FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Question 5: What are the current treatments for depression and what evidence is available for their safety and effectiveness?

PSYCHOTHERAPY

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Psychotherapy

- Over 400 different psychotherapies
- 'Bona fide' psychotherapies :
  - Cognitive behavioural therapies (CBT)
  - Interpersonal therapies (IPT)
  - Psychodynamic psychotherapies
  - Group therapies
  - Family and couple therapies

Evidence Based Practice (EBP)

Integration of:

- Best available research findings *efficacy*
- Clinical expertise *clinical utility*
- Patient characteristics, culture and preference *clinical utility*

Am Psychologist, 2006

Best available research

- Different questions - different designs
- Randomized controlled trials (RCTs)
  - Clinical guidelines: CBT & IPT first line treatments based on *numerous RCTs*
  - Brief psychodynamic psychotherapies effective in the *few RCTs* completed
- Naturalistic study design – effectiveness of interventions in community settings

Psychodynamic Psychotherapy

- Involves:
  – careful attention to the therapist – patient interaction
  – interpretation of unconscious factors, such as transference and resistance.
- Contributes to:
  – self-understanding
  – enhanced meaning in relationships

Psychodynamic Psychotherapy

- Short term (ST) dynamic therapies – some RCTs show effectiveness in depression

  Abbass et al, 2006

- 1st year: ST more effective than long-term (LT)
- 3 years later, LT more effective than ST

  Knekt et al, 2008

Interpersonal therapy (IPT)

- Universally important life issues addressed:
  - Life changes – social role Transitions
  - Bereavement - Grief
  - Disagreements
  - Deficits in social relationships
- Two major principles
  - Depression is a medical illness
  - Mood and life situation are related

CBT and IPT for depression

Christchurch Study, Luty et al, 2007

	IPT (n=91)	CBT (n=86)	
HRSD			
Baseline score	16.0 (4.7)	16.7 (4.6)	*ns*
Final score	9.1 (7.0)	7.6 (6.8)	*ns*
Final $\leq$ 6, n (%)	40 (44)	45 (52)	*ns*
BDI - II			
Baseline score	27.7 (9.4)	28.7 (10.4)	*ns*
Final score	17.1 (12.9)	14.8 (12. 4)	*ns*
Final $\leq$ 9, n (%)	31 (34)	37 (43)	*ns*

CBT and IPT for depression
Christchurch Study, Luty et al, 2007

- Percent included (1998 – 2003): 63%
- Percent completed: 56%
- Percent improved & completed 8 session: 58%
- Percent improved of entered: 52%
- Percent free of depression: *34 – 52%*
- Percent remained improved at 12-18 months of those who completed: *unknown*
- Percent seeking additional treatment by 2 years: *unknown*

A Consensus Development Conference on Depression in Adults: How to Improve Prevention, Diagnosis, and Treatment

Limitations of RCTS for evaluation of effectiveness of psychotherapy

1. *Untested assumption:* All with depression amenable to same treatment (e.g depression following cancer treatment vs. conflict over sexual orientation)
2. *Unknown:* are those who enter studies similar to those seeking therapy in the community
3. *Exclusion criteria* often for co-morbidity, yet co-mordity is common

A Consensus Development Conference on Depression in Adults: How to Improve Prevention, Diagnosis, and Treatment

Limitations of RCTS for evaluation of effectiveness of psychotherapy

4. *Assumption* that Axis I illness (depression) is malleable to brief interventions – many not fully remitted; high relapse rates
5. *Assumption* that Axis I (depression) is independent of personality
6. Does not address ideal *length of treatment*

Westen,2004 & 2005

A Consensus Development Conference on Depression in Adults: How to Improve Prevention, Diagnosis, and Treatment

"All must have prizes"

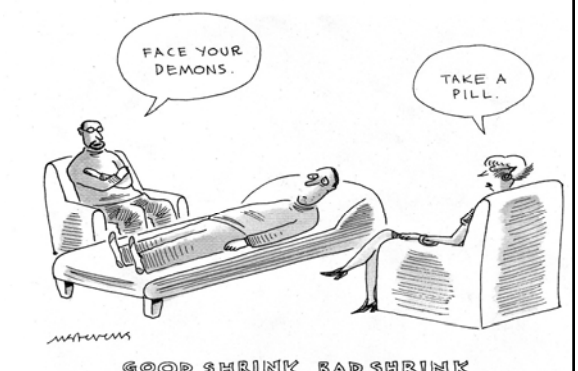
Common factors in psychotherapies

- Therapeutic alliance*: *Collaborative bond between patient and therapist*
- Clear theoretical rationale
- Success experiences with feedback *expectation of improvement*

Krupnick et al, 1996; Lambert, 2005; Wampold, 1997; Ahn & Wampold, 2001; Piper, 2004

Group vs. individual therapies

- Group therapy
  - as effective as individual therapy
  - more studies needed specific to depression
- Resistance common due to:
  - loss of individuality; understanding; privacy
- More cost–effective than individual therapy



Consider Integration Instead!!

Psychotherapy as an Adjunct to Anti-depressant treatment

- Moderate and severe depression:
  - IPT with anti-depressants better than IPT alone
  - CBT alone as effective as CBT in combination

  Thase et al, 1997
- Elderly patients maintenance therapy
  - Trend for less recurrence providing IPT with antidepressant over antidepressant alone

Clinical Expertise

- Allegiance to therapy model*

  Luborsky et al, 1999; Westen, 2004
- Treatment by a mental health professional usually worked

  Seligman, 1995
- Non-clinician college educated employees effectively provided IPT in Uganda

Patient Factors

Early response related to common factors of psychotherapy if:

- more resilience
- better prepared
- more motivated
- receptive to therapeutic response

Lambert, 2005

Patient factors (Naturalistic study)

- Active 'shoppers' did better in therapy
- Choice – important; when insurance limits choice of therapist or treatment duration – poorer outcome

(*Consumer's Report, n=4100) Seligman, 1995*

Recommendations: Clinical

- Patient factors: severity, culture, co-morbidity and choice must be considered
- Mental health professionals to train in:
  - 'bona fide' psychotherapies
  - psychotherapy's common factors
- Train primary care health professionals in IPT & CBT, with shared care back-up

Recommendations: Research

- Further evaluation of patient and therapist factors is necessary,
- Assess ideal length or frequency of acute or maintenance therapy
- Include expert clinicians in research studies