

Evidence-based Synthesis Program (ESP)

Brief Psychotherapy for Depression: Findings from a Systematic Review and Implications for Primary Care

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VA Evidence-based Synthesis (ESP) Program Overview

- **Sponsored by VA Office of R&D and HSR&D.**
- **Established to provide timely and accurate syntheses/reviews of healthcare topics identified by VA clinicians, managers and policy-makers, as they work to improve the health and healthcare of Veterans.**
- **Builds on staff and expertise already in place at the Evidence-based Practice Centers (EPC) designated by AHRQ. Four of these EPCs are also ESP Centers:**
 - Durham VA Medical Center; VA Greater Los Angeles Health Care System; Portland VA Medical Center; and Minneapolis VA Medical Center.

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- **Provides evidence syntheses on important clinical practice topics relevant to Veterans, and these reports help:**
 - develop clinical policies informed by evidence,
 - the implementation of effective services to improve patient outcomes and to support VA clinical practice guidelines and performance measures, and
 - guide the direction for future research to address gaps in clinical knowledge.
- **Broad topic nomination process – e.g. VACO, VISNs, field – facilitated by ESP Coordinating Center (Portland) through online process:**

<http://www.hsrd.research.va.gov/publications/esp/TopicNomination.cfm>

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- **Steering Committee** representing research and operations (PCS, OQP, ONS, and VISN) provides oversight and guides program direction.
- **Technical Advisory Panel (TAP)**
 - Recruited for each topic to provide content expertise.
 - Guides topic development; refines the key questions.
 - Reviews data/draft report.
- **External Peer Reviewers & Policy Partners**
 - Reviews and comments on draft report
- **Final reports posted on VA HSR&D website and disseminated widely through the VA.**

<http://www.hsrd.research.va.gov/publications/esp/reports.cfm>

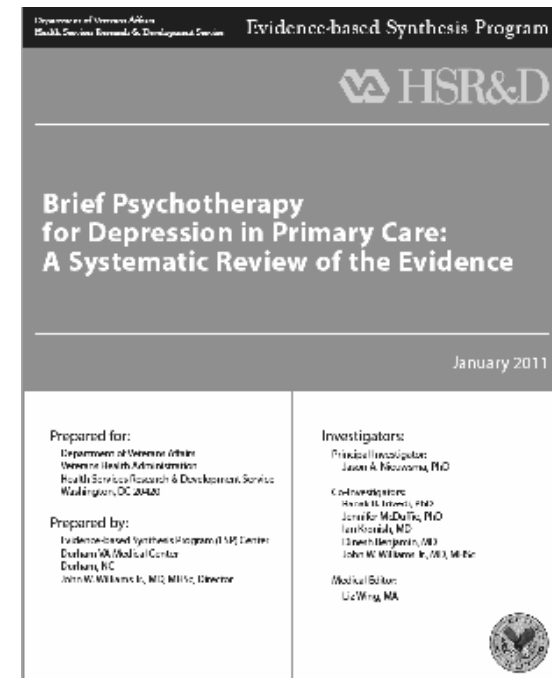
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Current Report

Brief Psychotherapy for Depression in Primary Care: A Systematic Review of the Evidence (February 2011)

Full-length report available on ESP website:

<http://www.hsrd.research.va.gov/publications/esp/brief-psychotherapy.cfm>



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Cyber Poll

- 1. Do you provide psychotherapy?**
 - a. Yes
 - b. No

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Cyber Poll

2. Among psychotherapy practitioners, what is the modal number of sessions that you provide to patients?

2. 1-3
3. 4-8
4. 9-11
5. 12-16
6. 17-20
7. 21-30
8. 31+

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Background

- **Depression is a major public health concern.**
 - High prevalence rates
 - Common among Veterans
 - Primary care is frontline of treatment
- **Efficacious treatments are available.**
 - Pharmacotherapy
 - Psychotherapy

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Background

- **Psychotherapy may have unique benefits.**
 - Patient preference
 - Medication alternative
 - Additive benefit w/ medication
 - Cost-effectiveness
 - Relapse prevention
- **Psychotherapy is underutilized in primary care settings.**
 - Space constraints
 - Lack of adequately trained workforce
 - Intervention fit

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Background

- **Brief psychotherapy (i.e., ≤ 8 sessions) may fit better in primary care than standard-duration (i.e., 12-20 sessions).**
 - Six is the new “brief.”
 - Many patients won’t complete 12-20 sessions.
- **Current Review:**
 - Are brief psychotherapies efficacious?
 - NOT: Should all psychotherapy be brief?

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Methods

- 1. Topic development**
- 2. Systematic searches for literature**
- 3. Study selection**
- 4. Data abstraction**
- 5. Quality Assessment**
- 6. Data Synthesis**
- 7. Peer Review**

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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?**

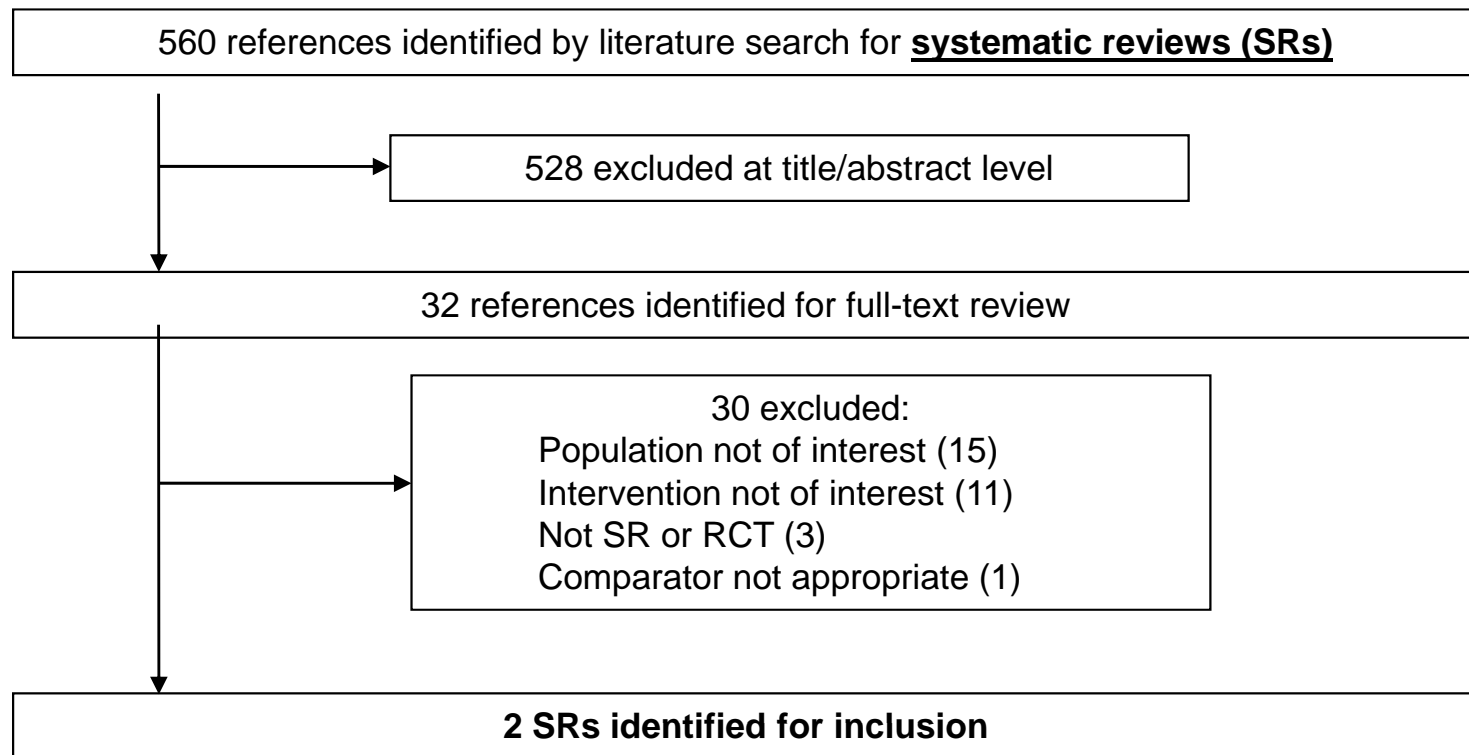
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Key Questions

- **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?**

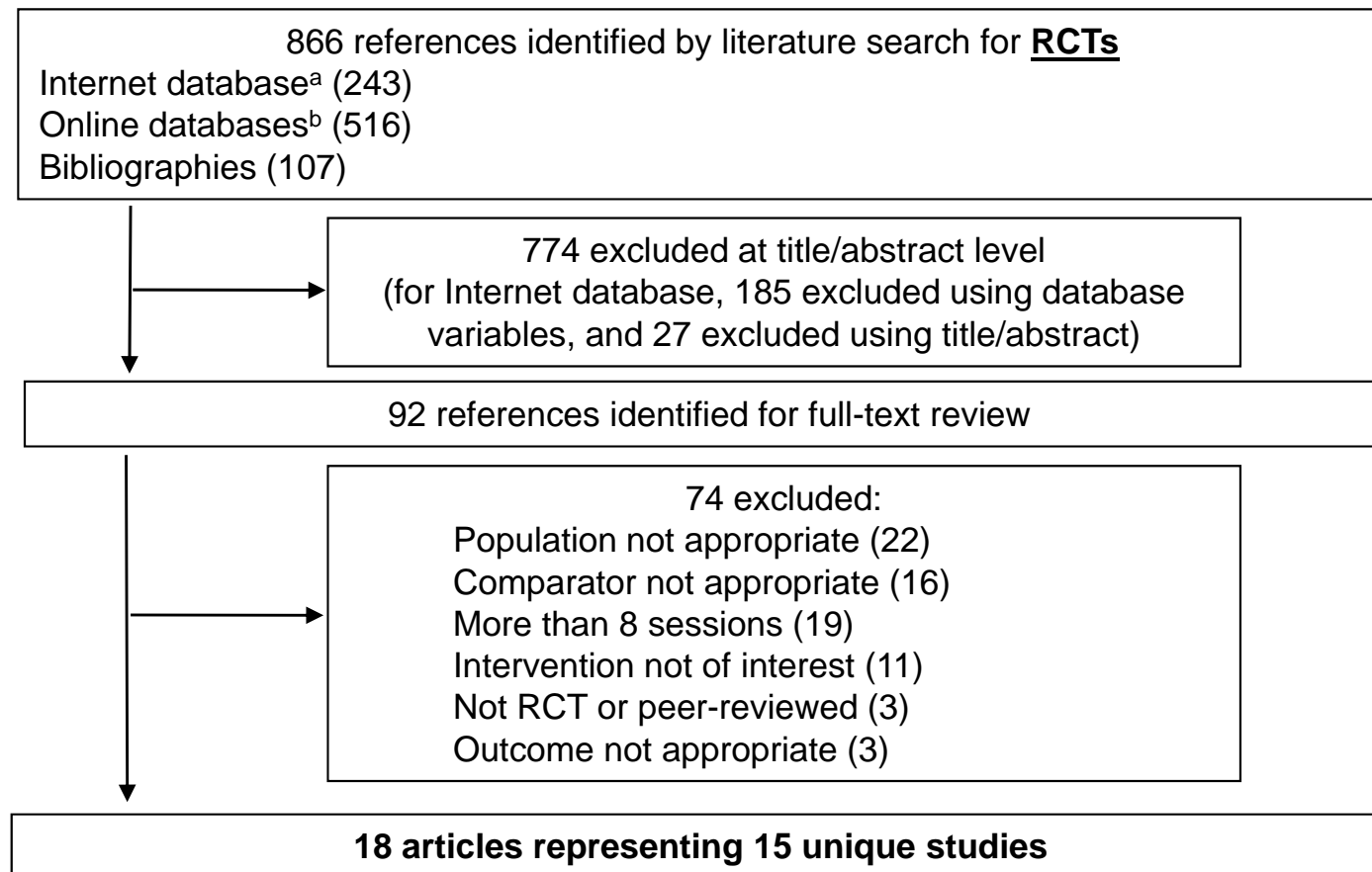
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Literature Flow: Systematic Reviews



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Literature Flow: Randomized Controlled Trials



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Inclusion/Exclusion Criteria

Study characteristic	Inclusion criteria	Exclusion criteria
Study design	Randomized controlled trial	None
Population	Adults with major depressive disorder (MDD), dysthymic disorder, or subthreshold (minor) depression in acute-phase treatment	Treatment-resistant depression, postpartum depression, premenstrual dysphoric disorder, bipolar disorder, seasonal affective disorder, or double depression (i.e., MDD and dysthymia)
Interventions	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 ≤ 8 planned sessions	Generic counseling, life review therapy, psychoeducational therapy, supportive therapy, bibliotherapy, or Internet-based psychotherapies
Comparators	Waitlist, attention control, usual care Antidepressant medication if intervention is psychotherapy and an antidepressant	Another psychotherapy
Setting	Outpatient general medical or general mental health	Study conducted outside of North America, Western Europe, New Zealand, or Australia
Outcome	Depressive symptoms using a validated instrument reported at ≥ 6 weeks after randomization	None

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Results: Study Characteristics

- **Systematic Reviews (2)**
 - Cuijpers et al. (2009) reviewed 15 RCTs, 7 of which examined psychotherapy of ≤ 6 sessions
 - Cape et al. (2010) reviewed 34 RCTs, all of which examined psychotherapy of < 10 sessions
- **Randomized Controlled Trials (15 total, 7 new)**
 - 8 PST, 6 CBT, & 1 MBCT
 - 6-8 sessions
 - Conducted mainly in U.S. & U.K.
 - 11 in PC and 4 in MH outpatient
 - Middle-aged, Caucasian females with mixed depression

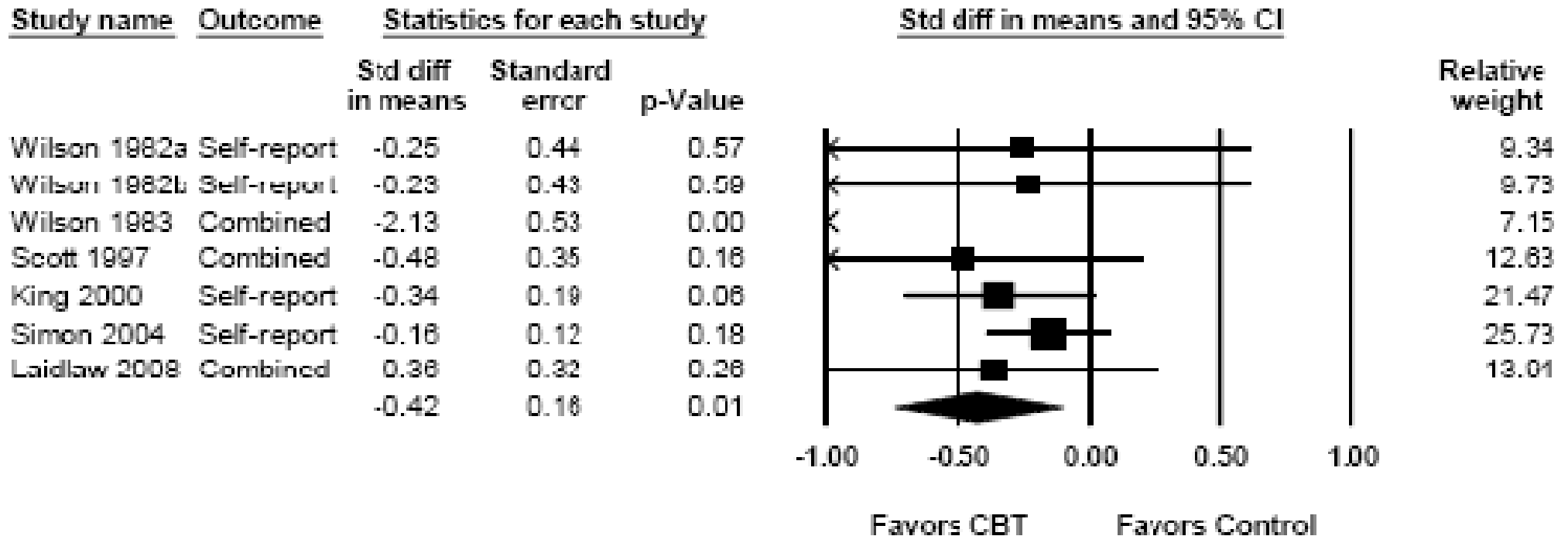
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KQ #1 Results: Efficacy

- **CBT and PST had small but statistically significant benefit.**
- **Health-related quality of life (HRQOL) was reported too infrequently to synthesize quantitatively.**
- **A new meta-analysis of CBT for depression was justified.**
- **Systematic Reviews:**
 - Both corroborated findings in favor of CBT and PST.
 - Cuijpers et al. (2009): GP referral > systematic screening
 - Cape et al. (2010): CBT for anxiety > CBT for mixed depression & anxiety

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Meta-Analysis of CBT



All studies: ES -0.42 (95% CI -0.74 to -0.10; NNT \approx 4.5)

Minus Wilsons: ES -0.24 (95% CI -0.42 to -0.06; NNT \approx 8)

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KQ #2 Results: Number of Sessions

- **Range too limited on 15 included RCTs.**
- **Cuijpers et al. (2009):**
 - No statistically significant difference between 6 or less (ES -0.25, 95% CI -0.48 to -0.02) compared to 7 or more (ES -0.36, 95% CI -0.54 to -0.17).
 - Comparisons were indirect.
 - There remains the possibility that a true and clinically meaningful difference exists between brief psychotherapy (i.e., 6 to 8 sessions) and standard duration psychotherapy (i.e., 12 to 20 sessions).

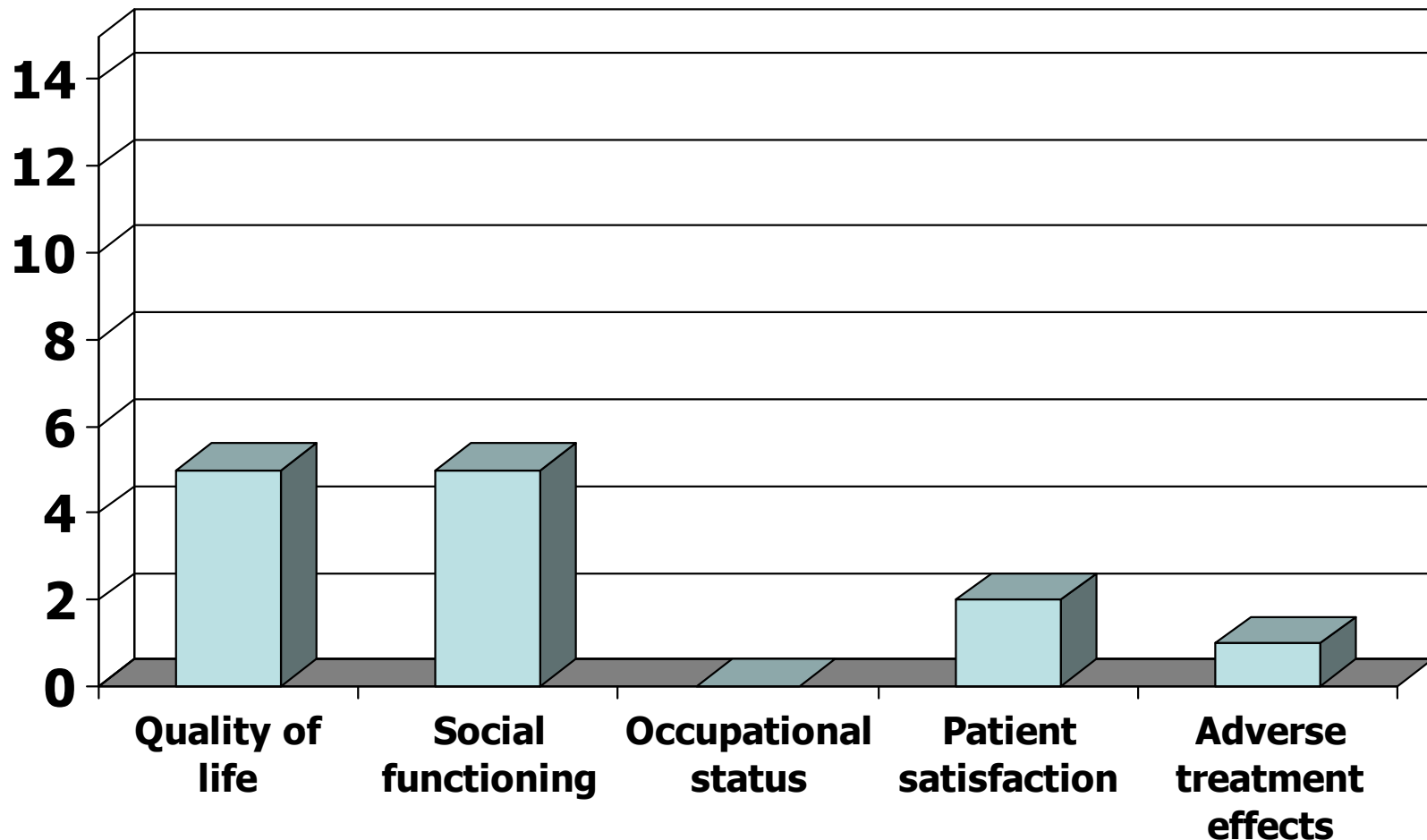
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KQ #3 Results: Providers & Interventions

- **Providers included psychologists, social workers, nurses, general practitioners, graduate students, and allied healthcare professionals.**
 - Only PST included non mental health providers
 - Current evidence does not suggest that non MH are less effective
- **Length of treatment varied from 3.5 hours of PST (delivered across 6 sessions) to 18 hours of MBCT (delivered across 8 sessions).**
- **Treatments were delivered primarily in individual, face-to-face sessions; however, two studies used group therapy, and three studies use telephone-based psychotherapy.**

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KQ #4 Results: Outcome Measures



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Discussion

- **CBT and PST more efficacious than usual care**
- **Comparator conditions may partially account for modest effect sizes**
- **GP referral rather than depression screening**
- **VA mission to expand access to and quality of MH tx**
 - Brief psychotherapy consistent with aims of PCMH
 - Fewer sessions means same workforce can treat more patients, and more patients may be willing to accept psychotherapy
 - A range of providers, sufficiently trained and supervised, could be considered for work with appropriate patient populations

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Conclusions

- Identified 2 systematic reviews and 15 RCTs of brief psychotherapy (i.e., ≤ 8 sessions) for depression
- 1716 patients included

Number of studies (subjects)	Risk of Bias: Design/Quality	Consistency	Directness	Precision	Standardized mean difference (95% CI) and strength of evidence
Brief CBT 6 (713)	RCTs/Fair	Consistent	Direct	Some imprecision	-0.42 (-0.10 to -0.74) Moderate
Brief PST 8 (973)	RCTs/Good	Consistent	Direct	Some imprecision	-0.26 (-0.49 to -0.30) Moderate
MBCT 1 (30)	RCT/Good	NA	Direct	Serious imprecision	Low
Other therapies	NA	NA	NA	NA	Insufficient

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Limitations

- **Indirect comparisons**
 - Number of treatment sessions
 - Types of provider
 - Types of psychotherapy
- **Only two psychotherapies reviewed**
- **Demographically homogeneous**
- **Missing key clinical outcome measures**

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Future Research

- **Head-to-head brief vs. standard duration psychotherapy**
- **Head-to-head for depression severities**
- **Beyond middle-aged Caucasian females**
- **Beyond CBT and PST**
- **Beyond measures of depressive symptom severity**
- **Training & supervision needed for non MH professionals**
- **Do brief psychotherapies deliver as promised?**
 - o Reduce stigma in PC?
 - o Broaden pt population?
 - o Increase cost-effectiveness?
 - o Prevent development of MDD?

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Questions?

**If you have further questions,
feel free to contact:**

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The full report and cyberseminar presentation is available on the ESP website:

<http://www.hsrd.research.va.gov/publications/esp/>