COGNITIVE-BEHAVIOURAL THERAPY EFFICACY IN MAJOR DEPRESSION WITH ASSOCIATED AXIS II RISK FACTOR FOR NEGATIVE PROGNOSIS

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Abstract: Patients with major depressive disorders and personality disorders have a high incidence of refractory cases to either psychotherapeutic or pharmacologic therapy. We prospectively evaluated 12 patients, female, with dual diagnosis, treated with cognitive-behavioral therapy addressed to both disorders, for 6 months, with weekly sessions. We used Beck Depression Inventory (BDI)- 21 items form and Global Assessment of Functioning (GAF) initially and every two weeks until the endpoint. Results: There were 4 cases of discontinuation after a mean duration of 10.6 weeks. These patients presented at 6 months a higher score on BDI (+6.5) and a lower degree of social and professional level of functioning (-15 on GAF); a follow-up session (after one year from baseline) observed more residual symptoms or recurrence of depression than in patients that participated in all study sessions (mean BDI score 15.6vs.9.5, GAF 78vs.89, 2 vs.0.5 depressive episodes incidence). Addressing dysfunctional schemas of histrionic personality disorder improves the long term prognosis in depressed patients with dual diagnosis.

Key-Words: major depression, personality disorders, cognitive- behavioral therapy, risk factors for negative prognosis, histrionic personality disorder, therapeutic efficacy

1 Introduction

Patients with dual diagnosis, major depressive disorders and personality disorders, have interesting but difficult peculiarities regarding the psychotherapeutic approach.

There are several studies [1, 2, 3] that indicate the significant influence of personality features over the evolution of depressive symptomatology on short, but also on long term. Therefore, the need for simultaneously treatment of both axis I and axis II pathologies is important.

Cognitive- behavioral therapy (CBT) has also been evaluated in dual diagnosis, where the results were better in patients with CBT and pharmacotherapy than in patients that received only antidepressants [4, 5].

Also the mechanisms involved in this difference were not investigated in a rigorously manner, possible factors contributing to a significant improvement when CBT was applied, are as follow: (a) dysfunctional core beliefs provide a higher vulnerability profile to depressive disorders because they bias events interpretation; (b) instrumental beliefs and coping strategies modulate therapeutic compliance and transference issues; (c) cognitive schemas influence long-term prognosis and evolution of depression and, if they are not addressed during psychotherapy sessions, could predict relapse or recurrence of the affective pathology.

CBT has also the advantage to specifically approach targets like lack of assertiveness, difficulties in emotions expression, lack of strategies for coping to stress, insufficient developed abilities for problem solving, inflexible attributional style. Methods used like asertivity training, graded exposure, activity planning, cognitive restructuring and role play help patients to resolve acute symptoms, but could be used as motivation to follow therapy for their basic problems, personality pathology.

There is no doubt that each

personality disorder or, at least, each cluster of personality disorders, has different effects over the depressive disorder. The main personalities that seem to worsen short- term treatment of depression were cluster A- specifically schizoid personality disorder [6] or cluster C- avoidant and dependent personality disorders [7].

The positive effects of CBT were proved in major depressive disorder or dysthymia associated with cluster C [3, 8] or borderline personality disorders [9, 10] using randomized clinical trials, but serial case reports, uncontrolled clinical reports, single- case design studies [11] included almost all actual DSM IV TR personality pathology.

Histrionic personality disorder has been less studied from CBT perspective, when associated with major depression. Specific techniques for treatment of histrionics [11] are positive and negative feedback, assertion training, desensitization, contingency management, with a specific focus on short-term goals operationalizing. Depression tends to be accompanied by parasuicidal attempts that should be seriously addressed because the “accidental” success of such attempts is not rare.

The involvement of histrionic patients in long-term therapy is a challenge for therapist, who needs to find real, actual, objectives to allow patients to verify the utility of psychotherapy in daily life; special attention for transference and counter-transference is needed, in order to distinguish reality from fantasies of ideal love, unrestricted admiration or other self-centered imagery; the therapeutic relationship should be maintained collaborative, preventing regressive behaviors development.

2 Study design

Our study is an open label, prospective, non-placebo controlled trial that investigated the efficacy of CBT in dual diagnosis, histrionic personality disorder and major depressive disorder, in a group of 12 patients. All participants were female, age between 25 and 42 years, mean age 35.5, without prior psychotherapeutic experience, who expressed their consent to participate in this study.

Diagnosis of personality disorder and major depressive disorder were realized according to DSM IV TR criteria.

Inclusion criteria referred to personal history of major depressive episodes and psychopharmacologic treatment which lead to incomplete remission of symptoms; Beck Depression Inventory (BDI)- 21 items initial score over 19 (moderate to severe depression); Global Assessment of Functioning (GAF) score under 70.

Exclusion criteria were schizophrenia and other psychotic disorders, either acute or chronic; bipolar I disorder; substance-related pathology; mental retardation; other significant axis II disorders; axis III diseases that interfere with the patient’s ability to communicate, understand therapeutic principles or comply to therapy requirements.

Patients entered a CBT program with weekly sessions for 6 months and pharmacologic treatment was also administered as needed.

Patients were hospitalized for a mean of 15.4 days (range between 12 and 21) and, after the improvement in depressive symptomatology, an out-patient monitoring program was instituted. Patients were free to withdraw from this study whenever they wanted and no financial motivation was applied.

Every 4 weeks, the BDI and GAF scores were measured and a self-rated evaluation of well-being was requested from each patient. A follow-up session was established after one year from baseline and the same measurements of psychological status were requested.

The study hypothesis was that CBT could improve both depressive symptoms and histrionic personality features. For this purpose we quantified depressive

symptoms on BDI, relational functioning and occupational or academic status, as well as global symptoms severity (depressive and personality disorder induced dysfunctions) on GAF; self-reported well-being evaluation on a visual analogic 10 points scale (VAS); the number of relapses was monitored for one year; suicidal or parasuicidal attempts were also monitored throughout the study, until the follow up session.

3 Results

There were registered 4 cases of drop-outs, patients discontinued combined treatment after a mean period of 10.6 weeks, within a 4 to 14 weeks range. As motives, they put forward lack of time needed for participating in therapy (n=2), lack of perceived benefit (n=1) and other priorities (n=1). These patients participated however at the final 6 months session and at the 1 year follow up session.

All our patients recorded significant lower BDI scores after hospitalization, with a mean decrease of 10.5 points and a GAF improvement evaluated as a mean increase of 16.5. Self- reported well-being on VAS increased with at least 2 points from baseline (mean increase 3.2).

After 6 months, patients that withdraw themselves from psychotherapy and continued only pharmacologic treatment, were evaluated and their results compared to those of patients maintained on combined treatment. Patients that finalized psychotherapeutic program had a consistent BDI improvement compared to drop-out group, the difference between groups was 6.5 points ($p<0.01$). The pre-post analysis in both groups revealed that patients in first group (drop-out) had a slower decrease during first 12 weeks and reaches a plateau of residual depressive symptoms, quantified by mean 15 BDI score, while the second group had a continuous decrease reflected in final BDI score of 8.5.

The evolution of GAF was similar, with final inter-group mean difference of 15 points (between 10 and 20) ($p<0.01$) and pre- post analysis in group one recording a plateau after 12 weeks –mean GAF 77, while the second group reach a plateau at a better level –GAF 92 after 16 weeks.

The VAS evolution paralleled the other two coordinates, final inter-group appreciation of well-being was significant better in the second group (+5.5 vs. +4.7, $p<0.05$). In the first group VAS increased slower until the 16 week and reach a value of 7.7, while the second group had a constantly increasing of VAS value until the 12th week, when reached the 8.5 final value.

No relapse was recorded during the 6 months in none of the groups. Parasuicidal attempts were mentioned in the first group (3 cases in 2 patients) during the 4-24 week period and in the second group (2 attempts in one patient) in the same interval. No serious threat to life was recorded.

After one year, all patients participated in a follow-up session. Patients were treated pharmacologically in this period and those who required emergency or boosting sessions of CBT received the help they needed.

However, the difference between groups maintained in all monitored variables. BDI scores reached a mean value of 15.6 vs. 9.5 in the first vs. the second group; the increase when compared to the 6 month values is attributed to the relapse incidence of major depressive episodes.

The longitudinal analysis established for the first group (mean values) a baseline BDI score of 26.8, a hospital release value of 16.4, a 6 months score of 15 and, as mentioned, a 1-year BDI 15.6. In this group, we recorded 6 major depressive episodes in 3 patients (mean of 2), mild to moderate severity (BDI between 14 and 20). Parasuicidal attempts throughout the 1-year period were recorded at a total number of 4 in the first group. No suicidal attempt with severe risk to life was recorded. GAF longitudinal evolution started at a baseline mean value of 55, hospital release score of 71, a 6 months value of 77 and a 1-year follow-up evaluation of 78. The VAS evolution started at 3, progressed to 6.3 at the

release from hospital, 7.7 at 6 months and a mean value of 8 after 1-year follow-up.

For the second group, the longitudinal evaluation established a BDI final score of 9.5, GAF value 89, VAS 8.9 and 0.5 depressive episodes relapses. BDI started at a baseline value of 26.6 and after hospitalization period decreased to 16, at 6 months value was 8.5 and after 1-year reached a value of 9.5. This increase in the last 6 months is caused by the 4 relapses recorded in this 8 patients group (mean 0.5), the intensity was mild (10 to 16 points on BDI). Parasuicidal attempts recorded were only 3 in 2 patients, without severe suicidal attempts. GAF evolution started at 55 and progressed to 72 at the hospital release, to 92 at 6 months and 89 at 1-year evaluation. The VAS evolution had a 3 baseline value, 6.1 at hospital release, 8.5 at 6 months and 8.9 at 1-year.

Fig.1 Comparative BDI evolution under treatment

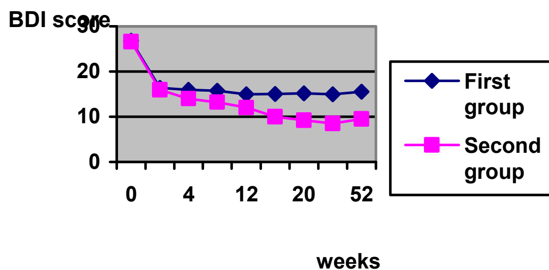


Fig.2 Evolution of GAF score under treatment

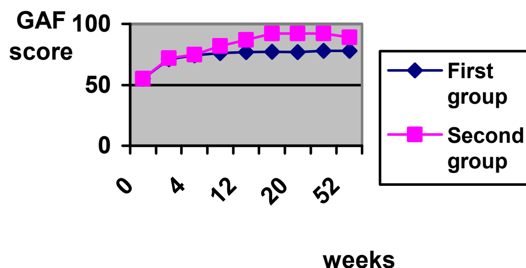
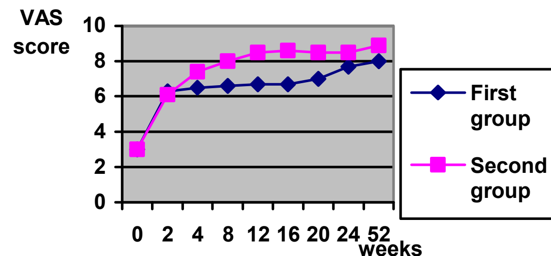


Fig.3 Evolution of VAS score under treatment



4 Conclusion

CBT stands as an efficient therapy for patients with dual diagnosis, histrionic personality disorder and major depressive disorder. Addressing basic beliefs that sustain personality disorder improves the long-term prognosis of patients, through reducing relapse and recurrence of depressive episodes. Measurements of social and occupational functioning, self-perceived improvement in clinical status and psychologist's evaluations of patient's symptoms are necessary perspectives in order to obtain a correct appreciation. Patients that finished the combined therapy obtained significant improvement in all measured variables when compared to their baseline values and to the patients that gave up psychotherapy.

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