The effect of interpersonal psychotherapy and other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder

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CRD summary
The review found no convincing evidence to support or refute the effectiveness of interpersonal therapy or psychodynamic therapy for treating major depressive disorder compared with treatment as usual. Any beneficial effect appeared to be small. The impact of these therapies on suicidality, survival and quality of life was unclear. The review was well conducted and the conclusions appear reliable.

Authors' objectives
To evaluate the benefits and harms of interpersonal psychotherapy and other psychodynamic therapies compared with treatment as usual for major depressive disorder.

Searching
Cochrane Central Register of Controlled Trials (CENTRAL), PubMed, EMBASE, PsycLIT, PsycINFO and Science Citation Index Expanded were searched to February 2010 for published and unpublished studies in any language.

Study selection
Randomised controlled trials (RCTs) of interpersonal psychotherapy or other psychodynamic therapies for adults (over 17 years) with major depressive disorder diagnosed with standardised criteria were eligible for inclusion. Eligible interventions were defined in the review. Controls were required to receive treatment as usual, defined as any standard non-specific supportive intervention. Studies with cointerventions in both groups were eligible. The primary review outcomes were depressive symptoms (measured with the Hamilton Depression Rating Scale (HDRS), Beck Depression Inventory (BDI) or the Montgomery-Asberg Depression Rating Scale), adverse events and quality of life. Secondary outcomes were (study-defined) failure to achieve remission and suicide-related outcomes. Outcomes could be reported at treatment cessation (primary time-point) and/or maximum follow-up. Studies of participants with comorbid serious somatic illness, late-life depression and depression associated with pregnancy, drugs or alcohol-dependence were excluded. Psychiatric comorbidity was not an exclusion criterion.

The populations of the included trials varied widely with respect to symptom severity and setting. The intervention in most studies was interpersonal psychotherapy. In most cases only individual therapy was used. Therapist level of experience and education was intermediate or unclear in most studies. Intervention duration varied from five weeks to about eight months. The form and duration of control treatment varied widely. Two studies used antidepressants in both groups. The longest follow-up was 12 months.

Two reviewers independently selected the studies. Disagreements were resolved by discussion.

Assessment of study quality
Reviewers classified studies as having low or high risk of bias. They used the Cochrane Risk of Bias tool to consider: generation of allocation sequence, allocation concealment, blinding, intention to treat analysis (ITT), drop-outs, reporting of outcome measures, economic bias and academic bias. They assessed whether the intervention was adequately defined (utilised a treatment manual and documented manual adherence).

Two reviewers independently assessed study validity. Disagreements were resolved by discussion or arbitration by a third reviewer.

Data extraction
Data were extracted on mean differences (MD) between the groups at follow-up for continuous outcomes and odds ratios (ORs) for dichotomous outcomes, with 95% confidence intervals (CIs). Data were not adjusted for baseline values. Results for remission rates were based on ITT: where data were missing it was assumed that remission did not occur.
Two reviewers independently extracted data. Disagreements were resolved by discussion or arbitration by a third reviewer. Primary study authors were contacted for more information where required.

Methods of synthesis
Studies were combined to calculate pooled mean differences and odds ratios, with 95% CIs, using both fixed-effect and random-effects models. Heterogeneity was assessed with $I^2$. Trial sequential analyses were conducted for primary outcomes to assess the risk of random error, with a minimal relevant difference of two HDRS points. Subgroup and sensitivity analyses were conducted by intervention type and setting, therapist level, cointervention and statistical model.

Results of the review
Six RCTs were included (643 participants reported in the table and 684 in the text). Five RCTs had usable data. All were deemed at high risk of bias. Items associated with a high or unclear risk of bias were: allocation concealment and academic bias (six RCTs); sequence generation, use of ITT analysis, drop-outs and selective reporting (five RCTs); and blinding and economic bias (three RCTs). Only three RCTs adequately defined the intervention.

Psychodynamic therapies significantly reduced symptom scores at treatment cessation (MD -3.12 HDRS, 95% CI -4.39 to -1.86; five RCTs and MD -3.09 BDI, 95% CI -5.35 to -0.83; three RCTs) and at follow-up (MD -4.61 HDRS, 95% CI -6.98 to -2.24; two RCTs). Trial sequential analysis of the HDRS data confirmed this finding. In one of three RCTs that reported adverse events there were significantly fewer events (hospitalisation, lost workdays) in the intervention group. No RCTs reported quality of life. The intervention significantly reduced the risk of no remission using HDRS measures (OR 0.36, 95% CI 0.24 to 0.55, NNT=4, 95% CI 3 to 8; three RCTs) but not using BDI measures (one RCT). Few data were available on suicide-related outcomes.

Heterogeneity was absent or very low in all analyses (0% to 2%). Findings in subgroups were similar to the overall findings.

Authors’ conclusions
No convincing evidence was found to support or refute the effectiveness of interpersonal therapy or psychodynamic therapy for treating major depressive disorder compared with treatment as usual. Any beneficial effect appeared to be small. The impact of these therapies on suicidality, survival and quality of life was unclear.

CRD commentary
The objectives and inclusion criteria of the review were clear. Relevant sources were searched for studies. There were no restrictions on language and publication status. Search terms were not reported. The risk of publication bias was not discussed; there were too few studies to assess this with formal tests. Steps were taken to minimise the risk of reviewer bias and error by having more than one reviewer independently select studies, undertake validity assessment and extract data. Appropriate statistical methods were used to combine studies, assess and explore for heterogeneity and assess the risk of random error. As the authors commented, the studies were clinically heterogeneous but the results were consistent. The authors suggested that the review findings were questionable, as there were few studies, samples were small, all studies had high risk of bias and only three trials used adequately defined interventions.

The review was well conducted and the authors’ conclusions appear reliable.

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

Research: The authors stated that future studies with low risk of systematic and random error should compare manualised psychotherapies, compare psychodynamic therapy with other active interventions for depression and/or compare psychodynamic and interpersonal psychotherapy head-to-head. Interventions should be manual-based, report quality of life and improve reporting of adverse events and suicidality (suicidal inclination, rate of suicides and suicide attempts). A new gold standard (other than HDRS) may be needed. More effective interventions should be developed.

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Record Status
This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.