KING'S College LONDON

INSTITUTE OF PSYCHIATRY,
PSYCHOLOGY & NEUROSCIENCE

Module:

Psychological Foundations of Mental Health

Week 5:

Psychological therapies: From behaviour modification to behaviour therapy

Professor Richard Brown

Topic 4

Evaluating the efficacy of cognitive therapy

Part 3 of 3

In this topic

- Introduction to the design and evaluation of clinical trials for psychotherapy research
- Systematic review
- ***The efficacy of CBT for adult depression***

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More questions about the efficacy of CBT for adult depression

Predictors of therapy outcomes

Q1. What **patient** factors predict outcome?

Q2. What **therapy** factors predict outcome?

One size does not fit all (Variable size and duration of any clinical benefit)

Match patient to optimal therapy

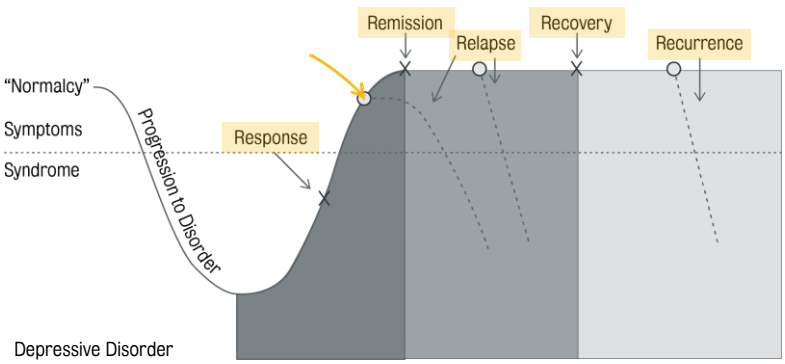
CBT may be good for some but not others.

Adapt therapy to meet patient needs

Permit use of the best treatment immediately

Q3. Is CBT effective in the long-term?

Measuring outcome in clinical trials



5 R's

Response	Remission	Recovery	Relapse	Recurrence
Severity is 50% of that at the start of the treatment.	*No or few symptoms for 1-2 months*	*Sustained remission of between 6 – 12 months*	*Episode of depression after remission but before recovery*	*Episode of depression after recovery*

Bockting et al. (2015)

Predictors and moderators of clinical outcome

Predictor

To describe any factors that, on its own, or in combination predicts clinical outcome

Non-specific predictors

Associated with overall outcome regardless of treatment

Moderator

Those baseline, or other characteristics, that interact with the treatment and influence the size of the eventual treatment effect.

On whom and under what conditions do treatments have different effects?

Alternative A: A patient with severe symptoms gets better quicker than one with mild symptoms, regardless of treatment

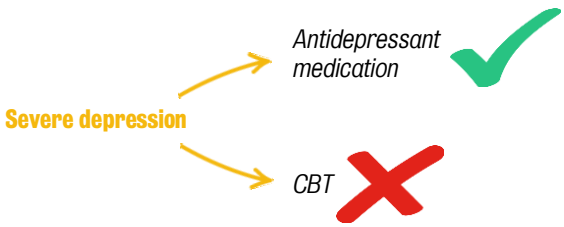
Would imply that Severity = **Non-specific predictor**

Alternative B: Severity of symptoms only affects outcome in patients receiving the active treatment

Would imply that Severity = **Moderator**

Is depression severity a moderator of CBT outcome?

Typical treatment guidance



Based on evidence that depression severity is a **moderator** of CBT outcome

- evidence from meta-analyses
- **but** based on average group effects across studies, not individual patient outcome

Weitz et al. (2015)
Individual patient-data meta-analysis

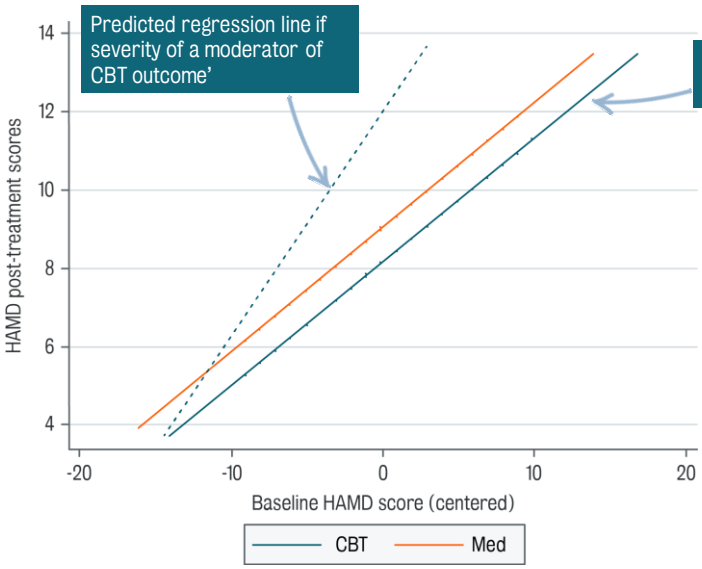
- N = 24 trials
  - Individual data from 16
- N = 1700 patients
  - 794 CBT
  - 906 medication

Does baseline severity predict outcome differences between CBT and Medication?

- change in mean depression scores
- response
- remission

Weitz et al. (2015)

Weitz et al. (2015)



- 'Depression severity does not moderate CBT outcome at individual patient level'
- 'Patients with more severe depression show a greater response whatever the treatment'
- 'Antidepressant medication should not be the automatic first choice treatment for patients with severe depression'

Weitz et al. (2015)

Other predictors or moderators

Factors that predict outcome in CBT

Therapist and centre expertise

- better outcomes with more experienced therapists
- better outcomes in specialist centres than in routine clinical settings
- therapists skill and experience will impact efficacy, conversely, inexperience may be a better gauge for real-world application

Patient characteristics

- Age? Gender? Education?
- Married / cohabiting patients do better than single patients
- Living status is a moderator variable?

Psychiatric co-morbidity
Poor response where depression is present with another significant psychiatric disorder

E.g. **STAR*D trial** (Farabaugh et al. 2012)
Various treatment pathways
Standard antidepressant → *IF no response* → Switch treatment (including CBT)
Patients with depression and anxiety show lower overall remission rates with both CBT and medication

Dysfunctional attitudes

- high baseline levels of dysfunctional attitudes predict poor treatment outcome to CBT and medication

Driessen et al. (2015), Farabaugh et al. (2012)

Predicting relapse and recurrence

How can we sustain treatment response?

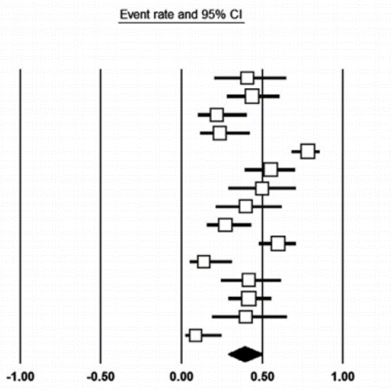
What factors can predict relapse or recurrence?

80% will show at least one more episode of depression later in their life

Steinert et al. (2014)
Meta-analysis

- N = 11 psychotherapy trials
- Follow-up data >= 2 years (Mean 4.4 years)
- 8 CBT
- 6 with non-pharmacological control

Study name	Subgroup within study	Outcome	Event rate	Lower limit	Upper limit	Z-Value	p-Value
Andersson et al., 2013a	E-mail therapy	self-report	0.410	0.209	0.646	-0.738	0.460
Andersson et al., 2013a	ICBT	self-report	0.440	0.285	0.607	-0.698	0.485
Andersson et al., 2013b	Face-to-face group CBT	observer rating	0.220	0.105	0.404	-2.823	0.005
Andersson et al., 2013b	ICBT	observer rating	0.240	0.119	0.425	-2.651	0.008
* Bockting et al., 2009	Cognitive group therapy	observer rating	0.784	0.686	0.858	4.976	0.000
* Conradi et al., 2007	CBT	observer rating	0.556	0.397	0.703	0.683	0.495
* Fava et al., 1998	CBT	observer rating	0.500	0.294	0.706	0.000	1.000
* Fava et al., 2004	CBT	observer rating	0.400	0.214	0.620	-0.888	0.374
* Maina et al., 2009	Brief dynamic therapy	observer rating	0.275	0.159	0.432	-2.738	0.006
* Paykel et al., 2005	CBT	observer rating	0.600	0.482	0.708	1.662	0.097
Huber et al., 2013	Psychoanalysis	self-report	0.140	0.055	0.313	-3.450	0.001
Huber et al., 2013	Psychodynamic psychotherapy	self-report	0.420	0.247	0.616	-0.797	0.426
Koppers et al., 2011	Supportive dynamic therapy	observer rating	0.420	0.295	0.557	-1.149	0.251
Krampen et al., 1999	Psychotherapy	observer rating	0.400	0.192	0.652	-0.769	0.442
Krampen et al., 1999	Psychotherapy + Autogenic training	observer rating	0.090	0.029	0.246	-3.804	0.000
			0.391	0.289	0.503	-1.913	0.056

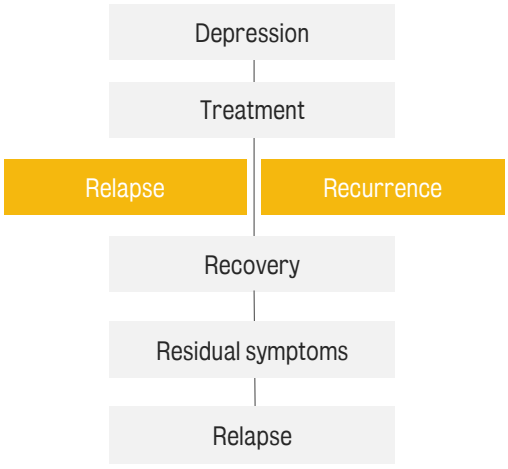


39.1% rate
of relapse or recurrence within 2-4 years

**Non-medication controlled trials (N=6)*
Therapy relapse/recurrence rate = 53.1%
Control condition rate = 71.1%

Steinert, Hofman, Kruse & Leichsenring (2014)

Residual symptoms and risk of relapse



Residual symptoms

- low mood
- irritability
- lack of enjoyment (anhedonia)
- low motivation
- social avoidance
- dysfunctional attitudes
- rumination
- sleep disturbance

What does this mean about the original treatment?

Do we need to adjust or provide additional forms of therapy?

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Figure adapted from Bockting et al 2015

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