The future of psychotherapies for mood disorders

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As developers of a psychotherapy for depression, we bring a point of view to the topic of the future of antidepressant psychotherapies. Let us state this view up front and emphasize it reflects that most of our experience has been in the United States. Our guiding principles are:

- Psychotherapies, like any treatments, should be evidenced based. Evidence is best derived from randomized controlled clinical trials like those used in testing medications.
- The effects of psychotherapies need assessment using a broad range of outcome variables, including symptoms, social functioning, costs, etc., since psychotherapy may have targets and consequences that differ from psychotropic medications.
- Psychotherapies need to be specified in manuals that describe procedures and their sequences with case illustrations. These manuals form the basis for training therapists and allow standardization of treatment.
- Effectiveness studies, which have broad diagnostic entry criteria and test treatments in real practice outside research settings, are useful, but few actually exist for psychotherapies. Although the virtues of these studies have been detailed, problems in their conduct and interpretation have not.
- Once the efficacy of a psychotherapy has been established, research on the active ingredients in the treatment process and factors mediating outcome deserve exploration.

Any discussion of the future is a wish list based on problems and gaps in past and present research. As a context for forecasting the future, we must first describe where we now stand in the psychotherapy of mood disorders. We shall describe trends in psychotherapy use over the past decade; the status of evidence-based psychotherapy (EBP); the expansion of psychotherapy to developing countries; the gap between research and training in EBPs; the need for more psychotherapy development and testing and for new methods of delivery; and finally, what we see as the future.

TRENDS IN THE UNITED STATES

Olfson et al (1) recently reported trends in American psychotherapy, comparing 1987 and 1997 surveys of medical expenditure, based on nationally representative adult samples. We could find no comparable international data and realize these findings reflect the unique and imperfect American health care system.

Between 1987 and 1997, total psychotherapy use in the US showed no statistically significant change. Slightly over 3% of adults reported receiving psychotherapy in each year. Older (55 to 64 years old), unemployed, and poor adults reported significant increases in psychotherapy use. Over the decade, psychotherapy visits for the primary diagnosis of mood disorders became more common (39.1% in 1997 vs. 19.5% in 1987). Psychotherapy patients reported markedly greater use of antidepressant medications (48.6% vs. 14.4%), mood stabilizers (14.5% vs. 5.3%), stimulants (6.4% vs. 1.9%), and psychotherapy provided by physicians (64.7% vs. 48.1%; data did not distinguish psychiatrists from other physicians). Psychotherapy by social workers doubled (12.5% vs. 6.8%), whereas psychologists remained stable (35.2% vs. 31.8%). Duration of treatment decreased: fewer patients attended more than 20 psychotherapy visits in 1997 (10.3%) than 1987 (15.7%). In both years a third of psychotherapy patients made only one or two visits (33.5% to 35.3%).

We conclude that American psychotherapy practice has changed substantially, with increased use by socioeconomically disadvantaged and older people; a rise in psychotherapy for mood disorders and in combination with psychotropic medications; declines in psychotherapy for non-specific conditions and in long-term psychotherapy; greater involvement of physicians (not necessarily psychiatrists), and increased treatment by social workers. These data say nothing about type of psychotherapy. Most was probably not EBP, since defining clinical EBP trials have been relatively recent. Incorporation of EBPs into training programs has been nearly non-existent. The reported trends will likely continue, suggesting the need for training a range of mental health professionals in time-limited, cost-efficient, efficacy-proven psychotherapies for mood disorders.

OVERVIEW OF EVIDENCE-BASED PSYCHOTHERAPY FOR MOOD DISORDERS

Comprehensive reviews have identified EBPs: psychotherapies defined by manuals, having specific criteria for training and competence evaluations, and supporting data from controlled clinical trials (2-4). Recent reviews have addressed mood disorders for adults (5,6) and for children and adolescents (7,8). Chambless and Ollendick (9) extensively reviewed EBPs of several disorders, integrating the efforts of eight workgroups from the US, UK, and Canada. Although criteria used to define EBPs differed among workgroups, at least one rigorous, randomized clinical trial was required to define empirically supported treatments.

Major depression

Both interpersonal psychotherapy (IPT) (4) and cognitive behavioral therapy (CBT) (10,11) have demonstrated efficacy in reducing symptoms comparable to psychotropic medication as acute treatments of major depressive disorder (MDD) in adult outpatients (12). Psychotherapies have a slower onset of action, however. An amalgam of CBT and IPT (cognitive behavioral analysis system of psychotherapy [CBASP]) (13) has been shown to reduce symptoms of chronic depression; combining CBASP with medication increased the response rate from 48% to 73% (14).

Major depression has a high relapse rate. When administered at the low dosage of once monthly following an acute phase of weekly treatment, both IPT and CBT decrease rates of relapse and recurrence (15). Even without continuation therapy, acute CBT may have an enduring protective effect (6). Combining antidepressant medication with IPT or CBT modestly increases efficacy over either treatment alone. Psychotherapies have also shown efficacy for depression secondary to other problems. For example, IPT reduced depressive symptoms of depressed patients with human immunodeficiency virus (HIV) infection relative to CBT and a supportive psychotherapy control (16), and both IPT and CBT reduced depression in patients with marital dysfunction (17,18).

Promising adaptations of EBPs are underway. Markowitz (19) tested an adaptation of IPT for patients with dysthymic disorder. CBT has been adapted for patients with treatment refractory depression. Several other variants of CBT, reviewed by Hollon et al (5), are being tested, including behavioral activation and mindfulness-based cognitive therapy (MBCT). An important clinical trial is comparing supportive/expressive psychodynamic psychotherapy to medication and placebo for major depression.

Depression in children and adolescents

Although fewer trials exist for adolescent depression, controlled trials also support the use of IPT and CBT (20-23). Mufson and Velting (7) found thirteen randomized controlled clinical trials of CBT with depressed youth. None treated clinically referred prepubertal depressed children. Studies of prepubertal children have been conducted in schools and treated children with depressive symptoms, not mood disorders. This likely reflects the low rate of full blown MDD prior to adolescence.

Bipolar disorder

The efficacy of acute and maintenance pharmacotherapy for patients with bipolar disorder has been established in clinical trials. Yet many patients have residual symptoms, relapses, and associated social and interpersonal problems during or following illness episodes. There is renewed interest in psychotherapy to help manage medicated bipolar patients. Family focused therapy (FFT), CBT and IPT have been modified to address the problems of bipolar patients. These treatments focus on medication adherence; patient and family education about the illness and signs of relapse; monitoring of early signs of relapse; and social and interpersonal consequences of the illness. CBT has been modified to focus on recognizing and treating early depressive or manic symptoms (24), addressing mediating mechanisms such as distorted cognitions and disrupted circadian rhythm. IPT has been modified by Frank et al (25) to include adding a behavioral focus to stabilize patients' social rhythms, particularly to ensure regular sleeping hours (interpersonal social rhythms therapy, IPSRT). FFT (26) aims to reduce family criticism and expressed emotion that may trigger or prolong symptoms, and to enhance frequency of positive family or marital interaction. Clinical trials are now underway.

The National Institute of Mental Health (NIMH) has awarded two large contracts for nationwide, loosely randomized clinical effectiveness trials of treatment algorithms for both treatment-resistant depression (STAR-D) and bipolar disorder (STEP-BD). Treatment choices in these trials include EBPs as well as pharmacotherapy.

POOR AND DEVELOPING COUNTRIES

Psychotherapy began as an expensive treatment for the well-to-do. Its cost and length have gradually decreased, making it more democratically available, as the recent US survey shows (1). Outcome studies in the US, which frequently involve poorer patients, have shown psychotherapeutic efficacy in a variety of ethnic and social groups (7,21).

Interest in psychotherapy to treat depression in developing countries is a recent trend. One exciting development is a clinical trial in Uganda, which was based on high local rates of both HIV infection and MDD and the observations that depression worsens attention to health and risky behavior (27). Pharmacotherapy was an unrealistic alternative because of physician shortage and cost. IPT

was selected because its focus on relationships appeared culturally compatible. The IPT manual was simplified and modified as a group treatment led by non-clinician, college educated therapists with two weeks of training (28). A clinical trial, randomizing by village and comparing group IPT to treatment as usual in 114 depressed men and women, showed positive results for group IPT in reducing depressive symptoms (29).

The Ugandan trial demonstrated the feasibility of conducting clinical trials in developing countries. Depression was definable and assessable in a different culture (27), as previous World Health Organization studies had shown. IPT proved transplantable to a very different culture from its origins, highlighting the universality of human experience with depression. The death of a loved one, disputes and disrupted attachment with family, and serious life changes are associated with depression everywhere. If social context and content differ - e.g., role disputes may concern a husband's taking a second wife in Uganda versus a mistress in the US - the emotional experience and symptoms are similar. Researchers adapting psychotherapy manuals to bring EBPs to other cultures must be sensitive to cultural differences but should not view such differences as insuperable obstacles.

FILLING THE GAP BETWEEN RESEARCH AND TRAINING

The availability of EBPs, indications for their use in official practice guidelines, and clinical interest in their use are all increasing. Unfortunately, the three mental health specialties - psychiatrists, psychologists and social workers - who provide most psychotherapy in the US receive little training in EBPs in their professional training programs. Nor is continuing education (CE) mandated for practicing professionals. Although psychotherapy workshops are held at professional meetings, their quality and content are not monitored, and there are no procedures for credentialing participants or for follow-up. Let us review the current status of training in EBPs in the US.

Psychiatrists

New accreditation criteria for US psychiatry residency programs set forth by the Accreditation Council for Graduate Medical Education (2000) do not stress training in EBPs but have emphasized again psychotherapy and exceed rival professions in requiring 'competency' in CBT. Residency programs are moving toward defining and standardizing general 'competency' criteria rather than emphasizing training in specific psychotherapies.

Psychologists

The American Psychological Association Committee on Accreditation Guidelines (1996) states that training should reflect 'the science of psychology' but allow each program to define its own 'philosophy of training'. The guidelines do not prioritize training in manualized EBPs, which are mentioned only parenthetically. Although psychologist researchers initiated much of the development and testing of EBPs, a survey of clinical psychology doctoral and internship programs revealed little training in them. In internship programs, where clinical psychologists receive the bulk of supervised clinical experience, only 59% of programs provided CBT supervision for depression; a mere 8% provided IPT supervision. University doctoral programs were somewhat better. Availability of supervision, however, does not require students to receive it.

Social workers

The Educational Policy of the Council on Social Work Education (1999) does not prescribe curricula for psychotherapy or counseling (30). No training guidelines exist for EBPs. Since most clinical training occurs through fieldwork, it is unlikely that students receive training in EBPs. We found no data on actual training or use of guidelines in social work graduate programs.

Continuing education

No formal process exists to disseminate EBPs to established practitioners (31). Clinicians trained ten years ago are unlikely to know the newer psychotherapies. CE programs could potentially fill this void. Workshops are given on EBPs at annual national and international meetings of psychiatrists and psychologists. CE workshops outside professional organizations are offered in increasing numbers in Canada, the UK, the Netherlands, and New Zealand. However, none of the mental health professions require updated training. There is no way to ensure the transfer of EBPs to established practitioners, to set standards or monitor quality. Already overworked by changes in healthcare delivery, experienced clinicians may resent additional requirements, time burdens, or possible practice restrictions. The gap in transfer of EBPs from research to clinical practitioners could compromise the viability of these psychotherapies. The increasing US penetration of managed care, and the proliferation of clinical practice guidelines in several countries, have raised the stakes for accountability. Failure to train clinicians in EBPs and thus make them available to the general public might reduce support for EBPs despite their efficacy data.

In response to this professional credentialing program, psychotherapy organizations are arising. Following the model of psychoanalysis, groups such as the Academy of Cognitive Therapy (http://www.academyofct.org/) and the International Society of Interpersonal Psychotherapy (http://www.interpersonalpsychotherapy.org/index.html) are attempting to impose some cohesion and treatment standards for EBPs.

THE NEED FOR MORE PSYCHOTHERAPY DEVELOPMENT AND TESTING

Two psychotherapies now dominate the evidence-based categories for mood disorders. This is insufficient in comparison to the numerous antidepressant medications available with differing chemical profiles and effects. More efficacy, effectiveness, and dose-finding trials are needed for both CBT and IPT as well as for older, widely used but little tested treatments, and for new ones yet to be developed. The high rate of first onset of MDD in adolescents demands more trials in this age group. Rates of MDD are low in prepubertal children, but depressive symptoms and specific phobias are not, especially in children with depressed parents and grandparents. We need psychotherapies adapted, developed and tested for children at high risk for depression. We need a better understanding of the active components of efficacious therapies to tailor them to particular patients. For example, MBCT combines strategies from dialectical behavioral therapy for borderline personality disorder and CBT (32). The trend has been to combine components of different therapies. Further work on dismantling to understand the active components of EBPs may focus treatment for specific subtypes of mood disorders. Dose finding of the optimal length and intensity of EBPs is also important.

METHODS OF DELIVERY

We need flexible methods to deliver treatment for women with children, a high risk group for depression. Lacking resources of child care, family support, and transportation, many women have difficulty attending weekly psychotherapy. So do women during and following pregnancy (33). To ease their burden, we have experimented with psychotherapy by telephone, following an initial in-person diagnostic assessment (34). This method has also been used for depressed patients immobilized by cancer.

The weekly 40-50 minute psychotherapy 'hour' may become less normative. Flexibility in length, frequency, and duration of sessions may more realistically match the course of mood disorders, which are chronic and/or relapsing, often with long periods of remission. The efficacy of monthly maintenance IPT for patients with serious recurrent depression offers a model for long-term management of mood disorders (35,36), although the optimal dosage of such maintenance treatment remains unclear. There has also been renewed interest in group psychotherapy (37). This format may not only be economical but preferred by some patients.

THE FUTURE OF PSYCHOTHERAPY FOR MOOD DISORDERS

The future of psychotherapy for mood disorders is robust, but treatment forms and populations will evolve. Psychotherapy will remain a strong component of the clinical treatment armamentarium for several reasons. The population at highest risk for MDD are women of childbearing age. Alternatives to medication during pregnancy and lactation are important, and many depressed women demand them. Onset of depression often occurs in adolescence, when risky behavior and suicide attempts are high, and when mood episodes can be devastating to personal and occupational choices. Psychotherapy, alone or with medication, can help guide adolescents through the acute episode and beyond. Suicide remains a serious complication of bipolar disorder, and medication adherence is an important component of prevention both of suicide and symptom relapse. Psychotherapies currently developed for bipolar disorder strongly emphasize psychoeducation and monitoring symptoms and social functioning. Preliminary evidence suggests that these are helpful to the patient and/or family in monitoring risk for relapse in medicated bipolar patients. Several psychotherapies developed for medicated bipolar patients are being tested. The future will see more testing of psychotherapy for depressed adolescents and, hopefully, prepubertal children with mood disorders, particularly those at high risk. More information is needed on the effect of maintenance treatment and the addition of medication for depressed youth.

We hope that the increasing democratization of psychotherapy, in the US and elsewhere, is a trend that will continue. This would likely mean a shift in psychotherapy to less expensive, less well trained therapists, however, making the balancing of cost and quality of treatment delivery a dilemma. Finally, without a radical change of training of mental health professionals in EBPs, a gap between research and practice will remain.

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