APPENDIX A: SEARCH STRATEGY

Primary Literature (January 2009 through July 2010)

Final limits: Human, Adult, 19+ years, English, Randomized Controlled Trial, Publication date from January 1, 2009 to July 31, 2010.

Step	Terms	Result
1. Replication of Cuijpers database therapy terms	Behavior therapy OR biofeedback OR cognitive analytic therapy PR counseling OR family therapy PR marital therapy PR psychoanalytic therapy OR psychotherapy PR relaxation therapy	1822
2. Replication of Cuijpers database depression terms	"depressive disorder"[MeSH Terms] OR ("depressive"[All Fields] AND "disorder"[All Fields]) OR "depressive disorder"[All Fields] OR "depression"[All Fields] OR "depression"[MeSH Terms] OR depressive[All Fields]	1152
3. Addition of other terms for types of therapy of interest for this report	Interpersonal therapy OR problem-solving therapy OR mindfulness-based cognitive therapy OR cognitive behavioral analysis system of psychotherapy OR dialectical behavior therapy OR functional analytic psychotherapy OR acceptance and commitment therapy	178
4. Final search	(#1 OR #3) AND #2	383

Systematic Reviews

Final limits: English, All Adult: 19+ years, Systematic Reviews, Publication date from 2000.

Step	Terms	Result
1	Search (("depressive symptoms"[All Fields]) OR ("Depression"[Mesh] OR "Depressive Disorder"[Mesh]) OR (depression))	51523
2	Search (minor AND depression) OR (subthreshold AND depression) OR (subsyndromal AND depression)	3689
3	Search major depressive disorder[mesh]	64244
4	Search dysthymia OR dysthymic disorder[mesh]	2407
5	Search adjustment disorder[mesh]	3615
6	Search 1 OR 2 OR 3 OR 4 OR 5	69903
7	Search ((cognitive behavioral therapy OR CBT OR cognitive therapy OR behavior therapy OR interpersonal therapy OR IPT OR problem-solving therapy OR PST OR mindfulness-based cognitive therapy OR MBCT OR ("cognitive behavioral analysis system" AND therapy) OR CBASP OR dialectical behavioral therapy OR DBT OR functional analytic psychotherapy OR FAP OR (acceptance AND commitment AND therapy) OR ACT OR short-term psychodynamic therapy) OR (psychotherapy, brief[mesh]))	297485
8	Search Cochrane Database Syst Rev [TA] OR search[Title/Abstract] OR meta-analysis[Publication Type] OR MEDLINE[Title/abstract] OR (systematic[Title/Abstract] AND review[Title/Abstract])	159125
9	Search 6 AND 7 AND 8	341

APPENDIX B: EVIDENCE TABLES

BRIEF PSYCHOTHERAPY FOR DEPRESSION IN PRIMARY CARE

Study ID: Barnhofer, Crane, Hargus, et al., 2009

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
Geographical location: Oxford, England **Recruitment method:** - Advertisement - Referral **Recruitment setting:** - Mental health - Nonclinical **Treatment setting:** - Mental health - Academic **Study design:** RCT **Number of participants enrolled:** 31 **Duration of followup:** 8 wk	**Age:** Mean (SD): 42 MBCT: 42.07 (11.34) TAU: 41.79 (9.52) Median: NR Range: 18 to 65 **Education:** Mean (SD) MBCT: 16.38 (3.04) TAU: 15.21 (3.19) **Sex:** Female n (%): 19 of 28 (68%) MBCT: 10 of 14 (71%) TAU: 9 of 14 (64%) **Race/ethnicity:** NR **Veterans:** NR **Baseline depression assessment(s):** Criterion: DSM-IV Disorder: Chronic MDD n (%) MBCT: 7 (50%) TAU: 12 (85%) Current: 100% Severity score: mean (SD) MBCT: 29.36 (9.66) TAU: 31.32 (10.79) Chronicity: 20+ years for current Prior episodes: At least 3 prior episodes lasting 2 yr	**Intervention description:** RCT of 2 arms: 1. MBCT: 14 participants 2. TAU: 14 participants **Depression intervention(s):** Behavioral intervention Type: MBCT for 8 sessions of 2-hr duration delivered via manual (Segal, 2002) modified for suicidality with homework of mindfulness practice 1 hr per day, 6 days per wk Delivery: Group Intensity: 8 weekly 2 hr Fidelity monitoring: Yes Other notes about intervention: All on some type of antidepressant Therapist Discipline: CBT Experience: NR Training: internship at the Center for Mindfulness in Medicine, University of Massachusetts **Comparator:** Behavioral control Type: TAU Delivery: Mixed Intensity: Mixed Fidelity monitoring: No Other notes about control: All on some type of antidepressant **Cointervention—psychotropic drugs:** None	**Eligible randomized:** 31 of 34 (91%) **Followup rate:** Total: 28 of 31 (90%) MCBT: 14 of 16 (86%) TAU: 15 of 16 (94%) **Important baseline differences:** Presence of chronic depression higher in TAU (n = 12) versus MBCT (n = 7), p = 0.04 **Depression outcomes:** BDI-II Response rates n (%): BDI fell to < 13 MBCT: 6 (37) TAU: 1 (6) P = 0.04 Change in diagnosis: MBCT: 7 of 10 TAU: 2 of 11 P = 0.03 Severity score: mean (SD) MBCT: 17.62 (10.94) TAU: 28.86 (12.97) **HRQOL outcomes:** NR **Other outcomes:** Social: No Occupational: No Satisfaction: No Suicidal ideation: Yes	**General comments:** Stats were LOCF – now frowned upon in favor of modeling or imputation **Study-level quality assessment:** Good **Assessment of adverse effects adequate?** Yes **Applicability:** - High education - Mostly women

Study ID: Barnhofer, Crane, Hargus, et al., 2009

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
	Comorbid psychiatric conditions: N (%) Alcohol/substance abuse: Excluded Anxiety disorder: MBCT: 4 (28%) TAU: 6 (42%) PTSD: NR Other: Suicide attempt: 8 (56%) MBCT: 4 (28%) TAU: 4 (28%) **Comorbid chronic medical conditions**: NR **Inclusion criteria:** 1. History of 3 episodes MDD 2. Current MDD or subthreshold MDD 3. History of suicidality 4. Absence of other severe mental health diagnosis, especially self-harm 5. Adequate written and oral English 6. Not currently in treatment 7. Ages 18 to 65 **Exclusion criteria:** NR		**Treatment discontinuation rate**: 3 (9.7%) **Adverse effects:** None reported related to intervention	

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Study ID: Laidlaw, Davidson, Toner, et al., 2008

Study Information

Geographical location: UK (Fife and Glasgow)

Recruitment method: Referral

Recruitment setting: Primary care

Treatment setting:
- Unclear
- Nonacademic

Study design: RCT

Number of participants enrolled: 44

Duration of followup: 6 mo

Participants

Age:
Mean (SD)
CBT: 74 (8.39)
TAU: 74.05 (7.62)
Median: NR
Range: NR

Education:
Mean (SD)
CBT: 10.10 (1.74)
TAU: 9.9 (1.29)

Sex:
Female n (%):
CBT: 11 (60%)
TAU: 18 (85%)

Race/ethnicity: NR

Veterans: NR

Baseline depression assessment(s):
BDI ns
CBT: 19.6 (5.22)
TAU: 19.5 (5.48)
GDS ns
CBT: 7.6 (2.7)
TAU: 8.5 (3.55)
HAM-D ns
CBT: 11.4 (3.08)
TAU: 11.8 (2.84)
Disorder: MDD
Severity: NR
Chronicity: NR
Prior episodes: NR

Interventions

Intervention description:
Two arms:
1. CBT: 21 participants
2. TAU: 23 participants

CBT followed conceptual model and protocol developed by Beck. TAU was as close to standard care as possible. No restrictions on type of treatment; also, no treatment was allowed if GP thought appropriate.

Depression intervention(s):
Behavioral intervention
Type: CBT
Delivery: Mean 8 sessions (SD = 4.7, range 2 to 17)
Intensity: NR (assumed weekly since adhering to Beck's protocol)
Fidelity monitoring: Yes, audiotaped and rated with Cognitive Therapy Rating Scale by cognitive therapy experts

Other notes about intervention: Assumption is that the sessions were weekly given that they said they adhered to Beck's model, in which case post results should approximate 8 sessions; however, frequency of sessions not provided.

Therapist
Discipline: Psychology
Experience: NR
Training: Master's level (except for one who was graduate level with several years of experience)

Results and Adverse Effects

Eligible randomized: 61% (based on Figure 1, 115 referred, 28 + 44 eligible, 44 randomized)

Followup rate: 40 (90.9%)

Important baseline differences: Gender (TAU had higher percentage of female; CBT had higher percentage of male)

Depression outcomes:
Response rates:
CBT: 20
TAU: 20

BDI

	CBT	TAU	F, p
Post treatment	9.4 (8.56)	13.25 (10.3)	1.65 0.21
3 mo	9 (8.16)	12.9 (9.34)	1.98 0.17
6 mo	10.55 (9.05)	15.10 (11.83)	1.87 0.18

GDS

	CBT	TAU	F, p
Post treatment	3.85 (3.83)	5.3 (3.48)	1.57 0.22
3 mo	5 (3.71)	4.9 (3.35)	0.008 0.93
6 mo	5.05 (3.46)	5.75 (3.72)	0.38 0.54

Comments/ Quality Scoring

General comments:
- Adequate randomization
- Missing data adequately addressed
- Blinding not possible given intervention but assessors were blinded
- No concerns regarding selective outcome reporting
- No conflicts of interest

Study-level quality assessment
Fair

Comments:
- Small sample size
- Missing information from the protocol that would allow evaluation of applicability to our question

Assessment of adverse effects adequate?
Unclear

Applicability:
To general population: Yes

To Veterans: Yes

Limitations:
- Not enough information on disease severity
- Intensity of therapy not given
- UK primary care may differ from US

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Study ID: Laidlaw, Davidson, Toner, et al., 2008

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring

Comorbid psychiatric conditions:
N (%)
Alcohol/substance abuse: NR
PTSD: NR
Other anxiety disorder: NR
Other: Axis I disorder: CBT-2 (10%), 6 (30%)

Comorbid chronic medical conditions:
Mean (SD)
CBT: 2.26 (1.2)
TAU: 2.2 (0.83)
Conditions not specified

Inclusion criteria:
1. Age 60 or over
2. Met DSM-IV criteria for MDD using the SADS-L structured interview
3. HAM-D = 7-24
4. BDI-II = 13 to 28
5. Can provide written consent
6. Not prescribed antidepression medication within 3 mo of referral to trial

Exclusion criteria:
1. Insufficient knowledge of English
2. MMSE < 22
3. Received more than 6 sessions of CBT in the past or currently receiving psychological therapy

Comparator:
Behavioral control
Type: TAU
Delivery: Standard care
Intensity: At GP's discretion
Fidelity monitoring: Yes, checking GP notes at the end of study and asking participants about treatment received; however, no adherence data since there were guidelines given to GPs

Other notes about control: 16 (80%) received medications

Cointervention—psychotropic drugs:
Drug name/dose: None provided by the study
Clinician discipline: NA

HAM-D

	CBT	TAU	F, p
Post treatment	5.25 (4.48)	7.75 (6.05)	2.2 0.15
3 mo	5.15 (4.75)	6.7 (6.23)	.78 0.38
6 mo	6.7 (5.03)	7.55 (6.13)	.23 0.63

HRQOL outcomes:
WHOQOL Physical Subscale

	CBT	TAU	F, p
Post treatment	22.4 (5.02)	19.85 (4.34)	0.29 0.59
3 mo	21.6 (3.66)	20.75 (5.3)	0.02 0.9
6 mo	21.35 (5.34)	20 (5.69)	.0.75 0.39

WHOQOL Psychological Subscale

	CBT	TAU	F, p
Post treatment	20.65 (3.13)	18.15 (3.66)	0.14 0.71
3 mo	19.65 (2.62)	19.15 (3.13)	0.08 0.78
6 mo	19.2 (3.43)	17.75 (3.99)	2.39 0.13

Other outcomes:
Social: WHOQOL Social Relationships

	CBT	TAU	F, p
Post treatment	10.05 (2.66)	9.95 (1.4)	1.72 0.09
3 mo	11 (1.26)	10.55 (1.23)	0.35 0.56
6 mo	10.5 (1.4)	10.2 (1.47)	0.77 0.44

Study ID: Laidlaw, Davidson, Toner, et al., 2008

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
			Occupational: NR Satisfaction: NR **Treatment discontinuation rate**: Withdrew from study at 6 mo followup: CBT: 2 TAU: 4 **Adverse effects:** NR	

Study ID: Mynors-Wallis, Gath, Day, et al., 2000

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
Geographical location: Oxfordshire, UK **Recruitment method:** Referral **Recruitment setting:** Primary care **Treatment setting:** - Primary care (i.e., patients' home or local health center) - Nonacademic **Study design:** RCT **Number of participants enrolled:** 71 **Duration of followup:** 52 wk	**Age:** Mean (SD) Med: 34 (NR) MedPST: 35 (NR) Median: NR Med range: 19 to 58 MedPST range: 19 to 62 **Education:** N (%) Med: 9 (25%) > 16 yr MedPST: 8 (23%) > 16 yr **Sex:** Female n (%) Med: 31 (86%) MedPST: 24 (69%) **Race/ethnicity:** White n (%) Med: 32 (89%) MedPST: 34 (97%) **Veterans:** No **Baseline depression assessment(s):** Criterion: HRSD ≥ 13 Disorder: 71 (100%) probable or definite MDD HRSD mean (95% CI) Med: 20.2 (19.1 to 21.4) MedPST: 19.8 (18.5 to 21.1) BDI mean (95% CI) Med: 30.2 (27.7 to 32.7) MedPST: 30.0 (27.3 to 32.6)	**Intervention description:** Four arms: 1. Problem-solving treatment (PST) alone provided by GP (excluded from this analysis): 39 participants 2. PST alone provided by nurse (excluded from this analysis): 41 participants 3. Medication alone (Med): 36 participants 4. Medication + PST (MedPST) provided by nurse: 35 participants **Depression intervention(s):** Behavioral intervention Type: MedPST; PST for use in primary care settings was added to GP prescription of fluvoxamine or paroxetine Delivery: Individual Intensity: 6 sessions (first session, 1 hr; rest 30 min) over 12 wk Fidelity monitoring: No Therapist Discipline: Research practice nurse Experience: Participated in previous study as problem-solving therapist Training: Nursing; trained in PST by study investigator **Comparator:** Behavioral control Type: Med; GP prescribed fluvoxamine or paroxetine in accordance with practice guidelines Delivery: Individual Intensity: NR Fidelity monitoring: No	**Eligible randomized:** 83% **Followup rate:** N (%) Med 6 wk: 34 of 36 (94%) MedPST 6 wk: 34 of 35 (97%) Med 12 wk: 34 of 36 (94%) MedPST 12 wk: 31 of 35 (89%) Med 52 wk: 30 of 36 (83%) MedPST 52 wk: 30 of 35 (86%) **Important baseline differences:** None **Depression outcomes:** HRSD Recovered (HRSD ≤ 7): Med 12 wk: 24 (67%) MedPST 12 wk: 21 (60%) Med 52 wk: 20 (56%) MedPST 52 wk: 23 (66%) Severity score mean (95% CI): Med 12 wk: 6.2 (3.7 to 8.6) MedPST 12 wk: 7.5 (5.2 to 9.9) Med 52 wk: 7.2 (5.1 to 9.2) MedPST 52 wk: 5.7 (3.4 to 7.9) BDI mean (95% CI) Med 12 wk: 11.8 (7.8 to 15.8) MedPST 12 wk: 9.3 (6.6 to 12.0) Med 52 wk: 11.5 (6.9 to 16.2) MedPST 52 wk: 8.6 (5.3 to 11.9) CIS mean (95% CI) Med 12 wk: 9.8 (6.1 to 13.5) MedPST 12 wk: 9.6 (6.3 to 12.9) Med 52 wk: 11.5 (7.3 to 5.6) MedPST 52 wk: 9.7 (5.9 to 13.6)	**General comments:** PST alone (provided by either GP or nurse) found to be equally efficacious to medication alone, and addition of PST to medication did not result in significant benefit **Study-level quality assessment** Good **Assessment of adverse effects adequate?** Yes; research interviewers were blind **Applicability:** To general population: - Comorbid conditions not reported - Therapists likely more skilled than typical providers - UK treatment settings different than typical US primary care To Veterans: - Patient sample predominantly female - From UK - Treatment often provided in home

Study ID: Mynors-Wallis, Gath, Day, et al., 2000

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
	CIS-D mean (95% CI) Med: 29.3 (27.3 to 31.2) MedPST: 29.0 (26.5 to 31.5) Chronicity: Med 12 (33%) > 6 mo MedPST: 13 (37%) > 6mo Prior episodes: Med ≥ 1: 19(53%) MedPST ≥ 1: 19(54%) **Comorbid psychiatric conditions:** Alcohol/substance abuse: NR (excluded) PTSD: NR (excluded) Other anxiety disorder: NR (excluded) **Comorbid chronic medical conditions**: NR **Inclusion criteria:** 1. GP suspected MDD 2. Probable or definite MDD on research diagnostic criteria 3. HRSD ≥ 13 4. MDD duration ≥ 4 wk **Exclusion criteria:** 1. Psychiatric disorder preceding MDD onset 2. Concurrent MDD treatment 3. Brain damage 4. Learning difficulties 5. Schizophrenia 6. Drug dependence 7. Recent alcohol abuse 8. Physical illness 9. MDD with psychotic features or suicidal intent	**Cointervention—psychotropic drugs :** Drug name/dose : Fluvoxamine/initial dose 100 mg ; or paroxetine/initial dose 20 mg Clinician discipline : GP	**HRQOL outcomes:** None **Other outcomes:** Social: Yes (social adjustment scale) Occupational: No Satisfaction: No **Treatment discontinuation rate**: Med: 6 (17%) MedPST: 6 (17%) **Adverse effects:** N (%) Med medication side effects: 2 (6%) MedPST medication side effects: 4 (11%)	

Study ID: Nezu, 1986

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
Geographical location: USA **Recruitment method:** Advertisement **Recruitment setting:** Nonclinical (ad) **Treatment setting:** **- Mental health** - Academic (university psychology clinic) **Study design:** RCT **Number of participants enrolled: 21** **Duration of followup:** - 8 wk for PST vs WLC - 6 mo for PST vs PFT	**Age:** Mean (SD): 41.73 (12.81) Median: NR Range: NR **Education:** Mean (SD):15.96 (2.59) yr **Sex:** Female n (%) PST: 10 (83%) WLC: 7 (78%) **Race/ethnicity: NR** **Veterans: No** **Baseline depression assessment(s):** Criterion: Research Diagnostic Criteria Disorder: 21 (100%) MDD BDI PST: 23.91 (7.09) WLC: 20.67 (5.39) MMPI-D PST: 81.36 (8.12) WLC: 78.76 (7.05) Chronicity: NR Prior episodes: NR **Comorbid psychiatric conditions:** Alcohol/substance abuse: NR (exclusion criterion) PTSD: NR Other anxiety disorder: NR Other: NR	**Intervention description:** Three arms: 1. Problem-focused therapy (PFT) (excluded from this analysis): 11 participants 2. Problem-solving therapy (PST): 12 participants 3. Waitlist control (WLC): 9 participants **Depression intervention(s):** <u>Behavioral intervention</u> Type: PST based on D'Zurrila and Nezu's (1982) five-component model Delivery: Group Intensity: 8 weekly 1.5 to 2 hr sessions Fidelity monitoring: Partial (weekly supervision to ensure adherence to relevant treatment manuals) Other notes about behavioral intervention: Therapist allegiance very likely a confound for PST vs PFT but not for PST vs waitlist <u>Therapist</u> Discipline: Two psychology graduate students Experience: Average 4.5 years supervised psychotherapy experience Training: Prior training in group therapy and PST model; weekly supervision from author during treatment period	**Eligible randomized:** 78% **Followup rate:** N (%) PST 8 wk: 11 of 12 (92%) WLC 8 wk: 6 of 9 (67%) (3 excluded because entered therapy in interim) PST 6 mo: 10 of 12 (83%) **Important baseline differences:** None **Depression outcomes:** BDI PST 8 wk: 9.82 (4.71) WLC 8 wk: 21.00 (6.27) PST 6 mo: 9.50 (3.64) MMPI-D PST 8 wk: 54.27 (4.62) WLC 8 wk: 76.33 (4.89) PST 6 mo: 52.50 (6.89) **HRQOL outcomes:** None **Other outcomes:** Social: No Occupational: No Satisfaction: No **Treatment discontinuation rate:** PST: 1 (8%) **Adverse effects:** NR	**General comments:** Therapist allegiance to and experience in PST both very high **Study-level quality assessment** Fair Comments: - 33% of WLC excluded from analysis because sought treatment - Outcome assessors were not blind (although clinical interview not used as outcome measure) - Therapist allegiance to PST likely very high **Assessment of adverse effects adequate?** No **Applicability:** <u>To general population:</u> - Patients recruited through newspaper ads - Therapist skill in and adherence to PST higher than typical clinician - Intensive treatment for PC setting

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Study ID: Nezu, 1986

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
	Comorbid chronic medical conditions: NR **Inclusion criteria:** 1. Responded to advertisement 2. BDI ≥ 16 3. Depressive episode ≥ 4 weeks 4. Meet Research Diagnostic Criteria for MDD 5. MMPI-D T score > 70 **Exclusion criteria:** 1. Mental retardation 2. Psychotic symptomatology 3. Active substance use 4. Organic brain syndrome 5. Current MDD treatment	**Comparator:** Behavioral control Type: WLC invited to receive treatment at the end of 8-wk program Delivery: NA Intensity: NA Fidelity monitoring: No **Cointervention—psychotropic drugs:** None		To Veterans: - Patient sample predominantly female - Comorbid conditions not reported - University psychology clinic setting

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Study ID: Simon, Ludman, Tutty, et al., 2004, and Simon, Ludman, and Rutter, 2009

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
Geographical location: Washington State and Northern Idaho, USA **Recruitment method:** Registry (Group Health Cooperative membership) **Recruitment setting:** Primary care **Treatment setting:** Primary care **Study design:** RCT **Number of participants enrolled:** 600 **Duration of followup:** 6 wk,12 wk, and 24 wk	**Age:** Mean (SD) Usual care: 44.0 (16.0) Care management (CM): 44.9 (15.3) Psychotherapy + CM: 44.7 (15.7) Median: NR Range: NR **Education:** College graduate: 39.3% **Sex:** Female: 74.33% **Race/ethnicity:** White: 80% **Veterans:** NR **Baseline depression assessment:** Criterion: Hopkins Symptom Checklist (SCL) Disorder: NR Severity: mean (SD) Usual Care: 1.55 (0.62) CM: 1.54 (0.61) Psychotherapy + CM: 1.52 (0.59) Chronicity: NR Prior episodes: NR **Comorbid psychiatric conditions:** NR Alcohol/substance abuse: NR Anxiety disorder: NR PTSD: NR Other: NR	**Intervention description:** Three arms: 1. Telephone-based psychotherapy (CBT) + CM: 195 participants 2. Telephone CM: 207 participants 3. Usual care: 195 participants **Depression intervention(s):** <u>Behavioral intervention</u> Type: CBT; 8 sessions structured assessment, motivational enhancement, behavioral activation, cognitive restructuring, self-care plan Delivery: Telephone Intensity: 8 sessions 30 to 40 min; first four sessions every wk, second four 1 to 4 wk apart Fidelity monitoring: No Other notes about intervention: Psychotherapy was in addition to CM <u>Therapist</u> Discipline: Master's-level psychologist Experience: At least 1 yr clinical experience Training: 12 hr didactic and role play, observation, and audiotaping of 6 sessions each, 1 hr weekly supervision, twice monthly motivational interviewing seminar	**Eligible randomized:** 95% **Followup rate:** N (%) 578 (96%) had 1 followup 532 (89%) completed 6 month followup CM: 97% had 1 contact 85% had 3 contacts Psychotherapy + CM: 14 (7%) had no sessions 2 (1%) had 1 session only 167 (84%) had ≥ 4 sessions 125 (25%) had ≥ 7 sessions **Important baseline differences:** None **Depression outcomes:** 6-mo followup using SCL (50% reduction) Response rates n (%): Usual care: 76 of 176 (43%) CM: 94 of 184 (51%) Psychotherapy + CM: 100 of 172 (58%) Severity score: NR	**General comments:** None **Study-level quality assessment:** Good Comments: - Comparable groups - Little missing data - Outcome assessors blinded - Not free of selective outcome reporting - PHQ results not reported - SCL scores at outcome not reported **Assessment of adverse effects adequate?** NR **Applicability:** -Severity of baseline depression, chronicity and comorbid condition not given - Sample was from a group model primary care clinic who did not want referral to mental health clinic - CM involved significant outreach (at least 5 phone calls) per participant, which is not routine clinical practice

Study ID: Simon, Ludman, Tutty, et al., 2004, and Simon, Ludman, and Rutter, 2009

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
	Comorbid chronic medical conditions: NR **Inclusion criteria:** 1. Beginning antidepressant 2. SCL Score > 0.5 **Exclusion criteria:** 1. Not a new episode of antidepressant treatment 2. Bipolar 3. Schizophrenia 4. Planning or receiving psychotherapy 5. Cognitive, language, or hearing impairment	**Comparator 1:** **Behavioral control** Type: Usual care; any treatment normally available including primary care physician visits and referral to mental health Delivery: NR Intensity: NR Fidelity monitoring: No **Comparator 2:** Behavioral control Type: Telephone CM; assessment of depression, antidepressant use, and adverse effects. Scripts for addressing concerns and motivational enhancement. Primary care physicians received summary and computer-generated recommendations. Also care coordination, outreach, and as-needed crisis intervention. Delivery: Telephone Intensity: Wk 4, 12, 20 Fidelity monitoring: No **Cointervention—psychotropic drugs:** NR	**HRQOL outcomes:** NR **Other outcomes:** NNT 6.4 for 50% reduction in SCL psychotherapy + CM versus usual care Social: NR Occupational: NR Satisfaction: Self-rated "very satisfied"— Usual care: 50 of 176 (29%) CM: 85 of 184 (47%) Psychotherapy + CM: 101 of 172 (59%) Self-rated "much improved"— Usual care: 97 of 176 (55%) CM: 121 of 184 (66%) Psychotherapy + CM: 100 of 172 (58%) Total depression costs: $ Mean (SD) Usual care: 1020 (1009) CM: 1485 (1258) Psychotherapy + CM:1670 (1110) Total health care costs $ Mean (SD) Usual care: 9406 (10554) CM: 10268 (9773) Psychotherapy + CM: 9334 (8432) **Treatment discontinuation rate:** N (%) 14 (7%) had no sessions 2 (1%) had 1 session only 167 (84%) had ≥ 4 sessions 125 (25%) had ≥ 7 sessions **Adverse effects:** NR	

Study ID: Wilson, 1982

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
Geographical location: Sydney, Australia **Recruitment method**: Advertisement **Recruitment setting:** Mental health **Treatment setting:** Academic **Study design:** RCT, stratified by sex **Number of participants enrolled:** 97; 64 analyzed **Duration of followup:** - 8 wk - 6 mo posttrial followup	**Age:** Mean (SD): 38.8 (NR) Median: NR Range: 20 to 55 **Education:** NR **Sex:** Female: 42 (65.6%) **Race/ethnicity:** NR **Veterans:** None **Baseline depression assessment(s):** Criterion: BDI Disorder: NR Severity: Amitriptyline +task assignment: 26.08 (7.61) Amitriptyline + relaxation therapy: 23.10 (3.51) Amitriptyline+ minimal contact: 25.8 (5.12) Placebo +task assignment: 27.22 (4.87) Placebo+ relaxation therapy: 25.82 (4.47) Placebo + minimal contact: 25.00 (5.77) Chronicity: NR Prior episodes: "Past psychological issues in 86%" **Comorbid psychiatric conditions:** NR **Comorbid chronic medical conditions**: NR	**Intervention description:** Patients randomly allocated within sex to: 1. Amitriptyline +task assignment 2. Amitriptyline + relaxation therapy 3. Amitriptyline+ minimal contact 4. Placebo +task assignment 5. Placebo+ relaxation therapy 6. Placebo + minimal contact **Depression intervention(s):** Behavioral intervention Type: Behavioral therapy, 7 sessions over 1 hr Delivery: Individual Intensity: NR Fidelity monitoring: NR Other notes about intervention: Adapted from MacPhillamy and Lewinsohn therapy Therapist Discipline: Psychology Experience: Graduate students Training: Previous experience with behavioral treatments (experimental and clinical) not specified further **Comparator:** Behavioral control Type: Minimal contact, participants described their problems, nondirective and no specific suggestions Delivery: Individual Intensity: Two 1-hr sessions Fidelity monitoring: NR	**Eligible randomized:** 97; 64 analyzed in completers analysis **Followup rate:** 64 (65.9%) **Important baseline differences:** None **Depression outcomes:** 8 wk: Placebo +task assignment: 11.89 (10.87) Placebo+ relaxation therapy: 16.55 (10.36) Placebo + minimal contact: 14.67 (11.12) 6 mo: Placebo +task assignment: 10.00 (8.14) Placebo+ relaxation therapy: 11.27 (7.98) Placebo + minimal contact: 15.18 (10.86) Response rates: NR Severity score: NR **HRQOL outcomes:** NR **Other outcomes:** Social: No Occupational: No Satisfaction: No **Treatment discontinuation rate**: NR **Adverse effects:** NR	**General comments:** None **Study-level quality assessment** Poor Comments: - Unclear randomization - Unclear allocation concealment - Incomplete data not addressed - Unclear blinding (not blinded to drug) - Selective outcome reporting **Assessment of adverse effects adequate?** No **Applicability:** To general population: - Done in Australia - University setting - Recruitment via advertising To Veterans: - 65% women - Comorbidities NR - Chronicity NR

Study ID: Wilson, 1982

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
	Inclusion criteria: 1. BDI ≥ 20 2. Depression ≥ 2 months (self-report)	Other notes about control: Described as a way for subjects to talk about their problems and see a solution to it themselves		
	Exclusion criteria: 1. No other major psychiatric disorders 2. Not getting any psychological or pharmacological treatments (apart from minor tranquilizers) 3. No contraindications to amitriptyline	**Cointervention—psychotropic drugs:** Drug name/dose: Randomized to drug or placebo. Amitriptyline 50 mg titrated to 150 mg over 6 wk and then titrated off over 6 days Clinician discipline: NR		

Study ID: Wilson, 1983

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
Geographical location: Sydney, Australia **Recruitment method:** Advertisement **Recruitment setting:** - Mental health, primary care, mixed - Nonclinical **Treatment setting:** **- Mental health outpatient** - Academic **Study design:** RCT **Number of participants enrolled:** 25 **Duration of followup:** - 8 wk - Naturalistic followup of interventions at 30 wk	**Age:** Mean : 39.5 Median: NR Range: 20 to 58 **Education:** 19 (76%) completed at least lower secondary school **Sex:** Female: 20 (80%) **Race/ethnicity:** NR **Veterans:** No **Baseline depression assessment(s):** - 7 participants had past hospitalization - 2 on antidepressants - 3 on minor tranquilizers Behavioral therapy arm Criterion: BDI Disorder: NR Severity: 21.13 (7.62) Chronicity: At least 3 mo Prior episodes: NR Criterion: HAM-D (17 item) Disorder: NR Severity: 13.89 (3.22) Chronicity: at least 3 mo Prior episodes: NR	**Intervention description:** 1. Behavioral therapy: 8 participants 2. Cognitive therapy: 8 participants 3. Waitlist: 9 participants **Depression intervention 1:** <u>Behavioral intervention</u> Type: Behavioral activation based on Lewinsohn et al. To increase the frequency, quality, and range of activities and social interactions; mood record also maintained. Delivery: Individual Intensity: Eight 1-hr weekly sessions Fidelity monitoring: No **Depression intervention 2:** <u>Cognitive intervention</u> Type: Cognitive restructuring based on Beck et al. Negative cognitive distortions and irrational beliefs evaluated and positive thought schedule developed for 3 times a day use; thought record also maintained. Delivery: Individual Intensity: Eight 1-hr weekly sessions Fidelity monitoring: No <u>Therapist</u> Discipline: NR Experience: NR Training: NR **Comparator:** <u>Behavioral control</u> Type: Waitlist only; no interaction Delivery: None Intensity: None Fidelity monitoring: No **Cointervention—psychotropic drugs:** NR	**Eligible randomized:** 29 **Followup rate:** NA; 3 participants in behavioral treatment and 1 in cognitive treatment dropped out and were replaced by new participants **Important baseline differences:** NR **Depression outcomes:** Response rates: NR Severity scores: BDI Behavioral therapy Pre Rx: 21.13 (7.62) Post Rx: 7.50 (4.55) Cognitive therapy Pre Rx: 27.25 (3.80) Post Rx : 9.00 (6.82) Waitlist Pre Rx : 23.66 (7.45) Post Rx: 21.44 (5.52) HAM-D Behavioral therapy Pre Rx: 13.89 (3.22) Post Rx: 5.25 (3.46) Cognitive therapy Pre Rx: 13.62 (2.40) Post Rx: 5.88 (5.01) Waitlist Pre Rx: 13.22 (4.08) Post Rx: 14.78 (5.96) **HRQOL outcomes:** NR **Other outcomes:** Social: No Occupational: No Satisfaction: No	**General comments:** None **Study-level quality assessment** Fair Comments: - Unclear randomization - Unclear allocation concealment - Unclear blinding - No selective outcome reporting - Patients who dropped out were replaced; possibly not randomized - Comorbidities NR - Limited information reported, but an old study **Assessment of adverse effects adequate?** No **Applicability:** <u>To general population:</u> - Recruited via advertising - Treated in Australia - Treatment in a university setting <u>To Veterans:</u> - 80% women - No comorbidities reported including substance abuse - Dropouts replaced

Study ID: Wilson, 1983

Study Information	Participants	Interventions	Results and Adverse Effects	Comments/ Quality Scoring
	Cognitive therapy arm Criterion: BDI Disorder: NR Severity: 27.25 (3.80) Chronicity: At least 3 mo Prior episodes: NR Criterion: HAM-D (17 item) Disorder: NR Severity: 13.62 (2.40) Chronicity: At least 3 mo Prior episodes: NR	Waitlist Criterion: BDI Disorder: NR Severity: 23.66 (7.45) Chronicity: at least 3 mo Prior episodes: NR Criterion: HAM-D (17 item) Disorder: NR Severity: 13.62 (4.08) Chronicity: At least 3 mo Prior episodes: NR **Comorbid psychiatric conditions:** Excluded Alcohol/substance abuse: NR PTSD: NR Other anxiety disorder: NR Other: NR **Comorbid chronic medical conditions**: NR **Inclusion criteria:** 1. BDI ≥ 17 2. Frequent episodes of depression (self-report) 3. Depression for at least 3 mo (self-report) **Exclusion criteria:** 1. Previous/concurrent use of major tranquilizers or lithium 2. No other major physical or psychiatric disorders 3. No suicidal ideation	**Treatment discontinuation rate**: 3 of 8 (37.5%) participants in behavioral treatment and 1 of 8 (12%) in cognitive treatment dropped out and were replaced by new participants **Adverse effects:** NR	

Abbreviations: AE = adverse effects, BDI-II = Beck Depression Inventory-II, CBT = cognitive behavioral therapy, CES-D = Center for Epidemiologic Studies-Depression Scale, CI = confidence interval, DIS = Diagnostic Interview Schedule, HDRS = Hamilton Depression Rating Scale, MDD = major depressive disorder, n = number, NA = not applicable, NR = not reported, ns = not significant, OR = odds ratio, p = probability, PHQ = Patient Health Questionnaire, RCT = randomized controlled trial, SD = standard deviation, SE = standard error, ST = standard treatment, vs = versus, wk = week/weeks, yr = year/years

LIST OF INCLUDED STUDIES FROM PRIMARY LITERATURE IN ALPHABETICAL ORDER

Barnhofer T, Crane C, Hargus E, et al. Mindfulness-based cognitive therapy as a treatment for chronic depression: A preliminary study. Behav Res Ther 2009;47(5):366-73.

Laidlaw K, Davidson K, Toner H, et al. A randomised controlled trial of cognitive behaviour therapy vs treatment as usual in the treatment of mild to moderate late life depression. Int J Geriatr Psychiatry 2008;23(8):843-50.

Mynors-Wallis LM, Gath DH, Day A, et al. Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. BMJ 2000;320(7226):26-30.

Nezu AM. Efficacy of a social problem-solving therapy approach for unipolar depression. J Consult Clin Psychol 1986;54(2):196-202.

Simon GE, Ludman EJ, Tutty S, et al. Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: a randomized controlled trial. JAMA 2004;292(8):935-42.

Simon GE, Ludman EJ, Rutter CM. Incremental benefit and cost of telephone care management and telephone psychotherapy for depression in primary care. Arch Gen Psychiatry 2009;66(10):1081-9.

Wilson PH. Combined pharmacological and behavioural treatment of depression. Behav Res Ther 1982;20(2):173-84.

Wilson PH. Comparative efficacy of behavioral and cognitive therapies of depression. Cognit Ther Res 1983;7(2):111-124

APPENDIX C: REVIEWER COMMENTS AND RESPONSES

Reviewer	Comment	Response
Question 1: Are the objectives, scope, and methods for this review clearly described?		
1	No – I can't follow the literature review here or in the text. KQ 1 involves evaluation of "brief therapies" which seem to be defined as 8 or fewer sessions.	We have added further explanation to both the Methods and Results sections of our overall approach and more explanation of what constitutes a "complex systematic review." We have also clearly delineated that, for the purposes of this review, ≤ 8 sessions are defined as "brief," 12 to 20 sessions are described as "standard," and psychotherapies of other durations are specifically designated.
	In general, I just don't get the Results for KQ1. I wonder if organizing your results by type of therapy might be more helpful. For example, "We identified X articles evaluating CBT: X were from the primary literature review and X were identified from the systematic reviews.	We have further clarified our overall approach and portions of KQ 1 to make apparent our structure of discussing systematic review findings prior to primary literature findings.
	Results: I have read this 3 times and still cannot follow the flow of literature. This needs to be clarified. Figure 2 also could be clarified by adding 2 boxes below the one describing the 2 SR's which shows how many articles come from each of the SR's and then connecting it to the very bottom box.	We have altered the literature flow figure to better indicate how we used the primary literature and systematic reviews.
	Nice summary and discussion.	Thank you.
	I think the important point that most of these studies involve women deserves more than a line in the limitations section. This is a huge issue for the VA. Were you able to tease out any gender sub-analyses from the SR's or the original articles?	We agree and have added consideration of this point to the discussion section. While we agree that a subanalysis would be interesting, we have not conducted such an analysis because the data are not adequate or appropriate, and AHRQ guidelines recommend against such analyses.
2	Unsure – Overall, the objectives, scope, and methods are clearly described. However, it is recommended that additional specificity be provided in references to "brief" versus "longer duration" psychotherapies throughout the manuscript, including the executive summary (e.g., p. 1, lines 14-15: "First, brief psychotherapies compared to longer duration psychotherapies had similar effect sizes.") The reference "longer duration" is often used in the report to refer to psychotherapy lengths that are still quite brief (e.g., 7-8+ sessions). Because this term is typically associated with psychotherapies of longer lengths (e.g,, 12-16+ sessions), it would likely be helpful to be specific in such references to avoid confusion. Furthermore, there was a finding of a larger effect for the somewhat longer duration EBPs, though overlapping confidence intervals led to the conclusion that the evidence was inadequate to make a definitive determination. Thus, it is somewhat unclear what led to the statement above of similar effect sizes for brief vs. "longer" duration psychotherapies.	We have now clearly delineated that, for the purposes of this review, ≤ 8 sessions are defined as "brief," 12 to 20 sessions are described as "standard," and psychotherapies of other durations are specifically designated. We have also clarified our interpretation of overlapping confidence intervals for "brief" versus "standard" length psychotherapy.
3	Yes – No comment.	Acknowledged
4	Yes – The rationale for focusing the review on brief (8 or fewer sessions) is clear. The methodology employed in the review is well described. It was somewhat surprising that there was not a key question included that focused on a comparison of brief versus slightly longer standard psychotherapy (e.g., 12 to 16 sessions) in primary care. The authors note on Page 1, line 10 that there are guidelines recommending 12 to 16 one-hour sessions. For this reviewer, this number of sessions is the usual "gold standard" for clinical treatment and for clinical research in this area. Thus it would have been helpful to have a sense whether there is evidence that briefer treatment (8 or fewer sessions) is as efficacious as longer treatment.	The review that we originally proposed to conduct would have made this comparison. However, a variety of reasons contributed to our VA stakeholders recommending against conducting this comparison. Fortunately, the Cuijpers' systematic review addresses this comparison and allows us to make some tentative conclusions about comparative efficacy.
5	Yes – The objectives and scope are very clearly described and this review adheres nicely to its objectives and scope. The description of the search strategy (page 14) was somewhat confusing, particularly with regards to the selection of the specific dates to include in the Jan 2009-Aug 2010 search of MEDLINE, PsycINFO, Embase. After reading it a few times, I think I understand why those dates were chosen, but am still not entirely confident.	We have reworked this section to provide clarification on our search strategy.

To Contents

Reviewer	Comment	Response
Question 2: Is there any indication of bias in our synthesis of the evidence?		
1	Not answered but no comments.	Acknowledged
2	No – no comment.	Acknowledged
3	No – no comment.	Acknowledged
4	No – This appears to be an exhaustive search of the literature, and the synthesis of the available data is excellent.	Thank you.
5	No – no comment.	Acknowledged
Question 3: Are there any studies of interest to the VA that we have overlooked?		
1	Not answered but also not addressed	Acknowledged
2	No – no comment.	Acknowledged
3	No – no comment.	Acknowledged
4	No – None that this reviewer is aware of.	Acknowledged
5	No – no comment.	Acknowledged
Question 4: Please write additional suggestions or comments below. If applicable, please indicate the page and line numbers from the draft report.		
1	On page 5 lines 6 and 7. 15 articles are described.	We have clarified the number of articles being described.
	Next, on page 5 line 16 is a description of findings from the systematic reviews of 6-16 sessions but I thought the focus was on brief interventions?	The reference to 6-16 sessions has been deleted so that the focus of this section of the Executive Summary is exclusively on brief psychotherapies.
	Line 21 then talks about a meta-analysis of 6 trials. Where did 6 come from?	This sentence was reworded to indicate that the 6 trials were a subset of CBT trials that we examined.
	Line 8 page 6—What about the other systematic review? Any data on number of sessions from it?	The other systematic review was limited exclusively to brief psychotherapies, so no comparison could be made between brief psychotherapies and standard-length psychotherapies.
	Page 8, lines 2 and 3 contain information that should be presented earlier in the Results section (perhaps page 5 first paragraph). This limitation should still be discussed in the conclusions.	This information is now also presented early in the Results section of the Executive Summary.
	Methods: Page 14 lines 9 on—This paragraph needs to be clearer and for clarity, each search strategy should probably have its own paragraph. I believe lines 11-14 belong in the Results section.	Separate paragraphs have been created to enhance clarity, and the referenced lines have been moved to appropriate places in the Results section.
	Methods: Data Synthesis—Clarify what you mean in line 20 page 17. Which findings are you summarizing—the unique studies or the reviews findings?	We have clarified that we summarize in narrative form the systematic review findings.
	On page 22 line 5 the 2 systematic reviews are described and the authors identify 7 articles that are relevant to the review. Next, on page 24 line 1, the authors describe a systematic review including 34 studies but imply, not clearly however, that 14 of them contribute to the KQ addressed in this review. How did you get from 34 articles to the 9 articles described on page 23 and in Figure 2? How many came from the Cape review? The entire paragraph describing the Cape review needs to be clarified.	The reason for this discrepancy is that the Cuijpers review was described on page 22, while the Cape review was described on page 24. We have made changes throughout the document to more fully describe the "complex systematic review" that we conducted, including why we report on reviews that cover some articles that did not meet our inclusion criteria for individual studies (i.e., a systematic review could meet our inclusion criteria for systematic reviews even if not every article covered in a review met our inclusion criteria for primary literature).
	Page 25. Lines 3-6 are already in Methods.	This section has been modified to parallel our description results for the systematic review search.
	Lines 9-12 on page 25 are helpful.	Acknowledged
	Page 29 line 1. It would be helpful to begin, "Of the 15 unique studies, six studies…" so that it is clear where you are going with this paragraph.	Change made as suggested.

Reviewer	Comment	Response
1 (cont.)	Page 29 line 11—I would begin a new paragraph with, "The intervention…"	Change made as suggested.
	Page 30 line 17—Why 15 RCT's? I though you only found 8? Help! Why are you reporting the findings from their review when it does not address KQ1 dealing with brief therapies? This is confusing!	Please see above response for how we clarified this apparent discrepancy.
	Page 31 line 7—34 studies? You just talked for a few pages about how you got to 15. Clarify.	Please see above response for how we clarified this apparent discrepancy.
	Page 32—lines 3-9 need to be clarified. Perhaps using subtitles such as CBT or MBCT would be helpful?	We have altered the position of CBT in the initial sentence to help clarify that this paragraph is exclusively about CBT.
	Page 36 line 20—? 9 sessions?	We have changed "fewer than 9" to "≤ 8."
	If you have data on medical therapy among the controls in the 15 studies this would be very helpful. Were most of the controls treated with medicine or just followed? Since this is the comparison most people are interested in, it seems to me that it deserves more discussion	For the purposes of this review, we intentionally excluded trials that used standardized medication protocols (i.e., what we considered a separate active treatment condition). Many of the control groups were "usual care," which could possibly entail patients receiving medication, but usual care was highly variable.
2	The conclusion that brief EBPs are efficacious is somewhat tenuous, given the limited state of the research in this area and the limitations of many of the studies (e.g., many low quality studies, high heterogeneity, limited definition of usual care comparison groups, small effect sizes), methodology required for the review (pooled comparisons), and significant differences between the samples included in the reviewed studies and the Veteran population. While the report notes many of these limitations, it is recommended that the conclusion in the Discussion (p. 40, lines 2-3; "We conclude that brief psychotherapy is an efficacious treatment option for patients with depression in VA primary care settings") be qualified somewhat. Further, in the Cuijpers review, the finding of a significant effect for brief EBPs was only seen for studies in which patients were referred by their GP for treatment but not for those recruited through systematic screening. Given the magnitude of the differential effect, it may be worth noting this more directly in response to Question 1 in the Discussion. Moreover, while it may very well be that brief EBP is an efficacious treatment option for VA primary care settings, the reviewed studies were conducted overwhelmingly on non-Veterans. Perhaps more significant, many of the studies had diagnoses commonly seen in Veteran primary care patients as exclusionary criteria (e.g., substance abuse, psychosis, suicidality). This is worth explicitly noting in the context of discussing and perhaps qualifying the conclusions somewhat. There is brief, one-sentence mention in the Limitations section that the studies in the review was composed primarily middle-aged, Caucasian females, which does not seem sufficient.	We concur with many of these points and have qualified the statement. We have now commented on the differential effect between GP referral and systematic screening in the Discussion of KQ 1. We have more overtly acknowledged the limitations for the Veteran population, including the low representation of Veterans in the studies we reviewed, lack of comorbidity, and overrepresentation by middle-aged Caucasian females.
	It seems difficult to make highly meaningful interpretations of the results of many of the treatment group comparisons (e.g., brief EBP vs. usual care), since usual care was poorly described and variable in the reviewed studies. Furthermore, it is safe to assume that care as usual in many of most of the reviewed studies did not consist of evidence-based "care management," as is now implemented in most VA primary care settings. It would likely be valuable to note this in the Discussion.	We have commented on the VA's commitment to evidence-based care management in the Discussion. To our knowledge, the data remain out on whether VA's investment in evidence-based care management has in practice resulted in significantly better usual care than was received in the studies we reviewed.
	Given the lack of research comparing brief EBPs with full course EBPs, it is important that the implementation of brief EBPs not come at the expense or replacement of full course EBPs (which could occur due to local leadership perception that brief EBPs are effective and a desire for efficiency). The report notes that a comparison of brief EBPs with full course EBPs was not directly tested in the studies included in the review and suggests this, appropriately so, as an area of future inquiry. While direct comparison of brief vs. full course EBPs was not tested in the studies included in the review, it might be valuable to note the effect sizes commonly found in reviews of full course CBT and PST, or to consider this separately.	We sympathize with these concerns. After careful consideration, we have decided not to cite effect sizes for evidence-based psychotherapies from other reviews, as these effect sizes could be misleading should the reader compare them to the effect sizes we report for brief psychotherapy. Fortunately, the Cuijpers review makes this comparison in a subset of carefully selected trials, and we have elaborated on the caution warranted in interpreting their comparison because it is indirect and large Cis are involved.

Reviewer	Comment	Response
2 (cont.)	P. 40, lines 11-12: There does not seem to be sufficient evidence to support the conclusion that "broad training in mental health may not be necessary to provide these therapies." It is noted in the manuscript that some of the studies included therapists who were "graduate students, nurses, general practitioners, and other allied health professionals." It is further suggested that "Within the VA, a range of providers could be considered, including nurses, nurse practitioners, primary care physicians, social workers, and chaplains" to deliver brief EBPs. However, the inclusion of some non-MH providers in some studies does not seem sufficient for determining that individuals without background in mental health could deliver these treatments effectively (or as effectively) as mental health professionals, and there is no data to indicate the extent to which mental health training had an impact on, or moderated, outcomes. In fact, because the results were pooled across different provider types, it is quite possible that effects would have been higher if the treatments were delivered by mental health providers. It is also possible that there was not a significant effect for CBT or PST when delivered by non-MH providers. Were results of the studies available by provider-type? In addition, GPs and others noted above were identified in some of the PST studies; were these provider-types also included for CBT? Furthermore, VA patients are typically more complex and often have comorbidities (substance abuse, suicidality, psychosis) that were excluded in many of the reviewed studies and would often require a higher level professional to monitor and sometimes adapt treatment for. In addition, several of provider-types noted above are not locally credentialed to deliver brief EBPs in VHA. It is also worth noting that graduate students and clinical social workers (as well as nurses with background in mental health) are considered mental health providers in VHA and often do deliver EBPs, along with psychologists and psychiatrists.	We have tempered our statements regarding necessary training and emphasized the need for more research on the use of "non–mental health professionals" to provide brief EBPs.
	EBPs have often been shown to more efficacious in treating major depression than dysthymia. It may be useful to break out results for different types of depression to the extent that this is possible (i.e., if there are sufficient number of studies/participants without mixed diagnostic groups).	We have now included in our KQ 1 Results information from the Cuijpers review on MDD versus "other" diagnoses.
	The finding of Cape of a large effect size for treatment of anxiety is interesting and significantly higher than the effect-sizes for mixed anxiety and depression and depression only. Although anxiety is beyond the scope of the current review, it would be interesting to know what type of anxiety this included (e.g., generalized anxiety or other specific forms of anxiety?). Might this finding be an artifact of the research (e.g., smaller sample size), rather than the being a true differential effect for this condition?	We now note that "anxiety" refers predominantly to diagnoses of panic and generalized anxiety disorder. Although we do not expound on this finding because it is beyond the scope of this review, we would caution interpretation of the difference due to the indirect comparison methodology, but we would also suggest that the finding may represent a true difference and is of value as a hypothesis generating finding.
3	This is a well done review. Methods used to identify studies were appropriate. Decision to review previously published reviews and add additional studies not included in those reviews seems a good one. Tables 3 and 4 do a nice job of summarizing the included studies – they are well organized and easy to understand.	Thank you.
	The moderate effect size in relation to usual care was noted. I wonder if an analysis could be done to see if there is an association between depression severity and effect size. I would hypothesize that psychotherapy would be most effective for those with moderate symptoms, less effective for those with mild symptoms, and least effective (at least as monotherapy) for those with severe symptoms. It would be useful to know if the literature supports targeting any subgroups of patients as the best candidates for brief psychotherapy.	Such an analysis was not possible with the data obtained from the primary literature. However, we have added as a limitation our inability to answer this question.
4	Given the large numbers of older veterans receiving care in the VA system, some mention of acceptability and efficacy of brief psychotherapies in older adults would help the discussion. Several of their cited studies include or are entirely focused on older adults, so some specific comment on this population would help. This is particularly relevant since older white males have among the highest rates of completed suicide, and studies have shown that a large proportion of completed suicide victims in this age group have recently seen a primary care physician. In sum, the inclusion of a discussion of the relevance of depression in older veterans would add much to the report.	The 2 out of 15 studies that contained elderly participant samples are now separately examined in the Results. Also, additional mention on lack of data in Veteran samples (or male/elderly samples) is now made in the Discussion.

Reviewer	Comment	Response
5	This is a very clearly written report that does a nice job utilizing the available research literature to address the key questions it sets out to answer. The ability of this review to identify and outline some shortcomings in our current knowledge base will provide an important foundation for future research on brief psychotherapies for depression and the use of psychotherapy in primary care settings. A study characteristic that is not addressed in this review, but may be useful to consider, or at least mention, is treatment dropout rate.	Thank you. We have revised a column heading in Table 4 to "Therapy completed" to indicate the number patients retained in the treatment condition (i.e., those that did not dropout).
	The remainder of my comments consist of minor wording suggestions or clarifications: Throughout the document, the word "Veteran" should be consistently capitalized. I would also suggest consistency in whether quality of life has hyphens between the words (i.e. quality-of-life) or not (i.e. quality of life).	"Veteran" and "Veterans" have been capitalized throughout. The phrase "quality of life" appears with hyphens when used as a unit modifier, as in "quality-of-life measures." Most instances in the report are not this usage, so we have left those without hyphens.
	P 7, line 17 and p 40, line 11: the suggestion that "broad" training in mental health may not be necessary. I would guess that all of the other non-mental health specialists being discussed here probably do in fact have "broad" training in mental health, but may not have "extensive" or "specialized" training in mental health, so there may be a more accurate way to capture what you are trying to say here.	We have tempered our statements to more strictly state what we found in the review and to emphasize the need for more research on the use of "non–mental health professionals" to provide brief EBPs.
	Page 11, line 7 – suggest using "intensive" rather than "demanding"	Changed as suggested.
	Page 11, lines 14-17 – the wording of this sentence is awkward and therefore does not convey the importance of this review as clearly and strongly as possible.	The sentence has been split into two sentences and reworded.
	Page 21 and 22 – in the description of the Cuijpers review, p21, line 17 refers to 15 studies, but p 22, line 5 says, "Of the 16 trials…"	16 was a mistake; we have changed to 15.
	Page 24, lines 13-14 – the sentence about what countries the studies were conducted in is confusing. Throughout most of this paragraph the authors are talking about the "14 depression studies" but then say that only one in seven were conducted in the US. Does this mean 2 of the 14 were conducted in the US?	Yes, that is what was meant. We have reworded the sentence to enhance clarity.
	Table 3: Does "most distal follow up" time period refer to the length of time between baseline and most distal follow up or between the end of treatment and the most distal follow up? It would be helpful to clarify this in the table (even if it is described in the text).	A footnote has been added to the table for clarification.
	Table 4: I would suggest moving the sample size to Table 3, since it seems more like a characteristic of the study than of the intervention. I would also suggest using "intervention n" or "treatment n" (and then define what this means) for that column rather than "completed n" and "control n". It would make sense to keep the completion rates for the intervention arm as a column in Table 4. The therapy intensity column of Table 4 is a little difficult to digest. Perhaps having separate columns for session length and frequency of sessions would make it easier to understand?	We have split the therapy intensity column into two columns as suggested and have changed the column heading for "completed n." We concur with the reviewer's sentiment that sample size is more a characteristic of the study than the intervention, but we decided not to move this information in order to consolidate information in Table 4 and to cut down on clutter in Table 3.
	Page 29, lines 17-18 – I would suggest re-wording this sentence to something like, "Follow-up duration was less than 6 months for 7 studies 6 months or greater for 8 studies."	Sentence has been reworded as suggested.
	Page 29, line 21 refers to the fact that only 2 study samples included any Veteran representation. It might be helpful to add a little more detail about what proportion of the samples were Veterans in those 2 studies, or if they were studies specifically of Veterans, etc.	Additional detail has been added here and throughout the report.
	In the Cuijpers review, was the ES for ≤ 6 sessions smaller than it was for interventions that included more than 6 sessions? Page 31, line 3, reports that brief psychotherapies had a small but significant positive effect for treatment of depression in primary care – did Cuijpers examine whether this ES of -0.25 was statistically smaller than that for the full range of studies they looked at (ES -0.31 reported on page 30, line 19)?	The Cuijpers review does make a comparison between ≤ 6 sessions and > 6 sessions, and they did not find a statistically significant difference. We report these findings in KQ 2 because the comparison between brief and standard-duration psychotherapies is the focus of KQ 2.
	In the Cape meta analysis, is the ES of -0.21 reported on page 31, line 11 referring to the combined ES for depression AND mixed anxiety and depression?	Yes. We have clarified by identifying the different diagnostic categories from the outset of this paragraph and by pointing out that the authors combined diagnostic categories for some of their analyses.

Reviewer	Comment	Response
5 (cont.)	Page 31, lines 16-18 – The sentences describing the ES for brief psychotherapies specifically for depression is somewhat contradictory. On the one hand, the authors report a "slightly smaller" effect for PST over usual GP care (as compared to the effect for CBT over usual GP care), but then report "no significant differences in efficacy between CBT and PST. This could possibly be re-worded to say that the ES was slightly smaller, but not significantly different, for PST, but even this is still somewhat contradictory. (i.e. if it's not statistically significantly smaller, can it be called smaller?)	The issue here is that at the p = 0.05 level, CBT demonstrated statistical significance and PST did not. Because there was no statistically significant difference between CBT and PST, because CBT narrowly demonstrated statistical significance at the p = 0.05 level, and because PST would demonstrate statistical significance at a slightly more lenient p level (e.g., p = 0.06 or 0.07), we feel that it would be misleading to draw too much attention to the fact that CBT achieved significance (narrowly) at the arbitrary 0.05 mark and PST did not (narrowly). We have reworded this sentence to remove the contradiction.
	Page 32, line 11: I would suggest replacing "judged to" with "rated as"	Changed as suggested.
	Page 32, line 14: Do you want to add (n=1) after the word antidepressant?	Yes, changed as suggested.
	Page 33, line 9: I am unsure of exactly what the term "irregular comparator condition" means.	We have clarified this sentence by replacing the term "irregular comparator" with a more accurate description of the control condition.
	Figure 3: In the labels under the Sd diff in means and 95% CI, do the authors intentionally use "Favours" in stead of "Favors"?	The British spelling has been changed to "Favors."
	Page 35, lines 12-14: Stating that "These results are consistent with both Cape's and Cuijpers' conclusion that PST is an efficacious option for the treatment of depression." may be slightly overstating it, since one of the 2 studies did find a difference and the other did not, especially since the better quality trial did not find that PST improved outcomes.	We have altered a sentence to clarify that although the Mynors-Wallis study found PST+Med no better than Med alone, they also found that PST alone was equally as effective as Med alone. On this basis, we still conclude that the results are consistent with the conclusion that PST is an efficacious treatment option.
	Page 37, lines 10-13: The authors could put the number of studies with each type of provider in parentheses (e.g. n=3), as they did on page 32 (lines 11-14)	We retained the sentence structure to avoid ambiguity (e.g., n = 3 could be interpreted as 3 studies or as 3 psychologists).
	On page 38, I would suggest adding a sentence after line 3 noting that the numbers of studies in each sub-group were too small to conduct quantitative analyses of provider type, individual vs. group, telephone vs. in person or treatment intensity. Though this is fairly obvious, it would make it explicit and also make it consistent with other sections of the review in which similar decisions were made.	Changed as suggested.
	On page 40, line 1-2, I would suggest saying more about the statement, "However, usual care may represent a more potent control condition than placebo controls used in antidepressant trials." What do the authors mean? What makes them think this could be the case?	We have expounded on this statement to describe that it may be the case that usual care is more effective than placebo control because patients treated with usual care are receiving what is intended to be an active treatment and could even be a "best practice" treatment.
	Page 40, line 14 – I would suggest changing the phrase "appropriate training and supervision" to something like "training and supervision specific to the intervention being conducted". Since many studies do not give much detail about the training provided, and since we really don't have data that tells us how much or what kind of training is needed to implement these interventions, I'm not sure it can be deemed "appropriate" (or inappropriate) based on the information provided in each study.	Changed as suggested. We have also tempered our statements to more strictly state what we found in the review and to emphasize the need for more research on the use of "non–mental health professionals" to provide brief EBPs.
	Page 41, line 16 – suggest using the term "screened" rather than "selected" in reference to identifying patients who would be appropriate for brief psychotherapy	Changed as suggested.
	Page 42, line 11 – I would suggest replacing "appropriate" (in reference to the quantitative synthesis methods) with something like "rigorous" or "robust" to convey that you not only chose analyses that were appropriate, but that you chose the best available methods. This is indeed a strength of this review and even that slight wording change conveys that in a stronger manner.	Changed as suggested.

APPENDIX D: EXCLUDED STUDIES

All studies listed below were reviewed in their full-text version and excluded for the reason indicated. An alphabetical reference list follows the table.

Reference	Population not appropriate	Intervention not of interest	Comparator not appropriate	Not SR or RCT	> 8 therapy sessions planned	Main outcome not of interest
Abbass-Allen, 2006 (535)	X					
Abraham, 1992 (656)					X	
Alexopoulis, 2003 (657)					X	
Anonymous, 2010 (733)				X		
Arean, 1993 (658)					X	
Barrera, 1979 (685)			X			
Bedi, 2000 (686)			X			
Bee, 2010 (708)	X					
Bell, 2009 (458)	X					
Beutler, 1987 (659)					X	
Boer, 2005 (575)	X					
Bortolotti, 2008 (71)		X				
Campbell, 1992 (660)						X
Catalan, 1991 (661)	X					
Ciechanowski, 2004 (662)			X			
Coelho, 2007 (447)	X					
Cole, 2008 (74)	X					
Comas-Diaz (702)			X			
Cuijpers, 2008 (469)	X					
Cuijpers, 2010 (31)		X				
Cuijpers, 2010 (467)		X				
Cuijpers, 2007 (137)	X					
Cuijpers, 2008 (76)				X		
Cuijpers, 2007 (462)	X					
de Mello, 2005 (355)					X	
Dhooper, 1993 (736)		X				
Doorenbos, 2005 (663)	X					
Dozios, 2009 (709)					X	
Driessen, 2010 (510)	X					
Ekers, 2008 (345)	X					
Fleming, 1980 (687)			X			
Floyd, 2004 (665)					X	
Fry, 1984 (737)					X	

Reference	Population not appropriate	Intervention not of interest	Comparator not appropriate	Not SR or RCT	> 8 therapy sessions planned	Main outcome not of interest
Fuchs, 1997 (688)		X				
Gardner, 1981 (689)			X			
Godbole, 1973 (667)	X					
Hamdan-Mansauer, 2009 (711)					X	
Haringsma, 2006 (668)					X	
Hegerl, 2010 (713)					X	
Hogg, 1988 (744)			X			
Holland, 2009 (714)	X					
Hsu, 2009 (715)		X				
Huffiziger, 2009 (716)						X
Hynninen, 2010 (718)	X					
Jarvik, 1982 (669)			X			
Kanter, 2010 (719)					X	
Katon, 2004 (672)	X					
Konnert, 2009 (720)	X					
Kotova, 2005 (342)					X	
LaPointe, 1980 (748)	X					
Latour, 1994 (738)		X				
Lichtenberg, 1996 (739)	X					
Lynch, 2010 (33)	X					
Mackin, 2005 (177)		X				
Mazzuchelli, 2009 (368)			X			
McCurren, 1999 (673)		X				
McKnight, 1992 (740)		X				
McNaughton, 2009 (21)		X				
Miranda, 2003 (691)			X			
Mohr, 2008 (498)		X				
Montgomery, 2010 (372)	X					
Mynor-Wallis, 1997 (674)	X					
Nezu, 1989 (678)					X	
Nezu, 2003 (677)	X					
Oranta, 2010 (722)	X					
Pace, 1993 (704)	X					
Parker, 2007 (517)				X		
Pecheur, 1984 (706)			X			
Peden, 2000 (697)	X					
Peng, 2009 (19)					X	

Reference	Population not appropriate	Intervention not of interest	Comparator not appropriate	Not SR or RCT	> 8 therapy sessions planned	Main outcome not of interest
Petersen, 2010 (734)	X					
Pigeon, 2009 (723)	X					
Powers, 2009 (358)	X					
Reynolds, 1999 (680)	X					
Sallis, 1983 (741)					X	
Serfaty, 2009 (724)					X	
Shaw, 1977 (698)		X				
Sirey, 2005 (692)		X				
Stulz, 2010 (728)				X		
Taylor, 1977 (707)			X			
Thompson, 1984 (742)				X		
Thompson, 1987 (743)					X	
Tsang, 2008 (93)		X				
Uebelacker, 2009 (729)				X		
Unutzer, 2002 (681)			X			
Van Calker, 2009 (730)	X					
Watkins, 2009 (693)		X				
Watkins, 2009 (732)		X				
Warmerdam, 2010 (731)		X				
Wierzbicki, 1987 (746)			X			
Wood, 1997 (682)	X					
Yang, 2009 (696)	X					
Zerhusen, 1991 (683)					X	

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LIST OF EXCLUDED STUDIES

Abbass Allan A, Hancock Jeffrey T, Henderson J, et al. Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database of Systematic Reviews 2006(4).

Abraham IL, Neundorfer MM, Currie LJ. Effects of group interventions on cognition and depression in nursing home residents. Nurs Res 1992;41(4):196-202.

Alexopoulos GS, Raue P, Arean P. Problem-solving therapy versus supportive therapy in geriatric major depression with executive dysfunction. Am J Geriatr Psychiatry 2003;11(1):46-52.

Anonymous. Cognitive Behavioral Therapy Effective for Depressed Elderly. J Natl Med Assoc 2010;102(4):358.

Arean PA, Perri MG, Nezu AM, et al. Comparative effectiveness of social problem-solving therapy and reminiscence therapy as treatments for depression in older adults. J Consult Clin Psychol 1993;61(6):1003-10.

Barrera M, Jr. An evaluation of a brief group therapy for depression. J Consult Clin Psychol 1979;47(2):413-5.

Bedi N, Chilvers C, Churchill R, et al. Assessing effectiveness of treatment of depression in primary care. Partially randomised preference trial. Br J Psychiatry 2000;177:312-8.

Bee PE, Bower P, Gilbody S, et al. Improving health and productivity of depressed workers: a pilot randomized controlled trial of telephone cognitive behavioral therapy delivery in workplace settings. Gen Hosp Psychiatry 2010;32(3):337-40.

Bell AC, D'Zurilla TJ. Problem-solving therapy for depression: A meta-analysis. Clin Psychol Rev 2009;29(4):348-353.

Beutler LE, Scogin F, Kirkish P, et al. Group cognitive therapy and alprazolam in the treatment of depression in older adults. J Consult Clin Psychol 1987;55(4):550-6.

Boer Peter CAM, Wiersma D, Russo S, et al. Paraprofessionals for anxiety and depressive disorders. Cochrane Database of Systematic Reviews 2005(2).

Bortolotti B, Menchetti M, Bellini F, et al. Psychological interventions for major depression in primary care: a meta-analytic review of randomized controlled trials. Gen Hosp Psychiatry 2008;30(4):293-302.

Campbell JM. Treating depression in well older adults: use of diaries in cognitive therapy. Issues Ment Health Nurs 1992;13(1):19-29.

Catalan J, Gath DH, Anastasiades P, et al. Evaluation of a brief psychological treatment for emotional disorders in primary care. Psychol Med 1991;21(4):1013-8.

Ciechanowski P, Wagner E, Schmaling K, et al. Community-integrated home-based depression treatment in older adults: a randomized controlled trial. JAMA 2004;291(13):1569-77.

Coelho HF, Canter PH, Ernst E. Mindfulness-based cognitive therapy: Evaluating current evidence and informing future research. J Consult Clin Psychol 2007;75(6):1000-1005.

Cole MG. Brief interventions to prevent depression in older subjects: a systematic review of feasibility and effectiveness. Am J Geriatr Psychiatry 2008;16(6):435-43.

Comas-Diaz L. Effects of cognitive and behavioral group treatment on the depressive symptomatology of Puerto Rican women. J Consult Clin Psychol 1981 ;49(5) :627-32.

Cuijpers P, van Straten A, Andersson G, et al. Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. J Consult Clin Psychol 2008 ;76(6) :909-922.

Cuijpers P, van Straten A, Bohlmeijer E, et al. The effects of psychotherapy for adult depression are overestimated: a meta-analysis of study quality and effect size. Psychol Med 2010;40(2):211-23.

Cuijpers P, van Straten A, Schuurmans J, et al. Psychotherapy for chronic major depression and dysthymia: A meta-analysis. Clin Psychol Rev 2010;30(1):51-62.

Cuijpers P, van Straten A, Warmerdam L. Problem solving therapies for depression: a meta-analysis. Eur Psychiatry 2007;22(1):9-15.

Cuijpers P, van Straten A, Warmerdam L, et al. Psychological treatment of depression: a meta-analytic database of randomized studies. BMC Psychiatry 2008;8:36. Available at: (http://www.psychotherapy-rcts.org/index.php?id=3). Accessed November 10, 2010.

Cuijpers P, van Straten FSA. Psychological treatments of subthreshold depression: A meta-analytic review. Acta Psychiatr Scand 2007 ;115(6) :434-441.

de Mello MF, de Jesus Mari J, Bacaltchuk J, et al. A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. Eur Arch Psychiatry Clin Neurosci 2005;255(2):75-82.

Dhooper S, Green S, Huff M, et al. Efficacy of a group approach to reducing depression in nursing home elderly residents. Journal of Gerontological Social Work 1993;20(3/4):87-100.

Doorenbos A, Given B, Given C, et al. Reducing symptom limitations: a cognitive behavioral intervention randomized trial. Psychooncology 2005 ;14(7) :574-84.

Dozois DJ, Bieling PJ, Patelis-Siotis I, et al. Changes in self-schema structure in cognitive therapy for major depressive disorder: a randomized clinical trial. J Consult Clin Psychol 2009 ;77(6) :1078-88.

Driessen E, Cuijpers P, de Maat SCM, et al. The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. Clin Psychol Rev 2010;30(1):25-36.

Ekers D, Richards D, Gilbody S. A meta-analysis of randomized trials of behavioural treatment of depression. Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences 2008;38(5):611-623.

Fleming BM, Thornton DW. Coping skills training as a component in the short-term treatment of depression. J Consult Clin Psychol 1980;48(5):652-4.

Floyd M, Scogin F, McKendree-Smith NL, et al. Cognitive therapy for depression: a comparison of individual psychotherapy and bibliotherapy for depressed older adults. Behav Modif 2004;28(2):297-318.

Fry P. Cognitive Training and Cognitive-Behavioral Variables in the Treatment of Depression in the Elderly. Clin Gerontol 1984;3(1):25-44.

Fuchs CZ, Rehm LP. A self-control behavior therapy program for depression. J Consult Clin Psychol 1977;45(2):206-15.

Gardner P, Oei TP. Depression and self-esteem: an investigation that used behavioral and cognitive approaches to the treatment of clinically depressed clients. J Clin Psychol 1981;37(1):128-35.

Godbole A, Verinis JS. Brief psychotherapy in the treatment of emotional disorders in physically ill geriatric patients. Gerontologist 1974;14(2):143-8.

Hamdan-Mansour AM, Puskar K, Bandak AG. Effectiveness of cognitive-behavioral therapy on depressive symptomatology, stress and coping strategies among Jordanian university students. Issues Ment Health Nurs 2009;30(3):188-96.

Haringsma R, Engels GI, Cuijpers P, et al. Effectiveness of the Coping With Depression (CWD) course for older adults provided by the community-based mental health care system in the Netherlands: a randomized controlled field trial. Int Psychogeriatr 2006;18(2):307-25.

Hegerl U, Hautzinger M, Mergl R, et al. Effects of pharmacotherapy and psychotherapy in depressed primary-care patients: a randomized, controlled trial including a patients' choice arm. Int J Neuropsychopharmacol 2010;13(1):31-44.

Hogg J, Deffenbacher J. A comparison of cognitive and interpersonal-process group therapies in the treatment of depression among college students. Journal of Counseling Psychology 1988;35(3):304-310.

Holland JM, Currier JM, Gallagher-Thompson D. Outcomes from the Resources for Enhancing Alzheimer's Caregiver Health (REACH) program for bereaved caregivers. Psychol Aging 2009;24(1):190-202.

Hsu YC, Wang JJ. Physical, affective, and behavioral effects of group reminiscence on depressed institutionalized elders in Taiwan. Nurs Res 2009;58(4):294-9.

Huffziger S, Kuehner C. Rumination, distraction, and mindful self-focus in depressed patients. Behav Res Ther 2009;47(3):224-30.

Hynninen MJ, Bjerke N, Pallesen S, et al. A randomized controlled trial of cognitive behavioral therapy for anxiety and depression in COPD. Respir Med 2010;104(7):986-94.

Jarvik LF, Mintz J, Steuer J, et al. Treating geriatric depression: a 26-week interim analysis. J Am Geriatr Soc 1982;30(11):713-7.

Kanter JW, Santiago-Rivera AL, Rusch LC, et al. Initial outcomes of a culturally adapted behavioral activation for Latinas diagnosed with depression at a community clinic. Behav Modif 2010;34(2):120-44.

Katon WJ, Von Korff M, Lin EH, et al. The Pathways Study: a randomized trial of collaborative care in patients with diabetes and depression. Arch Gen Psychiatry 2004;61(10):1042-9.

Konnert C, Dobson K, Stelmach L. The prevention of depression in nursing home residents: a randomized clinical trial of cognitive-behavioral therapy. Aging Ment Health 2009;13(2):288-99.

Kotova E. A meta-analysis of Interpersonal Psychotherapy. ProQuest Information & Learning; 2005.

LaPointe K, Rimm D. Cognitive, assertive, and insight-oriented group therapies in the treatment of reactive depression in women. Psychotherapy: Theory, Research and Practice 1980;17:312-321.

Latour D, Cappeliez P. Pretherapy training for group cognitive therapy with depressed older adults. Canadian Journal on Aging 1994;13(2):221-235.

Lichtenberg P. Behavioral Treatment of Depression in Predominantly African-American Medical Patients. Clin Gerontol 1996;17(2):15-33.

Lynch D, Laws KR, McKenna PJ. Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. Psychol Med 2010;40(1):9-24.

Mackin RS, Arean PA. Evidence-based psychotherapeutic interventions for geriatric depression. Psychiatr Clin North Am 2005;28(4):805-20, vii-viii.

Mazzucchelli T, Kane R, Rees C. Behavioral activation treatments for depression in adults: A meta-analysis and review. Clinical Psychology: Science and Practice 2009;16(4):383-411.

McCurren C, Dowe D, Rattle D, et al. Depression among nursing home elders: testing an intervention strategy. Appl Nurs Res 1999;12(4):185-95.

McKnight D, Nelson-Gray R, Barnhill J. Dexametnasone test and response to cognitive therapy and antidepressant medication. Behavior Therapy 1992;23(1):99-111.

McNaughton JL. Brief interventions for depression in primary care: a systematic review. Can Fam Physician 2009;55(8):789-96.

Miranda J, Chung JY, Green BL, et al. Treating depression in predominantly low-income young minority women: a randomized controlled trial. JAMA 2003;290(1):57-65.

Mohr DC, Vella L, Hart S, et al. The effect of telephone-administered psychotherapy on symptoms of depression and attrition: A meta-analysis. Clinical Psychology: Science and Practice 2008;15(3):243-253.

Montgomery EC, Kunik ME, Wilson N, et al. Can paraprofessionals deliver cognitive-behavioral therapy to treat anxiety and depressive symptoms? Bull Menninger Clin 2010;74(1):45-62.

Mynors-Wallis L, Davies I, Gray A, et al. A randomised controlled trial and cost analysis of problem-solving treatment for emotional disorders given by community nurses in primary care. Br J Psychiatry 1997;170:113-9.

Nezu AM, Nezu CM, Felgoise SH, et al. Project Genesis: assessing the efficacy of problem-solving therapy for distressed adult cancer patients. J Consult Clin Psychol 2003;71(6):1036-48.

Nezu AM, Perri MG. Social problem-solving therapy for unipolar depression: an initial dismantling investigation. J Consult Clin Psychol 1989;57(3):408-13.

Oranta O, Luutonen S, Salokangas RK, et al. The outcomes of interpersonal hristian on depressive symptoms and distress after myocardial infarction. Nord J Psychiatry 2010;64(2):78-86.

Pace T, Dixon D. Changes in depressive self-schemata and depressive symptoms following cognitive therapy. Journal of Counseling Psychology 1993;40(3):288-294.

Parker G, Fletcher K. Treating depression with the evidence-based psychotherapies: A critique of the evidence. Acta Psychiatr Scand 2007;115(5):352-359.

Pecheur D, Edwards K. A comparison of secular and religious versions of cognitive therapy with depressed hristian college students. Journal of Psychology and Theology 1984;12(1):45-54.

Peden AR, Hall LA, Rayens MK, et al. Reducing negative thinking and depressive symptoms in college women. J Nurs Scholarsh 2000;32(2):145-51.

Peng XD, Huang CQ, Chen LJ, et al. Cognitive behavioural therapy and reminiscence techniques for the treatment of depression in the elderly: a systematic review. J Int Med Res 2009;37(4):975-82.

Petersen T, Pava J, Burchin J, et al. The role of cognitive-behavioral therapy and fluoxetine in prevention of recurrence of major depressive disorder. Cognit Ther Res 2010;34:13-23.

Pigeon WR, May PE, Perlis ML, et al. The effect of interpersonal psychotherapy for depression on insomnia symptoms in a cohort of women with sexual abuse histories. J Trauma Stress 2009;22(6):634-8.

Powers MB, Zum Vörde Sive Vörding MB, Emmelkamp PMG. Acceptance and commitment therapy: A meta-analytic review. Psychother Psychosom 2009;78(2):73-80.

Reynolds CF, 3rd, Miller MD, Pasternak RE, et al. Treatment of bereavement-related major depressive episodes in later life: a controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. Am J Psychiatry 1999;156(2):202-8.

Sallis J, Lichstein K, Clarkson A, et al. Anxiety and depression management for the elderly. Stalgeitis, Sinternational Journal of Behavioral Geriatrics 1983;1(4):3-12.

Serfaty MA, Haworth D, Blanchard M, et al. Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care: a randomized controlled trial. Arch Gen Psychiatry 2009;66(12):1332-40.

Shaw BF. Comparison of cognitive therapy and behavior therapy in the treatment of depression. J Consult Clin Psychol 1977 ;45(4) :543-51.

Sirey JA, Bruce ML, Alexopoulos GS. The Treatment Initiation Program: an intervention to improve depression outcomes in older adults. Am J Psychiatry 2005;162(1):184-6.

Stulz N, Thase ME, Klein DN, et al. Differential effects of treatments for chronic depression: a latent growth model reanalysis. J Consult Clin Psychol 2010;78(3):409-19.

Taylor F, Marshall W. Experimental analysis of a cognitive-behavioral therapy for depression Cognit Ther Res 1977;1(1):59-72.

Thompson L. Efficacy of psychotherapy in the treatment of Advances in behavior research and therapy 1984;6(2):127-139.

Thompson L, Gallagher D, Breckenridge J. Comparative effectiveness of psychotherapy for depressed elders. Journal of Consulting and Clinical Pyshcology 1987;55(3):385-390.

Tsang HW, Chan EP, Cheung WM. Effects of mindful and non-mindful exercises on people with depression: a systematic review. Br J Clin Psychol 2008;47(Pt 3):303-22.

Uebelacker LA, Weisberg RB, Haggarty R, et al. Adapted behavior therapy for persistently depressed primary care patients: an open trial. Behav Modif 2009;33(3):374-95.

Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA 2002;288(22):2836-45.

van Calker D, Zobel I, Dykierek P, et al. Time course of response to antidepressants: predictive value of early improvement and effect of additional psychotherapy. J Affect Disord 2009;114(1-3):243-53.

Warmerdam L, van Straten A, Jongsma J, et al. Online cognitive behavioral therapy and problem-solving therapy for depressive symptoms: Exploring mechanisms of change. J Behav Ther Exp Psychiatry 2010;41(1):64-70.

Watkins ER, Baeyens CB, Read R. Concreteness training reduces dysphoria: proof-of-principle for repeated cognitive bias modification in depression. J Abnorm Psychol 2009;118(1):55-64.

Watkins ER, Moberly NJ. Concreteness training reduces dysphoria: a pilot proof-of-principle study. Behav Res Ther 2009;47(1):48-53.

Wierzbicki M, Bartlett T. The efficacy of group and individual cognitive therapy for mild depression. Cognit Ther Res 1987;11(3):337-342.

Wood BC, Mynors-Wallis LM. Problem-solving therapy in palliative care. Palliat Med 1997;11(1):49-54.

Yang TT, Hsiao FH, Wang KC, et al. The effect of psychotherapy added to pharmacotherapy on cortisol responses in outpatients with major depressive disorder. J Nerv Ment Dis 2009;197(6):401-6.

Zerhusen JD, Boyle K, Wilson W. Out of the darkness: group cognitive therapy for depressed elderly. J Psychosoc Nurs Ment Health Serv 1991;29(9):16-21.

APPENDIX E: ACRONYMS AND ABBREVIATIONS

ACT	acceptance and commitment therapy
AE	adverse effects
BDI-II	Beck Depression Inventory-II
CBASP	cognitive behavioral analysis system of psychotherapy
CBT	cognitive behavioral therapy
CES-D	Center for Epidemiologic Studies-Depression
CI	confidence interval
CM	care management
DBT	dialectical behavioral therapy
DHP	Diabetes Health Profile
DIS	Diagnostic Interview Schedule
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
FAP	functional analytic psychotherapy
GP	general practitioner
HAM-D	Hamilton Depression Scale
HRSD	Hamilton Rating Scale for Depression
HSLC-D	Headache Specific Locus of Control-Depression
IPT	interpersonal therapy
LOCF	last observation carried forward
MBCT	mindfulness-based cognitive therapy
MDD	major depressive disorder
MDE	major depressive episode
MH	mental health
MMPI-D	Minnesota Multiphasic Personality Inventory-Depression
MMSE	Mini Mental State Examination
MOS-D	Medical Outcomes Study-Depression
N or n	number
NA	not applicable
NNT	number needed to treat
NR	not reported
NS or ns	not significant
OR	odds ratio
p	probability
PC	primary care
PFT	problem-focused therapy
PHQ	Patient Health Questionnaire
PRIME-MD	Primary Care Evaluation of Mental Disorders
PST	problem-solving treatment
PTSD	posttraumatic stress disorder
RCT	randomized controlled trial
RDC	Research Diagnostic Criteria
Rx	medicine prescription
SADS-L	Schedule for Affective Disorders and Schizophrenia-Lifetime Version
SCAN	Schedules for Clinical Assessment in Neuropsychiatry
SCL	Symptom Checklist
SD	standard deviation
SE	standard error
ST	standard treatment
TAU	treatment as usual
vs	versus
WHOQOL	World Health Organization Quality of Life
wk	week or weeks
WLC	waitlist control
yr	year or years

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