

Medical (fluoxetine) and psychological (cognitive–behavioural therapy) treatment for premenstrual dysphoric disorder

A study of treatment processes

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Received 13 September 2001; accepted 25 January 2002

Abstract

Objectives: To investigate (i) the differential changes in premenstrual symptoms, mood, cognitions, and coping strategies during two treatments [cognitive–behavioural therapy (CBT) and fluoxetine] for premenstrual dysphoric disorder (PMDD) and (ii) the characteristics of those with good vs. poor outcome post treatment and at 1 year follow-up. **Methods:** Premenstrual symptoms, mood (Hospital Anxiety and Depression Scale, HADS), causal attributions, and use of cognitive and behavioural coping strategies were examined during 6 months of both treatments. The two treatment groups were then combined and divided on the basis of good vs. poor outcome posttreatment and at 1 year follow-up. Baseline measures were used to predict posttreatment outcome, and baseline and posttreatment measures were examined when attempting to

predict outcome at 1 year follow-up. **Results:** Both treatments were equally effective at the end of 6 months (prospective daily diary measure). Fluoxetine treatment had a more rapid effect and greater impact upon anxiety symptoms, while CBT was associated with increased use of cognitive and behavioural coping strategies and a shift from a biomedical to a biopsychosocial causal attribution of premenstrual symptoms. Depressed mood at baseline assessment was associated with poorer response to both treatments, and learning active behavioural coping strategies was associated with a good outcome at 1 year follow-up. **Conclusion:** These results provide evidence of differential treatment effects of fluoxetine and CBT for PMDD and offer information that will enhance clinical decision-making. © 2002 Elsevier Science Inc. All rights reserved.

Keywords: Cognitive–behavioural therapy; Premenstrual symptoms; Process; Psychological; SSRIs; Treatment

Introduction

Both pharmacological and psychotherapeutic treatments have been found to be effective in the treatment of a number of psychological disorders, such as major depression [1,2] and panic disorder [3], as well as problems presenting with both physical and psychological symptoms, such as chronic fatigue [4], postnatal depression [5], and premenstrual syndrome [6,7]. In several of these studies, antidepressants and cognitive–behavioural therapy (CBT) have been compared, and while in general comparable effects have been found, differential effects have also been noted, for example,

adverse effects in response to medication and long-term maintenance of improvements.

In a recent study, we found that fluoxetine (20 mg daily), a selective serotonin reuptake inhibitor (SSRI), and CBT were both equally effective in the treatment of women with premenstrual dysphoric disorder (PMDD), while a combination of treatments offered no additional benefits [8]. However, at 1 year following the cessation of treatment, significantly more of those having had CBT maintained improvement compared to those having had fluoxetine. We concluded that in the short to medium term, patient preference should guide the choice of treatments. However, in order to understand further the nature of change that occurs with these quite different treatments, the current study was carried out to investigate the process of change both during and following treatment with either fluoxetine or CBT. This information might then increase knowledge about the mech-

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anisms of treatment effects, as well as aid treatment decision-making.

The focus here is upon women with moderate to severe premenstrual problems, whom we defined using the DSM-IV criteria of PMDD [1]. It is acknowledged that the definitions of premenstrual problems have proved problematic [9,10], but this operational definition of PMDD was chosen in order to clarify communication about the client group.

There is a paucity of research exploring the process of pharmacological interventions and very little research to date that investigates the process of SSRI treatments such as fluoxetine. Ozeren et al. [11] found that whole blood serotonin, imipramine binding, and platelet serotonin uptake are decreased in the luteal phase in women with premenstrual problems, implying that decreased serotonergic activity has an important causal role in PMDD. In a recent systematic review of the effects of SSRIs for PMDD, it was suggested that the rapid onset of efficacy (within a few days) may reflect SSRI action at a different receptor site from that observed in affective disorders [7]. In a similar review, Romano et al. [12] emphasised the need for further investigation of the causal mechanisms of the treatment.

With regard to the possible mechanisms of CBT, a number of studies have begun to evaluate different components of therapy for women with premenstrual problems. For example, using a group format, Morse et al. [13] found that women in a coping skills group had a significantly greater decrease in premenstrual symptoms compared to those receiving relaxation training or hormone treatment. Christensen and Oei [14] compared a cognitive-behavioural group, which included cognitive restructuring and assertion training, with an information-focused group; both groups experienced changes in anxiety, depression, negative thoughts, and physical symptoms. Using individual CBT, Goodale et al. [15] found that relaxation on its own yielded significant symptomatic improvement in comparison to symptom monitoring or taking time out to read. More recently, Blake [16] has outlined a comprehensive theoretical perspective of CBT for premenstrual problems. She proposes that the key to premenstrual distress is the attributions that women make in response to their premenstrual changes. For example, they tend to attribute symptoms to not coping and being out of control, which in turn leads to low mood, anxiety, and tension, which triggers further negative thoughts and guilt. She also proposes that these women have thoughts and beliefs that contribute to their symptoms, for example, that they are responsible for the emotional well-being of those around them or that they have high expectations of personal performance. The therapist and client work collaboratively to challenge unhelpful thoughts and assumptions and to experiment with new behaviours. Blake et al. [6] have evaluated this approach by randomly allocating 23 women to either 12 sessions of cognitive therapy or a waiting list control; cognitive therapy was significantly more effective in reducing premenstrual symptoms than the control condition.

The current study uses a cognitive-behavioural approach based on Blake's model, but also includes relaxation therapy. The following hypotheses were tested:

Hypothesis 1: Both fluoxetine and CBT treatments would be equally effective in reducing premenstrual symptoms, as assessed by the Calendar of Premenstrual Experience (COPE) [17].

Hypothesis 2: Both fluoxetine and CBT treatments would be equally effective in reducing anxiety and depression (Hospital Anxiety and Depression Scale, HADS[18]).

Hypothesis 3: Significantly more women having CBT would develop biopsychosocial attribution of premenstrual symptoms compared to those having fluoxetine treatment.

Hypothesis 4: Significantly more of those having CBT would use cognitive and behavioural coping strategies after treatment compared with those having fluoxetine.

Hypothesis 5: Good outcome at posttreatment and follow-up would be associated with less severe premenstrual symptomatology and lower levels of anxiety and depressed mood at baseline, and good outcome at follow-up would be associated with use of cognitive-behavioural coping strategies and a biopsychosocial attribution of symptoms posttreatment.

Method

The context of this study was as part of a randomised trial comparing 10 sessions of CBT, 20 mg daily of fluoxetine, and a combination of both these approaches (CBT and fluoxetine) [8]. All treatments lasted for 6 months following which prescription of fluoxetine ceased. One hundred and eight women recruited from advertisements in newspapers and magazines were randomised into the three treatments (see Hunter et al. [8]). All the women fulfilled DSM-IV criteria for PMDD, confirmed by daily prospective ratings on the COPE [17]. This is a 22-item scale including 22 premenstrual symptoms rated daily throughout the cycle on a four-point scale (0 = not at all, 1 = slightly, 2 = moderately, 3 = severely). Further inclusion criteria were age between 20 and 45 years, not currently taking hormonal or psychotropic medication or experiencing major psychiatric illness, not being pregnant or lactating within the previous 12 months, and having regular menstrual cycles (21–35 days). The women completed questionnaires at baseline, 3 months after the start of treatment, and at the end of treatment (6 months after the onset of treatment). A postal questionnaire was sent to the women 1 year after the completion of treatment, enquiring about subsequent help-seeking behaviour, symptoms, and DSM-IV criteria. Significant improvement occurred in all three groups on measures of the COPE and percentage of women fulfilling PMDD criteria. At 1 year follow-up,

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