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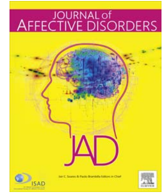

Research paper

Efficacy of an adjunctive brief psychodynamic psychotherapy to usual inpatient treatment of depression: Results of a randomized controlled trial

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ABSTRACT

Background: For severe and chronic depression, inpatient treatment may be necessary. Current guidelines recommend combined psychological and pharmacological treatments for moderate to severe depression. Results for positive effects of combined treatment for depressed inpatients are still ambiguous.
Methods: This randomised controlled trial examined the efficacy of adding an intensive and brief psychodynamic psychotherapy (IBPP) to treatment-as-usual (TAU) for inpatients with DSM-IV major depressive episode. The primary outcomes were reduction in depression severity, and response and remission rates at post-treatment, 3-month and 12-month follow-up points.
Results: A linear mixed model analysis (N=149) showed a higher reduction in the observer-rated severity of depressive symptoms at each follow-up point for the IBPP condition compared with the TAU condition (post-treatment ES=0.39, 95%CI 0.06–0.71; 3-month ES=0.46, 95%CI 0.14–0.78; 12-month ES=0.32, 95%CI 0.01–0.64). Response rate was superior in the IBPP group compared with the TAU group at all follow-up points (post-treatment OR =2.69, 95%CI 1.18–6.11; 3-month OR=3.47, 95%CI 1.47–8.25; 12-month OR=2.26, 95%CI 1.02–4.97). IBPP patients were more likely to be remitted 3 months (OR=2.82, 95%CI 1.12–7.10) and 12 months (OR=2.93, 95%CI 1.12–7.68) after discharge than TAU patients.
Limitations: Heterogeneous sample with different subtypes of depression and comorbidity.
Conclusions: IBPP decreased observer-rated depression severity up to 12 months after the end of treatment. IBPP demonstrated immediate and distant treatment responses as well as substantial remissions at follow-up. IBPP appears to be a valuable adjunct in the treatment of depressed inpatients.

1. Introduction

Depression is among the most common reasons for psychiatric hospitalization (Schneider et al., 2005; Stensland et al., 2012). Inpatients with depression have a high degree of severity, comorbidity, chronicity and treatment resistance. They belong to the most severe and disabled patient populations (APA, 2010). Meta-analyses have consistently shown the advantage of combined treatment for patients with depressive disorders that are complicated by comorbidity, chronicity, treatment resistance, recurrence, or high severity (Cuijpers et al., 2009; de Maat et al., 2007; Imel et al., 2008). Current clinical guidelines recommend a combination of pharmacotherapy and psychotherapy to treat either moderate to severe depression (APA, 2010; NICE, 2009) or severe depression only (DGPPN, 2012). Different psychotherapeutic interventions for depression such as cognitive-behavioral (CBT), interpersonal (IPT), and psychodynamic therapies have shown efficacy with no significant association between effect size and type of psychotherapy (Barth et al., 2013). Furthermore, by both mental health professionals and their patients value psychotherapy alone or the combination of psychotherapy and pharmacotherapy is highly as a way of hastening recovery, either through additive effects or by compensating for the limitations of monotherapy (Lelliott and Quirk, 2004; Pampallona et al., 2004; Peeters et al., 2013).

Some studies have documented the possible advantages of brief

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psychodynamic psychotherapy combined with antidepressants, as compared to antidepressants alone. One study found that although both groups experienced significant improvement, the combined treatment group had fewer treatment failures, better work adjustment, better global functioning, and a lower rate of hospitalization than the medication alone group (Burnand et al., 2002). De Jonghe et al. (2001) showed that patients found combined treatment significantly more acceptable than medication alone. The patients receiving combined treatment were significantly less likely to drop out and were also more likely to recover. The authors concluded that combined therapy is preferable to pharmacotherapy alone in treating ambulatory patients with major depression (De Jonghe et al., 2001). A more recent study found no difference in remission rates at the end of a 6-month acute treatment phase between a group of patients who received a brief psychodynamic psychotherapy combined with an SSRI and a group of patients who received medication alone (Maina et al., 2009). However, more patients in the combined group achieved sustained remission at the end of the follow-up period compared with patients who had only received medication during the acute phase.

Several recent position papers call for better quality of inpatient care (Craig, 2016; Porter et al., 2016). These position papers suggest that the positive aspects of inpatient admission, including the opportunity for assessment and intensive treatment, should be emphasized (Porter et al., 2016). The treatment options for better quality care include psychotherapy. Psychological treatment may improve the recovery of depressed inpatients and reduce their suffering for themselves as well as that of their relatives (Porter et al., 2016). In a systematic review and meta-analysis based on 12 studies, Cuijpers et al. (2011) showed a small (ES=0.29) but robust additional effect of psychological treatment on depression in depressed inpatients (Cuijpers et al., 2011). A previous meta-analysis (Stuart and Bowers, 1995), based on 4 controlled studies, showed higher effect sizes with a difference between self-report measures (ES=1.13) and independent observer measures (ES=0.38) at discharge from the hospital in favor of adding CBT to the usual treatment. These results contrast with a review of 6 studies on inpatients with depressive disorder (Huber, 2005) that showed less conclusive results. Three studies showed an additional effect of psychotherapy (corresponding to a moderate ES). Combined treatment was superior to pharmacotherapy in terms of remissions rates and relapse rates. Additionaly, three studies showed no additional effect. The results were clearer for more severely depressed inpatients or chronic inpatients. The author concluded that combined treatment is advantageous in the case of treatment resistance, or chronic or severe illness, and depends on patient preferences. Although these reviews found some indications for the positive effects of combined treatment for depressed inpatients, the results are still ambiguous. The number of studies included in the reviews was relatively small and their quality was not optimal. The vast majority of the included studies had relatively small sample sizes. Good-quality studies with larger sample sizes are needed to further examine the effects of psychotherapy for depressed inpatients (Cuijpers et al., 2011).

Most of the above mentioned studies reported on the effectiveness of cognitive and/or behavioral inpatient psychotherapies. Cuijpers et al. (2011) retrieved only 3 studies out of 12 did not involve CBT, among which a single study involved interpersonal psychotherapy. Huber (2005) reported on 5 CBT studies and on one client-centered psychotherapy study, while Stuart and Bower (1995) only examined cognitive therapy. Early research on the effectiveness of outpatient psychotherapies for depression also found evidence for the effectiveness of CBT first. The place of psychoanalytic treatment within psychiatry had been controversial for a moment (Gabbard et al., 2002); however, an increasing scientific litterature has since shown the effectiveness of psychotherapy in treating depression (Fonagy, 2015). Recent meta-analyses converge to conclude that the differences between psychotherapies in treating depression are small and unstable (Barth et al., 2013). Some people may respond better to interventions other than CBT (Barth et al., 2013). It may also be true for inpatients; hence, the potential of psychodynamic psychotherapies to be useful for inpatients warrants further research.

The purpose of the current study was to estimate the relative efficacy of adjunctive psychodynamic psychotherapy compared to the usual psychiatric and pharmacologic treatment on the short- and long-term outcomes of inpatients with either moderate or severe depression.

2. Methods

2.1. Procedure and study design

This single-blind one-month randomized controlled add-on trial compared (1) an intervention arm with (2) a treatment-as-usual arm (TAU). Inpatients in the intervention arm received an intensive brief psychodynamic psychotherapy (IBPP) as an add-on therapy to the TAU. IBPP was initiated within a few days after admission. When patients were discharged before the end of IBPP, IBPP continued on an outpatient basis. This RCT was single-blind as the participants were aware of their allocation when they received additional psychotherapy. Rationale, design and procedure of the study was extensively presented elsewhere (Ambresin et al., 2012). The University Ethical Committee approved the research protocol (April 12, 2010).

2.2. Participants

For inclusion, patients hospitalized in the university psychiatric hospital had to: (1) meet DSM–IV criteria for unipolar major depressive episode (MDE); (2) be 18–65 years of age, (3) have a Montgomery-Asberg Depression Rating Scale (MADRS) >18, and (4) have sufficient command of French. Exclusion criteria were limited to bipolar disorders, psychotic disorder, persistent substance use/abuse which might affect brain function (memory, level of consciousness, cognitive abilities) thereby impairing the individual from participating and benefiting from psychotherapy. The following comorbidities were considered as relative contraindications: Axis II paranoid, schizoid or schizotypal, borderline personality disorder, antisocial personality disorder, recent suicide attempts necessitating residential or day treatment and acute risk for suicide, and cognitive impairment.

2.3. Outcome measures

The outcome measures of depression severity were: (1) the Montgomery-Asberg Depression Rating Scale (MADRS) (Montgomery and Asberg, 1979), a clinician rating measure in 10 items, and (2) the Quick Inventory of Depressive Symptom - self-rated version (QIDS-SR_{16}) (Corruble et al., 1999), a 16-item self-report measure of depressive symptoms, which provides a sensitive measure of patient change in inpatient setting. Construct validity of MADRS has been demonstrated in an inpatient sample (Davidson et al., 1986) The Global Assessment of Functioning (GAF) was included as a measure of functioning. For the MADRS, treatment response was defined a priori as a reduction in symptom severity of 46% or higher of the baseline score and remission as a score of 7 or less, based on cut-off scores determined in a large inpatient population (Riedel et al., 2010); for the QIDS-SR_{16} response corresponded to a symptom reduction $>=50\%$, and remission as a score of score of 5 or less (Rush et al., 2006).

The diagnostic assessment relied on the French version of the Diagnostic Interview for Genetic Studies (DIGS) (Nurnberger et al., 1994), which elicits DSM-IV depression symptoms and revealed excellent inter-rater (kappa=0.93) and fair test-retest (kappa=0.62) reliability for MDE (Preisig et al., 1999). These semi-structured interviews were conducted by trained and experienced clinical psychologists who were independent and blind for treatment allocation. The efficacy of treatment was evaluated 4 weeks after the beginning of the treatment and 3 and 12 months post-hospitalization in terms of a

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