Journal of Affective Disorders 147 (2013) 101–106

Contents lists available at SciVerse ScienceDirect

Journal of Affective Disorders

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

Research report

Brief dynamic therapy and depression severity: A single-blind, randomized study

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ARTICLE INFO

Article history:
Received 10 September 2012
Received in revised form
23 October 2012
Accepted 23 October 2012
Available online 20 November 2012

Keywords:
Depressive disorders
Brief dynamic therapy
Supportive psychotherapy
Psychotherapy
Depression severity

ABSTRACT

Background: Brief dynamic therapy (BDT) has been shown to be effective in treating depressive disorders. Nevertheless, whether its effect is related to the severity of depression is still unknown. The aim of this study was to analyze whether the efficacy of BDT is related to severity of depressive symptoms in patients with mild to moderate unipolar depressive disorders.

Methods: A randomized clinical trial compared BDT with brief supportive psychotherapy (BSP) in 88 outpatients with depressive disorders. Two subgroups of patients were considered for statistical analysis: with mild depressive disorders (HAM-D_{17} baseline score: 8–13) and with moderate depressive disorders (HAM-D_{17} baseline score: 14–18). Patients were assessed at start of treatment (baseline-T0), at the end of treatment (T1) and at 6-month follow-up (T2).

Results: In the subgroup of patients with mild depressive disorders, no statistically significant differences emerged between the two treatments on all efficacy measures. In the subgroup of patients with moderate depressive disorders, the remission rates of patients treated with BDT were higher than those of patients treated with BSP at 6 month of follow-up (90.5% vs. 34.8%: $p < .005$).

Limitations: The sample size was relatively small; a longer follow-up period should be considered to assess the efficacy of BDT in terms of prevention of recurrences.

Conclusions: The efficacy of BDT in treating depressive disorders is higher in moderate than in mild depression.

1. Background

A recent meta-analysis investigating the efficacy of specific psychotherapeutic techniques in depression (Driessen et al., 2010a) underlies that when different types of psychotherapies prove to be superior to nonspecific controls (whether pill-placebos or nonspecific psychotherapy controls) such differences are only apparent among more severely depressed patients. These results suggest that nonspecific processes may be sufficient to produce change among patients with less severe depressions but that specific techniques may be required for patients with more severe depressions (Hollon and Ponniah, 2010).

Among the specific models of short-term psychotherapies, the brief dynamic therapy (BDT) is becoming more important and has made significant contributions in the treatment of depressive disorders giving a particular care to evaluation of results and applicability in public health services (Driessen et al., 2010a; Churchill et al., 2001; Salminen et al., 2008; Cuijpers et al., 2008; Imel et al., 2008; Rosso et al., 2009; Abbass et al., 2011; Bloch et al., 2012).

Recent studies suggest that BDT is an effective psychological treatment that works also after the end of treatment sessions (Abbass and Driessen, 2010; Driessen et al., (2010b)). In comparison with non-specific supportive psychotherapies, for patients treated with BDT a significant advantage was found in post-treatment observations (Maina et al., 2005). Similarly, some studies evidenced that the benefit of adding BDT to medication in the acute treatment of major depressive disorder is significantly higher over a subsequent six-month continuation phase (Abbass 2006; Maina et al., 2007). Moreover, patients treated with BDT combined with pharmacotherapy during their first major depressive episode seem less likely to experience a recurrence over a subsequent 48-month treatment-free follow-up (Maina et al., 2009). Further understanding of how depression responds to brief dynamic therapy is important to direct treatment strategies. Up to now, there have been no studies examining whether the effect of BDT is related to severity of depressive symptoms. This was the purpose of our study.

2. Methods

2.1. Sample

Subjects were recruited from the outpatient waiting list for BDT at the Mood and Anxiety Disorders Unit, Department of Neuroscience of the University of Turin, Italy. The criteria used for being included in the BDT waiting list were (a) patients

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http://dx.doi.org/10.1016/j.jad.2012.10.017

requesting a psychotherapeutic approach, (b) the presence of a focal problem and/or of a recent precipitant life event – as suggested by Malan (1963), (1976) and (Horowitz et al. (1997) – and (c) age 18–65 years. Exclusion criteria were (a) evidence of mental retardation, lifetime history of organic mental disorders, psychotic disorders, bipolar disorders or substance abuse and (b) severe axis II psychopathology (cluster A personality disorders, antisocial personality disorder and borderline personality disorder according to DSM-IV-TR).

Patients recruited from the BDT waiting list for the present study had also to fulfil the three following inclusion criteria: (1) main diagnosis of depressive disorder (major depressive disorder, dysthymic disorder, depressive disorder NOS, adjustment disorder with depressed mood) according to DSM-IV-TR; (2) a baseline score on the 17-item Hamilton Rating Scale for Depression (HAM-D17) >7 and <19 according to the American Psychiatric Association's Handbook of Psychiatric Measures which defines mild depression as HAM-D scores from 8 to 13 and moderate depression from 14 to 18 (Rush et al., 2008; Fournier et al., 2010); (3) written informed consent. Further, additional exclusion criteria for the investigation were: (1) current psychopharmacological drug treatment, (2) suicide risk evaluated as item 3 of the HAM-D17 >2 and/or on the basis of the clinical judgment, (3) concomitant severe or active neurological or physical disease. The protocol was approved by the local Ethical Committee.

Two hundred and forty-four subjects of the waiting list were screened consecutively for the inclusion in this study: 156 were excluded (27 with main diagnosis other than depressive disorder, 24 with HAM-D_{17} score ≥ 19, 103 already in treatment with antidepressant pharmacotherapy, 2 for concomitant severe physical disease) and 88 were considered because they fulfilled the requirements.

2.2. Procedure

A randomized parallel-group design was addressed to estimate the relative benefit of BDT over a non-specific supportive intervention (brief supportive psychotherapy—BSP) in patients with unipolar depressive disorders, across a range of initial symptom severity. Patients were allocated randomly to BDT or BSP by the study recruiter, who drew one of two coloured balls from a bag, the assignment of each therapy to a different coloured ball having been defined at the start of the study and maintained until the end of the recruitment period.

The trial was preceded by a 2-week period in which the diagnosis was assessed by means of the Structured Clinical Interview for DSM-IV axis I and II disorders (First and Spitzer (1997a, b)), the inclusion and exclusion criteria were checked. At the end of the acute treatment phase with BDT or BSP, the patients entered in a 6-month follow-up period.

Patients were treated by psychotherapists (psychiatrists, psychologists, or advanced supervised resident in psychiatry or clinical psychology).

2.3. Treatments

Brief Dynamic Therapy: the primary objective of BDT is to enhance the patient's insight into repetitive conflicts (intrapsychic and interpersonal) and trauma that underlie and sustain the patient's problems. The principal instruments of BDT are interpretation and clarification. The psychotherapeutic technique we apply in our Department as BDT derives from Malan's focused, short-term psychoanalytic psychotherapy (Malan, 1976). According to this model the therapist makes use of the actual relationship and attends to linkages with past significant relationships. In addition, to enhance insight, this psychotherapy provides a corrective emotional experience in which old and current traumas, "shameful" secrets and other warded off feelings and memories are brought to light and expressed in presence of the therapist. This kind of technique is supported by meta-analysis (Diener et al., 2007; Abbass et al., 2009) that found emotion focused brief dynamic therapies outperform more than insight based short term therapy models. An experienced BDT therapist who reviewed case notes and supervised treatment adherence according to manuals weekly monitored each BDT therapist (Horowitz et al., 1997; Malan, 1963, 1976).

Brief Supportive Psychotherapy: the primary objective of supportive therapy is to improve the patient's immediate adaptation to his/her life situation. Principal instruments are reassurance and encouragement and the treatment involves advice, praise and emphasis on strengths and talents. The treatment adherence of therapists was facilitated by strict compliance with manuals (Novalis et al., 1993).

In both therapies patients were told from the outset that their treatment would be time-limited with a number of sessions ranging from 15 to 30.

The principles of the technique of BDT and BSP have been already detailed in our previous works on this topic (Maina et al., 2005, 2007).

2.4. Clinical assessment

The primary outcome measure employed was the HAM-D_{17}. Moreover, patients were assessed by the Clinical Global Impression for Severity (CGI-S), Hamilton Rating Scale for Anxiety (HAM-A) and Sheehan Disability Scale (SDS).

Patients assigned to the two treatment strategies were assessed at the start of the treatment [time 0 (T0): baseline], at the end of the treatment [time 1 (T1)] and at the end of the 6-month follow-up phase [time 2 (T2)]. In addition, all patients were informed to contact their psychiatrist every time they experienced a worsening of symptoms; in this case, another evaluation was conducted by the same rating scales.

Two raters assessed all patients: they were 2 psychiatrists who did not participate in the study as therapists and were kept blind with respect to the treatment assignment. The patients were advised not to talk to the evaluators about the type of psychotherapy they were undergoing. In the early phase of the study, interrater agreement on the diagnosis as well as the classification regarding the clinical features of major depressive disorder were ascertained.

The interrater reliability of DSM-IV diagnosis was good ($k=0.79$, 95% confidence interval$=0.71$–0.87). To determine the interrater reliability, the two raters simultaneously assessed 10 depressed subjects before the start of this study; the score obtained by our raters on HAM-D_{17} correlated above 0.90.

2.5. Statistical analyses

All statistical analyses were performed by SPSS software version 17.0. The results of the statistical comparisons of the treatment groups were presented as two-sided p-values rounded off to 3 decimal places. The criterion for statistical significance in all comparisons was a p-value <0.050.

Analysis of variance was performed to test the comparability of continuous variables (index age and educational level) and to test intergroup differences in rating scale scores (HAM-D_{17}, HAM-A, CGI, SDS).

Pearson's χ^2 calculations were used to compare sex ratio, marital status and occupational status among the groups. Pearson's χ^2 calculations (two-sided; $p<0.05$) were also used to