



Research report

Therapist-rated outcomes in a randomized clinical trial comparing cognitive behavioral therapy and psychodynamic therapy for major depression



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ABSTRACT

Background: The efficacy of psychodynamic therapy (PDT) for depression is debated due to a paucity of high-quality studies. We compared short psychodynamic supportive psychotherapy (SPSP) to cognitive behavioral therapy (CBT) in a randomized clinical trial. We used therapist-rated outcomes to examine how the course of change during treatment could be best represented and to compare treatment efficacy, hypothesizing non-significant differences.

Methods: Three hundred and forty-one adults meeting DSM-IV criteria for a depressive episode and with Hamilton Depression Rating Scale (HAM-D) scores ≥ 14 were randomized to 16 sessions of individual manualized CBT or SPSP. Severely depressed patients (HAM-D > 24) received additional antidepressant medication. After each session, therapists rated the Clinical Global Impression Scale subscales 'Severity of Illness' (CGI-S) and 'Global Improvement' (CGI-I), and the DSM-IV Axis V Global Assessment of Functioning Scale (GAF). We fitted growth curves using mixed model analyses with intention-to-treat samples.

Results: CGI-S and GAF scores during treatment were best represented by a linear symptom decrease. CGI-I scores were best represented by an S-shaped curve with relative more improvement in the first and last phases than in the middle phase of treatment. No significant post-treatment treatment differences were found. A non-significant trend for a treatment effect on CGI-S scores vanished when controlling for therapist gender and profession.

Limitations: Therapists were not specifically trained for CGI and GAF assessments.

Conclusions: These findings add to the evidence-base of PDT for depression. Therapist characteristics and differences between severity and improvement measures might influence ratings and need to be taken into account when using therapist-rated outcome measures.

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1. Introduction

Therapist-rated instruments can provide valuable information regarding a patient's condition from a clinician's perspective. Therapist-rated measures as the Clinical Global Impression Scales

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(CGI; Guy, 1976) and the DSM-IV Axis V Global Assessment of Functioning Scale (GAF; American Psychiatric Association [APA], 2000) have a one-item structure, which allows for a concise and easy administration of a patient's global condition. For this reason, CGI and GAF are used extensively as efficacy measures in medical care and clinical research (Busner et al., 2009).

Research findings have provided support for the psychometric characteristics of the GAF (Hilsenroth et al., 2000) and, to a lesser extent, also for the psychometric characteristics of the CGI (see Forkmann et al., 2011). However, the latter has also been subject to criticism. For instance, the CGI scales have been criticized for being

too general to measure treatment efficacy validly and for possibly inducing inconsistent rating behavior (Beneke and Rasmus, 1992; Kadouri et al., 2007). Related, Busner et al. (2009) found that adverse events irrelevant to the condition under study affected clinical trials investigators' CGI ratings, while the CGI was designed to pertain only the disease under study. Aside from these issues, all therapist-rated outcome measures have also been criticized for being subjective and prone to bias, as raters often evaluate their own treatments (Ruhé et al., 2005).

Notwithstanding these limitations, therapist-rated outcome measures can provide valuable additional information to ratings conducted by observers and patients, as they provide a means of determining a patient's condition in the view of an experienced clinician (Busner et al., 2009). As these measures are often used in clinical practice to guide treatment decision-making, studying the implications of using therapist-rated outcome measures is important. Correlations between therapist-rated outcome measures on the one hand and patient-rated or observer-rated measures on the other hand have been found to be moderate to absent in some studies (Forkmann et al., 2011, Ruhé et al., 2005) and substantial outcome differences between these three different types of instruments have been reported (Spielmans and McFall, 2006). For these reasons, authors have advocated for the use of a variety of patient-rated, observer-rated and therapist-rated outcome measures when assessing treatment response in clinical trials (Forkmann et al., 2011; Spielmans and McFall, 2006).

We conducted a randomized clinical trial comparing the efficacy of psychodynamic therapy (PDT) with cognitive behavioral therapy (CBT) in the outpatient treatment of depression (Driessen et al., 2007). We conducted this study because the efficacy of PDT for depression is debated due to a paucity of high-quality trials (APA, 2010; NICE, 2010; Driessen et al., 2010). In this study, no significant treatment differences were found on observer-rated and patient-rated outcomes (Driessen et al., 2013). However, we designed the study to also include therapist-rated outcome measures for two reasons. First, given their easiness of administration, the therapist-rated outcomes could be administrated after each session, thereby providing the opportunity to examine the course of change during treatment. Second, we aimed to compare the efficacy of CBT and PDT from a therapist perspective as well as from the perspectives of the observer and the patient (Driessen et al., 2007). In this paper, we use therapist-rated outcome measures to examine how the course of change during treatment could be best represented and to compare CBT and PDT. We expected symptom decrease during treatment, but did not specify hypotheses regarding curves. We hypothesized no significant differences

between conditions on all therapist-rated outcome measures (Driessen et al., 2007).

2. Methods

2.1. Design

Detailed information about the original study has been described elsewhere (Driessen et al., 2007, 2013). This study is a randomized clinical trial (RCT) with an allocation ratio CBT:PDT of 1:1. The Dutch Union of Medical-Ethic Trial Committees for mental health organizations approved the study design.

2.2. Participants

Participants were referred by their general practitioner to one of three outpatient mental health clinics in Amsterdam, The Netherlands. Inclusion criteria were: 1) presence of a depressive episode according to DSM-IV criteria (APA, 2000) as assessed with the *MINI-International Neuropsychiatric Interview – Plus* (MINI-Plus; Sheehan et al., 1998), 2) *Hamilton Depression Rating Scale* (HAM-D; Hamilton, 1960) scores ≥ 14 , 3) age between 18 and 65 years, and 4) written informed consent.

2.3. Interventions

Both PDT and CBT encompassed 16 individual sessions within 22 weeks and were conducted according to published treatment manuals (de Jonghe, 2005; Molenaar et al., 2009). CBT was based on the principles described by Beck (1976) and included behavioral activation and cognitive restructuring according to a session-by-session protocol with homework assignments. Short psychodynamic supportive psychotherapy (SPSP; de Jonghe et al., 2013) was used to represent the psychodynamic intervention. This modality involved an open patient-therapist dialog that used supportive and insight-facilitating techniques to address the emotional background of the depressive symptoms by discussing current relationships, internalized past relationships, and intrapersonal patterns.

Psychotherapists in both conditions were trained psychiatrists or psychologists with at least a master's degree. Therapist characteristics are described in Table 1. No differences were found between conditions with regard to mean years of clinical experience therapists had after completing their master's degree or medical degree (CBT: 7.5 [SD=7.3]; SPSP: 7.4 [SD=6.7]; $U=13,711.00$, $z=-0.148$, $p=0.88$). However, CBT was conducted more

Table 1
Therapist characteristics per patient treated.

Variable	Total sample (n=322)		CBT (n=156)		Psychodynamic (n=166)		Test statistic (df)	p
	n	%	n	%	n	%		
Gender							$\chi^2(1)=14.80$	< 0.001
Male	119	37.0	41	26.3	78	47.0		
Female	203	63.0	115	73.7	88	53.0		
Profession							$\chi^2(1)=109.79$	< 0.001
Master level physician/Resident psychiatrist	48	14.9	13	8.3	35	21.1		
Master-level Psychologist/Licensed psychologist in training	73	22.7	53	34.0	20	12.0		
Licensed psychologist	51	15.8	45	28.8	6	3.6		
Psychotherapist (in training)/Clinical psychologist (in training)	91	28.3	44	28.2	47	28.3		
Psychiatrist	59	18.3	1	0.6	58	34.9		
	mean	SD	mean	SD	mean	SD		
Clinical experience after completing master's/medical degree (in years)	7.43	6.95	7.49	7.25	7.37	6.69	$U=13,711.00$, $z=-0.148$,	0.88

CBT=cognitive behavioral therapy, SD=standard deviation.

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