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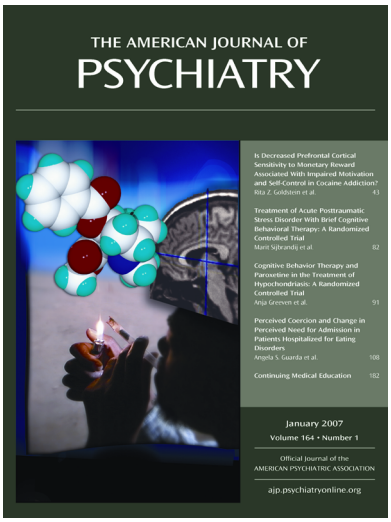

Editors' Column

In this Editors' Column we will continue our discussion about how to read and use *AJP* articles in a way that best lends itself to furthering your education and meeting your needs for clinical information. This month we will talk about how to approach the *Methods* section of Journal articles, which often is skipped over in favor of the *Results* and *Discussion* sections. However, the *Methods* offer some important insights into the research conducted, and perusing this section will often help inform your interpretation of an article. We will start with the description of the study sample, which should be present at the beginning of the *Methods* section. While it may seem a bit mundane, it is worthwhile to examine the sample characteristics and consider how they compare to the population in your clinic or region. Each article should tell you whether the sample was recruited from a representative population sample (as in epidemiologic studies), or whether they were samples of ready availability from clinical settings, including inpatient and chronic care facilities. The latter process may often be subject to a variety of selection biases that may be ultimately important to the interpretation of the study. For example, a sample that is recruited in a chronic long-term care facility may have quite different treatment expectations than a sample that is recruited from an ambulatory setting. Consider the article in December's issue by Carlbring et al., "Remote Treatment of Panic Disorder: A Randomized Trial of Internet-Based Cognitive Behavior Therapy Supplemented With Telephone Calls," in which the sample was recruited from a "waiting list of people who earlier had expressed an interest in participating in an Internet-administrated self-help program for panic disorder." This group could potentially have a different socioeconomic status and different treatment expectations than other possible samples of patients diagnosed with panic disorder. In contrast to the Carlbring study, the research volunteers recruited in December's Robinson et al. study of first episode schizophrenia were enrolled in two "not-for-profit facilities." The paper goes on to explain that the "Zucker Hillside Hospital serves a low- to middle-class population, and Bronx-Lebanon serves a mostly poor and primarily minority community." This description may be helpful for you to consider as you think about the treatment outcomes in this study and how they may compare to the patients diagnosed with schizophrenia in your own clinics.

In addition to the mode of sample recruitment and selection, another key portion of the *Methods* section is the statement indicating that each person participating in the study has provided written informed consent. Obtaining informed consent may seem like a straightforward process, but in the research setting the procedure is quite different than that typically used in clinical practice (for example, before a surgical procedure or other clinical intervention). The difference for informed consent for research procedures as opposed to routine clinical interventions is that each research study protocol and its consent forms must be evaluated by an institutional review board (IRB) that is affiliated with the research institution. IRBs are typically associated with university settings; however, there are also larger commercial IRBs that may act in a variety of settings as well. An IRB is an organized committee of scientists, doctors, clergy, and consumers at each health care facility that participate in evaluating documents associated with a clinical trial or other research activity. An IRB is designed to protect the study participants. The IRB is responsible for reviewing the study protocol, evaluating whether the trial is designed to test what it says it will test, ensuring that the study does not involve undue risks, and including the appropriate safeguards for patients. An IRB approval indicates that the research study has passed a level of safety and scrutiny appropriate for the involvement of human subjects.

The IRB process is often a cumbersome endeavor for clinical investigators, but it provides a safeguard for the study volunteer against unnecessary or inappropriate exposure to risk. It is important to recognize that IRBs do not require that research studies have no risk at all; they simply require that the risk be as low as possible for a given research question and that the risk is effectively explained to the volunteer. It may be worth noting that the involvement of persons with psychiatric disorders in research has often been the subject of controversy and debate. However, it is of critical importance that clinical research directed toward psychiatric disorders continues to advance knowledge at the same pace as other medical disorders so that our patients are not left behind.

The issue of consent for psychiatric research was addressed by a report from the National Bioethics Advisory Commission (NBAC) issued in 1999 titled "Research Involving Persons With Mental Disorders That May Affect Decision-Making Capacity." This report created a great deal of concern on the part of psychiatry researchers due to the unfortunate implication that persons with mental disorders necessarily lack decision-making capacity, which is clearly not the case in many circumstances. The fact that this study focused solely on mental illness was also unfortunate given that severely medically ill patients are also often involved in research and may have vulnerabilities in decision-making capacity as well. The NBAC report generated extensive discussion in the field and led to the implementation of additional procedures to ensure the safety of persons with mental disorders participating in research studies. One frequently used safeguard is to ask the patient's treating psychiatrist whether or not he or she can understand the process of consent. Thus, when you are asked to refer your patients for research in your department, you are participating in their informed consent.

You will notice in current issues of the *American Journal of Psychiatry* that there is a special feature within articles entitled "Patient Perspectives," which provide a brief synopsis of the experience for a volunteer participating in a given clinical research study. The importance of the patient perspective cannot be overestimated. When researchers conduct their informed consent procedures, it is important to be aware that the safety and well-being of each patient within the study and his or her clinical outcome is really at the heart of all that we do. As you read future articles in the *American Journal of Psychiatry*, please take special note of both the subject selection procedures as well as the patient perspective feature. They may help with your interpretation of the study results and assist in integrating that information into your clinical practice.

In future editions of the Residents' Journal, we will continue our discussion of research methods by reviewing a number of the most commonly used clinical rating scales and discussing how to interpret the scores in the context of daily fluctuations in various symptoms observed in clinical practice. We hope that you find this column helpful to you as you read the *American Journal of Psychiatry*, and we look forward to your feedback on other topics that may be useful.

Susan Schultz, M.D.
Robert Freedman, M.D.

Is Internet-Based Cognitive Behavior Therapy Effective Treatment for Panic Disorder?

Rachel A. Davis, M.D., PGY2
Department of Psychiatry, University of Colorado Health Sciences Center

In the December issue of the *American Journal of Psychiatry*, Carlbring et al. examine Internet-based cognitive behavior therapy (CBT) supplemented with weekly phone conversations with a therapist in the treatment of panic disorder (1). Sixty participants were randomly assigned to either a wait-list or a 10 week treatment course of Internet-based CBT supplemented with therapist contact via e-mail and a once-weekly telephone call. One month posttreatment, 77% of those in the treatment group no longer met the criteria for a diagnosis of panic disorder.

While this study does not include a standard CBT group, a previous study by Carlbring et al. compares Internet-based CBT to individual weekly CBT and finds both treatments equally effective (2). Interestingly, the earlier study, which targets a similar population and examines the same outcome measures, demonstrates a similar posttreatment clinical recovery rate (77% in the present study versus 80% in the earlier study), despite the fact that only 28% of the participants completed all the modules in the allotted 10 weeks. Of note is the fact that the addition of weekly phone calls in the present study correlates with a more robust overall effect size on the statistical analysis section of the self-report scales: posttreatment d=1.10 in the present study versus d=0.78 in the earlier study (d=0.99 for standard CBT in the earlier study). Nonetheless, the similar posttreatment recovery rate raises a question regarding the degree of benefit derived from the addition of weekly phone calls, and could be further evaluated using head-to-head comparison of live CBT versus Internet-based CBT supplemented with weekly phone calls.

As a resident interested in rural psychiatry, I am particularly interested in this study. It is promising because Internet-based CBT might be useful for several populations, particularly those suffering from agoraphobia and those in rural areas with limited access to mental health care. This study was designed for easy participation by both rural dwelling participants and those with agoraphobia. For example, the initial interview took place over the phone rather than requiring an in-person interview. However, it is unclear whether these findings would be applicable to the general population. As noted by the authors, the study sample represents a subset of individuals mostly working or studying (75%) during their participation. The study sample is also more highly educated than the general population (33% had completed college or university). The percentage of those suffering from agoraphobia was not documented, but the fact that 75% of the study sample were working or studying during their participation suggests less incidence of severe agoraphobia. Likewise, the number of urban versus rural dwelling participants was not noted. However, Census 2000 data indicates that only 17% of rural dwelling Americans has completed a 4-year college or university degree, versus 33% in this study (3).

How does one integrate the concept of therapeutic alliance with treatment modalities like the one discussed in this article? Many patients ultimately seek the help of a therapist due to a rift in interpersonal relationships. Can contact with a computer take the place of human empathy or judgment? The therapeutic relationship is difficult to quantify, but several studies demonstrate a positive correlation between therapeutic alliance and positive treatment outcomes. With CBT in particular, Kazdin et al. demonstrate a relationship between therapeutic alliance and changes in the behavior of children diagnosed with aggressive, antisocial, and opposi-tional behavior (4). Loeb et al. demonstrate a correlation between positive therapeutic alliance and decreased purging frequency in the CBT treatment of bulimia nervosa (5).

Does this study suggest that therapeutic alliance makes no difference? No. As mentioned previously, this study does not compare standard CBT to Internet-based CBT. Internet-based modules may have a beneficial effect that compensates for the lack of therapeutic alliance, but would Internet-based modules supplemented with face-to-face therapist contact have an additive effect and yield even stronger results? Perhaps there is a particular subset of patients who will do well with minimal therapeutic alliance, just as there are some patients who become highly self-motivated to change their diet or exercise upon learning that their cholesterol is too high. It remains to be seen whether or not Internet-based CBT patients can do as well.

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'Tis the Season for Termination

Amanda B. Mackey, M.D., PGY4

Department of Psychiatry and Behavioral Sciences, University of Louisville

The only thing that one really knows about human nature is that it changes. Change is the one quality we can predicate on. The systems that fail are those that rely on the permanency of human nature, and not on its growth and development.

- Oscar Wilde

Change is part of life, or so we learn. We strive to help patients tolerate change and the myriad of emotions that accompany such developments. Termination is change. As a fourth-year resident, termination is a reality facing myself and numerous colleagues. While termination is a process that occurs in psychotherapy, residents in training also face unique challenges in this process.

In an ideal world, the therapeutic relationship would be terminated in a mutual fashion, with both the therapist and patient agreeing that specific treatment goals have been accomplished. Yet the nature of training often dictates that terminations occur at a specific time, due to external variables such as changing rotation sites or graduation. In reviewing the literature, I was amused by the fact that most titles referring to this phenomenon use the term "forced termination," which in itself implies aggression (1-3). While a therapist-initiated termination stirs emotions within the patient, likened by Bostic et al. to Kubler-Ross's stages of grief, the literature places an emphasis on the countertransference phenomena that occur within the therapist (1). As patients experience symptoms, therapists also often feel sadness, guilt, and a desire to "rescue" the patient (2, 4).

While therapy termination is a challenge, it has been noted that the most inexperienced therapists are often the ones facing it the most frequently (3). It is probably not surprising that a number of therapists delay in telling patients or that this may not be approached in supervision sessions (1). Weddington and Cavenar explain that this may be due to the therapist's "avoidance or denial of the issues of rejection, loss and abandonment" (4).

Facing the end of training adds another dynamic to an already complicated task. While attending a conference with fellow PGY-4s earlier this fall, common themes seemed to arise. Where am I going after training? How will I balance personal and professional aspects of my life? These questions face me on a daily basis as I experience the process of terminating from a program in which I have trained over the past four years. Perhaps this is an opportunity to understand the concept of parallel process on an up close and personal basis (2).

Pondering termination often leaves me with even more questions. Are there any answers? There is a consensus among the literature that supervision is the key (1, 3–4). I am fortunate to sit with my supervisor weekly and discuss the process at length. In what I perceive as an attempt at reframing, my supervisor describes the process of termination as a gift for my patients and myself. I laughed nervously when I heard this. Yet as the holidays approach, heralding the New Year, I anticipate giving and receiving a new gift: termination. I must admit, something more traditional, purchased with my credit card perhaps, would be much easier.

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