

Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* **MH** *clinical question-answering service*

www.bestinmh.org.uk

Section for Evidence-Based Mental Health
P.O. Box 32
Health Services and Population Research Department
Institute of Psychiatry
De Crespigny Park
London
SE5 8AF

Tel: 020 7848 0498

Email: contact@bestinmh.org.uk

Question: In adults with depression how effective is individual psychodynamic therapy either alone or combined with pharmacotherapy compared with pharmacotherapy alone?

Clarification of question: Patients = adults with depressive disorders; Intervention = psychodynamic therapy (PDT) delivered individually over any time period either alone or in combination with pharmacotherapy; Comparison = pharmacotherapy alone, Outcome = any; **Focus on:** patients treated in the community, i.e. not in patients.

What does the evidence say?

The BEST in MH search strategy did not identify any studies of PDT versus pharmacotherapy alone.

Two reasonably well-conducted RCTs in outpatients with depression found benefits for combined PDT and pharmacotherapy compared with pharmacotherapy alone. A subsequent subgroup analysis of one of these trials found that combined therapy was more effective than pharmacotherapy alone for depressed patients with a comorbid personality disorder, but that, in those with no personality disorder there was no significant difference in the effectiveness of the two treatments. Overall, the evidence suggest that combined therapy is likely to be beneficial, however, possible methodological flaws in the identified studies mean that they cannot provide a definitive answer to this question.

This answer is a brief summary of the available evidence, if there is anything else you would like to know, please contact me on: contact@bestinmh.org.uk.

This question was received on 17.10.2006; the answer was completed on 30.10.2006 by Elizabeth Barley PhD CPsychol. **This answer is > 1 year old and so may need updating.**

METHODS

Search date: 25.10.2006

Source of Evidence	Search Terms	Search Results	Evidence Identified
NLH guideline finder	depression	23 hits, titles and potentially relevant guidelines searched for relevant trials	none
CDSR	Depress* AND psychodynamic; Depress* (title) AND combin* (title and abstract)	25; 13 - titles and texts of potentially relevant reviews searched for relevant trials	none
DARE		19; 19 - titles searched for relevant reviews: texts of 2 SRs (1;2) of combination therapy for depression searched for relevant RCTs	2 RCTs (3;4)
Clinical Evidence	Combining psychological treatments and antidepressant drugs section searched (ref)	SR of range of psychological therapies combined with drug treatment (search date 2004) - references searched for trials of psychodynamic therapy vs drug treatment	2 RCTs (as above), and one subgroup analysis of one of these trials (5)
PsiTri	Depression (health condition) AND psychodynamic (intervention)	15; titles screened for relevant trials after 2004 (search date of Clinical Evidence SR)	No new trials

EVIDENCE SUMMARY

The BEST in MH search strategy did not identify any trials of PDT alone *versus* pharmacotherapy alone.

There are two RCTs(3;4) of PDT combined with pharmacotherapy therapy *versus* pharmacotherapy alone. In both trials, the patients not receiving PDT received supportive therapy equivalent to the amount of PDT given. Both trials tested short-term individual PDT in

outpatients. Both trials found benefits in favour of combined treatment compared with pharmacotherapy alone. A subsequent subgroup analysis (5) of one trial(4) found that combination therapy was more effective than pharmacotherapy alone in depressed patients with comorbid personality disorder, but that in patients without personality disorder there was no difference in the effectiveness of the two treatments (results reported in Clinical Evidence, full text not available electronically) (6).

Both trials were reasonably well-conducted, but both had design limitations which mean that their findings are not definitive. For instance, both trials selected very few patients from those screened and had high drop out rates. One trial(4) did not describe fully the randomisation process and two analyses were not intention to treat(3;5). Finally, in one trial(3) the authors point out that psychodynamic psychotherapy may not be an appropriate term for the intervention used 'because the therapists were not certified psychotherapists and transference interpretation was not a central concern', however the PDT was manualised and was delivered by experienced nurses who received training and supervision throughout.

EVIDENCE DETAILS

RCTs

Comparison: Short Psychodynamic Supportive Psychotherapy (8 weeks weekly, then 8 weeks fortnightly for 45 mins) plus antidepressant therapy (three successive steps: fluoxetine, amitriptyline and moclobemide, adaptations made according to clinical status and plasma concentration levels) <i>versus</i> antidepressant therapy alone.		
author, date, country	setting	main findings
De Jonghe, 2001, Netherlands(4)	Outpatients with major depression, aged 18-60 yrs	At 16 and 24 weeks, the pharmacotherapy dropout rate was significantly lower in the combined therapy group (13% and 22%, respectively) than in the pharmacotherapy group (26% and 40%, respectively). At all assessment points (8, 16 and 224 weeks), the remission rates for the combined therapy group are significantly better than those for the pharmacotherapy group.

Kool 2003, Netherlands(5)	Subgroup analysis of treatment completers in above study	Depressed patients with comorbid personality disorder: combination therapy more effective at than pharmacotherapy alone at 24 weeks (remission rate 47% <i>versus</i> 19% $p < 0.01$) Depressed patients with no personality disorder: no significant difference between the two treatments (combination 34% <i>versus</i> pharmacotherapy alone 30%, $p = 0.74$).
Comparison: Short term PDT (over 10 weeks, number of sessions not stated) plus clomipramine <i>versus</i> clomipramine alone (25 - 125 mg, dose varied according to clinical status and plasma concentration levels, patients switched to citalopram if refused clomipramine or experienced side effects).		
Burnand 2002, Switzerland(3)	Outpatients with major depression, aged 20 -65	Patients receiving combined treatment less likely to experience treatment failure (major depressive episode present at 10 weeks) ($p=0.04$), and had better scores on the adjustment to work subscale ($p=0.04$). Cost effectiveness: combined treatment associated with overall savings—including direct and indirect costs—of \$2,311 over 10 weeks; for patients with stable employment, the savings were markedly higher at \$3,394 in indirect costs.

author, date	n	study weaknesses
De Jonghe, 2001(4)	167	1759 screened, 167 entered trial; randomisation not fully described
Burnand, 2002(3)	74	390 screened, 95 randomised; not intention to treat analysis, 21 dropped out after randomisation and not included in analyses; number of PDT sessions given not stated.
Kool, 2003(5)	98	Not intention to treat analysis (no other details as full text not available electronically)

Reference List

- (1) Pampallona S, Bollini P, Tibaldi G, Kupelnick B, Munizza C. Combined Pharmacotherapy and Psychological Treatment for Depression: A Systematic Review. Arch Gen Psychiatry 2004 Jul 1;61(7):714-9.

- (2) Friedman MA, Detweiler-Bedell JB, Leventhal HE, et al. Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Science and Practice* 2004;11:47-68.
- (3) Burnand Y, Andreoli A, Kolatte E, Venturini A, Rosset N. Psychodynamic Psychotherapy and Clomipramine in the Treatment of Major Depression. *Psychiatr Serv* 2002 May 1;53(5):585-90.
- (4) de Jonghe F, Kool S, van Aalst G, et al. Combining psychotherapy and antidepressants in the treatment of depression. *Journal of Affective Disorders* 2001;64:217-29.
- (5) Kool S, Dekker J, Duijsens IJ, et al. Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. *Harvard Review of Psychiatry* 2003;11:133-41.
- (6) Butler R, Carney S, Cipriani S, et al. *Clinical Evidence: Depression*. clinical evidence 2005 Available from: URL: www.clinicalevidence.com

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