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Enduring effects of evidence-based psychotherapies in acute depression and anxiety disorders versus treatment as usual at follow-up — A longitudinal meta-analysis

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HIGHLIGHTS

- Moderate superiority of evidence based psychotherapies (EBP) in comparison to TAU
- No growth of effects from post to follow-up assessments
- Limited number of studies investigating lasting efficacy of EBP compared to TAU

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ABSTRACT

Objective: This meta-analysis examined the enduring efficacy of evidence-based psychotherapies (EBP) in comparison to treatment as usual (TAU) by examining effects from termination to follow-up for acute anxiety and depression in an adult outpatient population. It was hypothesized that EBPs might extend their efficacy at follow-up assessment (Tolin, 2010).
Method: Longitudinal multilevel meta-analyses were conducted that examined the magnitude of difference between EBP and TAU. Targeted (disorder-specific) outcomes were examined, along with dropout rates at follow-up assessments.
Results: A total of 15 comparisons (including 30 repeated effect sizes [ES]) were included in this meta-analysis (average of 8.9 month follow-up). Small to moderate ES differences were found to be in favor of EBPs at 0–4 month assessments (Hedges' g = 0.40) and up to 12–18 month assessments (g = 0.20), indicating no extended efficacy at follow-up. However, the TAU-conditions were heterogeneous, ranging from absence of minimal mental health treatment to legitimate psychotherapeutic interventions provided by trained professionals, the latter of which resulted in smaller ES differences. Furthermore, samples where substance use comorbidities were not actively excluded indicated smaller ES differences. TAU-conditions produced slightly higher dropout rates than EBP-conditions.
Conclusion: Findings indicate small and no extended superiority of EBP for acute depression and anxiety disorders in comparison to TAU at follow-up assessment. There are a limited number of studies investigating the transportability and lasting efficacy of EBP compared to TAU, especially to TAU with equivalent conditions between treatment groups.

Contents

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1. Introduction

Depression and anxiety disorders are common mental health problems. In the past decade, over 150 million people worldwide have been diagnosed with severe depression (Kessler, Chiu, Demler, & Walters, 2005). In Western countries life-time prevalence rates are as high as 30% for depression and 20% for anxiety disorders (Somers, Goldner, Waraich, & Hsu, 2006; Waraich, Goldner, Somers, & Hsu, 2004). Comorbidities of depression and (specific) anxiety disorders are frequent (Kessler et al., 2003). In the USA, approximately 40 million adults were diagnosed with an anxiety disorder in 2009 alone (Kessler et al., 2005; NIMH, 2011), resulting in an economic cost of nearly 50 billion US dollars (Rosenblatt, 2010).

The development and dissemination of effective treatments for anxiety and depression that have enduring effects for patients over time is imperative (WHO, 2008). Substantial effort to identify such treatments are emphasized by the Division 12 of the American Psychological Association's Task Force for the Promotion and Dissemination of Psychological Procedures (Chambless & Hollon, 1998), and by the National Institute of Health and Care Excellence in the United Kingdom (NICE, 2013). The field has moved to "evidence-based psychotherapies" (EBPs) to describe psychological therapies that have been demonstrated to be efficacious in randomized clinical trials (RCTs).

RCTs are conducted in controlled, (quasi-) experimental settings. Efforts to disseminate EBPs to the "real world" clinic are strengthened by naturalistic studies that investigate the effectiveness of EBPs compared to treatment-as-usual (TAU). That is, implementation of EBPs in a practice setting should improve the quality of patient outcomes vis-à-vis what is currently being offered for anxiety and depression at a clinic (Comer & Barlow, 2014; Karlin & Cross, 2014). As straightforward as this sounds, no standardized definition of what constitutes TAU exists, which is problematic. For example, TAU may involve psychotherapy delivered by trained clinicians in the manner these clinicians feel is appropriate in one setting and, in contrast, may involve no mental health services in another (i.e. depressed and anxious patients in the service do not have access to psychotherapy or do not utilize the services even if they were available; see Weisz, Jensen-Doss, & Hawley, 2006; Wampold et al., 2011).

Meta-analyses examining the differences between EBP and TAU have found moderate effects at treatment termination for depression (Hedges' $g = 0.38$, Cuijpers et al., 2012), for depression and anxiety ($g = 0.45$, Wampold et al., 2011), but also more generally for youth ($g = 0.32$, Weisz et al., 2006; Spielmans, Gatlin, & McFall, 2010) and for personality disorders ($g = 0.40$, Budge et al., 2013). However, these ES differences were minimal when the TAU conditions were proximate to psychological interventions comparable to the EBP (Budge et al., 2013; Spielmans et al., 2010; Wampold et al., 2011). That said, none of the aforementioned meta-analyses assessed outcome differences beyond treatment termination and therefore outcome research that includes assessments at follow-up is needed (Lambert, 2013). While a recent summary has concluded that the maintenance of gains in psychotherapy "seem unrelated to the type of treatment" (Lambert, 2013, p. 181), it has been argued, that relative efficacy of EBPs appear to be enduring and the EBP might demonstrate there full potential at the follow-up assessments (Cuijpers, van Straten, van Oppen, & Andersson, 2008; Tolin, 2010). Therefore, an assessment of the value of EBPs for real world services has to examine whether the effects of EBPs are enduring.

Due to the relevance of and limited research examining enduring treatment efficacy, we meta-analytically examined the relative efficacy of EBPs compared to TAU for anxiety and depression in adults from termination up to 18-month follow-up assessments points. We considered disorder-specific measures (targeted outcomes; Wampold et al., 2011) as well as dropout rates (Swift & Greenberg, 2012) as outcome indicators. We also examined a number of study-level variables that might or might not moderate the lasting effects of EBPs.

1.1. Chronic conditions

Patients who suffer from an acute depression or anxiety disorder might differ in their history of disease. It was hypothesized by some researchers that patients with long-term chronic conditions have better long-term outcomes with EBP (e.g. Cuijpers et al., 2008; Tolin, 2010). Other researchers claim that chronic conditions (possibly embedded in a variety of bio-psycho-social risk factors) might well reduce the overall chances for lasting recovery (Hölzel, Härter, Reese, & Kriston, 2011; Saraga, Gholam-Rezaee, & Preisig, 2013). We tested whether EBP was superior to TAU at long-term follow-up assessment points where the samples indicated a chronic course of any kind of psychopathology.

1.2. Older adults

Generally, older adults seem to profit similarly from psychotherapy vis-à-vis younger adults (Cuijpers et al., 2009; Payne & Marcus, 2008). However, this generally requires the treatment to be adapted to cater to these populations (APA, 2014; Fiske, Wetherell, & Gatz, 2009). Due to the particular risk factors of older adults (e.g. Montgomery & Dennis, 2002; Smith, Jiang, & Ory, 2012), it is unknown whether the