خلاصـــــــــــات مراجعـــــــــات كوكـــــــــران المنهجيـــــــــة

مختارات من مكتبة كوكران في الطب النفسي

أ.د. محمـــــد أديـــــب العسالـــــي -رئيـــس البـــورد السـوري للطـب النفســي و رئيـــس المركـــز الطبـــي النفســي، دمشـق

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كانت الشبكة قد عرفت سابقاً بالمراجعات المنهجية من خلال نشر فصل كامل عنها: (www.arabpsynet.com/Archives/OP/opj2.essali.evidence based medicine.pdf)

وتخصص المجلة ابتداءً من هذا العدد زاوية لـــ" **خلاصات مراجعات كوكران المنهجية** ".

تهدف مراجعات كوكران المنهجية إلى تحديد قوة البراهين الداعمة لمختلف العلاجات بهدف تحديد العلاجات المسندة بالبراهين والتي ينصح باستخدامها، والعلاجات التي يجب الابتعاد عنها، والعلاجات التي مازالت بحاجة لمزيد من البحث العلمي.

تعتبر التجارب السريرية المعشاة randomized clinical trials أقوى أنواع البحث العلمي في تحديد فوائد وأضرار العلاجات، ويتم في المراجعة المنهجية جمع كافة التجارب السريرية المعشاة المتعلقة بعلاج ما وتقييمها تقييماً ناقداً ثم دمج نتائجها بغية تحديد قوة – أو ضعف – البراهين الداعمة للعلاج المعني. والعلاج هنا هو أي تداخل يقوم به المعالج سواءً أكان التداخل فيزيائياً أو نفسياً /سلوكياً/ استعرافياً أو بديلاً.

تُجمع مراجعات كوكران بشكل تراكمي منذ أوائل تسعينيات القرن الماضي، ولاتشتمل مكتبة كوكران حالياً على مراجعات لكافة العلاجات، فهناك علاجات لم تتم مراجعتها بعد، ولكن يتزاد عدد المراجعات – والبالغ حالياً حوالي خمسة آلاف مراجعة – بشكل مستمر.

بداية من هذا العدد وفي كل عدد من أعداد المجلة، نفتح زاوية خاصة لبعض المراجعات المنهجية في الطب النفسي من مكتبة كوكران.

مع الانتباه لتنوع اهتمامات قراء المجلة. وقع الخيار في هذا العدد على مراجعات متعلقة بعلاج الاكتئاب وتشمل:

1. **علاجات دوائية**
   a. أميتريبتيلين للإكتئاب
   b. سيرترالين مقارنة بباقي مضادات الاكتئاب
   c. العلاج الدوائي للإكتئاب الذهاني
   d. مضادات الاكتئاب لعلاج الاكتئاب المرافق لأمراض جسدية
   e. مقارنة مضادات الاكتئاب بالغفل عند مسنين مصابين بالاكتئاب
2. **علاجات فيزيائية غير دوائية**
   a. التحريض المغناطيسي عبر القحف لعلاج الاكتئاب
   b. التخليج الكهربائي لعلاج الاكتئاب عند المسنين
3. **علاجات نفسية فردية**
   a. العلاجات النفسية للإكتئاب عند المسنين
4. **علاج نفسي جماعي**
   a. العلاج الأسري للإكتئاب
   b. العلاج الزوجي للإكتئاب
5. **علاجات بديلة**
   a. الرياضة لعلاج الاكتئاب
   b. الاسترخاء لعلاج الاكتئاب
   c. علاج الاكتئاب بالموسيقى
   d. الوخز بالابر لعلاج الاكتئاب

لاتشمل هذه القائمة كافة العلاجات الممكنة للإكتئاب، ولكن راعينا فيها التنوع لتوضيح أمر هام. فالبراهين العلمية مطلوبة ليس فقط للعلاجات الدوائية بل لكافة العلاجات بما فيها العلاجات البديلة؛ فحتى النصيحة غير المسندة بالبراهين قد تكون قاتلة.

يتبين من خلاصات كوكران الواردة أدناه أن أدوية الاكتئاب القديمة (ثلاثية الحلقة) مثل أميتريبتيلين لها نفس فعالية أدوية الاكتئاب الأحدث منها ولكنها أكثر تسبيباً للأعراض الجانبية. أما بالنسبة للأدوية الحديثة، فلسيرترالين نفس فعالية الأدوية الأخرى في علاج الاكتئاب. وبينما قد تكفي مضادات الاكتئاب لوحدها في علاج الاكتئاب المترافق بأعراض ذهانية، فإنه ربما لزم إضافة دواء مضاد ذهان لاحقاً. ومضادات الاكتئاب أكثر فعالية من الغفل عند معالجة الاكتئاب لدى أشخاص مصابين بأمراض جسدية، وهي – على اختلاف زمرها الدوائية – فعالة في علاج الاكتئاب عند المسنين إذا أعطيت بجرعة كاملة لفترة ستة أسابيع على الأقل. أما معالجة اكتئاب المسنين بجرعات منخفضة من الأدوية ثلاثية الحلقة فغير مسند بالبراهين. كذلك فإنه لاتتوفر براهين على فعالية التحريض المغناطيسي عبر القحف في علاج الاكتئاب. ورغم أن فعالية التخليج الكهربائي مسندة بالبراهين في الأعمار الأصغر، فإن فعاليتها عند المتقدمين بالعمر مازالت بحاجة للدراسة في تجارب سريرية معشاة. كذلك فإن فعالية العلاجات النفسية عند المسنين مازالت بحاجة للبراهين، خصوصاً وأن هناك مايوحي بأن العلاج السوكي الاستعرافي فعال في هذه الفئة العمرية.

لاتتوفر تجارب سريرية معشاة للعلاج الأسري في الاكتئاب، كما لايوجد أي برهان على أن العلاج الزوجي هو أقل أو أكثر فعالية من العلاج النفسي الفردي أو من العلاج الدوائي. أما بالنسبة للعلاجات البديلة، فهناك سند ضعيف للرياضة في تحسين أعراض الاكتئاب، كما أن للإسترخاء تأثير مضاد للإكتئاب لايرقى إلى مستوى فعالية المعالجة النفسية. أما معالجة الاكتئاب بالموسيقى فتحسن المزاج ويتقبلها معظم المرضى ولكنها أيضاً تحتاج لبراهين أقوى. أخيراً فإنه لاتتوفر براهين تجعلنا ننصح بالابر الصينية لعلاج الاكتئاب.

Anxiety

Amitriptyline for depression

Guaiana G, Barbui C, Hotopf M. Amitriptyline for depression. Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD004186. DOI: 10.1002/14651858.CD004186.pub2.

Background

For many years amitriptyline has been considered one of the reference compounds for the pharmacological treatment of depression. However, new tricyclic drugs, heterocyclic compounds and selective serotonin reuptake inhibitors have been introduced on the market with the claim of a more favourable tolerability/efficacy profile.

Objectives

The aim of the present systematic review was to investigate the tolerability and efficacy of amitriptyline in comparison with the other tricyclic/heterocyclic antidepressants and with the selective serotonin reuptake inhibitors.

Search strategy

The Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Register (CCDANCTR-Studies) was searched on 28-11-2005. Reference lists of all included studies were checked.

Selection criteria

Only randomised controlled trials were included. Study participants were of either sex and any age with a primary diagnosis of depression. Included trials compared amitriptyline with another tricyclic/heterocyclic antidepressant or with one of the selective serotonin reuptake inhibitors.

Data collection and analysis

Data were extracted using a standardised form. The number of patients undergoing the randomisation procedure, the number of patients who completed the study and the number of improved patients were extracted. In addition, group mean scores at the end of the trial on Hamilton Depression Scale or any other depression scale were extracted. In the tolerability analysis, the number of patients failing to complete the study and the number of patients complaining of side-effects were extracted.

Main results

A total number of 194 studies were included in the review. The estimate of the overall odds ratio (OR) for responders showed that more subjects responded to amitriptyline in comparison with the control antidepressant group (OR 1.12 to 95% confidence interval (CI) 1.02 to 1.23, number needed to treat to benefit (NNTB) = 50). The estimate of the efficacy of amitriptyline and control agents on a continuous outcome revealed an effect size which also significantly favoured amitriptyline (Standardised Mean Difference (SMD) 0.13, 95% CI 0.04 to 0.23). Whilst these differences are statistically significant, their clinical significance is less clear. When the efficacy analysis was stratified by drug class, no difference in outcome emerged between amitriptyline and either tricyclic or selective serotonin reuptake inhibitor comparators. The dropout rate in patients taking amitriptyline and control agents was similar; however, the estimate of the proportion of patients who experienced side-effects significantly favoured control agents in comparison with amitriptyline (OR 0.66, 95% CI 0.59 to 0.74). When the tolerability analysis was stratified by drug class, the dropout rate in patients taking amitriptyline and the selective serotonin reuptake inhibitors significantly favoured the latter (OR 0.84, 95% CI 0.75 to 0.95, number needed to treat to harm (NNTH) = 40). When the responder analysis was stratified by study setting amitriptyline was more effective than control antidepressants in inpatients (OR 1.22, 95% CI 1.04 to 1.42, NNTB = 24), but not in outpatients (OR 1.01, 95%CI 0.88 to 1.17, NNTB = 200).

Authors' conclusions

This present systematic review indicates that amitriptyline is at least as efficacious as other tricyclics or newer compounds. However, the burden of side-effects in patients receiving it was greater. In comparison with selective serotonin reuptake inhibitors amitriptyline was less well tolerated, and although counterbalanced by a higher proportion of responders, the difference was not statistically significant.

Anxiety

Sertraline versus other antidepressive agents for depression

Cipriani A, La Ferla T, Furukawa TA, Signoretti A, Nakagawa A, Churchill R, McGuire H, Barbui C. Sertraline versus other antidepressive agents for depression. Cochrane Database of Systematic Reviews 2010, Issue 4. Art. No.: CD006117. DOI: 10.1002/14651858.CD006117.pub4.

Background

The National Institute for Health and Clinical Excellence clinical practice guideline on the treatment of depressive disorder recommended that selective serotonin reuptake inhibitors should be the first-line option when drug therapy is indicated for a depressive episode. Preliminary evidence suggested that sertraline might be slightly superior in terms of effectiveness.

Objectives

To assess the evidence for the efficacy, acceptability and tolerability of sertraline in comparison with tricyclics (TCAs), heterocyclics, other SSRIs and newer agents in the acute-phase treatment of major depression.

Search strategy

MEDLINE (1966 to 2008), EMBASE (1974 to 2008), the Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Register and the Cochrane Central Register of Controlled Trials up to July 2008. No language restriction was applied. Reference lists of relevant papers and previous systematic reviews were hand-searched. Pharmaceutical companies and experts in this field were contacted for supplemental data.

Selection criteria

Randomised controlled trials allocating patients with major depression to sertraline versus any other antidepressive agent.

Data collection and analysis

Two review authors independently extracted data.

Discrepancies were resolved with another member of the team. A double-entry procedure was employed by two reviewers. Information extracted included study characteristics, participant characteristics, intervention details and outcome measures in terms of efficacy (the number of patients who responded or remitted), acceptability (the number of patients who failed to complete the study) and tolerability (side-effects).

Main results

A total of 59 studies, mostly of low quality, were included in the review, involving multiple treatment comparisons between sertraline and other antidepressant agents. Evidence favouring sertraline over some other antidepressants for the acute phase treatment of major depression was found, either in terms of efficacy (fluoxetine) or acceptability/tolerability (amitriptyline, imipramine, paroxetine and mirtazapine). However, some differences favouring newer antidepressants in terms of efficacy (mirtazapine) and acceptability (bupropion) were also found. In terms of individual side effects, sertraline was generally associated with a higher rate of participants experiencing diarrhoea.

Authors' conclusions

This systematic review and meta-analysis highlighted a trend in favour of sertraline over other antidepressive agents both in terms of efficacy and acceptability, using 95% confidence intervals and a conservative approach, with a random effects analysis. However, the included studies did not report on all the outcomes that were pre-specified in the protocol of this review. Outcomes of clear relevance to patients and clinicians were not reported in any of the included studies.

Anxiety

Pharmacological treatment for psychotic depression

Wijkstra J, Lijmer J, Balk F, Geddes J, Nolen WA. Pharmacological treatment for psychotic depression. Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD004044. DOI: 10.1002/14651858.CD004044.pub2.

Background

Regarding the pharmacological treatment of psychotic depression there is uncertainty about the effectiveness of an antidepressant alone compared to the combination of an antidepressant and an antipsychotic.

Objectives

To compare the clinical effectiveness of pharmacological treatments for patients with a psychotic depression: antidepressant monotherapy, antipsychotic monotherapy, and the combination of an antidepressant and an antipsychotic, compared with each other and/or with placebo.

Search strategy

(1) The Cochrane Central Register of Controlled Trials (CENTRAL) was screened with the terms depressive disorder and drug treatment (April 2004).

(2) MEDLINE (1966 to April 2004) and EMBASE (1980 to April 2004) were searched using terms with regard to treatment of unipolar psychotic depression.

(3) Reference lists of related reviews and reference lists of all identified studies were searched.

(4) Personal communications.

Selection criteria

All randomised controlled trials (RCTs) with patients with major depression with psychotic features as well as RCTs with patients with major depression with or without psychotic features which reported on the subgroup of patients with psychotic features separately.

Data collection and analysis

Two reviewers assessed the methodological quality of the included studies, according to the Cochrane Handbook criteria. Data were entered into RevMan 4.2.5. We used intention-to-treat data. For dichotomous efficacy outcomes, the relative risk with 95% confidence intervals (CI) was calculated. For continuously distributed outcomes, it was not possible to extract data from the RCTs. Regarding the primary harm outcome, only overall drop-out rates were available for all studies.

Main results

The search identified 3333 abstracts, but only 10 RCTs with a total of 548 patients could be included in the review. Due to clinical heterogeneity, few meta-analyses were possible. We found no conclusive evidence that the combination of an antidepressant and an antipsychotic is more effective than an antidepressant alone (two RCTs; RR 1.44, 95% CI 0.86 to 2.41), but a combination is more effective than an antipsychotic alone (three RCTs; RR 1.92, 95% CI 1.32 to 2.80). There were no statistically significant differences in the overall drop-out rates between any of the treatments, neither in individual studies nor after pooling of studies.

Authors' conclusions

Treatment with an antipsychotic alone is not a good option. Starting with an antidepressant alone and adding an antipsychotic if the patient does not respond or starting with the combination of an antidepressant and an antipsychotic both appear appropriate options for patients with psychotic depression. In clinical practice the balance between risks and benefits suggests that initial antidepressive monotherapy and adding an antipsychotic if there is inadequate response should be the preferred treatment strategy for many patients. The general lack of available data limits confidence in the conclusions drawn.

Anxiety

Antidepressants for depression in physically ill people

Rayner L, Price A, Evans A, Valsraj K, Higginson IJ, Hotopf M. Antidepressants for depression in physically ill people. Cochrane Database of Systematic Reviews 2010, Issue 3. Art. No.: CD007503. DOI: 10.1002/14651858.CD007503.pub2.

Background

There is an increased risk of depression in people with a physical illness. Depression is associated with reduced treatment adherence, poor prognosis, increased disability and higher mortality in many physical illnesses. Antidepressants are effective in the treatment of depression in physically healthy populations, but there is less clarity regarding their use in

physically ill patients. This review updates Gill's Cochrane review (2000), which found that antidepressants were effective for depression in physical illness. Since Gill there have been a number of larger trials assessing the efficacy of antidepressants in this context.

Objectives

To determine the efficacy of antidepressants in the treatment of depression in patients with a physical illness.

Search strategy

Electronic searches of the Cochrane Depression, Anxiety and Neurosis Review Group (CCDAN) trial registers were conducted together with supplementary searches of The Cochrane Central Register of Controlled Trials (CENTRAL) and the standard bibliographic databases, MEDLINE, EMBASE and PsycINFO. Reference lists of included studies were scanned and trials registers were searched to identify additional unpublished data. Last searches were run in December 2009.

Selection criteria

Randomised controlled trials comparing the efficacy of antidepressants and placebo in the treatment of depression in adults with a physical illness. Depression included diagnoses of Major Depression, Adjustment Disorder and Dysthymia based on standardised criteria.

Data collection and analysis

The primary outcome was efficacy 6-8 weeks after randomisation. Data were also extracted at three additional time-points (4-5 weeks, 9-18 weeks, >18 weeks). Acceptability and tolerability were assessed by comparing the number of drop-outs and adverse events. Odds ratios with 95% confidence intervals were calculated for dichotomous data (response to treatment). Standardised mean differences with 95% CI were calculated for continuous data (mean depression score). Data were pooled using a random effects model.

Main results

Fifty-one studies including 3603 participants were included in the review. Forty-four studies including 3372 participants contributed data towards the efficacy analyses. Pooled efficacy data for the primary outcome provided an OR of 2.33, CI 1.80-3.00, p<0.00001 (25 studies, 1674 patients) favouring antidepressants. Antidepressants were also more efficacious than placebo at the other time-points. At 6-8 weeks, fewer patients receiving placebo dropped out compared to patients treated with an antidepressant. Dry mouth and sexual dysfunction were more common in patients treated with an antidepressant.

Authors' conclusions

This review provides evidence that antidepressants are superior to placebo in treating depression in physical illness. However, it is likely that publication and reporting biases exaggerated the effect sizes obtained. Further research is required to determine the comparative efficacy and acceptability of particular antidepressants in this population.

Anxiety

Antidepressants versus placebo for the depressed elderly

Wilson K, Mottram PG, Sivananthan A, Nightingale A. Antidepressants versus placebo for the depressed elderly. Cochrane Database of Systematic Reviews 2001, Issue 1. Art. No.: CD000561. DOI: 10.1002/14651858.CD000561.

Background

Depression warranting intervention is found in ten percent of people over the age of 60. Older depressed people are more likely to die than non-depressed. Relatively few receive therapeutic interventions, and those that do, tend to receive low dose antidepressant therapy. Depression in older people is thought to differ in terms of aetiology, presentation, treatment and outcome than in younger people. Concomitant physical illness and increasing social, physical and neurophysiological diversity are associated with the ageing process. Consequently drug treatment of older patients is often carried out in institutions and on patients suffering from multiple physical problems.

Objectives

To determine the efficacy of antidepressant medication compared with placebo in the treatment of depression in older patients.

Search strategy

The search strategy incorporated: electronic literature searches of databases held by the Cochrane Collaboration Depression, Anxiety and Neurosis Review Group (CCDAN) (see Collaborative Review Group Search Strategy). Reference lists of related reviews and references of located studies. Contact was made with authors working in the field.

Selection criteria

All randomised, placebo controlled trials using antidepressants in the treatment of the presenting episode of depression in patients described as elderly, geriatric senile or older adult.

Data collection and analysis

Two types of data were extracted (if available) from each study. The first type of data was dichotomous data, this consisted of recovered/not recovered. The second, continuous data,included: Hamilton Depression Rating Scale (HAM-D), Montgomery-Asberg Rating Scale (MADRS) and other depression rating scale scores. An analysis using Peto Odds ratios for the dichotomous data and weighted mean difference for continuous data was performed using RevMan 3.1. The presence of heterogeneity of treatment effect was assessed.

Main results

Seventeen trials contributed data to the analyses comparing the efficacy of antidepressant treatment and placebo. Analyses of efficacy were based on 245 patients treated with Tricyclic antidepressants (223 with placebo), 365 patients treated with SSRIs (372 with placebo) and 58 patients treated with MAOIs (63 with placebo). The results using a fixed effect model, for the three groups respectively were, TCAs; OR: 0.32 (95% CI: 0.21,0.47), SSRIs; OR; 0.51 (95% CI: 0.36,0.72), MAOIs: OR 0.17 (95% CI: 0.07,0.39).

Authors' conclusions

TCAs, SSRIs and MAOIs are effective in the treatment of older community patients and inpatients likely to have severe physical illness. At least six weeks of antidepressant treatment is recommended to achieve optimal therapeutic effect. There is little evidence concerning the efficacy of low dose TCA treatment. Further trials are required before low dose TCA treatment is routinely recommended.

Transcranial magnetic stimulation for treating depression

Rodriguez-Martin JL, Barbanoj JM, Schlaepfer TE, Clos SSC, Pérez V, Kulisevsky J, Gironelli A. Transcranial magnetic stimulation for treating depression. Cochrane Database of Systematic Reviews 2001, Issue 4. Art. No.: CD003493. DOI: 10.1002/14651858.CD003493.

Background

Transcranial magnetic stimulation can either excite or inhibit cortical areas of the brain, depending on whether the speed of the repetitive stimulation is applied at high or low frequencies. It has been used for physiological studies and it has also been proposed as a treatment for depression.

Objectives

To assess the clinical efficacy and safety of transcranial magnetic stimulationfor treating depression.

Search strategy

An electronic search was performed including the Cochrane Collaboration Depression, Anxiety and Neurosis Review Group trials register (last searched June 2001), the Cochrane Controlled Trials Register (Issue 2, 2001), MEDLINE (1966-2001), EMBASE (1974-2001), PsycLIT (1980-2001), and bibliographies from reviewed articles. Unpublished data and grey literature were searched through personal communications with researchers.

Selection criteria

Randomised controlled trials assessing the therapeutic efficacy and safety of transcranial magnetic stimulation for depression.

Data collection and analysis

All reviewers independently extracted the information and verified it by cross-checking. Disagreements were resolved through discussion.

Continuous data: When similar studies were grouped, the overall standardised mean difference was calculated under a fixed effect model weighted by the inverse variance method with 95% confidence intervals. (In the presence of statistical heterogeneity, a random effects model was to be used.)

Main results

Sixteen trials were included in the review and fourteen contained data in a suitable form for quantitative analysis. Most comparisons did not show differences between rTMS and other interventions. No difference was seen between rTMS and sham TMS using the Beck Depression Inventory or the Hamilton Depression Rating Scale, except for one time period (after two weeks of treatment) for left dorsolateral prefrontal cortex and high frequency; and also for right dorsolateral prefrontal cortex and low frequency, both in favour of rTMS and both using the Hamilton scale. Comparison of rTMS (left dorsolateral prefrontal cortex and high frequency) with electroconvulsive therapy showed no difference except for psychotic patients after two weeks treatment, using the Hamilton scale, which indicated that electroconvulsive therapy was more effective than rTMS.

Authors' conclusions

The information in this review suggests that there is no strong evidence for benefit from using transcranial magnetic stimulation to treat depression, although the small sample sizes do not exclude the possibility of benefit.

Electroconvulsive therapy for the depressed elderly

Stek ML, Wurff van der FFB, Hoogendijk WJG, Beekman ATF. Electroconvulsive therapy for the depressed elderly. Cochrane Database of Systematic Reviews 2003, Issue 2. Art. No.: CD003593. DOI: 10.1002/14651858.CD003593.

Background

Depressive disorders are common in old age, with serious health consequences such as increased morbidity, disability, and mortality. The frailty of elderly people may seriously hamper the efficacy and safety of pharmacotherapy. Therefore, electroconvulsive therapy (ECT) may be an alternative to treatment with antidepressants.

Objectives

To assess the efficacy and safety of ECT compared to simulated ECT or antidepressants in depressed elderly people.

Search strategy

We searched the CCDAN Controlled Trials Register on 21/1/2007, MEDLINE 1966-2006, EMBASE 1980-2006, Biological abstracts 1985-2006, CINAHL 1982-2006, Lilacs from 1982 onwards, Psyclit 1887-2006, Sigle 1980-2006. Reference lists of relevant papers were scanned. The Journal of ECT, the International Journal of Geriatric Psychiatry and the American Journal of Geriatric Psychiatry were handsearched.

Selection criteria

Randomised controlled trials of ECT for elderly people (>60 years) with depression, with or without concomitant conditions such as cerebrovascular disease, dementia (including Alzheimer's type and vascular) and Parkinson's disease were included.

Data collection and analysis

Data were independently extracted by at least two review authors. Weighted mean differences (WMD) between groups were calculated for continuous data.

Main results

Randomised evidence was sparse. Only four trials were eligible for inclusion, one comparing the efficacy of real ECT versus simulated ECT, two comparing the efficacy of unilateral versus bilateral ECT and the other comparing the efficacy of ECT once a week with ECT three times weekly. All trials had major methodological shortcomings; reports were mostly lacking essential information to perform a quantitative analysis. Although the findings from one study (35 participants) concluded that real ECT was superior to simulated ECT, these conclusions need to be interpreted cautiously. Only results from one of the trials (29 participants) comparing unilateral versus bilateral ECT could be analysed, and did not show convincing efficacy of unilateral ECT over bilateral ECT, WMD 6.06 (CI -5.20 to 17.32). Randomised evidence on the efficacy and safety

of ECT in depressed elderly with concomitant dementia, cerebrovascular disorders or Parkinson's disease was lacking completely. Possible side-effects could not be adequately examined because of the lack of randomised evidence and methodological shortcomings.

Authors' conclusions

None of the objectives of this review could be adequately tested because of the lack of firm, randomised evidence. Given the specific problems in the treatment of depressed elderly, a well designed randomised controlled trial should be conducted in which the efficacy of ECT is compared to one or more antidepressants.

Psychotherapeutic treatments for older depressed people

Wilson K, Mottram PG, Vassilas C. Psychotherapeutic treatments for older depressed people. Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD004853. DOI: 10.1002/14651858.CD004853.pub2.

Background

Despite a number of reviews advocating psychotherapy for the treatment of depression, there is relatively little evidence based on randomised controlled trials that specifically examines its efficacy in older people.

Objectives

To examine the efficacy of psychotherapeutic treatments for depression in older people.

Search strategy

CCDANCTR-Studies and CCDANCTR-References were searched on 11/9/2006. The International Journal of Geriatric Psychiatry and Irish Journal of Psychiatry were handsearched. Reference lists of previous published systematic reviews, included/excluded trial articles and bibliographies were scrutinised.Experts in the field were contacted..

Selection criteria

All randomised controlled trials that included older adults diagnosed as suffering from depression (ICD or DSM criteria) were included. All types of psychotherapeutic treatments were included, categorised into cognitive behavioural therapies (CBT), psychodynamic therapy, interpersonal therapy and supportive therapies.

Data collection and analysis

Meta-analysis was performed, using odds ratios for dichotomous outcomes and weighted mean differences (WMD) for continuous outcomes, with 95% confidence intervals. Primary outcomes were a reduction in severity of depression, usually measured by clinician rated rating scales. Secondary outcomes, including dropout and life satisfaction, were also analysed.

Main results

The search identified nine trials of cognitive behavioural and psychodynamic therapy approaches, together with a small group of 'active control' interventions. No trials relating to other psychotherapeutic approaches and techniques were found. A total of seven trials provided sufficient data for inclusion in the comparison between CBT and controls. No trials compared psychodynamic psychotherapy with controls. Based on five trials (153 participants), cognitive behavioural therapy was more effective than waiting list controls (WMD -9.85, 95% CI -11.97 to -7.73). Only three small trials compared psychodynamic therapy with CBT, with no significant difference in treatment effect indicated between the two types of psychotherapeutic treatment. Based on three trials with usable data, CBT was superior to active control interventions when using the Hamilton Depression Rating Scale (WMD -5.69, 95% CI -11.04 to -0.35), but equivalent when using the Geriatric Depression Scale (WMD -2.00, 95% CI -5.31 to 1.32).

Authors' conclusions

Only a small number of studies and patients were included in the meta-analysis. If taken on their own merit, the findings do not provide strong support for psychotherapeutic treatments in the management of depression in older people. However, the findings do reflect those of a larger meta-analysis that included patients with broader age ranges, suggesting that CBT may be of potential benefit.

Family therapy for depression

Henken T, Huibers MJ, Churchill R, Restifo KK, Roelofs JJ. Family therapy for depression. Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD006728. DOI: 10.1002/14651858.CD006728.

Background

People with depression often experience interpersonal problems. Family therapy for depression is a widely used intervention, but it is unclear whether this is an effective therapy for the treatment of depression.

Objectives

To assess the efficacy of family therapy for depression.

Search strategy

The following electronic databases were searched using a specific search strategy: CCDANCTR-Studies and CCDANCTR-References searched on 21/10/2005, The Cochrane Central Register of Controlled Trials, Medline (1966 to January 2005), EMBASE (1980 to January 2005), Psycinfo (1974 to January 2005). Reference lists of articles were also searched. Handsearches of relevant journals and bibliographies were conducted and first authors of included studies and experts in the field were contacted for further information.

Selection criteria

Included studies were randomised controlled and controlled clinical trials comparing family therapy with no intervention or an alternative intervention in which depression symptomatology was a main outcome measure.

Data collection and analysis

Methodological quality was independently assessed by two review authors using the Maastricht-Amsterdam Criteria List. The qualitative and quantitative characteristics of the selected trials were independently extracted by three review authors using a standardised data extraction form. Levels of evidence were used to determine the strength of the evidence available. It

was not possible to perform meta-analyses because of the heterogeneity of the selected studies.

Main results

Three high-quality and three low-quality studies, involving 519 people with depression, were identified. The studies were very heterogeneous in terms of interventions, participants, and measuring instruments. Despite fairly good methodological quality and positive findings of some studies, evidence for the effectiveness of family therapy for depression did not exceed level 3 (limited or conflicting evidence), except for moderate evidence (level 2), based on the non-combined findings from three studies, indicating that family therapy is more effective than no treatment or waiting list condition on decreasing depression, and on increasing family functioning.

Authors' conclusions

The current evidence base is too heterogeneous and sparse to draw conclusions on the overall effectiveness of family therapy in the treatment of depression. At this point, use of psychological interventions for the treatment of depression for which there is already an evidence-base would seem to be preferable to family therapy. Further high quality trials examining the effectiveness and comparative effectiveness of explicitly defined forms of family therapy are required.

Marital therapy for depression

Barbato A, D'Avanzo BBD. Marital therapy for depression. Cochrane Database of Systematic Reviews 2006, Issue 2. Art. No.: CD004188. DOI: 10.1002/14651858.CD004188.pub2.

Background

Marital therapy for depression has the two-fold aim of modifying negative interaction patterns and increasing mutually supportive aspects of couple relationships, thus changing the interpersonal context linked to depression.

Objectives

1. To conduct a meta-analysis of all intervention studies comparing marital therapy to other psychosocial and pharmacological treatments, or to non-active treatments.

2. To conduct an assessment of the internal validity and external validity.

3. To assess the overall effectiveness of marital therapy as a treatment for depression.

4. To identify mediating variables through which marital therapy is effective in depression treatment.

Search strategy

CCDANCTR-Studies was searched on 5-9-2005, Relevant journals and reference lists were checked.

Selection criteria

Randomised controlled trials examining the effectiveness of marital therapy versus individual psychotherapy, drug therapy or waiting list/no treatment/minimal treatment for depression were included in the review. Quasi-randomised controlled trials were also included.

Data collection and analysis

Data were extracted using a standardised spreadsheet. Where data were not included in published papers, two attempts were made to obtain the data from the authors. Data were synthesised using Review Manager software. Dichotomous data were pooled using the relative risk (RR), and continuous data were pooled using the standardised mean difference (SMD), and 95% confidence intervals (CIs) were calculated. The random effects model was employed for all comparisons. A formal test for heterogeneity, the natural approximate chi-squared test, was also calculated.

Main results

Eight studies were included in the review. No significant difference in effect was found between marital therapy and individual psychotherapy, either for the continuous outcome of depressive symptoms, based on six studies: SMD -0.12 (95% CI -0.56 to 0.32), or the dichotomous outcome of proportion of subjects remaining at caseness level, based on three studies: RR 0.84 (95% CI 0.32 to 2.22). In comparison with drug therapy, a lower drop-out rate was found for marital therapy: RR 0.31 (95% CI 0.15 to 0.61), but this result was greatly influenced by a single study. The comparison with no/minimal treatment, showed a large significant effect in favour of marital therapy for depressive symptoms, based on two studies: SMD -1.28 (95% CI -1.85 to -0.72) and a smaller significant effect for persistence of depression, based on one study only. The findings were weakened by methodological problems affecting most studies, such as the small number of cases available for analysis in almost all comparisons, and the significant heterogeneity among studies.

Authors' conclusions

There is no evidence to suggest that marital therapy is more or less effective than individual psychotherapy or drug therapy in the treatment of depression. Improvement of relations in distressed couples might be expected from marital therapy. Future trials should test whether marital therapy is superior to other interventions for distressed couples with a depressed partner, especially considering the role of potential effect moderators in the improvement of depression.

Exercise for depression

Mead GE, Morley W, Campbell P, Greig CA, McMurdo M, Lawlor DA. Exercise for depression. Cochrane Database of Systematic Reviews 2009, Issue 3. Art. No.: CD004366. DOI: 10.1002/14651858.CD004366.pub4.

Background

Depression is a common and important cause of morbidity and mortality worldwide. Depression is commonly treated with antidepressants and/or psychotherapy, but some people may prefer alternative approaches such as exercise. There are a number of theoretical reasons why exercise may improve depression.

Objectives

To determine the effectiveness of exercise in the treatment of depression

Search strategy

We searched Medline, Embase, Sports Discus, PsycINFO, the Cochrane Controlled Trials Register, and the Cochrane Database of Systematic Reviews for eligible studies in March 2007. In addition, we hand-searched several relevant journals, contacted experts in the field, searched bibliographies of retrieved articles, and performed citation searches of identified studies. We also searched www.controlled-trials.com in May 2008.

Selection criteria

Randomised controlled trials in which exercise was compared to standard treatment, no treatment or a placebo treatment in adults (aged 18 and over) with depression, as defined by trial authors. We excluded trials of post-natal depression.

Data collection and analysis

We calculated effect sizes for each trial using Cohen's method and a standardised mean difference (SMD) for the overall pooled effect, using a random effects model. Where trials used a number of different tools to assess depression, we included the main outcome measure only in the meta-analysis.

Main results

Twenty-eight trials fulfilled our inclusion criteria, of which 25 provided data for meta-analyses. Randomisation was adequately concealed in a minority of studies, most did not use intention to treat analyses and most used self-reported symptoms as outcome measures. For the 23 trials (907 participants) comparing exercise with no treatment or a control intervention, the pooled SMD was -0.82 (95% CI -1.12, -0.51), indicating a large clinical effect. However, when we included only the three trials with adequate allocation concealment and intention to treat analysis and blinded outcome assessment, the pooled SMD was -0.42 (95% CI -0.88, 0.03) i.e. moderate, non-significant effect. The effect of exercise was not significantly different from that of cognitive therapy. There was insufficient data to determine risks and costs.

Authors' conclusions

Exercise seems to improve depressive symptoms in people with a diagnosis of depression, but when only methodologically robust trials are included, the effect sizes are only moderate and not statistically significant. Further, more methodologically robust trials should be performed to obtain more accurate estimates of effect sizes, and to determine risks and costs. Further systematic reviews could be performed to investigate the effect of exercise in people with dysthymia who do not fulfil diagnostic criteria for depression.

Relaxation for depression

Jorm AF, Morgan AJ, Hetrick SE. Relaxation for depression. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD007142. DOI: 10.1002/14651858.CD007142.pub2.

Background

Many members of the public have negative attitudes towards antidepressants. Psychological interventions are more acceptable but require considerable therapist training. Acceptable psychological interventions that require less training and skill are needed to ensure increased uptake of intervention. A potential intervention of this sort is relaxation techniques.

Objectives

To determine whether relaxation techniques reduce depressive symptoms and improve response/remission.

Search strategy

The register of trials kept by the Cochrane Collaboration Depression, Anxiety and Neurosis Group was searched up to February 2008. We also searched the reference lists of included studies.

Selection criteria

Studies were included if they were randomised or quasi-randomised controlled trials of relaxation techniques (progressive muscle relaxation, relaxation imagery, autogenic training) in participants diagnosed with depression or having a high level of depression symptoms. Self-rated and clinician-rated depression scores and response/remission were the primary outcomes.

Data collection and analysis

Two reviewers selected the trials, assessed the quality and extracted trial and outcome data, with discrepancies resolved by consultation with a third. Trial authors were approached for missing data where possible and missing data were estimated or imputed in some cases. Continuous measures were summarised using standardised mean differences and dichotomous outcomes by risk ratios.

Main results

There were 15 trials with 11 included in the meta-analysis. Five trials showed relaxation reduced self-reported depression compared to wait-list, no treatment, or minimal treatment post intervention (SMD -0.59 (95% CI -0.94 to -0.24)). For clinician-rated depression, two trials showed a non-significant difference in the same direction (SMD -1.35 (95% CI -3.06 to 0.37)).

Nine trials showed relaxation produced less effect than psychological (mainly cognitive-behavioural) treatment on self-reported depression (SMD = 0.38 (95% CI 0.14 to 0.62)). Three trials showed no significant difference between relaxation and psychological treatment on clinician-rated depression at post intervention (SMD 0.29 (95% CI -0.18 to 0.75)).

Inconsistent effects were found when comparing relaxation training to medication and there were few data available comparing relaxation with complementary and lifestyle treatments.

Authors' conclusions

Relaxation techniques were more effective at reducing self-rated depressive symptoms than no or minimal treatment. However, they were not as effective as psychological treatment. Data on clinician-rated depressive symptoms were less conclusive. Further research is required to investigate the possibility of relaxation being used as a first-line treatment in a stepped care approach to managing depression, especially in younger populations and populations with subthreshold or first episodes of depression.

Music therapy for depression

Maratos A, Gold C, Wang X, Crawford M. Music therapy for depression. Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD004517. DOI: 10.1002/14651858.CD004517.pub2.

Background

Depression is a highly prevalent disorder associated with reduced social functioning, impaired quality of life, and increased mortality. Music therapy has been used in the treatment of a variety of mental disorders, but its impact on those with depression is unclear.

Objectives

To examine the efficacy of music therapy with standard care compared to standard care alone among people with depression and to compare the effects of music therapy for people with depression against other psychological or pharmacological therapies.

Search strategy

CCDANCTR-Studies and CCDANCTR-References were searched on 7/11/2007, MEDLINE, PsycINFO, EMBASE, PsycLit, PSYindex, and other relevant sites were searched in November 2006. Reference lists of retrieved articles were hand searched, as well as specialist music and arts therapies journals.

Selection criteria

All randomised controlled trials comparing music therapy with standard care or other interventions for depression.

Data collection and analysis

Data on participants, interventions and outcomes were extracted and entered onto a database independently by two review authors. The methodological quality of each study was also assessed independently by two review authors. The primary outcome was reduction in symptoms of depression, based on a continuous scale.

Main results

Five studies met the inclusion criteria of the review. Marked variations in the interventions offered and the populations studied meant that meta-analysis was not appropriate. Four of the five studies individually reported greater reduction in symptoms of depression among those randomised to music therapy than to those in standard care conditions. The fifth study, in which music therapy was used as an active control treatment, reported no significant change in mental state for music therapy compared with standard care. Dropout rates from music therapy conditions appeared to be low in all studies.

Authors' conclusions

Findings from individual randomised trials suggest that music therapy is accepted by people with depression and is associated with improvements in mood. However, the small number and low methodological quality of studies mean that it is not possible to be confident about its effectiveness. High quality trials evaluating the effects of music therapy on depression are required.

Acupuncture for depression

Smith CA, Hay PPJ, MacPherson H. Acupuncture for depression. Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD004046. DOI: 10.1002/14651858.CD004046.pub3.

Background

There is interest from the community in the use of self help and complementary therapies for depression. This review examined the currently available evidence supporting the use of acupuncture to treat depression.

Objectives

To examine the effectiveness and adverse effects of acupuncture in the treatment for depression.

Search strategy

The following databases were searched: CCDAN-CTR, Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE (1966 to Dec 2008), EMBASE (1980 to Dec 2008), PSYCINFO (1874 to Dec 2008), the Database of Abstracts of Reviews of Effectiveness (DARE), CINAHL (1980 to Dec 2008), Wan Fang database (to Dec 2008). The following terms were used: depression, depressive disorder, dysthymic disorder and acupuncture.

Selection criteria

Inclusion criteria included all published and unpublished randomised controlled trials comparing acupuncture with sham acupuncture, no treatment, pharmacological treatment, other structured psychotherapies (cognitive behavioural therapy, psychotherapy or counselling), or standard care. The following modes of treatment were included: acupuncture, electro acupuncture or laser acupuncture. The participants included adult men and women with depression defined by clinical state description, or diagnosed by the Diagnostic and Statistical Manual (DSM-IV), Research Diagnostic Criteria (RDC), International Classification of Disease (ICD) or the Criteria for Classification and Diagnosis of Mental Diseases CCMD-3-R.

Data collection and analysis

Meta-analyses were performed using relative risk for dichotomous outcomes and standard mean differences for continuous outcomes, with 95% confidence intervals. Primary outcomes were reduction in the severity of depression, measured by self rating scales, or by clinician rated scales and an improvement in depression defined as remission versus no remission.

Main results

This review is an update and now contains data from 30 studies. Following recent searches, 23 new studies have been added and a further 11 trials were excluded (due to suboptimal doses of medication, no clinical outcomes, insufficient reporting). Thirty trials with 2,812 participants are included in the meta-analysis.

There was a high risk of bias in the majority of trials. There was insufficient evidence of a consistent beneficial effect from acupuncture compared with a wait list control or sham acupuncture control. Two trials found acupuncture may have an additive benefit when combined with medication compared with medication alone. A subgroup of participants with depression as

a co-morbidity experienced a reduction in depression with manual acupuncture compared with SSRIs (RR 1.66, 95%CI 1.03, 2.68) (three trials, 94 participants). The majority of trials compared manual and electro acupuncture with medication and found no effect between groups.

Authors' conclusions

We found insufficient evidence to recommend the use of acupuncture for people with depression. The results are limited by the high risk of bias in the majority of trials meeting inclusion criteria.

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