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Research report

Cognitive Behavioural Analysis System of Psychotherapy (CBASP) for chronic depression: Clinical characteristics and six month clinical outcomes in an open case series.

John S. Swan [a,*], Robert MacVicar [b], David Christmas [b], Rob Durham [b], Petra Rauchhaus [c], James P. McCullough Jr[d], Keith Matthews [a]

[a] Division of Neuroscience, Medical Research Institute, University of Dundee, Ninewells Hospital and Medical School, UK
[b] Advanced Interventions Service, NHS Tayside and University of Dundee, Level 6, Ninewells Hospital and Medical School, Dundee, DD1 9SY, UK
[c] Dundee Epidemiology and Biostatistics Unit, Division of Population Health Sciences, Medical Research Institute, University of Dundee, UK
[d] Department of Psychology, Virginia Commonwealth University, Richmond, USA

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ABSTRACT

Background: Evidence-based guidance on how best to treat chronic depression is limited. Cognitive Behavioural Analysis System of Psychotherapy (CBASP) has shown some promise with this 'difficult-to-treat' clinical group. This case series was designed to assess the acceptability and utility of this novel treatment in routine clinical practice within the U.K. National Health Service.

Methods: We offered an open trial of CBASP to a cohort of 115 referred patients within primary and secondary care. Diagnostic interview and standardised outcome measures were administered before and after 6 months of CBASP with a trained, accredited therapist.

Results: Seventy-four patients entered therapy, with 46 completing. 30% met criteria for remission ($\leq$ 8 HRSD-24 score) and a further 30% met criteria for clinically significant change ($>$ 8 and $\leq$ 15 HRSD-24 plus 50% reduction in baseline score). Thirty-nine per cent made "No change". Group measures of quality of life, social functioning and interpersonal functioning also improved.

Limitations: This was an open study design with a moderate sample size and no control group. Ratings were not completed using a blinded procedure.

Conclusions: CBASP is an acceptable therapy for a large proportion of patients with chronic depression and was associated with clinically significant change in 60% of completers.

1. Introduction

Depressive episodes are conceptualised as being 'chronic' when diagnostic criteria for Major Depression are met continuously for two years or more with fewer than 8 weeks of remission (APA, 2000). One in five patients with a major depressive episode develop a chronic course of illness and chronic depression accounts for around half of all patients being treated in mental health care systems. Approximately 3% of the adult population in the Western world experiences a chronic Major Depressive Episode (Kessler et al., 1994; Arnow and Constantino, 2003; Torpey and Klein, 2008) and the mean duration of chronic episodes falls within the range of 17–30 years. This contrasts with a mean duration of 20 weeks for non-chronic episodes (Gilmer et al., 2005; Kocsis et al., 2008). It should be noted that all forms of depression impact adversely quality of life, social and occupational functioning (Ustun et al., 2004; Wittchen et al., 2011). Evidence indicates that these effects are more pronounced in the more chronic forms of the disorder (Wells et al. 1992). Those who develop chronic depression can expect reduced wellbeing leading to higher use of health services, more periods of illness, longer spells in hospital, higher rates of self-harm and reduced economic and social circumstances (Howland, 1993; Arnow and Constantino, 2003; Torpey and Klein, 2008).

The past 20 years have led to a clearer definition of the nature, characteristics and effects of chronic depressive disorders but treatment efficacy has not kept up with our ability to describe the phenomenon. Some pharmacological therapies have been shown to exert beneficial effects (De Lima et al., 1999; Kocsis et al., 2003; Cuijpers et al., 2010); however evidence supporting the efficacy of specific psychological therapies is, at best, modest (Stimpson et al., 2002; Cuijpers et al., 2010). Time limited, depression-specific therapies such as Interpersonal Therapy (IPT) (Klerman et al., 1974, Klerman et al., 1984) and Cognitive Behavioural Therapy for Depression (CBT-D) have been found to produce remission rates similar to those with antidepressant medication in studies of patients with acute major

* Correspondence to: University of Dundee, Advanced Interventions Service, Level 6, Ninewells Hospital and Medical School, Area 7, Level 6, South Block, Dundee, DD1 9SY, UK. Tel.: +44 1382 878742.
E-mail addresses: johnswan@nhs.net, jsswan@dundee.ac.uk (J.S. Swan).

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depression (Hollon et al., 2002), but these treatments have not been shown to be as efficacious when applied in the context of chronic depression (McCullough, 2000; Cuijpers et al., 2010)

Specific clinical guidelines for the treatment of chronic depression are sparse. The UK National Institute for Health and Clinical Excellence guideline for the treatment of depression (NICE 2009) suggests that the diagnosis, and hence the choice of treatment of depression should not simply rely on "symptom count" and that depression should be assessed and categorised by taking account of "both the degree of functional impairment and/or disability… *and* the duration of the episode". However this guideline only classifies depression in terms of "severities of depression" and denotes sub-threshold, mild, moderate and severe depression. These categories or distinctions *are* based on symptom count and degree of impairment; no consideration or guidance is given to the effect of symptom burden or impairment, and hence choice of treatment, in the context of the duration of episode. Therefore, the guidance contained within the NICE depression guide is problematic when considering evidenced-based psychotherapies for chronic depression.

Cuijpers et al. (2010) conducted a meta-analysis of 16 randomised trials examining the effects of psychotherapy specifically on chronic depression. Psychotherapy was found to have a small, but significant, effect ($d=0.23$). Combination treatment (with medication) was more effective than either medication or psychotherapy alone. Twenty one psychological therapies were examined including Cognitive Behavioural Therapy, Interpersonal Therapy and 8 remaining "other" studies. The Cognitive Behavioural Analysis System of Psychotherapy model (CBASP) was listed in the "other" category. Cuijpers et al. discussed possible reasons for the small overall effect size. The identification of small sample sizes and poor study design were notable, but one study was highlighted – the study of CBASP by Keller and colleagues – which was described as the most influential study in terms of sample size, effect size and as an exemplar of the possible effect of psychotherapy in patients with chronic depression.

CBASP was specifically formulated to meet the challenges and clinical requirements of the chronically depressed patient. The uniqueness of CBASP as a therapy cannot be understood in isolation from consideration of the idiosyncratic psychopathology of chronic depression. In attempting to transform habitual and treatment resistant patterns of behaviour, CBASP therapists choreograph a collaborative focus on resolving current problems of living using behavioural analytic procedures. In CBASP, patients are perceptually connected/re-connected with the interpersonal consequences of their behaviour. Once the perception of a functional connection between behaviour and consequences is learned, the patient is taught the behavioural skills necessary to bring about more empathically responsive/appropriate interactions in their specific interpersonal setting. The emphasis is on behavioural social problem-solving; cognitions are important but only in as much that they lead to environmental-social consequences. Simultaneously, CBASP therapists deliberately manage transference issues (learned interpersonal expectancies) within the therapeutic relationship. These learned expectancies have their roots in developmental histories of early adverse life events. The way CBASP therapists manage and modify these transference issues and the way they understand and manage their own reactions to the patient's learned expectancies, make CBASP a unique model when compared to other treatments for depressive disorders.

In a multicentre randomised controlled trial in the USA, Keller et al. (2000) compared the acute (12 week) efficacy of an antidepressant medication (nefazodone) both to CBASP when administered alone and to a condition where the drug was administered with CBASP. A total of 681 patients meeting criteria for the different subtypes of chronic depression and with a baseline HRSD-24 score of at least 20, were treated with nefazodone alone (titrated to a dose of 600 mg, $n=220$); CBASP alone (16–20 sessions, $n=216$); or a combination of both, ($n=226$). Post-therapy remission and rates of improvement (based on HDRS-24 scores) were: nefazodone (48%); CBASP (48%); combination (73%) (Keller 2000). A secondary analysis of these data suggests that psychotherapy in the form of CBASP provides additional benefit for those with a history of early adverse life events or childhood trauma (Nemeroff et al., 2003). However, in a more recent study comparing CBASP with supportive psychotherapy as an *adjunct* to pharmacotherapy in the management of treatment-resistant chronic depression (the REVAMP study), Koscis and colleagues failed to demonstrate a difference between the therapies, or an advantage over medication alone (Kocsis et al., 2010). The REVAMP study, however, deviated significantly from the original CBASP study design: (1) pharmacotherapy alone was administered during the acute phase I; (2) the non and partial responders were given an "augmented" dose of psychotherapy (CBASP or Supportive Therapy) in Phase II; (3) the majority of subjects opted for pharmacotherapy at the outset of the study; and (4) the mean number of CBASP psychotherapy sessions was fewer than thirteen (Schramm, 2010). There were also some significant differences in the clinical characteristics of the patients in the two studies. These key differences may help explain the failure to replicate findings from the Keller study.

In a small randomised controlled trial ($n=30$), in a European sample (Germany), a course of CBASP (mean number sessions=21.2), was shown to have roughly equivalent efficacy to a similar course of IPT (based on clinician rated depressive symptoms). Eligible patients were required to have a diagnosis of early-onset depression with a baseline HRSD of ≥ 16 (mean 23.2) and were required to be drug free prior to and for the duration of the study. Seventy two per cent of patients ($n=21$) had previously experienced psychotherapy with only 21% ($n=6$) having had no prior treatment of any kind (Schramm et al., 2011).

In the current study, the primary objective was to conduct an extended case-series of CBASP delivered by trained therapists to chronically depressed patients in order to test the feasibility, acceptability and utility of this approach within the context of a publicly-funded national healthcare system (UKNHS). In this paper we present a detailed description of the clinical characteristics of the cohort and address three main questions:

1. What proportion of patients would agree to a trial of CBASP?
2. Would offering 20 h of therapy within a 6 month period be a viable target or "dose" of therapy in future studies of CBASP?
3. What proportion of patients would meet criteria for improvement and remission within this 6 month period?

2. Methods

2.1. Participants

We recruited a cohort of patients who met diagnostic criteria for chronic depression and who were representative of patients routinely seen within secondary care mental health services in the UK. All participants provided written informed consent. Ethical approval for the conduct of this study was provided by the East of Scotland Research Ethics Service. Referrals of adult patients (≥ 18 years) with a primary diagnosis of chronic depression were invited from primary, secondary and tertiary mental health services located in Tayside and Lothian, Scotland, UK.

2.2. Inclusion criteria

1. The presence of chronic major depressive disorder based on DSM-IV using the Mini International Neuropsychiatry Interview V.5 (MINI) (Sheehan et al., 1998), or a recurrent major depressive disorder with incomplete remission between episodes (APA 2000).