



## Shorter communication

## Longer term outcome of cognitive-behavioural and psychodynamic psychotherapy in routine mental health care: Randomised controlled trial

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## ABSTRACT

We investigated the comparative effectiveness of cognitive-behavioural (CBT) and psychodynamic therapy (PDT) under clinically representative conditions as a subtrial of a prior study (Watzke et al., 2010, *BJP*). A consecutive sample of 147 patients with common mental disorders was randomised to either CBT or PDT in routine mental health care. In a primary per-protocol analysis patients randomised to CBT had a significantly better longer term outcome in the primary outcome symptom severity (General Severity Index of the SCL-14;  $p = .001$ ; partial  $\eta^2 = 0.073$ ) as well as in health related quality of life (Mental Component Summary of the SF-8;  $p = .013$ ; partial  $\eta^2 = .041$ ) and concerning interpersonal issues (Inventory of Interpersonal Problems, IIP-C;  $p = .001$ ; partial  $\eta^2 = .070$ ) 6 months after treatment than patients randomised to PDT. These results could be confirmed in intention-to-treat analyses ( $n = 180$ ) suggesting that there was no substantial attrition bias due to drop outs at the follow-up assessment. Thus, the so called equivalence outcome paradox was not replicated in this study.

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Investigations of comparative outcome between different psychological treatments have a long tradition (Luborsky, Singer, & Luborsky, 1975; Rosenzweig, 1936) and refer to a very relevant and controversial research issue. This has even gained more attention during the last years, especially in the context of the development of empirically supported treatments (EST, Chambless & Ollendick, 2001) and of evidence-based clinical guidelines for psychological therapies (NICE, 2004). Although some meta-analyses show differential effects among different treatment approaches (e.g. Grawe, Donati, & Bernauer, 1994; Shapiro & Shapiro, 1982; Svartberg & Stiles, 1991; Tolin, 2010), numerous meta-analyses and reviews have failed to demonstrate differences (e.g. Cuijpers, van Straten, Andersson, & van Oppen, 2008; Roth & Fonagy, 2004; Svartberg, Stiles, & Seltzer, 2004; Wampold et al., 1997), especially when referring exclusively to comparisons of *bona fide* treatments (Wampold, Minami, Baskin, & Tierney, 2002). The debate on this so called equivalence outcome paradox (i.e. that there are no differences in outcome between psychotherapeutic treatments working with theoretically and technically distinct approaches), also known

as the “Dodo verdict” (Luborsky et al., 1975; Rosenzweig, 1936) lasts for more than 3 decades to date and a definite empirical answer is still lacking. Some researchers (e.g., Howard, Krause, Saunders, & Kopta, 1997; Kazdin & Bass, 1989) doubt the equivalent outcomes paradox pointing to an insufficient methodical quality found especially in early studies (e.g. a low statistical power to detect differences) and meta-analyses (e.g. aggregating studies being too heterogeneous or including cross-study comparisons<sup>1</sup>). Proponents of the Dodo verdict emphasize the relevance of common beneficial factors being inert in all psychotherapeutic approaches (e.g. building a therapeutic alliance, increasing hope and expectations; offering a treatment rationale, e.g. Frank, 1971) as potential reason for the lack of differential outcome effects.

For the most widespread psychotherapeutic approaches in routine mental health care, i.e. for cognitive-behavioural (CBT) and psychodynamic therapy (PDT) (e.g. Barghaan, Schulz, Koch, & Watzke, 2009), some studies also show the result of equivalent outcomes (Murray, Cooper, Wilson, & Romaniuk, 2003; Shapiro et al., 1995; Stiles, Barkham, Mellor-Clark, & Connell, 2008), whereas some other studies give support for differential outcome effects (Gallagher-Thompson & Steffen, 1994; Thompson & Gallagher, 1984).

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<sup>1</sup> instead of referring exclusively to studies with direct comparisons, i.e. comparisons of treatments within one given trial.

The lack of differential effects in some studies is remarkable especially for the comparison of CBT and PDT given their very distinct profiles of treatment rationales and interventions which became salient within the context of experimental designs (Blagys & Hilsenroth, 2000, 2002) and under clinically representative conditions (Watzke, Rueddel, Koch, Rudolph, & Schulz, 2008). However, the results on comparative outcome of CBT and PDT are ambiguous so far and the empirical base seems to be still insufficient for a definite conclusion. For example, a recent meta-analysis (Cuijpers et al., 2008) focussing on the treatment of depression in adults found no differential outcome effects for CBT and PDT referring to seven studies which conduct direct comparisons. Contrariwise, Tolin (2010) including also studies with direct comparisons with the majority focussing on depression<sup>2</sup> concludes in his meta-analytic review that CBT is superior to PDT. In another review on the efficacy of CBT, Butler, Chapman, Forman, and Beck (2006) resume that – although most outcome research has focussed on CBT – there are relatively few direct comparisons between CBT and PDT and “not enough to provide the basis for a meaningful meta-analysis” (Butler et al., p. 23).

The majority of existing studies refer to the *efficacy* of treatments by examining the comparative outcome of therapies under – approximately – ideal conditions (with specifically trained therapists, manualized treatments etc.) in order to strengthen issues of internal validity. Complementary to efficacy research, studies on the *effectiveness* offer empirical knowledge on the outcome of psychotherapies under clinically representative conditions, i.e. they foster aspects of external validity and thus facilitate generalizability to day-to-day clinical practice (Goldfried & Wolfe, 1998; Nathan, Stuart, & Dolan, 2000). However, it is still an open question whether the generalizability of efficacy trials to clinical practice is limited. Although some studies suggest that the gap between research trials and routine care may not be as wide as some clinicians and researchers perceive (Shafran et al., 2009; Weisz, Weersing, & Henggeleler, 2004) no definite answer has yet been found in empirical research due to the relative lack of evidence on outcome in routine care (e.g. Westbrook & Kirk, 2005). This also holds true for studies on the *comparative* outcome in real world settings which are still rare (Stiles et al., 2008), especially those which strengthen external validity by investigating routine mental health care *and* at the same time internal validity by applying methodologically sound designs, ideally with randomisation to the treatments.

In a randomised controlled trial (Watzke et al., 2010) we compared patients randomised to an experimental group applying a systematic treatment selection procedure to CBT and PDT with patients randomised to a control group with a random treatment allocation to the two approaches. Results show that systematic treatment selection optimize treatment outcome for PDT but not for CBT, i.e. we found no general but a differential effect for a systematic treatment assignment strategy. The data of the control group of the trial, i.e. the condition with a random treatment allocation, allows investigating the question of comparative effectiveness of CBT and PDT within a randomised controlled trial (RCT) in routine mental health care. Given the relevance and controversy of the issue of comparative outcome, this perspective of the trial shifted into focus while discussing the study's main results on systematic treatment selection (Fonagy, 2010). In order to give this discussion a reliable base, we ran the appropriate analyses referring to the above mentioned subsample (in fact a complete “subtrial”) and report them in this paper. Moreover we broadened the

spectrum of outcome variables: In addition to symptom severity and health related quality of life we included interpersonal problems as further outcome which may be of special relevance for the evaluation of psychodynamic approaches. By these new analyses we are able to present results on the comparative effectiveness of CBT and PDT under clinically representative conditions.

## Method

### Participants

We included a consecutive sample of inpatients recruited from a psychotherapeutic inpatient unit in Germany from October 2002 to May 2003. All patients fulfilled the criteria for at least one mental disorder, according to ICD-10. Because of the naturalistic context of the study, patients were only excluded from the study if they could not undergo randomisation for clinical, ethical or practical reasons. Therefore the following exclusion criteria were set: 1. Extreme over- or underweight (Body-Mass-Index:  $12 > \text{BMI} > 50$ ), decompensated tinnitus with the patient's focus being symptomatic treatment and psychosis-like states. According to the clinic's standards, these patients always receive CBT and therefore could not undergo randomisation. 2. No complete diagnostic procedure, i.e., less than one week of inpatient stay. 3. Patients for whom the treatment approach was already set as they were admitted a second time to this specific clinic for treatment *continuation*.

### Procedures

The study, a parallel-group randomised controlled effectiveness trial, was approved by the human ethics committee of the responsible medical association and a written informed consent was obtained from all participants by the clinical staff. After the patients had given their consent, the randomisation to CBT or PDT (3:2 ratio) was conducted at the University Medical Centre Hamburg-Eppendorf by using a computer-generated random sequence. The ratio was determined by the capacities of the PDT and CBT treatment facilities in the unit. The information on treatment method was given to one person in the clinic making an entry in the patient file. According to this the patient received CBT or PDT. Patients were asked to fill in self-rated questionnaires at the beginning of treatment and at 6 months follow-up. Additionally, a supplementary (reduced) assessment took place at the termination of treatment.

### Treatments and therapists

In the treatment setting under investigation psychotherapy is conceptualized as the main therapeutic agent. The psychodynamic treatment (focal approach, e.g., Heigl-Evers & Ott, 1997) and the cognitive-behavioural treatment (e.g. Fiedler, 2001) were comprised of brief group therapy. Both were implemented with a similar dosage and frequency (3–4 sessions per week with an average treatment duration of 6 weeks) in separate departments of the clinic. For both treatment groups, one additional individual short session per week completed the treatment. In addition to psychotherapy, approximately one-fourth of the patients took psychotropic medication on a daily basis.

Because of the context of routine care, the CBT and PDT were not manualized and therapists were not trained especially for this study. However, results of a prior study including independent expert raters (video ratings) describe the main interventions of both treatments (Watzke et al., 2004, 2008) and suggest that there was sufficient treatment differentiation between the two treatments in the unit: CBT therapists used cognitive, behavioural and

<sup>2</sup> However, the included studies do only partly overlap with those analysed by Cuijpers et al. (2008).

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