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CADTH RAPID RESPONSE REPORT:
SUMMARY WITH CRITICAL APPRAISAL

Short-Term Psychodynamic Psychotherapy for the Treatment of Mental Illness: A Review of Clinical Effectiveness and Guidelines

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About CADTH: CADTH is an independent, not-for-profit organization responsible for providing Canada's health care decision-makers with objective evidence to help make informed decisions about the optimal use of drugs, medical devices, diagnostics, and procedures in our health care system.

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Context and Policy Issues

In 2012, 2.8 million Canadians aged 15 and older, or 10.1% of the population, reported symptoms consistent with at least one of the following mental or substance use disorders: generalized anxiety disorder, major depressive episode, bipolar disorder, and abuse of or dependence on alcohol, cannabis or other drugs.[1,2] In 2013, about one in six full-time Regular Force members of the Canadian Armed Forces reported symptoms of at least one of the following disorders: post-traumatic stress disorder (PTSD), generalized anxiety disorder, major depressive episode, panic disorder, and alcohol abuse or dependence.[3] Psychodynamic psychotherapies (a form of psychological therapy in which the main focus is to reveal the unconscious content of the psyche of the patient in order to reduce psychic tension), cognitive behavioural therapies (CBT), interpersonal therapies (IPT), pharmacological treatment and electroconvulsive therapy have been used in the treatment of mental disorders.[4-7] Short-term psychodynamic psychotherapy (STPP), which can be done in a shorter period of time (usually done in 16 sessions over 22 weeks) than long-term psychodynamic psychotherapy, has been used as an alternative to long-term psychotherapy models since the mid-1950sin the treatment of diverse mental disorders.[8-10]

This Rapid Response report aims to review the clinical effectiveness of STPP for the treatment of PTSD, depressive disorders, anxiety disorders, and substance-related and addictive disorders. Evidence-based guidelines regarding the use of STPP for the treatment of these mental illnesses will also be examined.

Research Questions

1. What is the clinical effectiveness of short-term psychodynamic psychotherapy for the treatment of adults with PTSD, depressive disorders, anxiety disorders, and substance-related and addictive disorders?

2. What are the evidence-based guidelines associated with short-term psychodynamic psychotherapy for the treatment of adults with PTSD, depressive disorders, anxiety disorders, and substance-related and addictive disorders?

Key Findings

Findings from two systematic reviews showed that short-term psychodynamic psychotherapy (STPP) could be more effective than control conditions (wait list, treatment as usual) in patients with depression or with common mental disorders at up to six to nine months post-treatment in most psychological outcome categories, while these effects did not reach statistical significance after nine or more months after the end of treatment. Two randomized controlled trials found that there were no statistically significant differences between STPP and cognitive behavioural therapy (CBT) in adults with major depressive disorder in depression symptoms and quality of life measures, and in adverse events rates between the two treatment modalities.

Clinical practice guidelines developed by the US Department of Veterans Affairs and Department of Defense and the National Institute for Health and Care Excellence

(NICE) working groups recommend STPP for patients with mild to moderate major depressive disorder who declined pharmacotherapy or who declined or didn't have access to first-line psychotherapies such as CBT and interpersonal therapies. A clinical practice guideline developed by NICE recommends STPP for adults with social anxiety disorder who decline cognitive behavioural and pharmacological interventions.

Methods

A limited literature search was conducted on key resources including Ovid Medline, Ovid PsycINFO, PubMed, The Cochrane Library, University of York Centre for Reviews and Dissemination (CRD) databases , Canadian and major international health technology agencies, as well as a focused Internet search. No methodological filters were applied to limit retrieval by publication type. The search was limited to English language documents published between January 1, 2012 and September 6, 2017.

Rapid Response reports are organized so that the evidence for each research question is presented separately.

Selection Criteria and Methods

One reviewer screened citations and selected studies. In the first level of screening, titles and abstracts were reviewed and potentially relevant articles were retrieved and assessed for inclusion. The final selection of full-text articles was based on the inclusion criteria presented in Table 1.

Table 1: Selection Criteria

Population	Adults with mental illness (depressive disorders, anxiety disorder (including PTSD), substance-related and addictive disorders)
Intervention	Short-term psychodynamic psychotherapy (also termed short-term psychodynamic therapy)
Comparator	Q1: In group or individual format: • CPT • CBT • Prolonged Exposure CBT for trauma • EMDR • Waitlist • Treatment as usual • No treatment Q2: No comparator
Outcomes	Q1: Clinical effectiveness and safety Q2: Guidelines
Study Designs	Heath technology assessments, systematic reviews, meta-analyses, RCTs, non-RCTs, evidence-based guidelines

CBT = cognitive behavioural therapy; CPT = cognitive processing therapy; EMDR = eye movement desensitization and reprocessing; PTSD = post-traumatic stress disorder; RCT = randomized controlled trial.

Exclusion Criteria

Articles were excluded if they did not meet the selection criteria outlined in Table 1, they were duplicate publications were already reported in the included SRs, or were published prior to 2012. Clinical practice guidelines that do not meet criteria for being evidence-based were excluded.

Critical Appraisal of Individual Studies

The included clinical studies, systematic reviews and guidelines were assessed using the Downs & Black,[11] AMSTAR,[12] and AGREE II[13] checklists, respectively. Summary scores were not calculated for the included studies; rather, a review of the strengths and limitations of each included study were described narratively.

Summary of Evidence

Quantity of Research Available

A total of 566 citations were identified in the literature search. Following screening of titles and abstracts, 557citations were excluded and nine potentially relevant reports from the electronic search were retrieved for full-text review. Three potentially relevant publications were retrieved from the grey literature search. Of these potentially relevant articles, five publications were excluded for various reasons, while seven publications met the inclusion criteria and were included in this report. Appendix 1 describes the PRISMA flowchart of the study selection.

Summary of Study Characteristics

The first included SR performed meta-analysis on the efficacy of STPP in adults with depression(major depressive disorder, other mood disorders, or elevated score on a standardized measure of depression).[14] Fifty four studies (33 RCTs) were included. Outcomes reported were pre-treatment to post-treatment changes at the end of treatment due to STPP compared to controls (wait list, treatment as usual) or to other psychotherapies (such as CBT, behavioural therapy) in general psychopathology measures, depression, anxiety, interpersonal functioning, and quality of life measures using validated scales. General psychological measures were not well defined and were understood as general psychological symptoms measured by scales as described in Appendix 2, Table 2. The SR was performed in the Netherlands.

The second included SR performed meta-analysis on the efficacy of STPP in adults with common mental disorders (anxiety disorders, depressive disorders, somatoform disorders, certain behaviour disorders such as eating disorder, self-injurious behaviour, and personality disorders).[15] Thirty three RCTs were included. Outcomes reported were changes in general psychopathology measures, depression, anxiety, interpersonal functioning, and social adjustment measures due to STPP compared to controls (wait list, treatment as usual) using validated scales. Outcomes were assessed in the short-term (less than three months after treatment was concluded), medium-term (three to nine months after treatment was concluded) and long-term (nine or more months after treatment is completed). The SR was performed in Canada, Australia, Germany, the Netherlands, US, Austria.

The two included clinical trials were randomized controlled trials (RCTs) that compared the efficacy of STPP (open patient-therapist dialogue using supportive and insight-facilitating techniques to address emotional background of the depressive

symptoms) to CBT in adult outpatients with major depression disorder.[16,17] Outcomes reported were general psychopathology, interpersonal functioning, pain, quality of life and adverse events at the end of treatment (both treatments included 16 individual 45-minute sessions within 22 weeks) and at follow-up up to 52 weeks.

The first included guideline is a clinical practice guideline developed by the US Department of Veterans Affairs and Department of Defense (VA/DoD) working group on major depressive disorder.[18] The target population was adults 18 years or older with major depressive disorder being treated in VA/DoD settings. Interventions were evidence-based psychotherapy in individual or group format (such as STPP, behavioral therapy, CBT, computerized CBT, IPT, problem-solving therapy). The guideline was based on a comprehensive systematic evidence search from 2006 to 2015. The guideline rates the evidence by using the grading system adopted from the GRADE (Grading of Recommendations, Assessments, Development, and Evaluation) workgroup. Strengths of recommendations were graded based on the NICE guideline manual.

The second included guideline is a clinical practice guideline developed by the NICE working group on depression.[19] The target population was adults 18 years or older with depression. Interventions were evidence-based psychotherapy in individual or group format (such as STPP, behavioral therapy, CBT, computerized CBT, IPT). The guideline was based on a comprehensive systematic evidence search (dates unclear). The guideline rates the evidence by using the grading system adopted from the GRADE (Grading of Recommendations, Assessments, Development, and Evaluation) working group. Strengths of recommendations were graded based on the NICE guideline manual.

The third included guideline is a clinical practice guideline developed by the NICE working group on social anxiety disorder[20] The target population was children and adults with social anxiety disorder. Interventions were all psychological treatments for social anxiety disorder. The guideline was based on a comprehensive systematic evidence search from 1997 to 2012. The guideline rates the evidence by using the grading system adopted from the GRADE working group. Strengths of recommendations were graded based on the NICE guideline manual.

Characteristics of the included studies are detailed in Appendix 2.

Summary of Critical Appraisal

The included SRs[14,15] had a priori design provided, independent studies selection and data extraction procedure in place, comprehensive literature search performed, list of included and excluded studies, studies characteristics provided, quality assessment of included studies provided and used in formulating conclusions, assessment of publication bias performed, and conflict of interest stated. Heterogeneity across trials in interventions, comparators, length of follow-up, was present in a number of pooled analyses.

The included clinical trials[16,17]are RCTs, had clearly described hypotheses, method of selection from source population and representation of the study population, main outcomes, interventions, patient characteristics, and main findings. Estimates of

random variability and actual probability values were provided. Assessors were not blinded to patient treatment assignment leading to potential assessment bias.

The included guidelines[18-20]had clear scope and purpose, the recommendations are specific and unambiguous, the method for searching for and selecting the evidence are clear, methods used for formulating the recommendations are clearly described, health benefits, side effects and risks were stated in the recommendations, and the procedures for updating the guidelines provided and target users of the guideline are clearly defined. Potential cost implications of applying the recommendation were included. It was unclear whether the guideline was piloted among target users, or whether patients' views and preferences were sought.

Details of the critical appraisal of the included studies are presented in Appendix 3.

Summary of Findings

1. *What is the clinical effectiveness of short-term psychodynamic psychotherapy for the treatment of adults with PTSD, depressive disorders, anxiety disorders, and substance-related and addictive disorders?*

The meta-analysis on the efficacy of STPP for adults with depression[14] found that STPP (individual, group, or on-line format) was significantly more effective than control conditions (wait list or treatment as usual) at post-treatment on depression, anxiety, general psychopathology, and quality of life measures. Improvements continue or were maintained from post-treatment to follow-up at six months or longer. Compared to other psychotherapies, such as behavioral therapy or CBT, depression measures were in favour of other psychotherapies at post-treatment. Anxiety measures were in favour of STPP. Adverse events were not reported in this SR. The authors concluded that there were clear indications that STPP is effective in the treatment of depression in adults.

The meta-analysis on the efficacy of STPP (individual format) for adults with common mental disorders[15] found that treatment with STPP led to significantly greater improvement compared to the control groups (wait list, treatment as usual) in the short-term and medium-term in all outcome categories (except for somatic measures in the short-term), while these effects did not reach statistical significance in the long-term (at least 9 months after the end of the treatment). Adverse events were not reported in this SR. The authors concluded that STPP continues to show promise for a wide variety of patients in the short and long-term follow-up.

The RCT that compared the efficacy of STPP to CBT in adult outpatients with major depressive disorder[16] found that there were no significant differences between STPP and CBT on any of the outcome measures (general psychopathology, interpersonal functioning, pain, quality of life and adverse events) at both post-treatment and 52 weeks follow-up. No difference in adverse events rates were found between the two treatment modalities. The authors concluded that STPP can be at least as efficacious as CBT for depression on important aspects of patient functioning.

The RCT that compared the efficacy of STPP to CBT in adult outpatients with major depressive disorder[17] found that there were no statistically significant differences in depression symptoms and quality of life measures at post-treatment. There was no

statistically significant difference in the two groups in patients' ratings of treatment credibility (measured by adherence to treatment; details not reported). No statistically significant difference in adverse events rates were found between the two treatment modalities. The authors concluded that STPP is not inferior to cognitive therapy on change in depression for the treatment of major depressive disorder in a community mental health setting.

2. *What are the evidence-based guidelines associated with short-term psychodynamic psychotherapy for the treatment of adults with PTSD, depressive disorders, anxiety disorders, and substance-related and addictive disorders?*

The clinical practice guideline developed by the VA/DoD working group on major depressive disorder[18] recommends:

"For patients with mild to moderate MDD who decline pharmacotherapy and who decline or cannot access first-line evidence-based psychotherapies, the Work Group suggests offering non-directive supportive therapy or short-term psychodynamic psychotherapy." (Recommendation 12 p 2)

The clinical practice guideline developed by the National Institute for Health and Care Excellence working group (NICE) on depression[19] recommends:

"For people with depression who decline an antidepressant, CBT, IPT (interpersonal therapy), behavioural activation and behavioural couples therapy, consider:

- *counselling for people with persistent subthreshold depressive symptoms or mild tomoderate depression*
- *short-term psychodynamic psychotherapy for people with mild to moderatedepression"* (Recommendation 1.5.1.4 p 23)

"For all people with mild to moderate depression having short-term psychodynamic psychotherapy, the duration of treatment should typically be in the range of 16 to 20 sessions over 4 to 6 months." (Recommendation 1.5.3.7 p 28)

The clinical practice guideline developed by the National Institute for Health and Care Excellence working group (NICE) on social anxiety disorder [20] recommends:

"For adults who decline cognitive behavioural and pharmacological interventions, consider short-term psychodynamic psychotherapy that has been specifically developed to treat social anxiety disorder (see recommendation 1.3.16). Be aware of the more limited clinical effectiveness and lower cost effectiveness of this intervention compared with CBT, self-help and pharmacological interventions" (Recommendation 1.3.7 p 21)

"Short-term psychodynamic psychotherapy for social anxiety disorder should consist of typically up to 25−30 sessions of 50 minutes' duration over 6−8 months and include the following:

- *education about social anxiety disorder*

- *establishing a secure positive therapeutic alliance to modify insecure attachments*
- *a focus on a core conflictual relationship theme associated with social anxietysymptoms*
- *a focus on shame*
- *exposure to feared social situations outside therapy sessions*
- *support to establish a self-affirming inner dialogue*
- *help to improve social skills"* (Recommendation 1.3.16 p 23)

The main findings of the included studies are presented in Appendix 4.

Limitations

Findings from the included SRs need to be interpreted with caution as heterogeneity across trials in interventions, comparators, length of follow-up, was present in a number of pooled analyses. Findings from the included RCTs are limited to the outpatient setting. Guidelines specific to all relevant mental illnesses were not identified.

Conclusions and Implications for Decision or Policy Making

STPP could be more effective than wait list or treatment as usual in patients with depression or with common mental disorders at up to six to nine months post-treatment in most psychological outcome categories, such as general psychiatric symptoms, anxiety, depression and quality of life, while these effects did not reach statistical significance after nine or more months after the end of treatment. There were no statistically significant differences between STPP and CBT in adults with major depressive disorder in depression symptoms and quality of life measures, and in adverse events rates between the two treatment modalities.

The success of psychodynamic psychotherapy also depends on many factors such as social support,[8] self-concept,[21] psychological factors such as flexibility of interactions, trial interpretation, reflective ability and motivation,[10] socio-demographic factors such as marital status and education level,[22] and therapists' professional and personal characteristics such as engaging and encouraging relational style.[23]

Clinical practice guidelines recommend STPP for patients with mild to moderate major depressive disorder who declined pharmacotherapy or who declined or didn't have access to first-line psychotherapies such as CBT. However, it is unclear why the recommendations do not appear to align with the findings of the two RCTs identified for this report, which suggest that STPP and CBT are equally effective for adults with major depressive disorder. More large RCTs are needed to formulate clinical-based guidelines on the use of short-term psychodynamic psychotherapy for the treatment of adults with PTSD, anxiety, and substance-related and addictive disorders.

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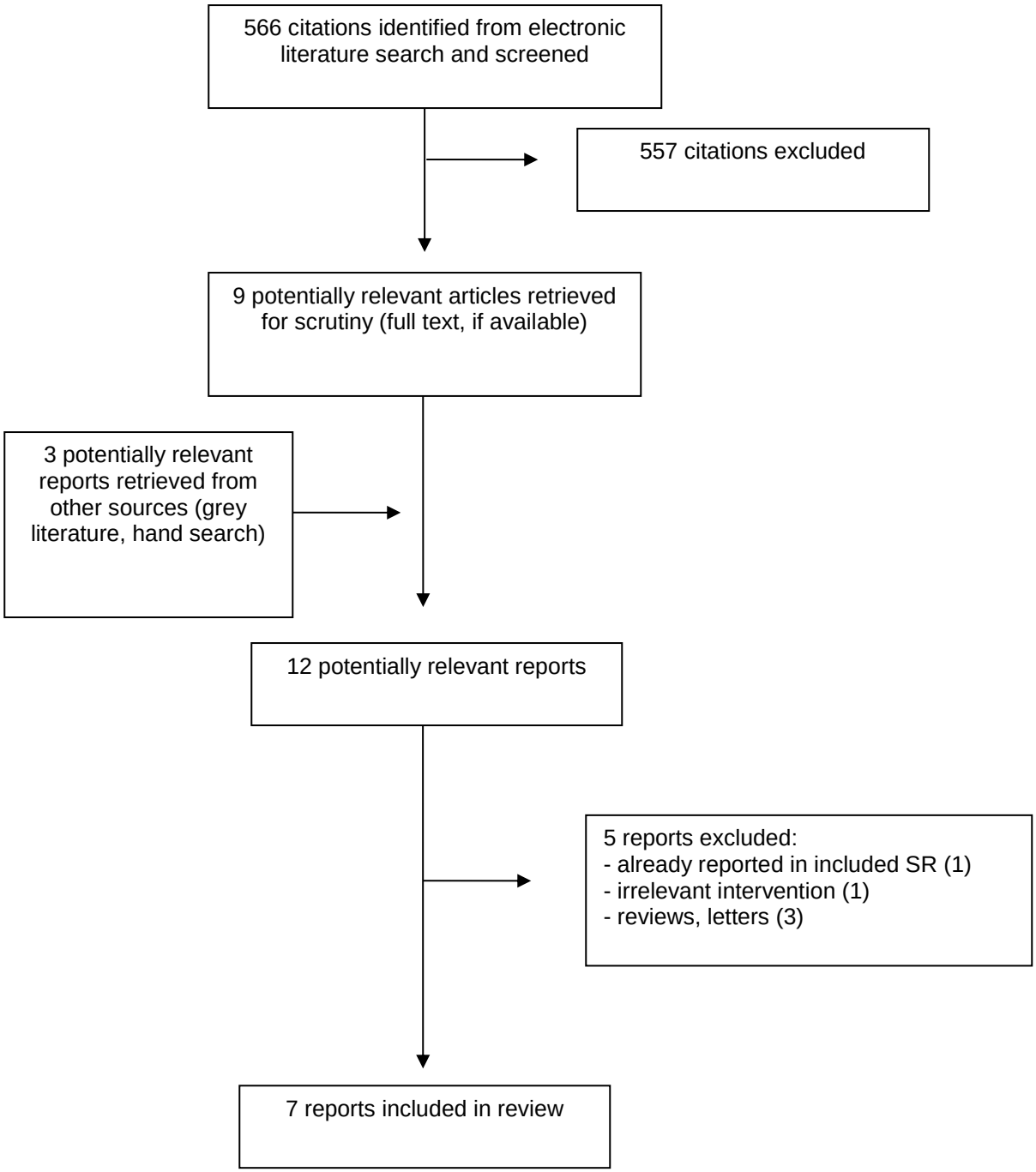
Appendix 1: Selection of Included Studies



Appendix 2: Characteristics of Included Publications

Table 2: Characteristics of Included Systematic Reviews

First Author, Year, Country	Objectives Literature Search Strategy	Inclusion Criteria	Exclusion Criteria	Studies included Main outcomes
Driessen,[14] 2015, The Netherlands	*"The efficacy of short-term psychodynamic psychotherapy (STPP) for depression is debated. Recently, a number of large-scale and high-quality studies have been conducted. We examined the efficacy of STPP by updating our 2010 meta-analysis."* (p 1) *"The searches were performed in March 2014. First, we searched the electronic databases PubMed, PsychINFO, Embase.com, Web of Science (SSCI) and Cochrane's Central Register of Controlled Trials (CENTRAL). Search terms included a wide range of synonyms, both in MeSH or index terms and text words"* (p 3) STPP included individual, group format, or online.	*"We included studies if they reported (a) outcomes on standardized measurements of (b) depressed (c) adult patients (d) receiving STPP"* (p 3).	*"Studies assessing the efficacy of Interpersonal Psychotherapy (IPT) were excluded, as IPT was not regarded as a psychodynamic psychotherapy... Studies had to include at least 10 subjects. Case studies were therefore excluded"* (p 3)	54 studies (33 RCTs) totally 3946 subjects Depression (HMD-D, BDI) Anxiety (Beck Anxiety Inventory, Brief Symptom Inventory — Anxiety subscale) General psychopathology (Brief Symptom Inventory - Global Severity Index, Clinical Global Impression Scales) Interpersonal functioning (Inventory of Interpersonal Problems) Quality of life (EQ-5D).
Abbass,[15] 2014, Canada, Australia, Germany, the Netherlands, US, Austria	*"To evaluate the efficacy of STPP for adults with common mental disorders compared with wait-list controls, treatments as usual and minimal contact controls in randomised controlled trials (RCTs)" (p 1)* *"The Cochrane Depression, Anxiety*	*"We included all RCTs of adults with common mental disorders, in which a brief psychodynamic therapy lasting 40 or fewer hours in total was provided in individual format."* (p 1)	Studies that did not meet selection criteria	33 RCTs of STPP involving 2173 participants with common mental disorders (anxiety disorders, depressive disorders, somatoform disorders, certain behaviour disorders such as eating disorder, self-injurious behaviour, and personality disorders).

First Author, Year, Country	Objectives Literature Search Strategy	Inclusion Criteria	Exclusion Criteria	Studies included Main outcomes
	and Neurosis Group's Specialised Register (CCDANCTR) was searched to February 2014, this register includes relevant randomised controlled trials from The Cochrane Library (all years), EMBASE (1974-), MEDLINE (1950-) and PsycINFO (1967-). We also conducted searches on CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, DARE and Biological Abstracts (all years to July 2012)" (p 1) STPP included was individual format			*Primary outcomes* General psychiatric symptoms (Symptoms Checklist 90) Somatic symptoms (McGill PIN Questionnaire) Anxiety (Hamilton Anxiety Rating Scale) Depression (BDI) *Secondary outcomes* Social adjustment (the Social Adjustment Scale) Interpersonal problem measures (Inventory of Interpersonal Problems)

BDI = Beck Depression Inventory; EQ- 5D = EuroQoL; HMD-D = Hamilton Rating Scale for Depression ; RCT = randomized controlled trial; STPP = short -term psychodynamic psychotherapy.

Table 3: Characteristics of Included Clinical Studies

First Author, Year, Country	Study Design Study Objectives	Interventions/Comparators	Patients	Main Outcomes
Driessen,[16] 2017, the Netherlands	RCT *"In a randomized clinical trial, we compared the efficacy of cognitive–behavioral therapy (CBT) and psychodynamic therapy for adult outpatient depression on measures of psychopathology, interpersonal functioning, pain, and quality of life"* (p 653)	CBT (16 sessions over 5 months) Short-term psychodynamic psychotherapy (16 sessions over 5 months)	341 adult outpatients with major depressive disorder	General psychopathology (Brief Symptom Inventory, Beck Anxiety Inventory, OQ-45 symptom distress) Interpersonal functioning (OQ-45 interpersonal relationship, OQ-45 social role) Pain (visual analog scale) Quality of life (EQ-5D) Adverse events
Connolly Gibbons,[17] 2016, US	*Randomized clinical non-inferiority trial* *"To determine whether DT is not inferior to cognitive therapy (CT) in the treatment of major depressive disorder (MDD) in a community mental health setting"* (p 904)	CBT (16 sessions over 5 months) Short-term psychodynamic psychotherapy (16 sessions over 5 months)	237 adult outpatients with major depressive disorder	*Primary outcomes* Depression (HMD-D) *Secondary outcomes* Symptoms (BASIS-24) Quality of life (Quality of life Inventory) Medical Outcomes (SF-36) Patient's perception on treatment credibility Adverse events

BASIS-24 = 24-item Behavior and Symptom Identification Scale; HMD-D = Hamilton Rating Scale for Depression; OQ-45 = Outcome Questionnaire; RCT = randomized controlled trial; SF-36 = 36-item Short Form

Table 4: Characteristics of Included Guidelines

Group, Year	Scope	Population	Evidence	Grading system
VA/DoD,[18] 2016	Guidelines for management of major depressive disorder	Adults with major depressive disorder	Systematic evidence review done by the Minnesota Evidence-based Practice Center; literature search from 1990 to 2013	The evidence and recommendation rating were adopted from the classification developed by the GRADE (Grading of Recommendations, Assessment, Development, and Evaluation) workgroup. The GRADE system primarily involves consideration of the following factors: overall study quality (or overall risk of bias or study limitations), consistency of evidence, directness of evidence, and precision of evidence.
NICE,[19] 2009	Guidelines for management of depression (major depressive disorder or with "subthreshold suppressive symptoms" (having at least one key symptom for depression but insufficient to meet the criteria for full diagnosis for major depressive disorder)	Adults with major depressive disorder or with "subthreshold suppressive symptoms"	Systematic evidence review done by the NICE working group (dates of search unclear)	The evidence and recommendation rating were adopted from the NICE guideline manual. The NICE Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into consideration the quality of the underpinning evidence
NICE,[20] 2013	Guidelines for management of social anxiety disorder	Children and adults with social anxiety disorder	Systematic evidence review done by the NICE working group from 1997 to 2012	The evidence and recommendation rating were adopted from the NICE guideline manual. The NICE Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into consideration the quality of the underpinning evidence

NICE = National Institute for Health and Care Excellence; VA/DoD = US Department of Veterans Affairs and Department of Defense.

Appendix 3: Critical Appraisal of Included Publications

Table 5: Strengths and Limitations of Systematic Reviews and Meta-Analyses using AMSTAR[12]

Strengths	Limitations
Driessen, 2015[14]	
• a priori design provided • independent studies selection and data extraction procedure in place • comprehensive literature search performed • list of included studies, studies characteristics provided • list of excluded studies provided • quality assessment of included studies provided and used in formulating conclusions • assessment of publication bias performed • conflict of interest stated	• heterogeneity across trials in STPP methods, controls (treatment as usual, wait list), length of follow-up, was present in a number of pooled analyses
Abbas, 2014[15]	
• a priori design provided • independent studies selection and data extraction procedure in place • comprehensive literature search performed • list of included studies, studies characteristics provided • list of excluded studies provided • quality assessment of included studies provided and used in formulating conclusions • assessment of publication bias performed • conflict of interest stated	• heterogeneity across trials in STPP methods, controls (treatment as usual, wait list), length of follow-up, was present in a number of pooled analyses

STPP = short-term psychodynamic psychotherapy.

Table 6: Strengths and Limitations of Clinical Studies using the Downs and Black checklist[11]

Strengths	Limitations
Driessen, 2017[16]	
• randomized controlled trial • hypothesis clearly described • method of selection from source population and representation described • loss to follow-up reported • main outcomes, interventions, patient characteristics, and main findings clearly described • estimates of random variability and actual probability values provided • study had sufficient power to detect a clinically important effect	• assessor not blinded to patient treatment assignment
Connolly Gibbons, 2016[17]	
• Randomized controlled trial • Patients and assessors blinded to patient treatment assignment. • hypothesis clearly described • method of selection from source population and representation described • loss to follow-up reported • main outcomes, interventions, patient characteristics, and main findings clearly described • estimates of random variability and actual probability values provided • study had sufficient power to detect a clinically important effect	• lack of follow-up assessments

Table 7: Strengths and Limitations of Guidelines using AGREE II[13]

Strengths	Limitations
VA/DoD 2016[18]	
• scope and purpose of the guidelines are clear • the recommendations are specific and unambiguous • the method for searching for and selecting the evidence are clear • methods used for formulating the recommendations are clearly described • health benefits, side effects and risks were stated in the recommendations • potential cost implications of applying the recommendation included • procedure for updating the guidelines provided • target users of the guideline are clearly defined	• unclear whether the guideline was piloted among target users • unclear whether patients' views and preferences were sought
NICE 2009[19]	
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NICE 2013[20]	
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NICE = National Institute for Health and Care Excellence; VA/DoD = US Department of Veterans Affairs and Department of Defense.

Appendix 4: Main Study Findings and Author's Conclusions

Table 8: Summary of Findings of Included Studies

Main Study Findings	Author's Conclusion
Driessen, 2015[14] (Systematic Review)	
Pre –specified effect size: d = 0 – 32 (small); d = 0.33 – 0.55 (moderate); d = 0.56 – 1.2 (large). If d is positive, it favours STPP STPP was individual format (79.6%), group format (16.7%), or on-line (3.7%) *Compared to control* (data from ten studies) STPP significantly more effective than control conditions at post-treatment on depression (d = 0.61), anxiety (d = 0.48), general psychopathology (d = 0.69) and quality of life measures (d = 0.49). *Compared to pre-treatment* (data from 41 studies) STPP significant improvements on all outcome measures at post-treatment (d = 0.57 to 1.18). Improvements continue or were maintained from post-treatment to follow-up≥ 6 months (d = 0.20 to 1.04) *Compared to other psychotherapies (details not specified)* - At post-treatment Depression: in favour of other psychotherapies (d = -0.25; 95% CI -0.49 to -0.02) (data from 15 studies) No significant differences between *individual* STPP and other psychotherapies (d = −0.14; 95% CI -0.34 to 0.06) (data from 13 studies) Anxiety: in favour of STPP (d = 0.35; 95% CI 0.12 to 0.59)(data from 5 studies) - At follow-up Depression: no significant difference between STPP and other psychotherapies (d = -0.08; 95% CI -0.32 to 0.17) (data from 12 studies) Anxiety: in favour of STPP (d = 0.76; 95% CI 0.23 to 1.28) (data from 4 studies)	*"We found clear indications that STPP is effective in the treatment of depression in adults"* (p 1)
Abbas, 2014[15] (Systematic Review)	
Short-term: less than three months after treatment was concluded Medium-term: three to nine months after treatment was concluded Long-term: nine or more months after treatment is completed STPP format was individual. *Primary outcomes (negative SMD for all measures indicates a better score for STPP relative to controls)* General psychiatric symptoms (Symptoms Checklist 90) Short-term: SMD -0.71, 95% CI -1.00 to -0.41 (data from 19 studies) Medium-term SMD -0.27, 95% CI -0.46 to -0.08 (data from 5 studies) Long-term: difference not statistically significant (data from 4 studies) Somatic symptoms (McGill PIN Questionnaire) Short-term: difference not statistically significant (data from 8 studies)	*"Except for somatic measures in the short-term, all outcome categories suggested significantly greater improvement in the treatment versus the control groups in the short-term and medium-term. Effect sizes increased in long-term follow-up, but some of these effects did not reach statistical significance."* (p 1)

Main Study Findings	Author's Conclusion
Medium-term SMD -1.39, 95% CI -2.75 to -0.02 (data from 4 studies) Long-term: difference not statistically significant (data from 3 studies) Anxiety (Hamilton Anxiety Rating Scale) Short-term: SMD -0.64, 95% CI -1.02 to -0.26 (data from 18 studies) Medium-term SMD -0.46, 95% CI -0.77 to -0.16 (data from 7 studies) Long-term: difference not statistically significant (data from 5 studies) Depression (Beck Depression Inventory) Short-term: SMD -0.50, 95% CI -0.61 to -0.39 (data from 18 studies) Medium-term SMD -0.34, 95% CI -0.60 to -0.09 (data from 18 studies) Long-term: difference not statistically significant (data from 7 studies) *Secondary outcomes*(only outcomes with data available, and pooled presented) Social adjustment (the Social Adjustment Scale) Short-term: SMD -0.51, 95% CI -0.66 to -0.36 (data from 9 studies) Long-term SMD -0.58, 95% CI -0.86 to -0.29 (data from 3 studies) Interpersonal problem measures (Inventory of Interpersonal Problems) Short-term: SMD -0.42, 95% CI -0.67 to -0.17 (data from 6 studies) Long-term SMD -0.49, 95% CI -0.92 to -0.05 (data from 3 studies)	

Driessen, 2017[16] (Randomized Controlled Trial)

Observed Values of the Outcome Measures on week 0 and week 52

No significant differences between STPP and CBT on any of the outcome measures at both post treatment and follow-up up to 52 weeks.

Measure	Condition	Week 0			Week 52		
Psychopathology		**N**	**Mean**	**SD**	**N**	**Mean**	**SD**
OQ-45 symptom distress	**CBT**	107	52.29	12.97	42	31.55	19.03
	SPSP	121	50.91	13.37	29	32.17	17.49
BSI	**CBT**	129	1.91	0.79	47	0.96	0.91
	SPSP	133	1.81	0.73	32	0.83	0.68
BAI	**CBT**	142	24.75	13.28	62	13.04	11.95
	SPSP	150	24.19	13.08	61	13.70	12.91
Interpersonal functioning							
OQ-45 interpersonal reltionship	**CBT**	106	20.41	6.06	38	14.50	8.28
	SPSP	101	20.58	6.44	31	14.74	7.09
OQ-45 social role	**CBT**	105	16.63	5.49	43	10.53	5.95
	SPSP	108	15.62	5.16	30	12.83	5.43
Pain							
VAS	**CBT**	129	19.87	10.48	NR	NR	NR
	SPSP	138	19.17	11.03			
Quality of life							
EQ-5D	**CBT**	121	0.43	0.32	47	0.68	0.33
	SPSP	140	0.39	0.31	34	0.68	0.31

"This is the first study that shows that psychodynamic therapy can be at least as efficacious as CBT for depression on important aspects of patient functioning other than depressive symptom reduction" (p 653)

Main Study Findings	Author's Conclusion
Non-inferiority analysis Non inferiority of psychodynamic therapy to CBT was shown for post treatment and follow-up anxiety measures, post treatment pain and quality of life measures (a priori non-inferiority margin Cohen's d = -30), but could not be demonstrated for interpersonal functioning measures. *Adverse events* No difference was found (CBT 6.1%; psychodynamic 6.2%), mainly increase in depressive symptoms or suicidality.	
Connolly Gibbons, 2016[17] (Randomized Controlled Trial)	
Primary outcomes: Change from baseline in depressive symptoms for the psychodynamic psychotherapy group is statistically not inferior to the change in the CBT group (a priori non-inferiority margin Cohen d 2.5) *Secondary outcomes* Cannot conclude that psychodynamic psychotherapy is not inferior to CBT on change on BASIS-24, QoL, SF-36 mental component (psychodynamic psychotherapy is not inferior to CBT on change on SF-36 physical component) (a priori non-inferiority margin Cohen d 0.29) No statistically significant difference in the 2 groups in patient's ratings of treatment credibility *Adverse events* 5/118 patients on psychodynamic psychotherapy and 10/119 patients on CBT experienced at least one serious adverse events (*P* 0.19). Most serious adverse events included non-psychiatric hospitalizations	*"This study suggests that DT (dynamic psychotherapy) is not inferior to CT (cognitive therapy) on change in depression for the treatment of MDD in a community mental health setting"* (p 904)
VA/DoD 2016[18] (Evidence-based Guideline)	
The strength of recommendation grading: Strong For, Weak For, Strong Against, Weak Against Recommendation categories: Reviewed, Not reviewed, New-added, New-replaced, Not changed, Amended, Deleted) For treatment of uncomplicated mild to moderate MDD: *"For patients with mild to moderate MDD who decline pharmacotherapy and who decline or cannot access first-line evidence-based psychotherapies, the Work Group suggests offering non-directive supportive therapy or short-term psychodynamic psychotherapy. (Weak For; Reviewed, New-replaced)"* (Recommendation12 p 2) (New-replaced: Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence)	Not applicable
NICE 2009[19] (Evidence-based Guideline)	
"For people with depression who decline an antidepressant, CBT, IPT, behavioural activation and behavioural couples therapy, consider: • *counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression* • *short-term psychodynamic psychotherapy for people with mild to moderate depression"* (Recommendation 1.5.1.4 p 23)	Not applicable

Main Study Findings	Author's Conclusion
"For all people with mild to moderate depression having short-term psychodynamic psychotherapy, the duration of treatment should typically be in the range of 16 to 20 sessions over 4 to 6 months." (Recommendation 1.5.3.7 p 28)	
NICE 2013[20] (Evidence-based Guideline)	
"For adults who decline cognitive behavioural and pharmacological interventions, consider short-term psychodynamic psychotherapy that has been specifically developed to treat social anxiety disorder (see recommendation 1.3.16). Be aware of the more limited clinical effectiveness and lower cost effectiveness of this intervention compared with CBT, self-help and pharmacological interventions" (Recommendation 1.3.7 p 21) *"Short-term psychodynamic psychotherapy for social anxiety disorder should consist of typically up to 25−30 sessions of 50 minutes' duration over 6−8 months and include the following:* • *education about social anxiety disorder* • *establishing a secure positive therapeutic alliance to modify insecure attachments* • *a focus on a core conflictual relationship theme associated with social anxiety symptoms* • *a focus on shame* • *exposure to feared social situations outside therapy sessions* • *support to establish a self-affirming inner dialogue* • *help to improve social skills"* (Recommendation 1.3.16 p 23)	Not applicable

BAI = Beck Anxiety Inventory; BSI = Brief Symptom Inventory; CBT = cognitive behavioral therapy; 95% CI = 95% confidence interval; EQ-5D = EuroQol; HAM-D: Hamilton Rating Scale for Depression; MDD = major depressive disorder; NICE = National Institute for Health and Care Excellence; NR = not reported; OQ-45 = 45-item Outcome Questionnaire; SD = standard deviation; SDM = standard mean difference; SPSP = short-term psychodynamic supportive psychotherapy; VA/DoD = US Department of Veterans Affairs and Department of Defense; VAS = visual analogue scale.