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The impact of comorbid personality difficulties on response to IAPT treatment for depression and anxiety

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ABSTRACT

The UK's Improving Access to Psychological Therapies (IAPT) initiative provides evidence-based psychological interventions for mild to moderate common mental health problems in a primary care setting. Predictors of treatment response are unclear. This study examined the impact of personality disorder status on outcome in a large IAPT service. We hypothesised that the presence of probable personality disorder would adversely affect treatment response.

Method: We used a prospective cohort design to study a consecutive sample of individuals (n = 1249).

Results: Higher scores on a screening measure for personality disorder were associated with poorer outcome on measures of depression, anxiety and social functioning, and reduced recovery rates at the end of treatment. These associations were not confounded by demographic status, initial symptom severity nor number of treatment sessions. The presence of personality difficulties independently predicted reduced absolute change on all outcome measures.

Conclusions: The presence of co-morbid personality difficulties adversely affects treatment outcome among individuals attending for treatment in an IAPT service. There is a need to routinely assess for the presence of personality difficulties on all individuals referred to IAPT services. This information will provide important prognostic data and could lead to the provision of more effective, personalised treatment in IAPT.

1. Introduction

In 2008, the Improving Access to Psychological Therapies (IAPT) programme was established in England, in order to improve access to psychological interventions for people with depression and anxiety. IAPT services offer a single point of access for evidence-based psychological therapies that are recommended by the National Institute of Health and Clinical Excellence (NICE) for mild to moderate anxiety or depression (e.g. cognitive behaviour therapy; CBT) (Clark, 2011; Layard et al., 2006). IAPT services now receive almost 900,000 referrals per annum with more than half of referred individuals entering treatment (Community and Mental Health team Health and Social Care Information Centre, 2014, 2015; Gyani, Shafran, Layard, & Clark, 2011). The services use a 'stepped care' approach for the delivery of time-limited, focused psychological treatment (high or low intensity intervention). Regular outcome and session-by-session monitoring data are collected via validated questionnaires of social functioning and symptoms, allowing progress to be routinely tracked.

IAPT services are commissioned with the remit of improving the health and well-being of their clients. One of the Key Performance Indicators that IAPT services are evaluated on is the rate of people 'moving towards recovery'. This has been operationally defined as an individual moving from a 'case' at pre-treatment to 'non-case' at post treatment based on scores on specific symptom measures for depression and anxiety. Recent national reports indicate that approximately 45% of those entering IAPT services achieve recovery status at the end of treatment and one report found that only 3

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national sites achieve a 50% recovery target (Community and Mental Health team Health and Social Care Information Centre, 2014, 2015; Gyani et al., 2011). Little is known about what characteristics predict an individual's response to treatment in IAPT services and the identification of predictors of treatment outcome could enable services to tailor their interventions more effectively and improve outcomes.

Although CBT is generally associated with medium-to-large effect sizes for depression and anxiety disorders (Butler, Chapman, Forman, & Beck, 2006; Cuijpers et al., 2013, 2014; Hoffman & Smits, 2008; Olatunji et al., 2014; Twomey, O'Reilly, & Byrne, 2014), there is heterogeneity in outcome, with initial symptom severity being an established risk factor for poorer treatment outcome (Haby, Donnelly, Corry, & Vos, 2006). Other predictors of poor response to CBT, and more specifically IAPT treatment, are more elusive, although a potentially important prognostic factor is the presence of co-morbid personality difficulties. The presence of a comorbid personality disorder has been shown to adversely affect treatment outcome for depression (e.g. Gorwood et al., 2010; Newton-Howes, Tyrer, & Johnson, 2006) and specific personality disorder diagnoses also appear to be associated with a poorer prognosis for certain anxiety disorders (Black, Wesner, Gabel, Bowers, & Monahan, 1994; Hansen, Vogel, Stiles, & Götestam, 2007; Steketee, Chambless, & Tran, 2001; Telch, Kamphuis, & Schmidt, 2011). However, the findings are mixed since other studies report null effects (e.g. Joyce et al., 2007; Kampman, Keijsers, Hoogduin, & Hendriks, 2008). Therefore personality disorder may be a highly relevant prognostic factor for IAPT treatment.

Individuals with a personality disorder suffer from high rates of comorbid depression and anxiety (Fribourg, Martinussen, Kaiser, Øvergard, & Rosenveinge, 2013; Zanarini et al., 1998). Moreover, compared to individuals without a co-morbid personality disorder, those with a co-morbid personality disorder may experience more episodes of depression and anxiety in the past, and tend to experience a more chronic course of illness (Gunderson et al., 2008). There are, however, no data available on the prevalence or impact of personality disorder in individuals accessing IAPT services. The prevalence of personality disorder among those attending primary care services (a setting from which substantial numbers of IAPT referrals derive) is known to be high (Moran, Jenkins, Tylee, Blizard, & Mann, 2000). Potentially, IAPT services may therefore be seeing large numbers of people with hitherto unrecognised personality difficulties or frank personality disorder. It is unclear whether the occurrence of these difficulties has an adverse impact on the effectiveness of psychological treatment offered by IAPT services.

Using a prospective cohort study design, we set out to examine whether the likely presence of personality disorder independently predicted treatment outcomes in a large established IAPT service in London. Based on the existing literature, we hypothesised that increased risk of a personality disorder would independently predict higher levels of symptomatology, greater functional impairment, and persistent caseness and reduced change at end of treatment. Secondary hypotheses were that, compared to individuals at lower risk of personality disorder, individuals at high risk of personality disorder would be more likely to drop out of treatment.

2. Method

2.1. Setting

Southwark Psychological Therapies Service (SPTS) is one of the 35 UK sites that initially implemented the IAPT programme. The majority of referrals are from the GP or self-referrals. Individual referrals are reviewed and clients are asked to complete an assessment battery, which includes a variety of demographic and clinical questionnaires (see Measures below), by post. Individuals are then offered an initial assessment appointment with a clinician, either on the telephone or face to face. The treatment options are discussed with the individual and a treatment plan is collaboratively agreed based on a number of factors, such as symptom severity, patient choice, and logistics. CBT is the predominant approach adopted by the service in both low and high intensity interventions.

2.2. Population, sample and data extraction

IAPTus is an online, secure electronic database where clinicians input data routinely collected on clients. For the purposes of this study, data were extracted from the IAPTus electronic patient database for all individuals who had attended an initial assessment session (phone or face to face) between January 1st 2012 and December 31st 2012 inclusive and who had a rating of personality disorder ($n = 1249$). All individuals were adults aged 18 or above. Some individuals were referred more than once during the specified time period and to ensure independence of data, only one treatment episode per person was included in the analysis. Of the 1249 individuals, 1005 individuals (81%) had end of treatment ratings of symptoms and these individuals formed the analytic sample.

2.3. Measures

The assessment battery includes validated self-report questionnaires for symptoms and functioning. Those listed below were used in analyses for the present study. Demographic data were collected via the initial assessment form. Clinical details (number of sessions, treatment allocation, and reason for end of treatment) were recorded by the treating therapist.

2.3.1. Patient health questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001)

This is a validated 9-item measure of depression completed at initial assessment and every clinical contact. A score of ≥ 10 is considered to be of clinical significance and is used as a cut-off to identify caseness. The PHQ-9 has good internal consistency when applied in primary care populations ($\alpha = .89$; Kroenke et al., 2001).

2.3.2. Generalised anxiety disorder assessment (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006)

This is a validated 7 item measure of anxiety completed at initial assessment and every clinical contact. A score of ≥ 8 is considered to be of clinical significance and is used as a cut off to identify caseness. Although developed to measure generalised anxiety disorder, the measure has satisfactory psychometric properties for detecting a range of anxiety disorders (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007) and has good internal consistency when applied in primary care ($\alpha = .92$; Spitzer et al., 2006).

2.3.3. Work and social adjustment scale (W&SAS; Mundt, Isaac, Shear, & Greist, 2002)

This is a validated 5-item measure of impaired functioning completed at the initial assessment and every clinical contact. The W&SAS assesses the impact of an individual's mental health difficulties on their work, home management, social leisure activities, private leisure activities and relationships. The W&SAS has good internal consistency when applied in