be part of treatment. (The effects of combined psychotherapy and medication vs. monotherapy have been reviewed elsewhere; e.g., Cuijpers, van Straten, Hollon, & Andersson, 2010; Cuijpers, van Straten, Warmerdam, & Andersson, 2009; Karyotaki et al., 2016). Measures of symptomatology and functioning were considered appropriate outcome variables, as were remission status, time to remission, and dropout. Finally, the study had to be published in English. There were no restrictions on disorder, population, publication date, or type of publication (journal article, chapter, or thesis). Abstracts were screened by graduate students, then full texts were reviewed by the first author and two graduate students to determine whether they met inclusion criteria. When it was unclear whether an article should be included, all authors made a consensual decision.

1.2. Coding of study characteristics

The authors divided the articles and independently extracted information. Each article was coded by only one author, except when the initial coder sought consultation with another author. Data extracted included disorder, population, nature of the treatment conditions (manual, format, and dose), sample size, outcome measure(s), moderator(s) and their measure(s), statistical approach, and findings for each moderation analysis. We recorded all available detail on the direction, magnitude, and significance of the moderation findings.

Additionally, we developed a list of criteria for evaluating study quality, drawing on recommendations for RCTs in general and for moderation analyses in particular (Higgins & Green, 2011; Kraemer et al., 2002; Moher et al., 2010; Pincus et al., 2011). For each criterion, we recorded whether it was clearly reported and whether it was addressed adequately, and if it was addressed inadequately we recorded the nature of the problem.

1.3. Synthesis

We sorted potential moderators into the following categories (with subcategories as appropriate): sociodemographic variables, clinical characteristics, personality, life events, medical factors/biomarkers, and beliefs about treatment or illness. For each category, one of the authors took primary responsibility for reviewing and synthesizing the information extracted from the reports. Because the majority of studies did not report enough information to compute an effect size for the interaction between the moderator and treatment conditions, we could not quantitatively combine findings in meta-analyses. Instead, we created narrative summaries.

In interpreting findings, it makes sense to put minimal evidentiary weight on individual nonsignificant findings because tests of statistical interactions are likely to produce false negatives due to low power. One simulation study found that if a trial is fully powered to detect main effects of treatment at 80%, the power to detect an interaction of the same magnitude as the treatment effect is only 29% (Brookes et al., 2004); most moderator effects are probably smaller than treatment effects, making detection unlikely. Therefore, a single nonsignificant test should not be considered strong evidence against the moderation. Nonsignificant effects can be given more weight if they are numerous: although absence of evidence is not *proof* of absence, it is *evidence* of absence, so the greater the number of studies that find no moderator by treatment effect for a variable, the less likely it is that the variable is a moderator. Additionally, one should remain skeptical when a

Download English Version:

<https://daneshyari.com/en/article/5038529>

Download Persian Version:

<https://daneshyari.com/article/5038529>

[Daneshyari.com](https://daneshyari.com)