

EXECUTIVE SUMMARY

BACKGROUND

The individual and societal burden of depressive disorders is widely acknowledged, but treating these disorders remains challenging. Clinical guidelines recommend that both pharmacotherapy and psychotherapy should be considered as first-line treatments. Yet, because primary care settings are often the frontline of treatment, pharmacological treatments take precedence. In part, this may be due to the perception that psychotherapy is lengthy and time intensive, with guidelines recommending 12 to 20 1-hour sessions for most evidence-based psychotherapies. However, recent evidence seems to suggest that psychotherapies that are briefer in both duration and intensity may be efficacious in acute-phase treatment. If true, these briefer psychotherapies may be more easily integrated in primary care settings. Thus, we conducted a systematic review of the peer-reviewed literature to answer the following key questions:

Key Question 1: For primary care patients with depressive disorders, are brief, evidence-based psychotherapies with durations of up to eight sessions more efficacious than control for depressive symptoms (i.e., on self-report and/or clinician-administered measures) and quality of life (i.e., functional status and/or health-related quality of life)?

Key Question 2: For primary care patients with depressive disorders treated with a brief, evidence-based psychotherapy, is there evidence that treatment effect may vary by the number of sessions delivered?

Key Question 3: For psychotherapies demonstrating clinically significant treatment effects, what are the characteristics of treatment providers (i.e., type of provider and training), and what are the modalities of therapy (i.e., individual/group, face-to-face/teletherapy/Internet-based)?

Key Question 4: How commonly reported are the key clinical outcomes of quality of life, social functioning, occupational status, patient satisfaction, and adverse treatment effects in randomized trials of psychotherapy?

This review was commissioned by the Department of Veterans Affairs' Evidence-based Synthesis Program. The topic was selected after a formal topic nomination and prioritization process that included representatives from the Office of Mental Health Services, Health Services Research and Development, the Mental Health QUERI, and the Office of Mental Health and Primary Care Integration.

METHODS

We utilized a combined approach, identifying and evaluating existing systematic reviews and supplementing these reviews by searching for and evaluating original research not included in these reviews. First, we searched for relevant, good-quality, English-language systematic reviews in MEDLINE® (via PubMed®), Embase®, and PsycINFO® from database inception through May 2010. Two good-quality systematic reviews were identified and evaluated for this report. Second, we used a well-documented Internet-accessible database of psychotherapy trials (www.psychotherapyrcts.org/index.php?id=3) that was current through January 2010. We used

this database of 243 trials as a data source for original research, searching for studies coded as including adults with a mood disorder who received face-to-face psychotherapy at a dose of eight or fewer therapy sessions. Finally, we searched for English-language publications in MEDLINE (via PubMed), PsycINFO, and Embase, from January 2009 (one year prior to the search date of the online database) through August 1, 2010. We supplemented electronic searching by examining the bibliographies of included studies and review articles.

Primary research articles were included if they were RCTs and included adults with major depressive disorder (MDD), dysthymic disorder, or subthreshold (minor) depressive disorder in acute-phase treatment. Relevant psychotherapy modalities included cognitive behavioral therapy (CBT) (including cognitive therapy and behavior therapy), interpersonal therapy (IPT), problem-solving therapy (PST), mindfulness-based cognitive therapy (MBCT), cognitive behavioral analysis system of psychotherapy (CBASP), dialectical behavioral therapy (DBT), functional analytic psychotherapy (FAP), acceptance and commitment therapy (ACT), or short-term psychodynamic therapy with eight or fewer planned sessions. Eligible comparators of active treatment included waitlist control, attention control, usual care, or antidepressant medication if the intervention included a combination of psychotherapy and an antidepressant medication. Patients had to be recruited from outpatient general medical or mental health clinics located in North America, Western Europe, New Zealand, or Australia for the greatest generalizability to the Veteran population. Finally, RCTs were required to measure depressive symptoms using a validated instrument reported at 6 weeks or more after randomization.

Quality of the systematic reviews was rated using 12 design-and-reporting characteristics and summarized as “good,” “fair,” or “poor.” Quality and risk of bias of the RCTs were rated good, fair, or poor using the Agency for Healthcare Research and Quality (AHRQ) criteria. Data were synthesized both in narrative form and via updated meta-analysis where it appeared that the primary literature was sufficient to facilitate an updated effect size. All results are reported such that a negative effect size indicates greater reduction in depressive symptoms for the intervention compared to the control condition. We graded the strength of evidence for each key question using principles from the Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) Working Group. This approach assesses the strength of evidence for each critical outcome by considering risk of bias, consistency, directness, precision, and publication bias. Other domains relevant to observational designs were not pertinent to our review. After considering each domain, a summary rating of “high,” “moderate,” “low,” or “insufficient” strength of evidence was assigned.

RESULTS

Using the combined literature search, 560 potential systematic reviews were identified. From these, two eligible reviews were retained. The first review completed a good-quality meta-analysis of 15 studies that examined psychotherapeutic interventions for depression in primary care. The second review completed a good-quality meta-analysis and meta-regression of 34 studies examining the effectiveness of brief psychological therapies in primary care for anxiety disorders, depressive disorders, and mixed anxiety and depression.

Our search of the primary literature yielded 243 references from the Internet-accessible database

of psychotherapy trials and 516 citations from the search of PubMed, PsycINFO, and Embase. After excluding ineligible articles, our search identified eight unique trials from the two included systematic reviews and seven unique trials from our primary literature search. The brief therapies evaluated were PST (eight studies), CBT (six studies), and MBCT (one study). Interventions were monitored for treatment fidelity in nine studies. Study participants were predominantly middle-aged, female, and Caucasian.

Key Question 1: For primary care patients with depressive disorders, are brief, evidence-based psychotherapies with durations of up to eight sessions more efficacious than control for depressive symptoms (i.e., on self-report and/or clinician-administered measures) and quality of life (i.e., functional status and/or health-related quality of life)?

The systematic reviews found that, compared to control, brief psychotherapies had a small but statistically significant benefit, with effect size estimates ranging from -0.33 to -0.25. Only CBT and PST were evaluated as brief therapies. Findings from the systematic reviews were consistent with the meta-analysis that we conducted on six trials of CBT, which showed that six to eight CBT sessions were more efficacious than control (ES -0.42, 95% CI -0.74 to -0.10), but results were statistically heterogeneous ($I^2 = 56\%$). A sensitivity analysis excluding a poor-quality study and one with a waitlist control showed homogeneous but smaller treatment effects (ES -0.24, 95% CI -0.42 to -0.06, $I^2 = 0\%$). Health-related quality of life (HRQOL) was reported too infrequently to synthesize quantitatively.

Key Question 2: For primary care patients with depressive disorders treated with a brief, evidence-based psychotherapy, is there evidence that treatment effect may vary by the number of sessions delivered?

One of the systematic reviews completed a meta-analysis showing no statistically significant difference in efficacy between psychotherapies of more than six sessions (ES -0.36, 95% CI -0.54 to -0.17) compared to those of six or fewer sessions (ES -0.25, 95% CI -0.48 to -0.02). Because confidence intervals overlapped and comparisons were indirect, there remains the possibility that a true difference in efficacy between brief and standard-duration psychotherapies (i.e., 12 to 20 sessions) could exist and that it could be clinically meaningful. Current evidence is inadequate to answer this question.

Key Question 3: For psychotherapies demonstrating clinically significant treatment effects, what are the characteristics of treatment providers (i.e., type of provider and training), and what are the modalities of therapy (i.e., individual/group, face-to-face/teletherapy/Internet-based)?

Treatment providers and modalities varied across studies. Providers included clinical psychologists, social workers, nurses, general practitioners, and graduate students trained specifically to deliver the treatment as prescribed in the study protocol. Length of treatment varied from 3.5 hours of PST (delivered across six sessions) to 18 hours of MBCT (delivered across eight sessions). Finally, treatments were delivered primarily in individual, face-to-face sessions; however, two studies relied on group therapy, and one trial relied on telephone-based psychotherapy.

Key Question 4: How commonly reported are the key clinical outcomes of quality of life, social functioning, occupational status, patient satisfaction, and adverse treatment effects in randomized trials of psychotherapy?

Of the 15 RCTs evaluating brief psychotherapies, 5 reported HRQOL, 5 reported social functioning, 0 reported occupational status, 2 reported patient satisfaction with treatment, and 1 reported adverse treatment effects. The most commonly used measure of quality of life for studies that examined this clinical outcome was the SF-36. The one study that reported adverse treatment effects examined the side effects of taking psychotropic medication in tandem with psychotherapy.

FUTURE RESEARCH RECOMMENDATIONS

Several questions may be answered by future studies. First, brief psychotherapies (i.e., ≤ 8 sessions) compared to standard-duration psychotherapies (i.e., 12 to 20 sessions) did not significantly differ in their effect sizes, but these comparisons were based on relatively few studies and indirect comparisons, and thus direct comparisons in RCTs would be needed to answer this question definitively. Second, our review found that brief psychotherapies have been provided by an array of trained health care professionals, including non-mental health professionals. Because descriptions of training were incomplete, the degree of training necessary to replicate findings from these studies is uncertain. Third, we discovered that effects on occupational status, patient satisfaction with treatment, and adverse treatment effects were seldom reported; HRQOL and social functioning were more commonly reported but still only considered in less than half the trials examined in this review. Therefore, future research should aim to include these secondary but important clinical outcomes. Fourth, evidence regarding brief therapies other than CBT and PST was nonexistent or sparse. Finally, further research needs to expand participants beyond the mostly middle-aged, female, Caucasian subjects included in studies to date.

CONCLUSIONS

Based on our systematic review of two recent literature reviews and of seven additional RCTs, the collective evidence suggests that six to eight sessions of brief CBT or PST are more efficacious than control for the treatment of depression in primary care; however, the effects are modest (moderate strength of evidence). Current evidence suggests that these treatments might be effectively delivered by providers of various professional disciplines, provided they receive adequate training and supervision. This may be important in terms of balancing cost to the Veterans Health Administration with access to mental health treatment among Veterans. As the VA moves to the Patient-Aligned Care Team model of the patient-centered medical home, it is encouraging to find empirical evidence to support the provision of brief psychotherapy in primary care.