The acceptability to patients of computerized cognitive behaviour therapy for depression: a systematic review

Kaltenthaler E, Sutcliffe P, Parry G, Beverley C, Rees A, Ferriter M

CRD summary
This review found a lack of information on the acceptability of computerised cognitive behavioural therapy to patients and concluded that future studies should collect such information through surveys and qualitative research. These conclusions follow from the limited data available and are likely to be reliable.

Authors’ objectives
To determine the acceptability to patients of computerised cognitive behavioural therapy for depression.

Searching
Fifteen electronic databases (including MEDLINE, PsycINFO, CINAHL and EMBASE) and grey literature databases were searched from 1966 to June 2007. Reference lists of relevant articles were screened and various health services research related resources were searched using the Internet. Some details of the search strategies were reported. Authors of relevant studies were contacted for additional and unpublished studies.

Study selection
Studies that included adults with mild to moderate depression with or without anxiety were eligible for conclusion. The intervention needed to consist of cognitive behavioural therapy delivered alone or as part of a package of care via a computer interface or over the telephone with a computer response. Eligible studies had to report data on patient recruitment, drop-outs or information on preference, satisfaction or acceptability of treatment. Randomised controlled trials (RCTs), non-randomised comparative studies and non-comparative studies were eligible.

Comparators in studies that included a control group were: therapist-led cognitive behavioural therapy; usual treatment; waiting list; internet discussion group; variations of a computerised cognitive behavioural therapy programme; and a depression information website. Participants were recruited from various sources, including media advertisements, self-referral and referral from health professionals. Some participants were clinically depressed; others were not given a diagnosis of depression. Treatment duration ranged from one to 33 sessions.

The authors stated neither how the papers were selected for the review nor how many reviewers performed the selection.

Assessment of study quality
The authors did not state that they assessed validity.

Data extraction
Data were extracted by one reviewer, who used a standardised form, and were checked by a second reviewer.

Methods of synthesis
A narrative synthesis was reported.

Results of the review
Sixteen studies were included (n=5,162): eight RCTs (n=4,348); one comparative non-randomised trial (n=45); and seven non-comparative trials (n=769). The mean drop-out rate in the included studies was 32% (range 0 to 75%). Only six studies provided information on reasons for drop-outs; the most common reasons were that participants were too busy or had changes in circumstance; two studies reported treatment was not useful as a reason for withdrawal. Three studies reported on take-up rates that were low (range 3.3% to 25%).

Twelve trials reported data on acceptability and satisfaction of computerised cognitive behavioural therapy. All studies
reported data only for patients who completed the studies, with no information for those who dropped out. Most
patients who responded to questions regarding computerised cognitive behavioural therapy rated their treatment
positively.

Authors’ conclusions
Trials of computerised cognitive behavioural therapy should include more detailed information on patient recruitment
methods, drop-out rates and reasons for dropping out. Well-designed surveys and qualitative studies should be included
alongside trials to assess levels and determinants of patient acceptability.

CRD commentary
The review addressed a clear question supported by well-defined inclusion criteria, although criteria for study design
were broad. The literature search was extensive and included attempts to locate unpublished studies, although it was
unclear whether language restrictions were applied. Appropriate steps were taken to minimise bias and errors in the
extraction of data, but it was unclear whether such steps were also taken in the selection of studies.

Study quality was not formally assessed, but given the review objective this was less problematic than if the review had
assessed the benefits of an intervention. Very few details were reported of the included studies, especially in relation to
participants, which made it difficult to determine the generalisability of the review findings. Although a narrative
synthesis of results was appropriate (given the outcomes assessed and differences between studies) some further details
of the magnitude and statistical significance of any findings would have been helpful.

The authors’ conclusions followed from the limited data available and are likely to be reliable.

Implications of the review for practice and research
Practice: The authors did not state any implications for practice.

Research: The authors stated that computerised cognitive behavioural therapy trials should include more detailed
information on patient recruitment methods, drop-out rates and reasons for dropping out. Well-designed surveys and
qualitative studies should be included alongside trials to assess levels and determinants of patient acceptability.

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