

Short-term psychodynamic psychotherapies for anxiety, depression and somatoform disorders (Unknown)

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BACKGROUND

Short-term Psychodynamic Psychotherapy (STPP) has been developed over the past 40 years by a number of proponents including Mann, Malan, Davanloo and Sifneos (Davanloo 1980). Common features of these therapies include the use of selection, therapist focus, active therapist involvement, use of the transference (therapeutic) relationship and time restriction. Further, most STPP's use the triangle of conflict (feelings, anxiety and defence) and the triangle of person (past, therapist and current) in the therapeutic focus. (Davanloo 1980)

In the early phase of STPP development, case based research showed that a range of patients could be successfully treated by these brief therapies and that the gains were maintained in follow-up. (Davanloo 1980) Over the past 20 years, clinicians have studied STPP with a broad range of patients in controlled and randomised controlled trial formats. Our preliminary estimate is that there are well over 50 such studies published in the English language literature.

With this major upsurge in research, meta-analyses have also been performed as a further means of evaluating and summarizing the literature. These meta-analyses have yielded differing results over-time due to different study selection, and different methods of analysis and interpretation of results. Three meta-analyses found STPP to be superior to no treatment. (Crits-Christoph 1992, Svartberg 1991, Anderson 1995) Using narrow inclusion criteria, Crits Christoph (1992) found STPP significantly superior to minimal treatment controls and equal to other treatment controls. Svartberg (1991) using a largely different group of studies, found the treatment to be inferior to other treatments and equal to minimal treatments. Anderson and Lambert (1995) again found

superiority over waitlist controls and minimal treatment controls but found it equal to other formal therapies. Areas of conflict and controversy have included the inclusion or exclusion of papers studying Interpersonal Therapy and how to evaluate the studies with major differences in methodologies. (Svartberg 1993). Thus, the stage is set for a formal Cochrane review of these treatment approaches for patients who have anxiety, depression or somatoform disorders. By somatoform disorders, we mean conditions with non-medically explained physical symptoms

OBJECTIVES

This review evaluates the efficacy of STPP treatments for the treatment of adults with depression, anxiety or somatoform disorders in randomised controlled trials. Specifically, STPP will be compared with waiting list and minimal treatment controls which were designed as "placebo treatments". The review also seeks to specify the differential effects of STPP for certain patients (e.g. depression, anxiety or somatoform disorders) and treatment characteristics (e.g., manual driven vs non-manualised therapies).

CRITERIA FOR CONSIDERING STUDIES FOR THIS REVIEW

Types of studies

All randomised controlled trials (RCTs).

Types of participants

The population will be limited to adult outpatients with anxiety, depression or somatoform disorders (i.e. patients over 17

years old). Medical or psychiatric co-morbidity may be present, although patients with psychotic disorders will be excluded.

Types of intervention

All psychotherapies in which 1) the authors designated at least one treatment group as psychodynamic in nature and treatment lasted 40 weeks or less on average; 2) The treatment technique was derived from the work of one or more developers of short-term psychodynamic psychotherapies such as Mann, Sifneos, Malan, Davanloo, Luborsky (Davanloo 1980) or was specifically developed and described for a brief psychodynamic approach 3) the treatment under investigation was given in an individual format and 4) with standard length sessions of 45-60 minutes.

We have defined brief psychotherapy as being less than 40 sessions, as this is the definition used in previous meta-analyses.

Types of outcome measures

The primary outcome measure will be a significant reduction in anxiety or depression as defined by standardised psychiatric instruments or criteria such as the General Health Questionnaire, Beck Depression Inventory, Zung Depression Scale, Hamilton Anxiety and Depression Scales, Hospital Anxiety and Depression Scales, Present State Examination, Somatic Symptom Index and Composite International Diagnostic Interview.

Secondary outcome measures of interest will be:

- Quality of life e.g. Short Form 36 scores
- Behavioural measures e.g. attempts at self-harm
- Interpersonal problem measures
- Social adjustment e.g. return to full-time employment
- Patient satisfaction as measured by standardised instruments e.g. the Visit Specific Questionnaire
- Health service use e.g. hospital admission, outpatient contacts, visits to primary care
- Death (suicide and all-cause mortality)

SEARCH STRATEGY FOR IDENTIFICATION OF STUDIES

See: search strategy

1. Initially, the CCDAN specialised register will be checked to identify all potentially eligible studies (the last date the register was checked will be noted).
2. Electronic databases such as the Cochrane Controlled Trial Register (CCTR)/ Cochrane Library CENTRAL Register (record the issues searched, search strategy, and mistakes made), MEDLINE (1966 to present), CINAHL (1982 to present), EMBASE (1980 to present), PSYCH Info (1887 to present), the Database of Abstracts of Reviews of Effectiveness (DARE)

and Biological Abstracts (January 1980 to present) will also be searched to identify potentially eligible studies and review articles. For CCTR we will use the following search terms:

- #1 ANXIETY
- #2 DEPRESSION
- #3 (PANIC next DISORDER)
- #4 (DEPRESSIVE next DISORDER)
- #5 (DEPRESSIVE next SYMPTOMS)
- #6 (ANXIOUS next SYMPTOMS)
- #7 (SOMATIZATION next SYMPTOMS)
- #8 (SOMATISATION next SYMPTOMS)
- #9 (SOMATIZATION next DISORDER)
- #10 (SOMATISATION next DISORDER)
- #11 (SOMATOFORM next SYMPTOMS)
- #12 (SOMATOFORM next SYMPTOMS)
- #13 ((((((#1 or #2) or #3) or #4) or #5) or #6) or #7) or #8) or #9) or #10) or #11) or #12)
- #14 (BRIEF next PSYCHODYNAMIC)
- #15 (BRIEF next DYNAMIC)
- #16 (TIME-LIMITED next PSYCHODYNAMIC)
- #17 (TIME-LIMITED next DYNAMIC)
- #18 (BRIEF next PSYCHOANALYTIC)
- #19 (BRIEF next ANALYTIC)
- #20 (TIME-LIMITED next PSYCHOANALYTIC)
- #21 (TIME-LIMITED next ANALYTIC)
- #22 (((((((#14 or #15) or #16) or #17) or #18) or #19) or #20) or #21)
- #19 (#13 and #22)

All relevant foreign language papers will be translated. For MEDLINE, we will expand the search to ANALYTIC, PSYCHOANAYTIC, DYNAMIC or PSYCHODYNAMIC as the National Library of Medicine has defined brief psychotherapy as being not more than 20 sessions for indexing purposes since 1973. This will ensure we will not miss therapies of up to 40 sessions.

3. The reference lists of all references that are retrieved as full papers and potentially relevant, as well as relevant systematic reviews and literature reviews, will be checked to identify other potentially relevant articles. These articles will be retrieved and assessed for possible inclusion in the review.

4. Personal communications - The lead author of all relevant reported identified will be written to in order to ascertain if they know of any additional published or unpublished studies that might be relevant to the review.

5. Abstracts from national and international psychiatry and psychology conferences will be scrutinised to identify unpublished studies. These will include meetings organised by national and international medical colleges, specialty societies and professional organisations. The authors of these studies will be contacted to obtain further details about the study and to enquire if they know of any other unpublished or published relevant work.

METHODS OF THE REVIEW

Selection of studies for inclusion/exclusion

1. Two reviewers will independently select suitable studies for inclusion in this review as detailed below. Where the two reviewers disagree about the inclusion of a study, disagreements will be resolved by consensus of opinion, and a third reviewer consulted if they cannot be resolved. Where resolution is not possible the author will be contacted to obtain more information and clarification.

The titles and abstracts of studies identified by searching electronic databases will be assessed to determine whether each article meets the eligibility criteria. In order to prevent any bias, a list of all titles and abstracts will be printed out excluding the author's names, institutions, and journal title. If the title and abstract contain sufficient information to determine that the article does not meet the inclusion criteria, then it will be rejected. A record of all rejected papers and the reasons for rejection will be documented.

2. The full papers of all remaining titles and abstracts deemed relevant will then be retrieved. In addition, all other potentially relevant articles identified by the various search strategies (reference checking, personal communications etc) will also be reviewed. All papers in languages other than English will be translated/reviewed by someone who speaks the language. All articles will be reviewed independently by two of the reviewers, who will complete a form for each study and score the quality of the research as defined below. The reasons for exclusion will be documented. Where the same study has more than one article written about the outcomes, all articles will be treated as one study and the results will be presented only once.

Critical appraisal of studies

Assessment of the quality of a particular trial will be made in accordance with guidelines in the Cochrane Handbook.

1. Assessment of the method and adequacy of randomisation

To prevent selection bias, someone who is not responsible for recruiting the participants, such as a central trial office or someone not involved in the trial should conduct the randomisation. The method of randomisation will be noted on the data extraction form.

2. Assessment of the degree of blinding (treatment and outcome assessment)

Allocation concealment will be assessed as follows as described in the Cochrane Reviewers Handbook (Clarke 2000). (A) adequate description of the allocation procedure; (B) unclear description of the allocation procedure; (C) inadequate description of the allocation procedure; and (D) allocation concealment was not used. If the reviewers disagree over which category a trial is allocated to, resolution will be attempted by discussion or by obtaining further information. In addition, reviewers will be blinded to the author's names, institutions and journal title to prevent any bias.

3. Losses to follow-up

The paper should give an adequate description of the loss of its participants in terms of the number of withdrawals, dropouts, and protocol deviations. Where more than 20% of those originally randomised have been lost to follow-up, the data will not be presented in this review.

4. Addressing publication bias

Data from all identified and selected trials will be entered in to a funnel plot (size of study versus effect size) (Egger 1997), to attempt to detect the possibility of publication bias.

CCDAN criteria will be used to determine external validity. Each study will be rated on 23 items to give a score ranging from 0 to 43. These studies will be stratified into four categories, scores of 0 to 9, 10 to 19, 20 to 29, and 30 or more. These categories will inform the sensitivity analyses for quality of studies.

Data extraction

The two reviewers will complete the extraction of data from the papers on to a form to elicit the following information:

- General: Published/unpublished, title, authors, source, contact address, country, , language of publication, year of publication, duplicate publications)
- Trial characteristics: design, duration, randomisation and method, allocation concealment and method, blinding of outcome assessors, check of blinding
- Interventions (frequency, timing, individual vs group, up to 20 sessions vs 20-40 sessions, manual driven vs non-manualised therapies), comparison interventions, co-medications
- Patient characteristics - sampling, exclusion criteria, number of participants, age, sex, ethnicity, marital status, educational status, duration of symptoms, number of complications, similarity of groups at baseline (including any co-morbidity), withdrawals/losses to follow-up (reasons/descriptions)
- Primary diagnosis (e.g. depression, anxiety or somatoform disorders)
- Type of medical co-morbidity if present
- Type of psychiatric co-morbidity - clinical diagnosis or symptomatology assessed by questionnaire
- Type of outcome - self-report or observer-rated
- Type of assessment tool used to assess psychiatric co-morbidity - e.g. Beck Depression Inventory, Zung Depression Scale, Hospital Anxiety and Depression Scale, Structured interview, DSM-IV criteria.
- Cut-off used on psychiatric scale, percentage of people defined as psychiatric cases on this basis; mean (SD) symptom score.
- Timing of follow-up - short-, medium- or long-term (see definition under type of outcomes)
- Assessment of methodological quality - stratified into four categories using CCDAN criteria (scores of 0 to 9, 10 to 19, 20 to 29, and 30 or more); method of randomisation used, if stated; method of allocation concealment (adequate, unclear, inadequate, or allocation concealment not used); blinding of outcome assessors (yes, no, unclear); and patients lost to follow-up (cut-off of 20% attrition or more), intention-to-treat

analysis.

Data Analysis

1. Data entry

A summary of data extracted from included studies will be reported. If studies are available that are sufficiently similar and of sufficient quality we will pool those that can be grouped together and use the statistical techniques of meta analysis. The data will be synthesised using MetaView within the Cochrane Review manager software

2. Method of analysis

The comparisons necessary to achieve the review objectives and to test hypotheses are of the type: STPP vs no treatment control or STPP vs. minimal treatment.

3. Obtaining unpublished data for the included trials

Where it is not possible to quantitatively analyse data as reported in published studies, we will contact the first author to obtain the additional data required. Where no further usable data is provided, studies will not be included in the meta-analysis, and will be listed as excluded due to missing data.

4. Data types

Outcomes will be assessed using continuous (for example, changes on depression scales), categorical (for example, one of three categories on a quality of life scale, such as 'better', 'worse' or 'no change'), or dichotomous (for example, either depressed or not-depressed) measures.

Continuous data: Many rating scales are available to measure outcomes in psychological trials. These scales vary in the quality of their validation and reliability. Therefore, if a rating scale's validation has not been published in a peer-reviewed journal, then the data will not be included in this review. In addition, the rating scale should be either self-report or completed by an independent observer or relative. Trials that have used the same instrument to measure specific outcomes will be used in direct comparisons where possible. Where continuous data are presented from different scales rating the same effect both sets of data will be presented and the general direction of the effect inspected. The mean and standard deviation will be reported. Where standard deviations are not reported in the paper, attempts will be made to obtain from the authors or to calculate them using others measures of variation that are reported, such as the confidence intervals. If possible, we will meta-analyse data from different scales rating the same effect using the Standardised Mean Difference.

Dichotomous data : Continuous outcome measures will be converted to dichotomous data where necessary. If the authors of the study have used a designated cut-off point for determining clinical effectiveness the reviewers will use this where appropriate. Otherwise, cut-offs on rating scales will be identified and participants will be divided on basis of whether they are 'clinically improved' or 'not clinically improved'. For dichotomous outcomes, a Mantel-Haenszel odds ratio with its

associated 95% confidence intervals (CI) will be estimated. As a summary measure of effectiveness, where possible, the number needed to treat statistic (NNT) will also be calculated.

5. Heterogeneity

Graphical representations of the data will be inspected; if the confidence intervals for the results of the study do not overlap, it suggests that the differences are likely to be statistically significant (Walker 1988). In addition, differences between the results of each included trial will be checked using a test of heterogeneity. As these tests usually have low statistical power, a type I error level of 0.10 rather than the customary 0.05 was used for rejecting the null hypothesis of homogeneity. If there is statistically significant heterogeneity the data will be presented separately rather than pooled. Results will be analysed using both the fixed effect and random effects methods. However, where there is significant heterogeneity, a random effects model will be used and the reviewers will attempt to explore the reasons for this heterogeneity in post hoc analyses.

6. Sensitivity analyses

Factors, which may lead to differences between the results of individual studies, will be investigated using sensitivity analyses. This review will investigate

- differences in outcome between depression, anxiety or somatoform disorders
- group vs individual therapy
- manual driven vs non-manualised therapies
- therapy of up to 20 sessions vs 20-40 sessions
- differences between studies that give self-reported or observer-rated outcomes
- differences between analyses involving all studies and excluding trials of low methodological quality as defined by CCDAN criteria.

POTENTIAL CONFLICT OF INTEREST

The principal reviewer, Allan Abbas has a career focus on a variant of STPP. He acknowledges a psychotherapeutic bias in his clinical work and teaching in favour of STD but is aware of the deficits in the available literature, and of the need to review the literature, and improve upon the research done in this field. To balance this view, 3 colleagues without such a conflict of interest are participating in this review.

SOURCES OF SUPPORT

External sources of support

- Cochrane Canada CANADA

Internal sources of support

- Department of Psychiatry, Dalhousie University CANADA

REFERENCES

Additional references

Anderson 1995

Anderson E, Lambert M. Short-term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review* 1995;**15**(6):503–14.

Clarke 2000

Clarke M, Oxman A. *Cochrane Reviewers Handbook*. 4.1 Edition. Oxford: Update Software, 2000.

Crits-Christoph 1992

Crits-Christoph P. The efficacy of brief dynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry* 1992;**149**(2):151–8.

Davanloo 1980

Davanloo H. *Short-term dynamic psychotherapy*. New York, NY: Jason Aronson, 1980.

Egger 1997

Egger M, Davey Smith G, Schneider M, Minder CE. Bias in meta-analysis detected by a simple, graphical test. *BMJ* 1997;**315**(7109):629–34.

Svartberg 1991

Svartberg M, Stiles T. Comparative effects of short-term psychodynamic psychotherapy: a meta-analysis. *Journal of Consulting & Clinical Psychology* 1991;**59**(5):704–14.

Svartberg 1993

Svartberg M, Stiles T. Efficacy of brief dynamic psychotherapy. *American Journal of Psychiatry* 1993;**150**(4):684–5.

Walker 1988

Walker AM, Martin-Moreno JM, Artalejo FR. Odd man out: a graphical approach to meta-analysis. *American Journal of Public Health* 1988;**78**(8):961–6.

*Indicates the major publication for the study

COVER SHEET

Title	Short-term psychodynamic psychotherapies for anxiety, depression and somatoform disorders
Reviewers	Abbass AA, Hancock JT, Henderson J, Kisely S
Contribution of reviewer(s)	Abbass will be the guarantor of this review Abbass and Hancock originally conceived the review Abbass, Kisely and Hancock designed the review Hancock, Henderson and Abbass did data collection for the review Hancock developed the search strategy Hancock and Henderson undertook searches All screened retrieved papers against inclusion criteria Abbass and Kisely appraised quality of papers Hancock, Henderson and Abbass abstracted data from papers Abbass and Hancock wrote to authors of papers for additional information Henderson did data management for the review Henderson and Kisely entered data into RevMan, All analyzed data, interpreted data All provided a methodological perspective Abbass provided a clinical perspective All will write the review Abbass will secure funding for the review
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Date new studies found but not yet included/excluded	Information not supplied by reviewer
Date new studies found and included/excluded	Information not supplied by reviewer
Date reviewers' conclusions section amended	Information not supplied by reviewer
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