



Does migration affect the outcome of inpatient psychotherapy? Results from a retrospective cohort study



Jan F. Wiborg*, Eveline Ben-Sliman, Silke Michalek, Wolfgang Tress, Ljiljana Joksimovic

Department of Psychosomatic Medicine and Psychotherapy, Heinrich Heine University Düsseldorf, Germany.

ARTICLE INFO

Article history:

Received 13 January 2016

Received in revised form 17 May 2016

Accepted 20 June 2016

Available online xxxx

Keywords:

Migration

Inpatient Psychotherapy

Treatment Outcome

ABSTRACT

Objective: Reliable data to determine whether migrant patients benefit sufficiently from evidence-based mental health interventions are scarce. Our aim was to examine the effect of migration on the outcome of inpatient psychotherapy.

Methods: We conducted a retrospective cohort study and predicted the course of the global severity index of the Symptom Checklist 90 during therapy based on data from our routine clinical practice ($N = 542$). We used mixed models for our analysis and included relevant clinical characteristics.

Results: One hundred and twenty-one patients of our sample had a history of migration which was consistently associated with more symptoms at baseline assessment. Patients with direct experiences of migration had the highest level of symptoms before therapy but also showed the largest decrease of symptoms during therapy ($B = -0.09$, $SD = 0.04$, $p = 0.030$). This interaction effect could be accounted for by our clinical variables. Patients with indirect experiences of migration did not differ from other patients in their level of improvement ($B = -0.05$, $SD = 0.04$, $p = 0.149$).

Conclusion: According to our preliminary data, migration does not seem to negatively affect the outcome of inpatient psychotherapy. Limitations of these promising findings are discussed together with the strong need for more advanced studies in this area of research.

© 2016 Elsevier Inc. All rights reserved.

1. Introduction

The challenge of providing adequate care to migrant patients in mental health settings has received increasing attention during the past years [1,2]. Recent developments such as the humanitarian crisis in the Middle East have further brought this important issue to the attention of policy makers, service providers and clinicians. As a consequence, there is a growing need for reliable data about the appropriateness of commonly provided mental health interventions for migrant patients. Current review articles have pointed out that such data are still largely missing with potentially vital consequences for the generalisability of the treatment effects of evidence-based interventions [3,4]. One of the areas in which there is a particular salient lack of studies is inpatient psychotherapy. There is substantial evidence from clinical studies that this type of intervention provides effective help for the more heavily-burdened patient [5,6]. Yet, virtually none of the available studies has focused on the influence of migration on the effects of this type of intervention. We examined treatment outcome data from

our routine clinical practice to analyse whether migration affects the outcome of inpatient psychotherapy.

2. Methods

2.1. Design and Sample

We included the routinely collected anonymised data from 542 consecutive patients with admission to our psychosomatic clinic between January 2011 and December 2014. Of the 542 included patients, 317 received treatment at our inpatient clinic and 225 at our day clinic where patients were allowed to sleep at home at night. Both groups received the same treatment program which consisted of a set of psychodynamically oriented interventions mostly delivered in groups. Main diagnosis and reason for admission was an affective disorder in most cases ($n = 421$). A majority of patients had at least one comorbid psychiatric disorder. Patients were assessed at the moment of admission (baseline), about four weeks later (interim) and at the moment of discharge (post). Missing data were 30% or less on all three assessments (except one item on the Inventory of Interpersonal Problems with 39%). Strategies for the imputation of missing data will be discussed in the statistical analysis section. The retrospective design of this study was approved by the

* Corresponding author at: Department of Psychosomatic Medicine and Psychotherapy, Heinrich Heine University Düsseldorf, P.O. Box 101007, 40001 Düsseldorf, Germany.
E-mail address: Jan-Frederic.Wiborg@ivr.de (J.F. Wiborg).

medical ethics committee of the Heinrich Heine University Düsseldorf (Germany).

2.2. Instruments

The global severity index (GSI) of the revised Symptom Checklist 90 (SCL-90) was used to assess the level of symptomatology during therapy [5,7]. The baseline level of posttraumatic stress symptoms was assessed using the total score of the Posttraumatic Stress Scale (PTSS) [8]. The total score of the Inventory of Interpersonal Problems (IIP) was used to assess the level of interpersonal problems at baseline assessment [9]. Item nine (suicidal wishes) of the Beck Depression Inventory (BDI) [10] was used to assess suicidality at baseline assessment with scores larger than zero indicating suicidality.

2.3. Statistical Analysis

Missing data were handled using multiple imputation with five imputations (fully conditional specification) according to the predictive mean matching method [11]. Data from the original sample are presented where pooled data were unavailable. The course of the global severity index (GSI) of the SCL-90 was analysed using linear mixed models analysis. In this analysis, the GSI was included as repeated measure at the within subject level of the model. The three assessments (baseline, interim, posttreatment) of the GSI were nested within the individual patient at the between subject level of the model. The intercept was included as random factor. We computed a basic model with migration and the interaction effects between migration and assessment as fixed effects. In a second step, we added demographic and clinical variables together with the interaction effects between these variables and the factor assessment to the model. This complete model was adjusted for the treatment setting of the individual patient. We used IBM SPSS Statistics 22 for all computations and $p < 0.05$ as threshold for significance.

3. Results

The characteristics of the total sample and the patients with and without a history of migration are presented in Table 1. From the 542 included patients, 121 had a history of migration. A majority of these patients ($n = 82$) were born in Germany but had one or more parent who was born abroad (i.e. indirect experiences of migration) as opposed to patients ($n = 39$) who were themselves born abroad (i.e. direct experiences of migration). Most patients with direct experiences of migration were born in the European Union or other European countries (i.e.

Poland, Switzerland, Austria, Kosovo, Spain, Greece, the Netherlands, Ukraine, Rumania), followed by patients from Asia (i.e. Turkey, Iran, India, Russia, Korea) and single patients from Africa and South America. For one patient with direct experiences of migration, there were no data available about the specific country of origin.

Our linear mixed models analysis (Table 2, basic model) revealed that patients with experiences of migration had significantly higher scores on the GSI at the start of the therapy than other patients of the sample. While all patients improved significantly from baseline to the following two assessments on the GSI ($B = -0.21$, $SD = 0.01$, $p < 0.001$), our analysis of the interaction effects revealed that patients with direct experiences of migration benefited significantly more during the intervention in terms of a decrease on the GSI than other patients. The decrease on the GSI of patients with indirect experiences of migration did not differ significantly from that of others.

When we added demographic and clinical predictors to the model (Table 2, complete model), only the effect of direct experiences of migration on the baseline score of the GSI remained significant. In addition, suicidality and higher levels of posttraumatic stress symptoms and interpersonal problems were positively and significantly associated with the baseline score of the GSI. Patients who had previously been in psychotherapy had significantly lower baseline scores on the GSI. According to the analysis of interaction effects, patients who had more posttraumatic stress symptoms and interpersonal problems at baseline assessment benefited significantly more during the course of therapy, while patients who had already been in psychotherapy at baseline assessment benefited significantly less in terms of a decrease on the GSI. Experiences of migration were no longer significant in this context. The treatment setting did also not yield significance.

4. Discussion

Consistent with previous research [12,13], we found that migrant patients had more severe symptoms at baseline assessment than other patients. However, migration did not negatively affect the course of symptoms during therapy in our sample. Instead, patients with direct experiences of migration improved significantly more than other patients. Subsequent analysis revealed that clinical variables account for this interaction effect. In particular, patients with higher baseline levels of posttraumatic stress symptoms and interpersonal problems were more likely to benefit from the intervention independent of their origin.

These promising findings are generally in line with a number of other preliminary studies which showed that culturally adapted interventions for depressed migrants might be effective [14–17].

Table 1

Characteristics of the sample considering the history of migration of patients.

	Total sample (N = 542)	No history of migration ¹ (n = 420)	History of migration ¹ (n = 121)	
			direct experiences of migration ² (n = 39)	indirect experiences of migration ³ (n = 82)
<i>Demographic data</i>				
Age (in years)	42.6 (13.2)	43.5 (13.2)	42.0 (11.2)	38.0 (12.5)
Female (n)	326 (60%)	248 (59%)	23 (59%)	55 (67%)
Relationship (n)	376 (69%)	284 (68%)	32 (82%)	60 (73%)
Employed (n)	491 (91%)	380 (90%)	35 (90%)	76 (93%)
<i>Clinical data</i>				
Treatment duration (in weeks)	14.7 (7.2)	14.7 (7.1)	13.6 (6.4)	14.8 (8.1)
Previously in psychotherapy	426 (79%)	327 (78%)	34 (87%)	65 (79%)
Suicidality (BDI)	234 (43%)	175 (42%)	18 (46%)	41 (50%)
Level of posttraumatic stress symptoms (PTSS)	27.7 (11.6)	27.0 (11.4)	33.6 (11.6)	28.3 (11.9)
Level of interpersonal problems (IIP)	209.1 (83.6)	206.0 (85.6)	230.0 (72.4)	215.0 (80.6)
Global severity index (SCL-90)				
- baseline assessment	1.25 (0.63)	1.19 (0.60)	1.63 (0.75)	1.36 (0.76)
- interim assessment	1.11 (0.64)	1.06 (0.61)	1.38 (0.83)	1.20 (0.65)
- posttreatment assessment	0.80 (0.60)	0.77 (0.58)	1.02 (0.80)	0.84 (0.64)
Treatment drop-out (n)	74 (14%)	57 (14%)	5 (13%)	12 (15%)

Note. Presented are mean scores (SD) unless otherwise indicated. ¹The numbers of patients with and without history of migration may not add exactly to the total number of patients due to the pooling of data in the context of the multiple imputation of data. ²Patients born abroad. ³Native patients with at least one parent born abroad.

Download English Version:

<https://daneshyari.com/en/article/7325754>

Download Persian Version:

<https://daneshyari.com/article/7325754>

[Daneshyari.com](https://daneshyari.com)