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Research report

Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. II. Psychotherapy alone or in combination with antidepressant medication

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ABSTRACT

Background: In 2001, the Canadian Psychiatric Association and the Canadian Network for Mood and Anxiety Treatments (CANMAT) partnered to produce evidence-based clinical guidelines for the treatment of depressive disorders. A revision of these guidelines was undertaken by CANMAT in 2008–2009 to reflect advances in the field. This article, one of five in the series, reviews new studies of psychotherapy in the acute and maintenance phase of MDD, including computer-based and telephone-delivered psychotherapy.
Methods: The CANMAT guidelines are based on a question–answer format to enhance accessibility to clinicians. Evidence-based responses are based on updated systematic reviews of the literature and recommendations are graded according to the Level of Evidence, using pre-defined criteria. Lines of Treatment are identified based on criteria that included evidence and expert clinical support.
Results: Cognitive-Behavioural Therapy (CBT) and Interpersonal Therapy (IPT) continue to have the most evidence for efficacy, both in acute and maintenance phases of MDD, and have been studied in combination with antidepressants. CBT is well studied in conjunction with computer-delivered methods and bibliotherapy. Behavioural Activation and Cognitive-Behavioural Analysis System of Psychotherapy have significant evidence, but need replication. Newer psychotherapies including Acceptance and Commitment Therapy, Motivational Interviewing, and Mindfulness-Based Cognitive Therapy do not yet have significant evidence as acute treatments; nor does psychodynamic therapy.
Limitations: Although many forms of psychotherapy have been studied, relatively few types have been evaluated for MDD in randomized controlled trials. Evidence about the combination of different types of psychotherapy and antidepressant medication is also limited despite widespread use of these therapies concomitantly.
Conclusions: CBT and IPT are the only first-line treatment recommendations for acute MDD and remain highly recommended for maintenance. Both computer-based and telephone-delivered psychotherapy—primarily studied with CBT and IPT—are useful second-line recommendations. Where feasible, combined antidepressant and CBT or IPT are recommended as first-line treatments for acute MDD.

Introduction

The Canadian Psychiatric Association and the Canadian Network for Mood and Anxiety Treatments (CANMAT), a not-for-profit scientific and educational organization, collaborated

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on the publication in 2001 of evidence-based clinical guidelines for the treatment of depressive disorders (Kennedy and Lam, 2001). A revision of these guidelines was undertaken by CANMAT in 2008–2009 to update the recommendations based on new evidence. The scope of these guidelines encompasses the management of adults with unipolar major depressive disorder (MDD). This section reviews psychotherapy, alone and in combination with medication, while a series of 4 companion sections review other aspects of MDD. There are separate CANMAT guidelines for Bipolar Disorder (Yatham et al., 2009).

Psychotherapy refers to the treatment of psychiatric and behavioural disorders through a method of communicating that invokes a psychological model of illness. This method of communication begins with a patient who seeks alleviation of current symptoms or prevention of recurrence of symptoms. Historically this required the establishment of a professional relationship between a patient and a therapist; with the advent of computer, internet, self-help, and to a lesser extent telephone therapies, the relationship is more explicitly between the patient and the psychological model, with an implicit link to the 'therapist' who designed the therapy.

Psychotherapy predates somatic therapies and includes a host of models, several of which have been rigorously tested, specifically for MDD. This review summarizes depression-specific psychotherapies as well as newer therapies which are promising, and seeks to clarify the evidence and usefulness of each major psychotherapy. While most psychotherapies share many common elements, the major treatments for MDD may be characterized by a number of key components: (a) the goal of treatment is alleviation of the core symptoms of depression, (b) there is careful attention to a specific method to deliver the therapy (typically a manual), (c) the psychotherapy focuses on the current problems of the patient, (d) high levels of activity are expected both of the therapist and the patient (who frequently has 'homework'), (e) careful symptom monitoring, preferably with rating scales, is expected, (f) psychoeducation about the illness is a universal component, and (g) the treatment is generally time-limited, often paralleling the time course for pharmacotherapy. Furthermore, many of these therapies have been modified to be delivered in a group format. While a group approach may allow for integration of new techniques involving peer feedback and may be more cost-effective, the core of the psychotherapy remains unchanged, so group interventions are not evaluated in these guidelines as a separate "group therapy". Similarly, context-specific therapies (such as marital therapy for MDD coinciding with a severe marital dispute) are not evaluated, since such therapies do not generalize to the average person with depression. Indications for a specific therapy, and the choice of either psychotherapy or pharmacotherapy alone or in combination are reviewed in a number of the following questions. The recommendations are presented as guidance for clinicians who should consider them in the context of individual patients, and not as standards of care.

Methods

The full methods have been described elsewhere (Kennedy et al., 2009) but, in summary, relevant English language publications from January 1, 2000 to December 31, 2008 were identified using computerized searches of electronic databases (PubMed, PsychInfo, Cochrane Register of Clinical Trials), inspection of bibliographies, and review of other guidelines and major reports. The previous question–answer format has been retained based on feedback from clinicians. Recommendations for each Line of Treatment are based on the Level of Evidence and clinical support (Table 1). A first-line treatment represents a balance of efficacy, tolerability and clinical support. Second-line and third-line treatments are reserved for situations where first-line treatments are not indicated or cannot be used, or have not worked.

CANMAT recognizes that much of the evidence is based on studies using strict inclusion/exclusion criteria with intensive and frequent follow up for a short duration of treatment, and therefore may not be applicable to the average patient seen by clinicians. Hence, there are few absolute recommendations and these guidelines should be viewed as guidance that must be tailored to an individual patient, and not as standards of care.

2.1. When is psychotherapy indicated for treatment?

Many factors influence the decision of when and where to employ psychotherapy. Employing a broad perspective, there are patient, provider, and (health) system issues that each play a role. Among the patient factors are adequacy of clinical evidence for a specific patient population (e.g. women during pregnancy); medication contraindications; patient preference; and the ability of a patient to engage in treatment. Patient preferences may in turn be influenced by social or cultural convictions regarding the efficacy of particular non-medical therapies, and the fear of potential medication side

Table 1
Criteria for level of evidence [a] and line of treatment [b].

Level	Criteria
1	At least 2 RCTs with adequate sample sizes, preferably placebo-controlled, and/or meta-analysis with narrow confidence intervals.
2	At least 1 RCT with adequate sample size and/or meta-analysis with wide confidence intervals.
3	Non-randomized, controlled prospective studies or case series or high quality retrospective studies.
4	Expert opinion/consensus.

Line of treatment	Criteria
First-line	Level 1 or Level 2 evidence, plus clinical support [c]
Second-line	Level 3 evidence or higher, plus clinical support [c]
Third-line	Level 4 evidence or higher, plus clinical support [c]

[a] Note that Levels 1 and 2 evidence refer specifically to treatment studies in which randomized comparisons are available. Recommendations involving epidemiological or risk factors primarily arise from observational studies, hence the highest level of evidence is usually Level 3. Higher order recommendations (e.g., principles of care) reflect higher level judgment of the strength of evidence from various data sources, and therefore are primarily Level 4 evidence.

[b] A first-line treatment represents a balance of efficacy, tolerability and clinical support. Second-line and third-line treatments are reserved for situations where first-line treatments are not indicated or cannot be used, or when first-line treatments have not worked.

[c] Clinical support refers to application of expert opinion of the CANMAT committees to ensure that evidence-supported interventions are realistic in clinical practice. Therefore, treatments with higher levels of evidence may be downgraded to lower lines of treatment due to clinical issues such as side effect or safety profile.