Psykodynamisk terapi i ett framtidsperspektiv – ny kunskap och nya möjligheter

Björn Philips

2013

Disposition

1. Exempel på effektstudier
2. Slutsatser från effektforskningen
3. Varför effektforskning om PDT?
4. PDT i framtiden

A Randomized Controlled Clinical Trial of Psychoanalytic Psychotherapy for Panic Disorder

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Objective: The purpose of this study was to determine the efficacy of panic-focused psychodynamic psychotherapy relative to applied relaxation training, a credible psychotherapy comparison condition. Despite the widespread clinical use of psychodynamic psychotherapies, randomized controlled clinical trials evaluating such psychotherapies for axis I disorders have lagged. To the authors' knowledge, this is the first efficacy randomized controlled clinical trial of panic-focused psychodynamic psychotherapy, a manualized psychoanalytical psychotherapy for patients with DSM-IV panic disorder.

Method: This was a randomized controlled clinical trial of subjects with primary DSM-IV panic disorder. Participants were recruited over 5 years in the New York City metropolitan area. Subjects were 49 adults ages 18–55 with primary DSM-IV panic disorder. All subjects received assigned treatment, panic-focused psychodynamic psychotherapy or applied relaxation training in twice-weekly sessions for 12 weeks. The Panic Disorder Severity Scale, rated by blinded independent evaluators, was the primary outcome measure.

Results: Subjects in panic-focused psychodynamic psychotherapy had significantly greater reduction in severity of panic symptoms. Furthermore, those receiving panic-focused psychodynamic psychotherapy were significantly more likely to respond at treatment termination (73% versus 39%), using the Multicenter Panic Disorder Study response criteria. The secondary outcome, change in psychosocial functioning, mirrored these results.

Conclusions: Despite the small cohort size of this trial, it has demonstrated preliminary efficacy of panic-focused psychodynamic psychotherapy for panic disorder.

(Am J Psychiatry 2007; 164:265–272)

Panic disorder is an ongoing public health problem. Patients with panic disorder report poor physical and emotional health, high prevalence of alcohol and substance abuse, and high prevalence of attempted suicide (1, 2). Medical costs are high for panic disorder: one-half of all primary care visits in the United States are precipitated by physical sensations associated with panic disorder, including dizziness, heart palpitations, chest pain, dyspnea, and abdominal pain (1). Patients with panic disorder account for 20% of emergency room visits (2) and are 12.6 times as likely to visit emergency rooms as the general population (3). Panic disorder patients have the highest rates of morbidity and health care utilization relative to patients with other psychiatric diagnoses and to patients without psychiatric diagnoses (4).

Panic disorder impairs psychosocial functioning through high anxiety, somatic symptoms, restricted life style, increased incidence of comorbid psychiatric conditions, and high rates of suicide and untimely death (1, 4, 5). Panic sufferers in the community have similar health and social consequences to people with major depression (3).

Empirically-Supported Treatments for Panic Disorder

There has been substantial research progress in determining efficacious treatments for panic disorder. Pharmacotherapy and cognitive behavior therapy (CBT) have shown efficacy for panic disorder (6, 7); both have enduring effects (7, 8). Only a few trials have studied combinations of pharmacotherapy with psychotherapy for panic disorder, with mixed results (9–11).

Panic treatment studies of all modalities report substantial proportions of patients (29%–48%) who do not respond to treatments of demonstrated efficacy (8–10). Another meaningful proportion (25%–35% [2, 12–14]) prematurely terminates treatment (9, 10, 12). The need to test additional nonpharmacological treatments for panic disorder derives partly from the need to further investigate

This article is featured in this month's AJP Audio.

Milrod et al. (2007)

- Panikfokuserad psykodynamisk psykoterapi (PFPP) för paniksyndrom
- PFPP vs tillämpad avslappning (24 sessioner)
- 49 patienter (26 + 23)
- Majoritet med agorafobi, vanligt med personlighetsstörning och depression
- PFPP signifikant mer effektiv än TA avs. paniksymptom (ES=0,95), andel förbättrade (73% vs 39%) och funktion (ES=0,74)

Randomized Controlled Trial of Outpatient Mentalization-Based Treatment Versus Structured Clinical Management for Borderline Personality Disorder

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Objective: This randomized controlled trial tested the effectiveness of an 18-month mentalization-based treatment (MBT) approach in an outpatient context against a structured clinical management (SCM) outpatient approach for treatment of borderline personality disorder.

Method: Patients (N=134) consecutively referred to a specialist personality disorder treatment center and meeting selection criteria were randomly allocated to MBT or SCM. Eleven mental health professionals equal in years of experience and training served as therapists. Independent evaluators blind to treatment allocation conducted assessments every 6 months. The primary outcome was the occurrence of crisis events, a composite of suicidal and severe self-injurious behaviors and hospitalization. Secondary outcomes included social and interpersonal functioning and self-reported symptoms. Outcome measures, assessed at 6-month intervals, were analyzed using mixed effects logistic regressions for binary data, Poisson regression models for count data, and mixed effects linear growth curve models for self-report variables.

Results: Substantial improvements were observed in both conditions across all outcome variables. Patients randomly assigned to MBT showed a steeper decline of both self-reported and clinically significant problems, including suicide attempts and hospitalization.

Conclusions: Structured treatments improve outcomes for individuals with borderline personality disorder. A focus on specific psychological processes brings additional benefits to structured clinical support. Mentalization-based treatment is relatively undemanding in terms of training so it may be useful for implementation into general mental health services. Further evaluations by independent research groups are now required.

(Am J Psychiatry 2009; 166:1355–1364)

Borderline personality disorder is characterized by affective instability, impulsivity, interpersonal problems, cognitive distortions, and suicidality (1). Suicide risk is estimated at up to 10% (2). Randomized controlled trials have shown psychological treatments to be effective relative to routine care or other therapies (3–8). However, specialist treatment may show superiority to routine care primarily because it is delivered in a structured, protocol-driven manner by better-trained and better-supervised practitioners. Moreover, the requirement of extensive training and stringent monitoring of adherence to standards for most evidence-based therapies are obstacles to comprehensive implementation across mental health services.

For broad dissemination, treatment for borderline personality disorder should be manualized, with minimal training and supervision demands. A randomized design for assessing such a treatment must meet the following minimal criteria: 1) a comparison group also receiving a manualized, structured treatment with equivalent supervision; 2) delivery of both by professionals trained to similar levels; 3) statistical power to detect relatively small differences; and 4) a representative sample of clinically referred patients with a confirmed diagnosis of borderline personality disorder at high risk of suicide. The present trial of mentalization-based treatment (MBT) was initiated to meet these criteria and reports outcomes after 18 months of treatment.

MBT (9, 10) is a psychodynamic treatment rooted in attachment and cognitive theory. It requires limited training with moderate levels of supervision for implementation by generic mental health professionals. It aims to strengthen patients' capacity to understand their own and others' mental states in attachment contexts in order to address their difficulties with affect, impulse regulation, and interpersonal functioning, which act as triggers for acts of suicide and self-harm (11).

MBT delivered by generic mental health professionals in the context of a partial hospital program was cost-effective and superior to treatment as usual over a period of 36 months (12–14). Treatment effects remained 5 years after all index treatment had ceased (14). The present pragmatic randomized superiority trial investigated MBT as a treatment for suicidal and self-harming patients with borderline personality disorder when delivered in an out-

Bateman och Fonagy (2009)

- Mentaliseringsbaserad terapi (MBT) för borderline personlighetsstörning
- MBT i öppenvård (individ + grupp) vs strukturerad stödjande behandling, 18 mån
- 134 patienter med BPS
- MBT signifikant mer effektivt vid avslut avseende självmords- och självskadehandlingar, sjukhusdagar och psykiatriska symptom
- Skillnaderna var dock små – klar förbättring i båda grupperna
- I tidigare mindre studie (N=38) var MBT överlägset mer effektivt än sedvanlig psykiatrisk vård

Intensive Short-Term Dynamic Psychotherapy for DSM-IV Personality Disorders

A Randomized Controlled Trial

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Abstract: This study evaluated the efficacy and long-term effectiveness of intensive short-term dynamic psychotherapy (ISTDP) in the treatment of patients with DSM-IV personality disorders (PD). Twenty-seven patients with PD were randomized to treatment with ISTDP or a minimal-contact, delayed-treatment control condition. ISTDP-treated patients improved significantly more than controls on all primary outcome indices, reaching the normal ranges on both the brief symptom inventory (1.51–0.51, $p < 0.001$) and inventory of interpersonal problems (1.56–0.67, $p < 0.001$). When control patients were treated, they experienced benefits similar to the initial treatment group. In long-term follow-up, the whole group maintained their gains and had an 83.3% reduction of personality disorder diagnoses. Treatment costs were thrice offset by reductions in medication and disability payments. This preliminary study of ISTDP suggests it is efficacious and cost-effective in the treatment of PD. Limitations of this study and suggestions for future research are discussed.

Key Words: Psychotherapy, short-term, personality disorder, psychodynamic.

(*J Nerv Ment Dis* 2008;196: 211–216)

The empirical foundation for various forms of short-term psychodynamic psychotherapy (STPP) for a broad range of disorders is growing (Abbass et al., 2006; Anderson and Lambert, 1995; Leischsenring et al., 2004). However, the evidence base for its use with patients with personality disorders (PD) remains relatively small. A handful of randomized controlled trials have examined the use of different forms of STPP for PD (Hellerstein et al., 1998; Svartberg et al., 2004; Vinnars et al., 2005; Winston et al., 1994) yet none have studied intensive short-term dynamic psychotherapy (ISTDP), a method that Davanloo (1990, pp. 1–47) developed in the past 20 years specifically for treating patients with PD.

The emphasis of ISTDP is to rapidly help the patient experience unconscious emotions that are leading to unconscious anxiety, symptom disturbances, and various defenses. The main technical interventions are to encourage the awareness and experience of feelings while clarifying and challenging defenses in collaboration with the patient. This process mobilizes "complex transference feelings" with the therapist and simultaneously, the "unconscious therapeutic alliance" which works against the defenses (Davanloo, 1990, pp. 1–47). With the defenses reduced, the patient can then work through unresolved feelings related to broken attachments in the past and other subsequent trauma.

Davanloo's videotape-based research over the past 25 years has resulted in a range of improvements over the method he developed in the 1970s. First, he clarified the types, purpose, timing, and application of each of the main interventions. He elaborated on how to monitor signals of unconscious activation. To broaden the utility of ISTDP, he developed a specialized process called the "graded format" for patients with low anxiety tolerance, depression, somatization, conversion, and dissociative phenomena. (Davanloo, 1990, pp. 47–101) This format, which involves cycles of mobilization of unconscious anxiety and cognitive recapitulation, gradually builds anxiety tolerance making it possible to access unconscious feelings in these more fragile groups of patients. These innovations have greatly increased the proportion of referred patients that are candidates for ISTDP and improved clarity of process compared with earlier iterations of his method (Abbass, 2002b; Davanloo, 2000, pp. 1–37).

ISTDP has appeared clinically effective and cost-effective in case series of mixed psychiatric samples (Abbass, 2002a,b, 2003), in a specialized hospital setting for PD (Cornelissen, 2002), and in a sample of patients with treatment resistant depression and PD (Abbass, 2006). These naturalistic studies suggested the method showed promise for patients with PD leading us to the following randomized controlled trial of ISTDP for PD.

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Supported with grants from the Lions Gate Research Foundation, Dalhousie Medical Research Foundation, Queen Elizabeth II Health Sciences Centre Research Foundation, and the Dalhousie University Department of Psychiatry.

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ISSN: 0022-3018/08/19603-0211
DOI: 10.1097/NMD.0b013e3181662ff0

Abbass et al. (2008)

- Intensive Short-Term Dynamic Psychotherapy (ISTDP) för personlighetsstörningar
- Fas 1: ISTDP, 2-64 sessioner (m=28) vs väntelista
- Fas 2: Kontrollgruppen fick ISTDP
- 27 patienter (14 + 13)
- Borderline ps 44%, tvångsmässig ps 37%, fobisk ps 33%, vanligt med depression och ångest
- ISTDP signifikant mer effektivt än kontrollgrupp avseende psykiatriska symptom och interpersonella problem
- Långtidsuppföljning efter 2 år: 83% reduktion av ps-diagnoser, 74% slutade med psykofarmaka, alla utom en återgick i arbete, besparingar genom terapin tre gånger större än kostnaderna

Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial

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Summary

Background Psychotherapy is the treatment of choice for patients with anorexia nervosa, although evidence of efficacy is weak. The Anorexia Nervosa Treatment of OutPatients (ANTOP) study aimed to assess the efficacy and safety of two manual-based outpatient treatments for anorexia nervosa—focal psychodynamic therapy and enhanced cognitive behaviour therapy—versus optimised treatment as usual.

Methods The ANTOP study is a multicentre, randomised controlled efficacy trial in adults with anorexia nervosa. We recruited patients from ten university hospitals in Germany. Participants were randomly allocated to 10 months of treatment with either focal psychodynamic therapy, enhanced cognitive behaviour therapy, or optimised treatment as usual (including outpatient psychotherapy and structured care from a family doctor). The primary outcome was weight gain, measured as increased body-mass index (BMI) at the end of treatment. A key secondary outcome was rate of recovery (based on a combination of weight gain and eating disorder-specific psychopathology). Analysis was by intention to treat. This trial is registered at http://isrctn.org, number ISRCTN72809357.

Findings Of 727 adults screened for inclusion, 242 underwent randomisation: 80 to focal psychodynamic therapy, 80 to enhanced cognitive behaviour therapy, and 82 to optimised treatment as usual. At the end of treatment, 54 patients (22%) were lost to follow-up, and at 12-month follow-up a total of 73 (30%) had dropped out. At the end of treatment, BMI had increased in all study groups (focal psychodynamic therapy 0·73 kg/m², enhanced cognitive behaviour therapy 0·93 kg/m², optimised treatment as usual 0·69 kg/m²); no differences were noted between groups (mean difference between focal psychodynamic therapy and enhanced cognitive behaviour therapy −0·45, 95% CI −0·96 to 0·07; focal psychodynamic therapy *vs* optimised treatment as usual −0·14, −0·68 to 0·39; enhanced cognitive behaviour therapy *vs* optimised treatment as usual −0·30, −0·22 to 0·83). At 12-month follow-up, the mean gain in BMI had risen further (1·64 kg/m², 1·30 kg/m², and 1·22 kg/m², respectively), but no differences between groups were recorded (0·10, −0·56 to 0·76; 0·25, −0·45 to 0·95; 0·15, −0·54 to 0·83, respectively). No serious adverse events attributable to weight loss or trial participation were recorded.

Interpretation Optimised treatment as usual, combining psychotherapy and structured care from a family doctor, should be regarded as solid baseline treatment for adult outpatients with anorexia nervosa. Focal psychodynamic therapy proved advantageous in terms of recovery at 12-month follow-up, and enhanced cognitive behaviour therapy was more effective with respect to speed of weight gain and improvements in eating disorder psychopathology. Long-term outcome data will be helpful to further adapt and improve these novel manual-based treatment approaches.

Funding German Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung, BMBF), German Eating Disorders Diagnostic and Treatment Network (EDNET).

Published Online October 14, 2013 http://dx.doi.org/10.1016/S0140-6736(13)61746-8

See Online/Comment http://dx.doi.org/10.1016/S0140-6736(13)61940-6

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Introduction

Anorexia nervosa is associated with serious medical morbidity[1,2] and pronounced psychosocial comorbidity.[3] It has the highest mortality rate of all mental disorders[4,5] and relapse happens frequently.[6] The course of illness is very often chronic, particularly if left untreated.[7] Partial syndromes are also associated with adverse health outcomes. Quality of life for patients is poor, and the cost and burden placed on individuals, families,[3] and society is high.[8] The overall incidence of anorexia nervosa is at least eight people per 100 000 per year, with an average prevalence of 0·3% in girls and young women.[9] The severity, poor prognosis, and low prevalence of the disorder are reasons why large randomised controlled trials are needed and why difficulties arise in implementation of treatment studies.[10]

According to international treatment guidelines, psychotherapy is the treatment of choice for patients with anorexia, although no evidence clearly supports the efficacy of any specific form of psychotherapy.[11] Guidelines from the UK's National Institute for Health and Care Excellence (NICE) outline 75 recommendations for the treatment of anorexia nervosa.[12] 74 of these treatments have received a grade of C, meaning that good quality, directly applicable

Zipfel et al. (2013) i Lancet

- Fokuserad psykodynamisk terapi för anorexia nervosa
- PDT, KBT eller optimerad standardbehandling i 10 månader
- 242 patienter (80 + 80 + 82)
- Avslut: BMI ökade i alla grupper, inga signifikanta skillnader (PDT: 0,73 kg/m^2; KBT: 0,93 kg/m^2; TAU: 0,69 kg/m^2)
- 1-årsuppföljning: Fortsatt BMI-ökning, ingen signifikant skillnad mellan grupperna (PDT: 1,64 kg/m^2; KBT: 1,30 kg/m^2; TAU: 1,22 kg/m^2

Psychodynamic Therapy and Cognitive-Behavioral Therapy in Social Anxiety Disorder: A Multicenter Randomized Controlled Trial

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Objective: Various approaches to cognitive-behavioral therapy (CBT) have been shown to be effective for social anxiety disorder. For psychodynamic therapy, evidence for efficacy in this disorder is scant. The authors tested the efficacy of psychodynamic therapy and CBT in social anxiety disorder in a multicenter randomized controlled trial.

Method: In an outpatient setting, 495 patients with social anxiety disorder were randomly assigned to manual-guided CBT (N=209), manual-guided psychodynamic therapy (N=207), or a waiting list condition (N=79). Assessments were made at baseline and at end of treatment. Primary outcome measures were rates of remission and response, based on the Liebowitz Social Anxiety Scale applied by raters blind to group assignment. Several secondary measures were assessed as well.

Results: Remission rates in the CBT, psychodynamic therapy, and waiting list groups were 36%, 26%, and 9%, respectively. Response rates were 60%, 52%, and 15%, respectively. CBT and psychodynamic therapy were significantly superior to waiting list for both remission and response. CBT was significantly superior to psychodynamic therapy for remission but not for response. Between-group effect sizes for remission and response were small. Secondary outcome measures showed significant differences in favor of CBT for measures of social phobia and interpersonal problems, but not for depression.

Conclusions: CBT and psychodynamic therapy were both efficacious in treating social anxiety disorder, but there were significant differences in favor of CBT. For CBT, the response rate was comparable to rates reported in Swedish and German studies in recent years. For psychodynamic therapy, the response rate was comparable to rates reported for pharmacotherapy and cognitive-behavioral group therapy.

(Am J Psychiatry 2013; 170:759–767)

Social anxiety disorder is one of the most prevalent mental disorders, with a lifetime prevalence of 12% and a 12-month prevalence of 7% (1, 2). The disorder has an early onset and a chronic course and can result in severe psychosocial impairments and high socioeconomic costs (3, 4). Social anxiety disorder has secondary effects on other mental disorders (e.g., depression), social role functioning, and help seeking (4). There is evidence from a large body of research that cognitive-behavioral therapy (CBT) is beneficial for patients with social anxiety disorder (5, 6). It has been noted, however, that many psychotherapy studies of social anxiety disorder used small samples or were carried out at only one site, thus limiting generalizability and statistical power (7). In a meta-analysis by Acarturk et al. (6), for example, the sample size per group ranged from seven to 91, with a mean of 22.1, which allows detection of only a large effect size of 0.86 with a power of 0.80 (8). Psychodynamic therapy is frequently used, both in social anxiety disorder and in clinical practice in general (9–12). However, evidence for the efficacy of psychodynamic therapy in social anxiety disorder is scant (13). Thus, further studies of both CBT and psychodynamic therapy of social anxiety disorder are needed, using larger patient samples and multiple study sites.

The Social Phobia Psychotherapy Network (SOPHO-NET) was established to address some of these limitations (14). The SOPHO-NET encompasses several independent but interrelated studies of different aspects of social anxiety

This article is featured in this month's AJP Audio, is an article that provides Clinical Guidance (p. 767), and is discussed in an Editorial by Dr. Milrod (p. 703)

Leichsenring et al. (2013)

- Supportive Expressive Psychotherapy för social fobi
- SEP, KBT (max 25 sessioner) eller väntelista
- 495 patienter (207 + 209 + 79)
- Andel återhämtade: KBT=36%, SEP=26%, VL=9%
- Andel förbättrade: KBT=60%, SEP=52%, VL=15%
- Skillnad mellan behandlingar förklarade 1-3% av variansen i utfall
- Skillnad mellan terapeuter förklarade 5-7% av variansen i utfall

Psychological Medicine, Page 1 of 11. © Cambridge University Press 2010
doi:10.1017/S0033291710000292

ORIGINAL ARTICLE

A randomized clinical trial of cognitive behavioural therapy *versus* short-term psychodynamic psychotherapy *versus* no intervention for patients with hypochondriasis

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Background. Hypochondriasis is common in the clinic and in the community. Cognitive behavioural therapy (CBT) has been found to be effective in previous trials. Psychodynamic psychotherapy is a treatment routinely offered to patients with hypochondriasis in many countries, including Denmark. The aim of this study was to test CBT for hypochondriasis in a centre that was not involved in its development and compare both CBT and short-term psychodynamic psychotherapy (STPP) to a waiting-list control and to each other. CBT was modified by including mindfulness and group therapy sessions, reducing the therapist time required. STPP consisted of individual sessions.

Method. Eighty patients randomized to CBT, STPP and the waiting list were assessed on measures of health anxiety and general psychopathology before and after a 6-month treatment period. Waiting-list patients were subsequently offered one of the two active treatments on the basis of re-randomization, and assessed on the same measures post-treatment. Patients were again assessed at 6- and 12-month follow-up points.

Results. Patients who received CBT did significantly better on all measures relative to the waiting-list control group, and on a specific measure of health anxiety compared with STPP. The STPP group did not significantly differ from the waiting-list group on any outcome measures. Similar differences were observed between CBT and STPP during follow-up, although some of the significant differences between groups were lost.

Conclusions. A modified and time-saving CBT programme is effective in the treatment of hypochondriasis, although the two psychotherapeutic interventions differed in structure.

Received 14 May 2009; Revised 20 January 2010; Accepted 26 January 2010

Key words: Cognitive behavioural therapy (CBT), health anxiety, hypochondriasis, randomized clinical trial (RCT), short-term psychodynamic psychotherapy (STPP).

Introduction

Hypochondriasis is common (Gureje *et al.* 1997) and costly (Barsky *et al.* 2001). The application of cognitive behavioural theories of health anxiety has led to the development of cognitive behavioural therapy (CBT; Salkovskis *et al.* 2003). Such treatment seems appropriate for this problem as hypochondriasis is a cognitive disorder, defined as a preoccupation with illness based on the person's misinterpretation of bodily sensations and other bodily variations (APA, 1995). Hypochondriacal patients can be reluctant to accept psychiatric treatment because they believe themselves to be physically ill, which makes the focus on misinterpretation a particularly useful strategy for engaging patients in treatment (Salkovskis & Warwick, 1986). This strategy has led to a well-defined cognitive behavioural treatment (Salkovskis *et al.* 2003), which has been examined in case studies, uncontrolled trials, and in two controlled trials (Warwick & Marks, 1988; Warwick *et al.* 1996; Clark *et al.* 1998).

Barsky (1996) developed a similar understanding of hypochondriasis as a self-perpetuating disorder of cognition and bodily perception with focus on the cognitive and behavioural amplification of benign bodily symptoms. A treatment model based on this understanding has been examined in two controlled designs. One study included only a few patients (Avia *et al.* 1996) with a waiting-list group as the control, and

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Sörensen et al (2010)

- Ospecifik ”relationell” psykodynamisk terapi utan särskilt fokus för hypokondri
- PDT vs KBT (16 sessioner) vs väntelista
- 80 patienter (20 + 20 + 36)
- 1 PDT-terapeut, 6 erfarna KBT-terapeuter
- KBT var signifikant mer effektivt än PDT och VL avseende hälsoångest
- Ingen signifikant skillnad mellan PDT och väntelista på något utfallsmått
- Liknande skillnader mellan terapierna vid 1-årsuppföljning

Slutsatser 1

- Gemensamt för effektiva varianter av PDT:
- Speciellt utformade för viss problematik
- Gedigen grund i forskning och teori kring etiologi och verksamma terapeutiska principer för den aktuella problematiken
- Aktiv och fokuserad terapeutisk hållning, ofta affektfokuserad

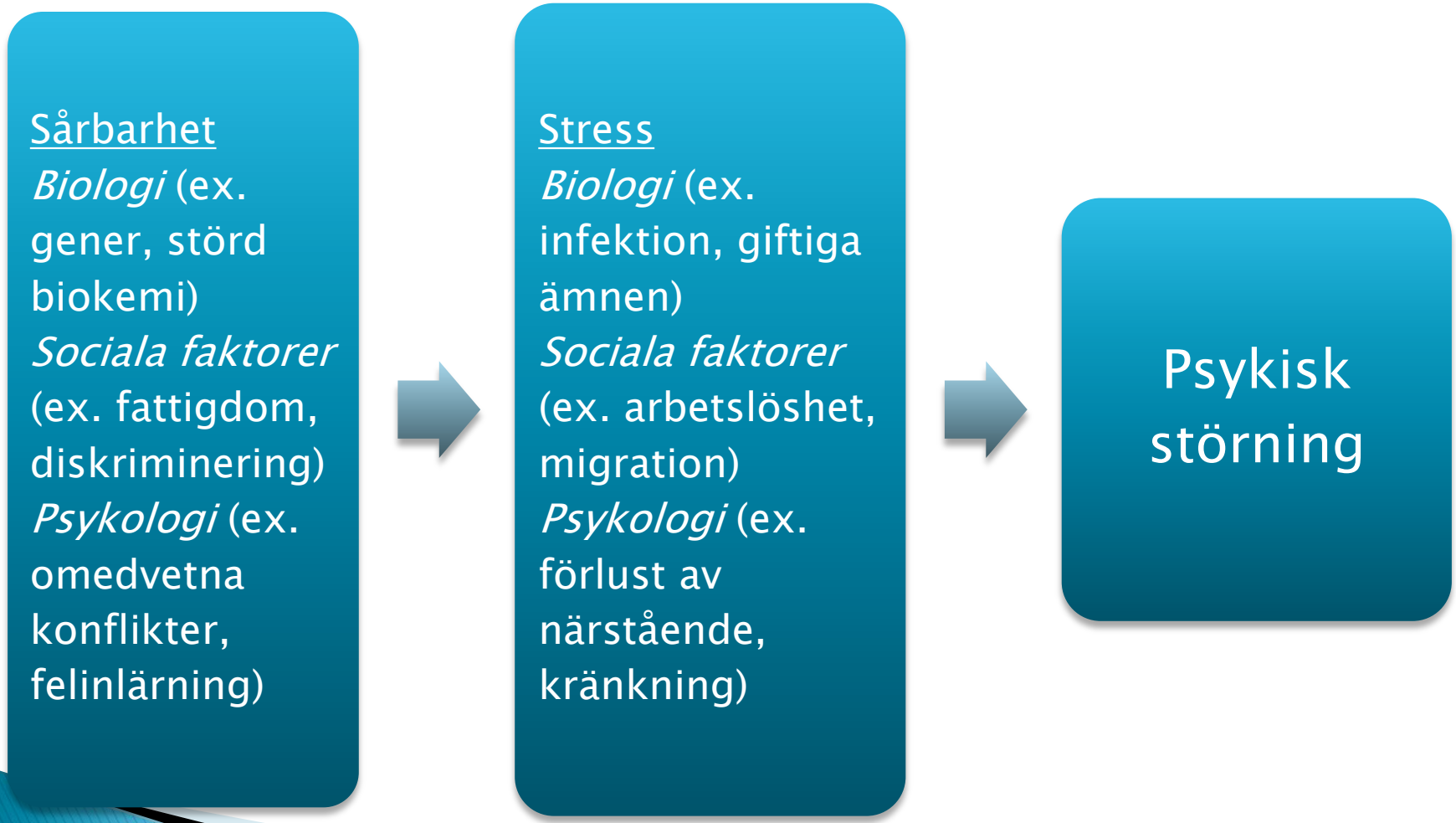
Slutsatser 2

- Gemensamt för mindre effektiva varianter av PDT:
- Allmän ”generisk” variant av PDT utan specialanpassning till problematiken
- Inte grundad i forskning och teori kring etiologi och verksamma terapeutiska principer för den aktuella problematiken
- Mer klassisk psykoanalytisk hållning utan specifikt fokus, trots begränsning till kort tid

Varför effektforskning om PDT?

- Psykoterapi är till för människor med svårt psykiskt lidande och är ofta offentligt finansierad, det vill säga:
- Önskvärt att psykoterapin är till hjälp för den som lider och en klok användning av skattebetalarnas pengar
- Dessa praktiska hänsyn är viktigare än vetenskapsteoretiska invändningar, dvs:
- Effektforskning bör göras även om den är reduktionistisk och inte fångar människan och psykoterapin som fenomen i sin helhet
- Det finns andra teorier och behandlingsmetoder och PDT:s roll måste preciseras

Biopsykosociala sårbarhet-stress-modellen



Förklaringsmodeller

	Psykodyn. & humanistisk	Inlärnings-teori	Trait & biologisk	Social
Sårbarhet	Medfödda behov/drifter i konflikt med omgivningens svar	Inlärnings-historia	Medfödd avvikelse	Social utsatthet
Stress	Aktivering av konflikt eller brist	Stressande stimuli	Biologisk stress	Social stress
Vidmakthål-lande faktor	Inre konflikt eller brist	Ond cirkel	Dysfunktion i hjärnan	Ogynnsam social miljö
Störning	Psykisk störning			

Vilken annan forskning behövs?

- Mer grundforskning om etiologi och vidmakthållande faktorer vid olika slags problematik
- Mer forskning om hur faktorer hos patienten och terapeuten påverkar terapiutfallet, helst stora naturalistiska studier som analyseras med multilevel-analyser
- Mer explorativ forskning om hur terapiprocess och terapirelation hänger samman med terapiutfall, då psykoterapi till stor del är spontan och samskapad

Psykodynamisk terapi i framtiden

Vad behöver vi göra?

Intellektuell uppryckning

- Överge luddig relativism
- Ha en kritisk hållning till en förenklad medicinsk syn på psykoterapi
- Ta del av psykoterapiforskningens fynd
- Stöd genomförandet av mer högkvalitativ psykoterapiforskning
- Stöd systematisk utvärdering av psykoterapi i befintliga verksamheter

Klinisk uppryckning

- Lär terapimetoder som är utformade och visat effektiva för olika typer av problematik, t ex PFPP, MBT, TFP, ISTDP, APT, BRT, IPT
- Var aktiv, engagerad och fokuserad som terapeut (undvik ”as if-psykoanalys”)
- Tänk i termer av vidmakthållande faktorer och verksamma terapeutiska principer
- Videoinspela terapier: använd till egen-, kamrat- eller reguljär handledning
- Större fokus på terapeutisk skicklighet på psykoterapiutbildningar (t ex handledning på videoinspelade terapier)