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Research report

Long-term effects of psychotherapy on moderate depression: A comparative study of narrative therapy and cognitive-behavioral therapy

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ABSTRACT

Background: In a previous clinical controlled trial (Lopes et al., 2014), narrative therapy (NT) showed promising results in ameliorating depressive symptoms with comparable outcomes to cognitive-behavioral therapy (CBT) when patients completed treatment. This paper aims to assess depressive symptoms and interpersonal problems in this clinical sample at follow-up.
Methods: Using the Beck Depression Inventory-II and Outcome Questionnaire-45.2 Interpersonal Relations Scale, naturalistic prospective follow-up assessment was conducted at 21 and 31 months after the last treatment session.
Results: At follow-up, patients kept improving in terms of depressive symptoms and interpersonal problems. The odds that a patient maintained recovery from depressive symptoms at follow-up were five times higher than the odds that a patient maintained recovery from interpersonal problems. In the same way, the odds of a patient never recovering from interpersonal problems were five times higher than the odds of never recovering from depressive symptoms.
Limitations: The study did not control for the natural course of depression or treatment continuation.
Conclusions: For depressed patients with greater interpersonal disabilities, longer treatment plans and alternative continuation treatments should be considered.

1. Introduction

The short-term effects of brief outpatient psychotherapy for unipolar depression have been widely reported in the psychotherapy research literature over the past 60 years (e.g., Cuijpers et al., 2008a; Demaat et al., 2007; Dobson, 1989; Elkin et al., 1989; Gloaguen et al., 1998; Hansen et al., 2002; Hollon and Ponniah, 2010; Lambert and Ogles, 2004). Cognitive-behavioral therapy (CBT) for depression and its variants have also been well explored (Beck et al., 1979; Butler et al., 2006; Cuijpers et al., 2008a, 2008b; Gibbons et al., 2010). Despite effective treatments, approximately 20% of patients (Keller and Boland, 1998) or more (Barkow et al., 2003; Barnhofer et al., 2013) develop a chronic form of the disorder for at least two years. Accordingly, Angst (1992) found that 75% of patients had one or more recurrences of depression at a 10-year follow-up. The chances of having another depressive episode are approximately 50% higher for those who have already had a first major depressive episode (Hollon et al., 2002; Judd et al., 1998). The more episodes one has experienced, the more likely a patient is to experience reoccurrence or relapse. For instance, chances for a fourth episode can reach 90% for those who have already experienced three previous episodes (American Psychiatric Association, 2000). Given the recurrence and chronicity of MDD, long-term follow-ups should be considered to evaluate treatment efficacy (Chambless and Hollon, 1998; Cooper, 2008; Lambert and Ogles, 2004; Shapiro et al., 1995).

In a comparative short-term controlled clinical trial, Lopes et al. (2014) found that depressed patients who received narrative therapy (NT) showed significant reductions in depressive symptoms. The authors concluded that those who completed NT or CBT had significantly superior outcomes when compared to a waiting list benchmark (Minami et al., 2007). The dropout rate was high (approx. 35%), which led to less impressive results on the intend-to-treat analysis compared with those who completed the treatment. A significant difference was found in depressive symptom reduction, which favored CBT when all patients, dropouts and completers, were included in the analysis. Despite this difference, no differences between treatments

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were found for interpersonal problems. Although almost half of all patients fulfilled the criteria for clinical recovery by the end of treatment (Jacobson and Truax, 1991), the rest remained unimproved. The aim of this paper is to assess long-term outcomes of the patient sample who have undergone either NT or CBT in the Lopes et al. (2014) clinical trial, with special emphasis on the differential course of depressive symptoms and interpersonal problems.

1.1. Long-term assessment of psychotherapy outcomes

There is vast evidence showing that psychotherapy relapse rates for depression (mainly with CBT) are significantly lower than pharmacotherapy relapse rates (e.g., 56% against 26.5%, Demaat et al., 2007; 60% against 29.5%, Gloaguen et al., 1998; 50% against 33%, Shea et al., 1992). However, there is a lack of evidence comparing the differential long-term effects of different psychological interventions (Cuijpers et al., 2008a). Although available research suggests that different psychological treatments have equivalent effects over time (Blay et al., 2002; e.g., Deffenbacher et al., 1995; Shea et al., 1992), some evidence suggests the superiority of certain treatments (Ellison et al., 2009). For instance, Shapiro et al. (1995) found equivalent post-treatment outcomes for depression through CBT and psychodynamic-interpersonal psychotherapy, but at the one year follow-up assessments, CBT showed significantly better outcomes. Given these inconsistent findings, outcome follow-up assessments seem to be an essential part of studies on the effectiveness of psychological treatments (Chambless and Hollon, 1998; Cooper, 2008; Lambert and Ogles, 2004).

Evidence suggests that post-treatment scores predict follow-up scores (Cooper, 2008; Nicholson and Berman, 1983; Robinson et al., 1990), and some studies suggest a delayed response to treatment. For instance, Anderson and Lambert (2001) found that among 102 patients, who were treated for diverse psychological problems, the overall improvement rate increased from 39% at post-treatment to 53% at the six-month follow-up. Keller et al. (1992) also showed that the probability of depression recovery was 70% two years after discharge and increased up to 80% three years after discharge. Accordingly, in research studying longer follow-up periods, recovery rates increased from 20.4% at 15 years after discharge to 32.7% at 25 years after discharge (Brodaty et al., 2001). Clinical gains are thus expected in the follow-up assessments.

Despite findings that suggest some post-treatment improvement, limited follow-up intervals are major limitations in most long-term effect studies of psychotherapy; patients are often assessed for no longer than a year after treatment (Cooper, 2008; Westen and Morrison, 2001). This trend of relatively short follow-ups appears in a systematic review of 53 high-quality comparative outcome studies examining psychotherapy for depression (Cuijpers et al., 2008a). This study revealed a mean follow-up period of 5.6 months ($SD=5.1$, median = four months), and 93.4% of the studies only reported follow-up data for less than 12 months (only one study presented 24-month follow-up data). To the authors' knowledge, the only study that evaluated the follow-up effects of NT for depression (Vromans and Schweitzer, 2011) had a brief follow-up interval (of only three months). Therefore, to better understand the long-term effects of psychological treatment, a longer follow-up period (more than one year) is strongly recommended (Brodaty et al., 2001; Cooper, 2008; Lambert and Ogles, 2004; Lambert, 2007).

1.2. Symptomatic vs. interpersonal change in depression

In daily practice, clinicians frequently observe that symptomatic change occurs faster than changes on interpersonal levels (e.g., interpersonal problems, dysfunctional relationship patterns). Accordingly, the phase model of change (Howard et al., 1993; Swift et al., 2010) suggests that interpersonal improvements will take longer to achieve when compared to symptomatic improvements. Research examining brief treatments supports this observation. For instance, Kopta et al. (1994) assessed clinically significant changes for different symptom clusters. The authors found that for 50% of patients to recover from symptoms of acute distress, five sessions were necessary. For the same 50% of patients to recover from chronic distress, 14 sessions were necessary. For the characterological symptoms cluster, which described interpersonal problems, more than 104 sessions were required for 50% of patients to recover, suggesting greater constancy of these problems. In another study, Barkham et al. (2002) assessed 105 moderately depressed patients who were assigned to three treatment conditions with different therapy lengths, i.e., two-session, eight-session and 16-session intervention conditions. Results revealed that although many patients recovered from depressive symptoms, significantly fewer patients recovered from interpersonal problems in all conditions. Accordingly, a reanalysis of the data from the Lopes et al. (2014) clinical trial found that more patients have improved depressive symptoms than improved interpersonal problems and that depressive symptom improvement occurred significantly faster than interpersonal problem improvement during their brief psychological treatment of depression (Lopes et al., 2013). This finding suggests that time might be an important factor in improving interpersonal problems.

None of the aforementioned studies showed evidence of the long-term differential effects of different psychotherapies on depressive symptoms and interpersonal problems (i.e., the phase model). Thus, it is our goal to evaluate whether the differential recovery from depressive symptoms and interpersonal problems is maintained or reduced in a long-term evaluation and whether these changes are different in CBT when compared to NT.

1.3. Research questions

The general purpose of this study is to evaluate the long-term effects of NT and CBT in the aforementioned clinical trial (Lopes et al., 2014) and to assess whether the two treatments differ in stability over time. To address the aforementioned evidence gap, specific research questions include the following: (1) Are therapeutic gains maintained over time at 21- and 31-month follow-ups, i.e., do patients keep improving, stabilize or relapse? (2) Do changes in depressive symptoms differ from changes in interpersonal problems at long-term follow-ups? (3) Do any of these effects (referred to in Questions 1 and 2) have differential outcomes according to treatment modality (i.e., NT and CBT)?

2. Method

2.1. Participants

The sample in the original study (Lopes et al., 2014) comprised 63 patients diagnosed with major depressive disorder (MDD; American Psychiatric Association, 2000) with moderate severity at the onset of the study [Global Assessment of Functioning (GAF, American Psychiatric Association, 2000): $M=59.84$ ($SD=10.47$)]. Some patients (20.6%) were included in the sample with secondary anxiety diagnoses or symptoms. Two patients (3%) had pre-treatment scores in the functional range of the BDI-II, and seven patients (11%) had scores in the functional range of the OQ-45.2 IR subscale (Lopes et al., 2013). Patients were blindly assigned according to their incoming order, alternating between NT ($n=34$) and CBT ($n=29$). All baseline demographic and clinical characteristics were equivalent for both groups. Patients were on average 35.44 years old ($SD=11.51$), and 81% were female.