Psicothema

Motivation for change as a predictor of treatment response for dysthymia

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Abstract

Objective: Dysthymia constitutes a chronic, mild affective disorder characterized by heterogeneous treatment effects. Several predictors of clinical response and attendance have been postulated, although research on the role of the psychological variables involved in this mental disorder is still scarce. **Method:** Fifty-four adult patients, who met criteria for dysthymia completed an ongoing naturalistic treatment based on the brief interpersonal psychotherapy (IPT-B), which was delivered bimonthly over 16 months. As potential predictor variables, the therapeutic alliance, coping strategies, perceived self-efficacy, and motivation for change were measured at baseline. Outcome variables were response to treatment (Clinical Global Impression and Beck's Depression Inventory) and treatment attendance. **Results:** Stepwise multiple linear regression analyses revealed that higher motivation for change predicted better response to treatment. Moreover, higher motivation for change also predicted treatment attendance. Therapeutic alliance was not a predictor variable of neither clinical response nor treatment attendance. **Conclusions:** These preliminary findings support the adjunctive use of motivational interviewing (MI) techniques in the treatment of dysthymia. Further research with larger sample size and follow-up assessment is warranted.

Keywords: Motivation for change, predictor, treatment, dysthymia, motivational interviewing.

Resumen

Motivación para el cambio como predictor de la respuesta terapéutica en la distimia. **Objetivo:** la distimia constituye un trastorno afectivo crónico caracterizado por una respuesta heterogénea al tratamiento. Se han postulado diversas variables predictoras de dicha respuesta terapéutica, aunque la investigación acerca del papel de las variables psicológicas es todavía escasa. **Método:** cincuenta y cuatro pacientes diagnosticados de distimia completaron un tratamiento naturalístico bimensual de 16 meses de duración basado en la psicoterapia interpersonal. Como posibles variables predictoras se evaluó al inicio del tratamiento la alianza terapéutica, las estrategias de afrontamiento, la autoeficacia percibida y la motivación para el cambio. Las variables de tratamiento fueron la respuesta terapéutica (Escala de Impresión Clínica Global e Inventario de Depresión de Beck) y la adherencia terapéutica. **Resultados:** los análisis de regresión múltiple indicaron que una mayor motivación para el cambio predijo una mejor respuesta al tratamiento. Por otra parte, una mayor motivación para el cambio también predijo una mayor adherencia al tratamiento. La alianza terapéutica no fue una variable predictora ni de la respuesta ni de la adherencia al tratamiento. **Conclusiones:** estos resultados preliminares apoyan el uso complementario de la entrevista motivacional en el tratamiento de la distimia. Son necesarios estudios adicionales con un mayor tamaño muestral y evaluaciones adicionales durante el seguimiento postratamiento.

Palabras clave: motivación para el cambio, predictor, tratamiento, distimia, entrevista motivacional.

Dysthymia constitutes a mild, prolonged depressive disorder usually associated with a heterogeneous response to psychotherapy and psychopharmacological treatments (Cuijpers et al., 2010). Both randomized controlled and open trials have pointed out some psychological variables that may predict treatment response in dysthymia or chronic depression, namely: rumination (Schmaling, Dimidjian, Katon, & Sullivan, 2002), perceived stress (Pedrelli, Feldman, Vorono, Fava, & Petersen, 2008), therapeutic reactance (Arnow et al., 2003), patient's treatment preference (Steidtmann

et al., 2012) or dysfunctional attitudes (Shankman et al., 2013). However, the role of other psychological variables associated with the therapeutic process has been almost neglected so far. Specifically, scientific literature has barely addressed to what extent patient's motivation for change and therapeutic alliance may influence the response to treatment or attendance rates (Arnow et al., 2013). This is particularly striking taking into account that both psychological variables have been proved to intervene as predictor variables for treatment outcomes in other mental disorders such as borderline personality disorder, obsessive-compulsive disorder or eating disorders (Bedics, Atkins, Harned, & Linehan, 2015; Fitzpatrick & Weltzin, 2014; Keeley, Geffken, Ricketts, McNamara, & Storch, 2011). Furthermore, relative to patients with non-chronic depressive mood, those with dysthymia or chronic depression have also reported poorer scores on psychological variables such as self-efficacy and adaptive coping strategies, which in turn

have been postulated as maintenance psychological variables for depressive episodes (Riso et al., 2003; Wiersma et al., 2011). In spite of this evidence, there are no studies aimed at addressing how these additional prominent psychological variables may predict the response and attendance to treatment among dysthymic patients.

In addition, there is a need to address to what extent these potentially predictor psychological variables may influence clinical outcomes of naturalistic treatments rather than those from randomized controlled trials. To date, there is a lack of empirical research on the former types of treatments. Particularly, this limitation is remarkable, as the financial crisis in Southern Europe has led to a poorer patient-clinician ratio within the public mental health services of some local administrative regions (Salvador-Carulla, Costa-Font, Cabases, McDaid, & Alonso, 2010). Accordingly, efficacious psychotherapeutic treatments from randomized controlled trials are far from being implemented in such conditions (e.g., time interval between sessions) and have little ecological validity within these clinical contexts (Leichsenring, 2004; Vivian & Salwen, 2013). Hence, research should provide further evidence regarding the potential role of psychological factors as predictor variables for treatments in real clinical settings.

Method

Participants

Sixty-one adult patients from an outpatient mental health center (Mataró, Spain), who met DSM-IV (Diagnostic and statistical manual of mental disorders-text revision- 4th edition; American Psychiatric Association [APA], 1994) criteria for dysthymia, initially enrolled an ongoing, naturalistic treatment study started in February 2013. Diagnostic criteria for dysthymia were based on the Dysthymia module at the Clinical Interview for DSM-IV axis I Disorders, Research Version (SCID-I/RV). Of the 61 patients, 54 patients completed the outcome assessment instruments at the end (last session) of the treatment study and were finally included for the purpose of this research.

Exclusion criteria were comorbid diagnosis of pervasive developmental disorder, mental retardation, psychotic disorder, bipolar disorder or substance dependence as indicated by chart reviews.

All patients were aged 18-65 years (M = 49.88, SD = 8.33); women were more prevalent than men (64.8% vs. 35.2%). Concerning marital status, most patients were either married (57.4%) or divorced (33.33%). Regarding occupation, 50% of patients were retired due to disability and 25.2% of patients were unemployed. Education level was as follows: 50% primary, 40.74% secondary and 9.26% tertiary (see Table 1).

Procedure

The naturalistic treatment was based on the brief interpersonal psychotherapy (IPT-B), which has been proved to be effective in the treatment of chronic depression (Schramm et al., 2008; Swartz et al., 2004). The IPT-B comprised 8 sessions delivered bimonthly and individually by the clinicians (clinical psychologists) over 16 months. Each session lasted 45 minutes and included techniques such as behavioral activation and interpersonal problem-solving skills.

In addition, all participants underwent prior antidepressant treatments as follows: 31 of them took selective serotonin reuptake inhibitors (SSRIs) alone; 9 patients took SSRIs plus tricyclic antidepressants (TCAs); 11 patients took SSRIs plus serotonin and norepinephrine reuptake inhibitors (SNRIs); 3 patients took SSRIs plus serotonin antagonist and reuptake inhibitor (SARIs). There were no drug-free patients. Mean daily dosage was defined and converted to fluoxetine equivalents by using the same methodology widely adopted for antipsychotics (Huyasaka et al., 2015). All participants took the same antidepressants and dosages during the study period.

The clinicians were blind to the aims of the study. They had at least ten years of experience in treating patients with dysthymia and had been trained in IPT-B through official courses provided by national experts.

The treatment study was approved by the hospital's Institutional Review Board, and informed consent was obtained from all patients who joined the research.

Instruments

Predictor variables

Patient's motivation for change. For the purpose of this study, motivational readiness to change was measured at baseline through the Spanish version of the University of Rhode Island Change Assessment Scale (URICA; Di Clemente & Hughes, 1990; Rojas & Espinoza, 2008). The URICA is a 32-item self-administered assessment instrument in which participants answer each item according to a Likert scale (1= *strongly disagree*, 5= *strongly agree*). Four subscales (stages of changes) are measured following the theoretical approach of the authors: precontemplation (PC), contemplation (C), action (A) and maintenance (M). The subscales are combined arithmetically (C + A + M - PC) to yield a second-order continuous readiness to change score that can be used to assess "readiness to change". The Spanish version of the URICA has good internal consistency (α = .83 – .89).

Table 1	
Sociodemographic characteristics of patients with dysthymia	

Variables	Dysthymic patients (N = 54) n (%)
Age (mean/*SD*)	49.88 (8.33)
Gender (female)	35 (64.8)
Level of education	
Primary	27 (50)
Secondary	22 (40.74)
University	5 (9.26)
Marital Status	
Single	4 (7.4)
Married	31 (57.4)
Separated	18 (33.33)
Widowed	1 (1.85)
Occupation	
Employee	12 (22.2)
Unemployed	14 (25.92)
Retired due to disability	27 (50)
Student	1 (1.85)

Therapeutic alliance. For the purpose of this study, therapeutic alliance was measured at the end of Session 1 through the Spanish version of the Working Alliance Theory of Change Inventory (WATOCI; Duncan & Miller, 1999). The WATOCI is a 17-item self-administered inventory developed in relation to Bordin's transtheoretical model of alliance (Bordin, 1994), which uses a 7-point Likert scale to yield both an overall score for alliance quality and four summed subscale scores (bond, goals, tasks and theory of change). The internal consistency reliabilities for the total score, and subscales were good (α = .82 –.93).

Patient's coping strategies. For the purpose of this study, coping strategies were measured at baseline through the Spanish version of the Coping Strategies Inventory (CSI; Cano, Rodríguez, & García, 2007; Tobin, Holroyd, Reynolds, & Kigal, 1989). The Spanish version of CSI is a 40-item self-reported questionnaire that uses a 5-point Likert response format (0 = *totally disagree*, 4= *totally agree*) to measure 8 subscale scores (coping strategies): problem solving, self-criticism, cognitive restructuring, social support, express emotions, problem avoidance, wishful thinking, and social withdrawal. Unlike the original version, the Spanish validation has not yielded secondary factors with adequate psychometric properties. The internal consistency reliabilities for the subscales have been quite good (α = .63 – .89).

Patient's perceived self-efficacy. For the purpose of this study perceived self-efficacy was assessed at baseline through the Spanish version of the General Self-Efficacy Scale (GSE; Baessler & Schwarcer, 1996; Jerusalem & Schwarcer, 1992), which consists of a 10-item self-reported scale that uses a 4-point Likert response format (1= *totally disagree*, 4 = *totally agree*) to obtain an overall score on. The Spanish validation has obtained adequate internal consistency (α = .87).

Outcome variables

Treatment response. For the purpose of this study the Spanish version of the 13-item short form of Beck's Depression Inventory (BDI) was completed by the patients at baseline and at the end of the treatment (Beck & Beck, 1972; Conde & Useros, 1975). The Spanish version has been shown to be a reliable instrument for assessing the severity of depressed moods (internal consistency, α=.90). In addition, the patients' response to treatment was also assessed by the clinicians through the Spanish translation of the Clinical Global Impression, Improvement Scale (CGI-I; Guy, 2000). They also completed the CGI, Severity Scale (CGI-S) at baseline.

Treatment attendance. To assess this outcome variable we calculated the percentage of outpatient psychotherapeutic sessions attended from the beginning to the end of treatment, according to the clinical charts (McIvor et al., 2004).

Data analysis

Raw scores on sociodemographic and clinical variables were displayed as mean plus *SD*. To assess whether baseline variables predicted the response and attendance to treatment, stepwise multiple linear regression analyses under the forward method were conducted for each outcome variable separately. Pearson´s correlations were performed to rule out significant relationships between predictors. All P-values are based on 2-tailed tests with α=0.05. Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS for Windows, Version 15.0).

Results

Raw scores on potential baseline predictors and outcome variables are displayed in Table 2.

Results from the stepwise multiple linear regression analyses are detailed in table 3. Higher "expression of emotions" (CSI subscale) and motivation to change (A and M subscales and "readiness to change" from the URICA) predicted better response to treatment as measured by the CGI-I. These predictors statistically accounted for the variability of CGI-I scores ($F_{(29,24)}$=2.55, p=.03, R^2=.77). There were no other potential predictor variables that significantly contributed to the general stepwise regression model (e.g., BDI pre-treatment, clinical severity, dosage of antidepressant, perceived self-efficacy, therapeutic alliance).

Higher perceived self-efficacy (GSE total score) predicted better response to treatment as measured by the BDI post-treatment (B=-.74, t=-2.43, p<.001). This predictor statistically accounted for the variability of BDI scores ($F_{(29,24)}$=3.45, p=.01, R^2=.36). There were no other potential predictor variables that significantly contributed to the general stepwise regression model (e.g., BDI pre-treatment, clinical severity, dosage of antidepressant, motivation for change, therapeutic alliance, coping strategies).

"Readiness to change" and A subscale from the URICA predicted higher treatment attendance (B=4.11, t=2.51, p<.001;

Table 2
Clinical features of patients with dysthymia

Variables	Dysthymic patients (N =5 4) mean (SD)
Baseline variables	
Motivation to change: precontemplation	15.53 (6.24)
Motivation to change: contemplation	33 (5.22)
Motivation to change: action	29.68 (6.54)
Motivation to change: maintenance	29.59 (5.95)
Motivation to change: readiness to change	76.44 (16.82)
Therapeutic alliance: bond	22.85 (4.74)
Therapeutic alliance: goals	21.79 (4.27)
Therapeutic alliance: tasks	22.62 (4.65)
Therapeutic alliance: theory of change	27.59 (5.13)
Therapeutic alliance: total score	93.74 (17.14)
Coping strategies: problem solving	9.82 (5.24)
Coping strategies: self-criticism	10.97 (4.87)
Coping strategies: cognitive restructuring	9.15 (4.8)
Coping strategies: social support	15.88 (3.99)
Coping strategies: express emotions	7.71 (5.62)
Coping strategies: problem avoidance	6.71 (5.78)
Coping strategies: wishful thinking	5 (4.03)
Coping strategies: social withdrawal	10.62 (4.78)
Perceived self-efficacy	20.15 (6.62)
CGI severity	4.15 (0.74)
BDI pre-treatment	28.21 (5.12)
Fluoxetine Eq. (mg/day)	53.33 (15.44)
Outcome variables	
CGI improvement	3.21 (0.88)
BDI post-treatment	17.59 (8.2)
Therapy attendance (%)	87.82 (15.06)

BDI, Beck's Depression Inventory; CGI, Clinical Global

Table 3
Stepwise multiple linear regression analyses

Outcome variables	Model	Predictor variables	*B*	SD	df	*p*	*R*²
CGI improvement	Step 1	Coping strategies: Express emotions[a]	-.12	.04	1	.03	.24
		Constant	1.53	.48	1	.03	
	Step 2	Coping strategies: Express emotions	-.11	.01	1	.03	.43
		Motivation to change: Action[b]	-.19	.08	1	.02	
		Constant	1.37	.49	1	.03	
	Step 3	Coping strategies: Express emotions	-.12	.04	1	.03	.59
		Motivation to change: Action	-.19	.05	1	.01	
		Motivation to change: Maintenance[c]	-.16	.06	1	.02	
		Constant	1.42	.48	1	.03	
	Step 4	Coping strategies: Express emotions	-.09	.01	1	.03	.77
		Motivation to change: Action	-.23	.09	1	.01	
		Motivation to change: Maintenance	-.17	.04	1	.02	
		Motivation to change: Readiness to change[d]	-.17	.03	1	.02	
		Constant	1.25	.59	1	.02	
BDI post-treatment	Step 1	Perceived self-efficacy[a]	-.74	.25	1	.001	.36
		Constant	1.33	.48	1	.02	
Therapy attendance	Step 1	Motivation to change: Action[a]	4.03	.83	1	.001	.28
		Constant	-2.43	.76	1	.03	
	Step 2	Motivation to change: Action	4.11	1.03	1	.001	.43
		Motivation to change: Readiness to change[b]	3.43	.77	1	.001	
		Constant	-2.25	.97	1	.02	

BDI, Beck's Depression Inventory; CGI Clinical Global Impression; DF, degree of freedom; SD, standard deviation
[a,b,c,d] New variable entered on each step

B=3.43, t=2.28, *p*<.001). These predictors statistically accounted for the variability of treatment attendance ($F_{(15,38)}$=2.73, *p*=.01, R^2=.43). There were no other potential predictor variables that significantly contributed to the general stepwise regression model (e.g., BDI pre-treatment, clinical severity, dosage of antidepressant, perceived self-efficacy, therapeutic alliance, coping strategies).

There were no statistically significant correlations between baseline predictors.

Discussion

This study aimed to elucidate the role of some relevant psychological variables in clinical response and attendance in the naturalistic treatment of dysthymia. Of note, motivation for change was the most significant predictor both of response to treatment and therapy attendance.

Our main finding is in accordance with the theoretical assumptions of the Motivational Interviewing (MI) approach (Miller & Rollnick, 2002). Accordingly, MI techniques should be included when treating patients with dysthymia, specifically among those with low motivation for change (pre-contemplation) at baseline. Some authors are indeed adapting MI techniques for the treatment of non-chronic depression (Heilemann, Pieters, Kehoe, & Yang, 2011), but their generalization is still insufficient.

Moreover, greater therapeutic alliance at baseline was not associated with better response to treatment. This contradicts previous findings among chronically depressed patients (Arnow et al., 2013) and suggests that a strong therapeutic alliance since the beginning of the treatment does not guarantee a better clinical outcomes.

Motivation for change did not significantly correlate with any other baseline variable. It was not associated with depression severity or self-perceived efficacy. We suggest that other psychological variables may impact on the motivation for change. For instance, we usually observe that dysthymic patients with greater sick role behaviors are more reluctant to make therapeutic changes. Chronic pathologies are used by some patients to define their own identity and obtain primary (seeking emotional attention) and secondary (awarding of monetary reimbursement) reinforcements (Prior & Bond, 2008). Accordingly, clinicians should be aware of abnormal illness behaviors when dealing with dysthymic patients with low motivation to change.

This study has several limitations. Because this is an ongoing naturalistic treatment, the research lacks follow-up assessment and the sample size needs to be higher. Furthermore, we did not compare different psychological treatments. Hence, we cannot confirm whether these psychological variables may have a clinical impact on other psychotherapies.

Our study also has several strengths. We addressed diverse psychological variables previously overlooked in the treatment of dysthymia, specifically motivation for change. In addition, we enhanced the ecological validity by adapting the IPT-B to the real clinical practice of a considerable portion of outpatient mental health centers from Spain (at least 2-month interval between sessions).

Our results support the idea that patient's motivation for change may be a key element when treating patients with dysthymia. Further research is needed to elucidate which psychological variables may influence on the motivation for change among these patients.

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