New 2015

Comparative effectiveness of different formats of psychological treatments for depressive disorder.

SCOPING QUESTION: In adults and older adolescents with depressive disorder, what is the comparative effectiveness of different formats of psychological treatments?

BACKGROUND

Depressive disorder is a highly prevalent and disabling disorder. Its relative disease burden is pronounced in high- and middle-income countries and it is also a major cause of disease burden in low-income countries. It is associated with reduced quality of life, impaired social and personal relationships, disturbed academic and professional life, a variety of physical health problems and elevated economic costs with both individual and societal impacts. The adverse impact of depressive disorder on the lives of individuals and their families underscores the need for treatment.

Available data have demonstrated that psychological treatments are effective in treating depressive disorders (1,2). The WHO mhGAP programme has existing guidelines recommending structured brief psychological treatments (e.g., interpersonal psychotherapy, cognitive behavioural therapy, including behavioral activation) for adults with moderate and severe depressive disorder. In addition, it recommends problem-solving treatment and relaxation training as an adjunct treatment (e.g., in combination with antidepressants) for adults with moderate and severe depressive disorder.

Not many people with depressive disorder seek help for their symptoms or utilize mental health services. Even well-endowed health care systems may find it difficult to employ enough qualified therapists to offer interventions. As a consequence, a significant number of individuals suffering from depressive disorder remain underserved and untreated (3,4). Other barriers to psychological treatment include the cost of treatment and fear of stigmatization (5,6). One key issue is whether health care services can provide treatments that are both effective and increase access to therapy. In this context, several different formats of psychological treatments have been developed in order to overcome many of the aforementioned barriers. Among these different formats are several forms of self-help therapy (e.g., internet-based therapy), group psychological treatment and therapy delivered by lay therapists.

A growing body of literature has addressed the issue of the effectiveness of the different psychological treatment formats for depressive disorder. The results so far present variability. For instance, research on individual formats of psychological treatment shows better short-term results compared to group therapy but with no differences at follow-up (7). Additionally, web-based treatment with a therapist show similar effect sizes to conventional face-to-face treatments in treating depressive and anxiety disorders (8-10), while unguided self-help interventions (i.e. where no therapist support is provided) show lower effect sizes compared to guided behavioural interventions (11). It is essential to further examine the comparative effectiveness of different treatment formats to determine the extent to which treatment formats could increase access while reducing

the costs of treatment. The objective of this evidence profile is to examine the comparative effectiveness of different formats of psychological treatments for adults and older adolescents with depressive disorder.

For the purpose of this review, *older adolescents* are 16–19 years old and *lay therapists* are people who do not have professional licensure for the provision of psychotherapy. In this review the term *adults with elevated depressive symptoms* is used as a close proxy for *depressive disorder*. This is relevant because many RCTs in this area of research do not involve formal ICD-10[i] depressive disorder diagnoses. For example, many studies involve participants who score high on the Beck Depression Inventory or another self-report measure validated for major depression.

PART 1: EVIDENCE REVIEW

Population/ Intervention / Comparison / Outcome (PICO)

- **Population:** Adults and older adolescents with depressive disorder.
- **Interventions:**
    a) Individual psychological treatment
    b) Face-to-face psychological treatment
    c) Guided self-help psychological treatment
    d) Lay therapist in face-to-face psychological treatment
- **Comparison:**
    a) Group psychological treatment
    b) Self-help psychological treatment
    c) Unguided self-help psychological treatment
    d) Professional therapist in face-to-face psychological treatment
- **Outcomes:**
    - **Critical outcomes** - Reduction of symptoms, improved functioning/quality of life, adverse effects of treatment
    - **Important outcomes** - Remission, dropout

Search strategy

In order to locate relevant systematic reviews, two researchers independently conducted a systematic literature search of existing systematic reviews in the bibliographic databases of MEDLINE, PsycINFO, Embase and the Cochrane Library. Each of these databases were searched until January 2014. Several keywords for psychological treatment and depressive disorder were combined with filters for systematic reviews. The results of the searches were entered into Endnote. Titles and abstracts were examined after duplicate publications were removed. Studies were retrieved and examined in full-text when they showed potential to meet the inclusion criteria. Consensus was sought in cases where the researchers disagreed on inclusion and, if needed, the opinion of a third researcher was sought. **Available systematic reviews were updated and when no systematic review was available, a new review was conducted for the purposes of this evidence profile.**

To identify RCTs, an existing database of randomized trials on psychological treatment for depressive disorder was searched, comprising studies from 1966 with newly identified studies added annually to January 2014. Furthermore, references of other systematic reviews and meta-analyses of the main psychological treatments for depressive disorder were also searched.

The computer program Comprehensive Meta-Analysis (version 2.2.021) was used to calculate pooled relative risk. The random effects model was used to pool the studies because considerable heterogeneity among the studies was expected. For each comparison (e.g., face-to-face vs. guided self-help vs. unguided self-help; digital vs. paper format for self-help; group vs. individual and lay vs. professional for face-to-face) the effect size (i.e. Hedge's g) of the difference between the two groups at post-treatment assessment was calculated. Only those outcome measures that explicitly measured depressive disorder or quality of life were used in the calculation of effect sizes. If the studies reported more than one outcome measure, a mean score of the effect sizes was calculated according to the procedures of Bornstein et al. (2009). For dichotomous outcomes, the odds ratio (OR) of an outcome was calculated, based on dichotomous results, such as remission or dropout.

To examine heterogeneity across the included studies, the I^2 statistic, as an indicator of heterogeneity in percentages, was calculated (with 0% indicating no observed heterogeneity, 50% indicating moderate heterogeneity and 75% indicating high heterogeneity), while 95% CI around I^2 was calculated by non-central chi-squared-based approach within the heterogi module for Stata. (15).

We tested publication bias by inspecting the funnel plot on primary outcome measures and by Duval and Tweedie's 'trim and fill' procedure, which yields an estimate of the effect size after the publication bias has been taken into account. We also conducted Egger's test to examine the asymmetry of the funnel plot. Finally, the quality of studies was examined according to Cochrane's risk of bias assessment tool (16).

Included in GRADE tables or footnotes

The systematic literature search resulted in 5505 references (PubMED: 1, 634; Embase: 1999; PsycInfo: 721 and Cochrane Library: 1150). After removing duplicates, the titles and abstracts of 4377 reports were examined, which resulted in 363 articles being examined in full text. Reasons for exclusion are listed in the paragraph below entitled 'Excluded from GRADE and footnotes' and in Figure 1, outlining the studies selection process.

Scoping sub-question for intervention (a): One systematic review was selected on the comparison between group vs. individual format for face-to-face treatment:

- Cuijpers P, Van Straten A, Warmerdam L (2008). Are individual and group treatments equally effective in the treatment of depression in adults? A meta-analysis. European Journal of Psychiatry.22(1):38-51.

Scoping sub-questions for interventions (b), (c) and (d):

There was no updated systematic review covering all studies on the comparison between face-to-face and self-help psychological treatment, nor guided vs. unguided self-help, nor lay vs. professional face to face. Thus, we conducted a separate search on RCTs. Figure 2 presents a flow chart of the RCTs selection process. Of 1616 papers examined full text, 13 papers met our inclusion criteria (see Figure 2). **No studies were identified on adolescents. Thus, the review only covers adults with depressive disorder.**

Figure 1. Systematic review selection process for group vs. individual psychological treatment for adults with depressive disorder

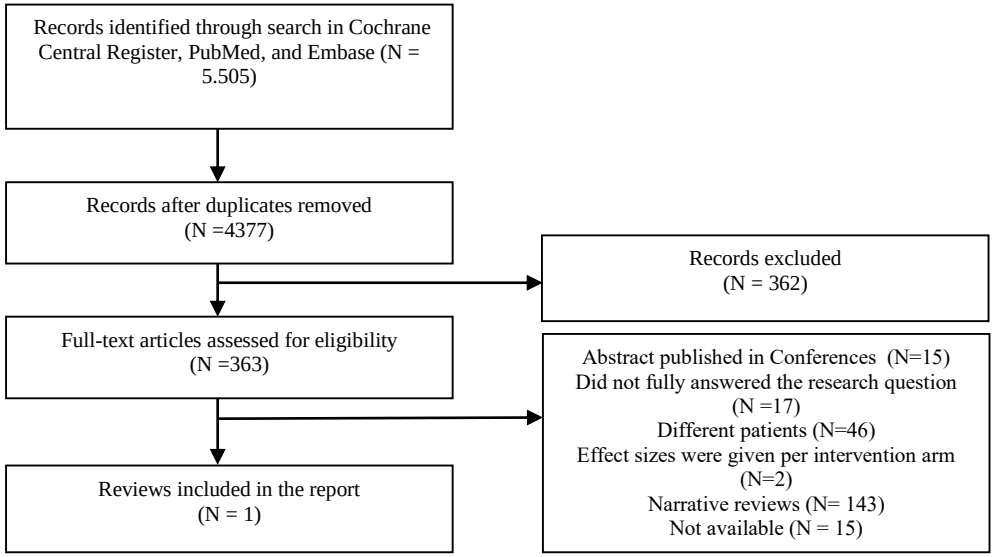
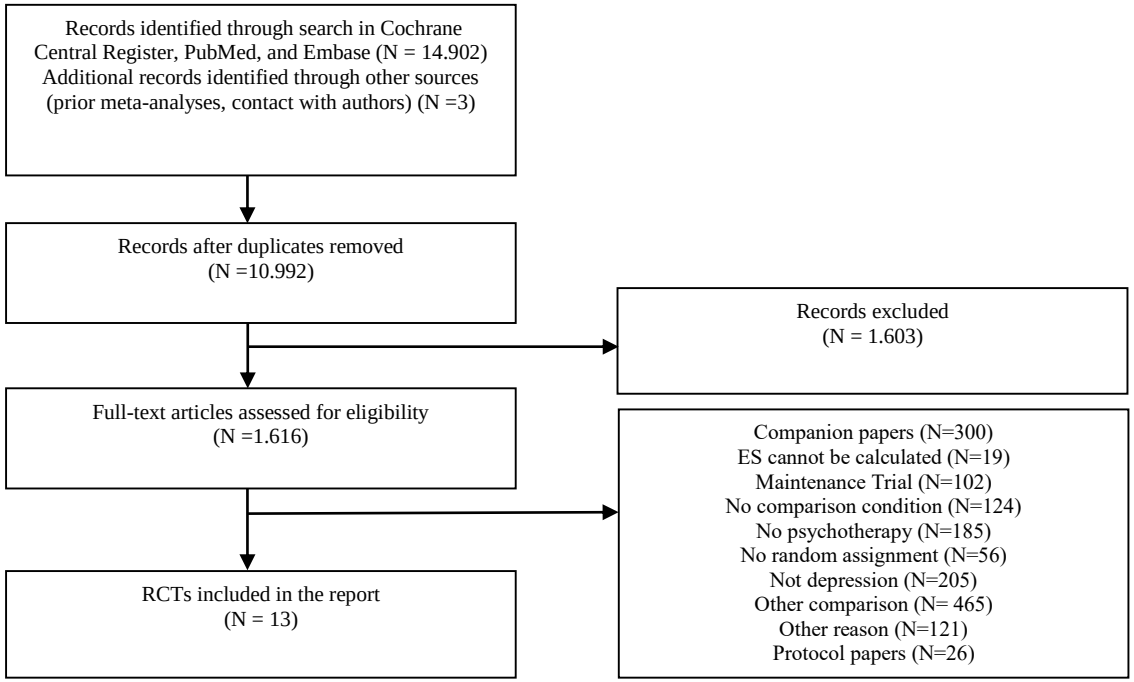


Figure 2. RCT selection process for comparisons (b) and (c)



Excluded from GRADE tables and footnotes

With respect to the search for systematic reviews on the comparison between group vs. individual format for face-to-face treatment (i.e. scoping sub-question [a]), two systematic reviews were excluded because the effect sizes were given per intervention arm rather than for the relevant comparison (17, 18).

There were 143 reviews excluded as narrative reviews (19-161).

There were 15 articles that were not available and so were also excluded (162-176),

There were 15 excluded because they were abstracts published in scientific conferences (13, 177-190).

There were 124 reviews excluded because they examined other interventions,comparisons or outcomes (8, 191-329).

There were 46 reviews excluded because they studied individuals with different health problems (11, 330-374).

With respect to the search for systematic reviews on the comparison between face-to-face psychological treatment and self-help for depressive disorder (i.e. scoping sub-question (c)), two systematic reviews, and one currently in press (2) by Andersson et al., examining this comparison. None of these reviews answered the research question in full (e.g., the reviews were focused only on web-based interventions); furthermore, none of these were up to date. Thus, we conducted a new systematic review.

PICO Table

Population: Adults and older adolescents with depressive disorder[1]					
Intervention	**Comparison**	**Outcome**	**Systematic reviews used for GRADE**	**Justification for systematic review used**	**Relevant GRADE table**
Individual psychological treatment	Group psychological treatment	Reduction of symptoms	Cuijpers et al., 2008	Comparison of all individual and group treatments for adults with depressive disorder	Table 4
		Functioning/quality of life	NO DATA		
		Remission	Cuijpers et al., 2008	Comparison of all individual and group treatments for adults with depressive disorder	Table 4
		Adverse effects of treatment	NO DATA		
		Dropout	NO DATA		
Face-to-face psychological treatment	Self-help psychological treatment	Reduction of symptoms	New review carried out		Table 5
		Functioning/quality of life	NO DATA		
		Remission	New review carried out		Table 5

[1] Due to the limited number of trials on adults and older adolescents with depressive disorder, we extended our search to adults with elevated depressive symptoms (people who score high on self-report outcome measures for depression).

		Adverse effects of treatment	NO DATA		
		Dropout	New review carried out		Table 5
Guided self-help psychological treatment	Unguided self-help psychological treatment	Reduction of symptoms	New review carried out		Table 6
		Functioning/quality of life	NO DATA		
		Remission	NO DATA		
		Adverse effects of treatment	NO DATA		
		Dropout	NO DATA		
Lay therapist in face-to-face psychological treatment	Professional therapist in face-to-face psychological treatment	Reduction of symptoms	New review carried out		Table 7
		Functioning/quality of life	NO DATA		
		Remission	New review carried out		Table 7
		Adverse effects of treatment	NO DATA		
		Dropout	NO DATA		

Narrative description of the studies that went into the analysis

Scoping sub-question (a) Systematic review of individual vs. group psychological treatment in adults with depressive disorder

Cuijpers et al. (2008) examined whether individual and group psychological treatments are equally effective in treating adult depressive disorder. The authors conducted a meta-analysis of 15 studies in which individual and group psychological treatments were compared to each other. The types of psychological treatment examined include behavioural therapy, cognitive behavioral therapy, counselling, interpersonal psychological treatment and supportive therapy. The authors found that individual treatments outperformed group format treatments at the post-treatment symptom reduction assessment (SMD: 0.20, 95% CI 0.05 to 0.35; p<0.01) (See GRADE Table 4, data row 1). Heterogeneity was zero. However, this difference was no longer significant at 6 months follow up (See GRADE Table 4, data row 2). Individual interventions resulted also in a lower dropout rate compared to group interventions (OR=0.56, 95% CI 0.37 to 0.86; p<0.01) (See GRADE Table 4, data row 6). Seven studies reported on remission. Individual psychological treatment did not differ significantly from group psychological treatment on remission of depressive disorder at post-treatment assessment (7) (See GRADE Table 4, data row 3). No studies reported on quality of life, work related outcomes and adverse effects.

Scoping sub-question (b): Face-to-face therapy vs. self-help in adults with depressive disorder, study characteristics

There were 11 RCTs examining the comparative efficacy of face-to-face therapy and self-help therapy for elevated depressive symptoms (375-385). All included studies recruited outpatients from the community. The included studies were conducted across six different countries: Australia (n=2), Finland (n=1), Sweden (n=1) Switzerland (n=1), Netherlands (n=1) and United States of America (n=5). People entered into the trials if they

experienced elevated depressive symptoms or met criteria for major depressive disorder (MDD), minor depression or dysthymia (DYS). The types of face-to-face psychological treatment used included acceptance and commitment therapy (ACT), cognitive behavioural therapy (CBT) and person-centered therapy (PCT). There were five studies that delivered face-to-face treatment in a group format, while six studies delivered individual psychological treatment. The types of self-help therapy used included ACT, bibliotherapy and CBT. The self-help treatment was delivered through the web in four studies, through books in two studies, through telephone and books in two studies and through computers in the remaining three studies. The face-to-face psychological treatment consisted of 8-20 sessions, while the self-help psychological treatment consisted of 3-10 modules. In some cases one face-to-face session accompanied the self-help intervention. Study characteristics are presented in Table 1 below.

Table 1. Summary of RCTs examining face-to-face therapy vs. self-help psychological treatment in adults with elevated depressive symptoms

Studies	Recruitment	Diagnosis	Psychological treatment (face-to-face)	N sessions	N participants	Self-help	N sessions	Format of self-help	N participants	Outcome	Country
Andersson et al. (2013) (375)	Community	MDD, DYS (SCID)[ii]	Group CBT	8	33	iCBT[iii]	7	Web	32	MADRS-S[iv], BDI	SE
Brown et al. (1984) (376)	Community	*Depression (RDC[v])*	*Individual CBT* *Group CBT*	12	13	Guided telephone CBT	1 FTF[vi] session, 11 telephone	Book, telephone	14	BDI, CES-D[vii]	USA
Floyd et al. (2004) (377)	Community	MDD, DYS, mind (DSM[viii]-IV)	CBT	12-20	16	Guided telephone CBT	NR	Book, telephone	16	HAMD[ix], GDS[x]	USA
Kay-Lambkin et al. (2009) (378)	Community	MDD (SCID)	CBT	10	35	cCBT[xi]	10	Computer	32	BDI-II	AU
Kay-Lambkin et al. (2011) (379)	Community	Depressive symptoms (BDI[xii]-II>17)	• CBT • PCT[xiii]	9	• 88 • 89	cCBT	9	Computer	97	BDI	AU
Lappalainen et al. (2014) (380)	Community	Depressive symptoms (3 questions,	ACT	6	19	iACT	6 web sessions, 1FTF	Web	19	BDI-II, SCL-90-D[xiv]	FIN

		diagnostic interview)									
Schmidt et al. (1983) (381)	Community	Depressive symptoms (BDI>10)	Individual CBT Small group CBT • Large group CBT	• 8 • 8 • • 8	• 12 • 11 • • 11	Bibliotherapy	1 FTF, 1 tel	Book	12	BDI, MMPI[xv], POMS[xvi], SDS[xvii]	USA
Selmi et al. (1990) (382)	Community	MDD, mind (RDS[xviii])	CBT	6	12	cCBT	NR	Computer	12	BDI, SCL-90-D, HAMD	USA
Spek et al. (2007) (383)	Community	Depressive symptoms (EPDS[xix]>12)	Group CBT	10	99	Unguided iCBT	10	Web	102	BDI-II	NL
Wagner et al. (2014) (384)	Community	Depressive symptoms (BDI-II>12)	CBT	8	30	Guided iCBT	8	Web	32	BDI	CH
Wollersheim et al. (1991)	Community	Depression (DSM-III)	Group CBT	10	8	Bibliotherapy	3	Book	8	BDI, CR, MMPI	USA

Scoping sub-question (b): Face-to-face therapy vs. self-help in adults with depressive disorder, results of meta-analyses

Eleven studies examined the comparative efficacy of face-to-face psychological treatment and self-help therapy (guided or unguided) in reducing depressive symptoms in people with elevated depressive symptomatology (375-385). Face-to-face therapy did not result in a significantly different decrease in depressive symptoms compared to self-help psychological treatment at the post-treatment assessment (g=0.07, 95%CI: -0.08 to 0.22; p>0.05; see GRADE Table 5, data row 1). Heterogeneity was low (I^2= 0.1%, 95%CI 0 to 58%, p>0.05). There was some indication of publication bias. The 'trim and fill' procedure suggested that one study was missing. However, Egger's test was not significant.

Four studies assessed remission at post treatment. Face-to-face psychological treatment did not differ significantly in remission compared to self-help therapy (OR = 0.8, 95%CI 0.41 to 1.51, p>0.05; see GRADE Table 5, data row 2). Heterogeneity between studies was low (I^2= 26.6%, 95%CI 0 to 72%, p>0.05) and there was no indication of publication bias.

Only two studies reported on quality of life. Andersson et al. (375) and Wagner et al. (384) found no statistically significant differences between face-to-face and internet-based therapy on quality of life. Only one study reported on adverse effects. Andersson et al. (375) reported that there were no adverse effects directly related to the examined treatments (one group had 0/33 adverse events and the other has 0/32 adverse events; data are not

included the GRADE table as no odds ratio can be produced). Furthermore, five studies reported on treatment dropout. Face-to-face therapy resulted in non-significant differences on treatment dropout compared to self-help psychological treatment (see GRADE Table 5, data row 1). Heterogeneity between studies was low (I^2= 16%, 95%CI 0 to 83%, p>0.05) and there was no indication of publication bias. No studies reported on work related outcomes.

Scoping sub-question (c): Guided self-help vs. unguided self-help psychological treatment in adults with depressive disorder

Only one small study examined the comparison between guided and unguided self-help psychological treatment for depressive symptoms. Berger et al. (2011) (386) examined the differences of guided internet-based CBT compared to unguided internet-based CBT in the reduction of depressive symptoms. They found that guided internet-based CBT resulted in a non-significant difference in depressive symptoms compared to unguided internet-based CBT at post treatment (g=0.28, 95%CI: -0.26 to 0.83; p>0.05; see GRADE Table 6). They also reported that 3/25 people in unguided internet-based CBT group did not complete the post-treatment assessment, while none of the participants in the guided internet-based CBT group dropped out (386). No studies reported on quality of life, work related outcomes and adverse effects. Table 2 summarizes the characteristics of the examined study.

Table 2. Summary of RCTs examining guided vs. unguided self-help psychological treatment for depressive symptoms.

Study	Recruitment	Diagnosis	Guided self-help psychological treatment	No. of modules	No. of participants	Unguided self-help psychological treatment	No. of modules	Format of self-help	No. of participants	Outcome	Country
Berger et al. (2011) (386)	Community	Depressive symptoms (BDI-II>13)	Guided iCBT	10	25	Unguided iCBT	10	Web	25	BDI-II	CH

Scoping question (d): Lay vs. professional therapists in face-to-face psychological treatment for adults with depressive disorder

One small study examined the comparison between psychological treatment delivered by professionals and psychological treatment delivered by lay therapists. Bright et al. (1999) (387) found no significant differences in depressive symptoms at follow-up between psychological treatment delivered by professionals and psychological treatment delivered by lay therapists (g=0.53, 95%CI: -0.09 to 1.15; p>0.05; see GRADE Table 7, data row 1). However, the authors found that people who followed therapy delivered by professionals had greater odds of being classified as not having a

depressive disorder or remission (OR=3.8, 95%CI 1.05 to 13.78) compared to people who received psychological treatment delivered by lay therapists. More specifically, 15/26 participants in the group of CBT delivered by professionals and 5/19 in the group of CBT delivered by lay therapists were classified as non-depressed at the post-treatment assessment (see GRADE Table 7, data row 2). Dropout did not differ significantly by therapist type (387). No studies reported on quality of life, work related outcomes or adverse effects. **Table** 3 summarizes the characteristics of the examined study.

Table 3. Summary of RCTs examining outcomes of lay vs. professional therapists in face-to-face psychological treatment for adults with depressive symptoms

Study	Recruitment	Diagnosis	Psychological treatment I	No. of sessions	No. of participants	Psychological treatment II	No. of sessions	No. of participants	Outcome	Country
Bright et al. (1999) (387)	Community	Depressive symptoms (HAM-D>10, SCID)	• CBT professionals	• N/A	• 27	• CBT professionals	• NR	• 21	BDI, HAM-D	USA

GRADE Tables

Table 4. Individual vs. group psychological treatment in adults with depressive symptoms

Authors: E Karyotaki and P Cuijpers
Question: In adults and older adolescents with depressive disorder, what is the comparative effectiveness of different formats of psychological treatments?
Bibliography: .Cuijpers P, Van Straten A, Warmerdam L (2008). Are individual and group treatments equally effective in the treatment of depression in adults? A meta-analysis. European Journal of Psychiatry. 22(1): 38-51.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Individual	Group psychological treatment	Relative (95% CI)	Absolute		
Reduction in depressive symptoms with individual vs. group psychological treatment in adults with depressive symptoms at post-treatment (SMD is in favor of individual therapy)												
15	Randomized trials	Serious[1]	No serious inconsistency	Serious[2]	No serious imprecision	None	333	335	-	SMD 0.20 higher (0.05 to 0.35 higher)	⊕⊕OO LOW	CRITICAL
Reduction in depressive symptoms with individual vs. group psychological treatment in adults with depressive symptoms at 6 months follow up (SMD is in favor of group therapy, no significant differences between conditions)												
7	Randomized trials	No serious risk of bias	No serious inconsistency	Serious[2]	Serious[3]	None	94	135	-	SMD -0.17 lower (-0.53 to 0.19 higher)	⊕⊕OO LOW	CRITICAL
Remission with individual vs. group psychological treatment in adults with depressive symptoms, post-treatment												
7	Randomized trials	Serious[1]	No serious inconsistency	Serious[2]	Serious[3]	Reporting bias[4]	72/121 (59.5%)	70/134 (52.2%)	OR 1.24 (0.64 to 2.40)	53 more per 1000 (from 111 fewer to 202 more)	⊕OOO VERY LOW	IMPORTANT
Functioning/ Quality of life												
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CRITICAL
Adverse effects												

N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CRITICAL
Treatment dropout												
10	Randomized trials	Serious[1]	No serious inconsistency	Serious[2]	Serious[3]	Reporting bias[4]	31/175 (17.7%)	70/286 (24.5 %)	OR 0.56, (0.37 to 0.86)	108 fewer per 1000 (from 34 fewer to 154 fewer)	⊕OOO VERY LOW	IMPORTANT

[1] 15/15 RCTs at high risk of bias due to unclear/inadequate sequence generation and due to unclear/inadequate allocation concealment; 10/15 RCTs due to unblinded assessment of all outcomes; 11/15 RCTs at high risk due to the handling of incomplete data; 7/7 RCTs at high risk of bias due to unclear/inadequate sequence generation and due to unclear/inadequate allocation concealment; 5/7 RCTs at high risk due to the handling of incomplete data; 10/10 RCTs at high risk of bias due to unclear/inadequate sequence generation and due to unclear/inadequate allocation concealment; 6/10 RCTs at high risk due to the handling of incomplete data.

[2] Several different types of psychological treatment have been examined; adults with elevated depressive symptoms.

[3] The confidence interval (CI) ranges from substantial benefit with individual psychological treatment to substantial benefit with group psychological treatment; 95%CI includes no effect, 95%CI crosses a suggested minimal important difference of an OR of 1.5 or an OR of 0.67 (Cuijpers et al., 2014). (388)

[4] According to 'trim and fill' procedure, three studies were missing.

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Table 5. Face-to-face therapy vs. self-help in adults with elevated depressive symptoms

Authors: E Karyotaki and P Cuijpers
Question: In adults and older adolescents with depressive disorder, what is the comparative effectiveness of different formats of psychological treatments?
Bibliography: New systematic review and meta-analysis involving 11 studies (375-385)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Face-to-face	Self-help	Relative (95% CI)	Absolute		
Reduction of depressive symptoms with face-to-face therapy vs. self-help psychological treatment in adults with depressive symptoms (SMD in favor of face-to-face therapy, no significant differences between conditions)												
11	Randomized trials	Serious[1]	No serious inconsistency	Serious[2]	Serious[3]	None	476	376	-	SMD 0.07 higher (0.08 lower to 0.22 higher)[4]	⊕OOO VERY LOW	CRITICAL
Remission with face-to-face therapy vs. self-help psychological treatment in adults with depressive symptoms												
4	Randomized trials	Serious[5]	No serious inconsistency	Serious[2]	Serious[3]	None	42/227 (18.5%)	30/144 (20.8%)	OR 0.8 (0.41 to 1.55)	34fewer per 1000 (from 81 more to 111 fewer)	⊕OOO VERY LOW	IMPORTANT
Functioning/ Quality of life												
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CRITICAL
Adverse effects												
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CRITICAL
Treatment dropout												
5	Randomized trials	No serious risk of bias	No serious inconsistency	Serious[2]	Serious[3]	None	177/368 (48.1%)	102/247 (41.3%)	OR 1.15 (0.72 to 1.83)	34 more per 1000 (from 77 fewer to 150 more)	⊕⊕OO LOW	IMPORTANT

[1] 7/11 RCTs at high risk of bias due to unclear/inadequate sequence generation; 7/11 RCTs at high risk of bias due to unclear/inadequate allocation concealment; 5/11 RCTs at high risk of bias due to (the handling of) incomplete data.
[2] Several different types of psychological treatment have been examined; adults with elevated depressive symptoms.
[3] 95%CI includes no effect, 95%CI crosses a suggested minimal important difference of an OR of 1.5 or an OR of 0.67 or a SMD of 0.24 (Cuijpers et al., 2014). (388)
[4] Hedges's g scores.
[5] 3/4 RCTs at high risk of bias due to unclear/inadequate sequence generation, unclear/inadequate allocation concealment and due to the handling of incomplete data.

Table 6. Guided vs. unguided self-help psychological treatment in adults with elevated depressive symptoms

Authors: E Karyotaki and P Cuijpers
Question: In adults and older adolescents with depressive disorder, what is the comparative effectiveness of different formats of psychological treatments?
Bibliography: . New systematic review that identified 1 study (386)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Guided self-help**	**Unguided self-help**	**Relative (95% CI)**	**Absolute**		
Reduction in depressive symptoms with guided vs. unguided self-help in adults with depressive symptoms (SMD in favor of guided self-help, no significant differences between conditions)												
1	Randomized trials	No serious risk of bias	No serious inconsistency	Serious[1]	Serious[2]	None	25	25	-	SMD 0.28 higher (0.26 lower to 0.83 higher)[3]	⊕⊕OO LOW	CRITICAL
Remission in depressive symptoms with guided vs. unguided self-help in adults with depressive symptoms												
4	Randomized trials	Serious[5]	No serious inconsistency	Serious[2]	Serious[3]	None	42/227 (18.5%)	30/144 (20.8%)	OR 0.8 (0.41 to 1.55)	34fewer per 1000 (from 81 more to 111 fewer)	⊕OOO VERY LOW	IMPORTANT
Functioning/ Quality of life												
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CRITICAL
Adverse effects												
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CRITICAL

Treatment dropout												
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IMPORTANT

[1] Adults with elevated depressive symptoms.
[2] 95%CI includes no effect, 95%CI crosses a suggested minimal important difference of an OR of 1.5, or an OR of 0.67 or a SMD of 0.24 (Cuijpers et al., 2014). (388)
[3] Hedges's g scores.

Table 7. Lay vs. professional therapists in face-to-face psychological treatment for adults with depressive symptoms

Authors: E Karyotaki and P Cuijpers
Question: In adults and older adolescents with depressive disorder, what is the comparative effectiveness of different formats of psychological treatments?
Bibliography: New systematic review that identified 1 study (386)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Lay	Professional	Relative (95% CI)	Absolute		
Reduction in depressive symptoms with lay vs. professional therapists in face-to-face psychological treatment in adults with depressive symptoms (SMD in favor of lay therapists, no significant differences between conditions)												
1	Randomized trials	Serious[1]	No serious inconsistency	Serious[2]	Serious[3]	None	22	28	-	SMD 0.53 higher (0.09 to 1.15 higher)[4]	⊕OOO VERY LOW	CRITICAL
Remission with lay vs. professional therapists in face-to-face psychological treatment in adults with depressive symptoms, post-treatment												
1	Randomized trials	Serious[1]	No serious inconsistency	Serious[2]	Serious[3]	None	5/19 (26.3%)	15/26 (57.7%)	OR 3.81 (1.05 to 13.78)	262 more per 1000 (from 12 more to 373 more)	⊕OOO VERY LOW	IMPORTANT

Functioning/ Quality of life												
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	CRITICAL
Adverse effects												
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	CRITICAL
Treatment dropout												
1	Randomized trials	Serious[1]	No serious inconsistency	Serious[2]	Serious[3]	None	8/28 (28.6%)	8/22 (36.4%)	OR 0.7 (0.21 to 2.31)	78 fewer per 1000 (from 205 more to 256 fewer)	⊕OOO VERY LOW	IMPORTANT

[1] At high risk of bias due to unclear/inadequate sequence generation and due to unclear/inadequate allocation concealment.
[2] Adults with elevated depressive symptoms.
[3] Only one study contributed to the analysis with less than 50 participants per treatment arm. The CI is wide and ranges from almost no difference to a substantial beneficial effect associated with professional therapists; 95%CI includes no effect, 95%CI crosses a suggested minimal important difference of an OR of 1.5, or an OR of 0.67 or a SMD of 0.24 (Cuijpers et al., 2014).
[4] Hedges's g scores.

Additional evidence not mentioned in GRADE tables

When *guided* self-help is compared to control groups, it produces greater effect sizes and greater adherence than when *unguided* self-help is compared with control groups. For example, Richards and Richardson (2012) reported on a systematic review and meta-analysis of 19 RCTs on computer-based self-help (11). The authors found that in studies where the subjects are therapist-supported, the mean post-treatment effect size across all depression measures was d=1.35 (across 18 effect sizes), with d=1.29 at follow-up (across 13 effect sizes). In studies where administrative support is provided, the mean post-treatment effect size was d=0.95 (across 23 effect sizes), with d=1.20 at follow-up (across 10 effect sizes). In studies without support and self-help is unguided, the mean post-treatment effect size was d=0.78 (across 17 effect sizes), with d=1.13 at follow-up (across 11 effect sizes).

PART 2: FROM EVIDENCE TO RECOMMENDATIONS

Summary of evidence table

Outcome	Individual psychological treatment vs. group psychological treatment *(Number of studies, OR or SMD [95% CI], findings and quality)*	Face-to-face psychological treatment vs. self-help psychological treatment *(Number of studies, OR or SMD [95% CI], findings and quality)*	Guided self-help psychological treatment vs. unguided self-help psychological treatment *(Number of studies, OR or SMD [95% CI], findings and quality)*	Lay therapist in face-to-face psychological treatment vs. professional therapist in face-to-face psychological treatment *(Number of studies, OR or SMD [95% CI], findings and quality)*
Response	15 studies (post-treatment) SMD 0.20 (0.05 to 0.35) In favour of individual psychological treatment LOW quality 7 studies (6 months) SMD -0.17 (-0.53 to 0.19) No difference LOW quality	11 studies SMD 0.07 (-0.08 to 0.22) No difference VERY LOW quality	1 study SMD 0.26 (-0.26 to 0.83) No difference LOW quality	1 study SMD 0.53 (0.09 to 1.15) No difference VERY LOW quality
Remission	7 studies OR 1.24 (0.64 to 2.40) No difference VERY LOW quality	4 studies OR 0.80 (0.41 to 1.55) No difference VERY LOW quality	1 study OR 08 (0.41 to 1.55) No difference VERY LOW quality	1 study OR 3.81 (1.05 to 13.78) In favour of professional therapist VERY LOW quality
Functioning	_____	_____	_____	_____
Adverse events	_____	_____	_____	_____
Dropouts	10 studies	5 studies	_____	1 study

	OR 0.56 (0.37 to 0.86) In favour of individual psychological treatment VERY LOW quality	OR 1.15 (0.72 to 1.83) No difference LOW quality		OR 0.70 (0.21 to 2.31) No difference VERY LOW quality

Evidence to recommendation table

Benefits	**Individual vs. group psychological treatment in adults with depressive disorder:** There is low quality evidence demonstrating no difference in reduction of depressive symptoms between individual and group psychological treatment at 6-months follow-up, despite individual psychological treatment resulting in a greater reduction in depressive symptoms compared to group psychological treatment in adults with elevated depressive symptoms immediately after treatment. **Face-to-face therapy vs. self-help in adults with depressive disorder:** • There is very low quality evidence that self-help psychological treatment and face-to-face psychological treatment are similarly effective in reducing depressive symptoms in adults with elevated depressive symptoms. **Guided vs. unguided self-help psychological treatment in adults with depressive disorder:** • There is low quality evidence that unguided and guided self-help are similarly effective in terms of reducing depressive symptoms in adults with elevated depressive symptoms; however, the results of this comparison should be interpreted with caution because they are based only on one small study. Additionally, trials comparing unguided self-help interventions with control groups result in smaller effect sizes than trials comparing guided self-help interventions with

	control groups. **Lay vs. professional therapists in face-to-face psychological treatment for adults with depressive disorder:** • There is limited evidence that lay therapists and professional therapists are similarly effective in reducing depressive symptoms through psychological treatment in adults with elevated depressive symptoms. The confidence estimate is VERY LOW. • Moreover, there is very low quality evidence that psychological treatment delivered by professional therapists results in better remission rates in adults with elevated depressive symptoms compared to psychological treatment delivered by lay therapists.
Harms	**Individual vs. group psychological treatment in adults with depressive disorder:** • There is very low quality evidence that individual and group psychological treatments are similarly effective in terms of remission and dropout rates in adults with elevated depressive symptoms. **Face-to-face therapy vs. self-help in adults with elevated depressive symptoms:** • There is low quality evidence that face-to-face and self-help psychological treatments have similar dropout rates in adults with elevated depressive symptoms.
Summary of the of quality of evidence	The quality of the research comparing individual and group treatment of depressive disorder is LOW and no good conclusions can be drawn at this moment. However, the preliminary evidence suggests that the difference between individual and group treatment is small or non-existent. With respect to face-to-face vs. self-help treatment, the research is somewhat more extensive, but the quality is VERY LOW; therefore, the evidence is still insufficient to draw definite conclusions. However,

	the available evidence does suggest that there are probably no differences or only small differences between treatment formats. Other than drop-outs, adverse effects have not been systematically compared. Most policy makers thus far (e.g., NICE[xx]) assume that benefits outweigh harms. Although the systematically reviewed evidence is on depressed adults, it is likely that this evidence could be generalized and applied to depressed older adolescents.

Values and preferences	
In favour	If treatment format is not very relevant for the desired outcome then factors that affect the delivery of treatments should be especially important, such as costs and the availability of human and other resources. **Values** Given the treatment gap and limited availability of mental health professionals, there is value in looking for different ways to offer evidence-based interventions to ensure horizontal health equity, especially in communities with limited or no access to mental health care. Many self-help interventions teach people psychological skills that will allow them to manage problematic situations better. This has value beyond reducing symptoms of depression. **Preferences** Self-help approaches, such as those delivered through internet or books, offer less stigmatizing ways to access care. However, there is very little evidence on factors that determine individual treatment preferences in terms of willingness to receive treatment and specific types of treatment delivery approaches, such as medication, individual and group face-to-face psychotherapies and guided and self-guided therapies. This makes assessment of preferred treatment delivery types difficult.

Against	Although a variety of low intensity interventions help make mental health care more widely available, there are some issues that impact vertical health equity: 1. IT-based interventions require access to computers and/or smart phones, which makes these interventions largely inaccessible for low-income individuals or those living in poverty. 2. Self-help books require sufficient literacy skills, which can be very low in low-income countries, especially among elderly women. 3. Delivering interventions via mobile telephone support may be more feasible in low-income settings; however, the very poor may not have access to mobile telephones. Furthermore, lay therapists tend not to be members of national associations that regulate the quality and quantity of training and supervision; therefore, care delivered by lay therapists may be more difficult to regulate.
Uncertainty or variability?	Overall, there is substantial certainty in the value of expanding care through different means.

Feasibility (including resource use considerations)	Different self-help approaches can be made available on a large scale in a complementary way. Lay therapists are a potentially widely available resource. Lay therapists may deliver treatments as effectively as professional therapists with only small differences. This supports the use of less intensive treatment formats, as well as the use of lay therapists in delivering psychological treatments in low- and middle-income countries. However, lay therapists need supervision, which requires resources. Different treatment formats require different levels of resources: • Lay therapists typically have lower salaries than professionals, while community volunteers likely require incentives instead of salaries. • IT-based interventions involve initial programme development costs and may involve costs to maintain programs hosted on the internet. • Internet-based self-help approaches require a reliable internet connection with sufficiently high speeds, which is not continuously available in many low- and middle-income countries. • Not all subgroups of the population may be able to access all types of interventions.

	• Independent of treatment format, developing brief psychological treatment is less resource-intensive per person helped than offering longer-term psychological treatment. • If all else is equal, group face-to-face interventions are less resource-intensive per person helped than individual face-to-face interventions. However, groups are more difficult to organize (in terms of setting appointments at a mutually convenient time and finding an appropriate, private space for group sessions). Other considerations include the need for initial individual assessments for each group member, preparation of individuals for group treatment and that the number of sessions delivered is not tailored to individual needs. In many countries, people do not attend health care at pre-specified appointment times and so this could lead to high drop-out rates or delayed session start times. • When all else is equal, unguided self-help is less resource intensive than guided self-help. • Structured psychological treatments can be manualized and are easier to train and supervise than unstructured psychological treatments.
Uncertainty or variability?	Overall, there appears to be substantial certainty that it is feasible to expand the delivery of psychological interventions beyond care by mental health professionals.

Recommendation and remarks

Recommendation

Health care providers can offer different treatment formats of WHO's recommended, structured psychological interventions for adults and older adolescents with depressive disorder. These include behavioural activation [BA], cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), or problem-solving treatment as an adjunct treatment (e.g., in combination with antidepressants). Different treatment formats for consideration include (a) individual and/or group face-to-face psychological treatments delivered by professionals and supervised lay therapists, as well as (b) self-help psychological treatment.
While face-to-face psychological treatment or guided self-help psychological treatment are likely to have better outcomes

than unguided self-help, the latter may be suitable for those people who either (a) do not have access to face-to-face psychological treatment or guided self-help psychological treatment or (b) are not willing to access such treatments.

Rationale: There is low-quality evidence suggesting that the difference between individual and group treatment is small or non-existent. With respect to face-to-face versus self-help treatment, the research is more extensive, but the quality is very low. Overall there is substantial certainty in the value of expanding care through different means, and in the feasibility of expanding the delivery of psychological interventions beyond care by mental health professionals.

Remarks

Choice of treatment format depends on social and health systems context.

WHO-recommended structured psychological treatments for depressive disorders in adults include: behavioural activation (BA), cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT). In addition, existing WHO-recommended structured brief psychological treatments include problem-solving treatment as an adjunct treatment (e.g., in combination with antidepressants) for depressive disorder.
WHO recommended structured psychological treatments for emotional disorders in adolescents include: cognitive behavioural therapy, interpersonal psychotherapy, and caregiver skills training .
Self-help psychological treatment may involve information-technology (IT) supported self-help materials and paper-based self-help books.

Judgements about the strength of a recommendation

Factor	Decision
Quality of the evidence	□ High □ Moderate **X Low** □ Very low
Balance of benefits versus harms	**X Benefits clearly outweigh harms** □ Benefits and harms are balanced □ Potential harms clearly outweigh potential benefits
Values and preferences	□ No major variability **X Major variability**
Resource use	**X Less resource-intensive** □ More resource-intensive
Strength	**CONDITIONAL**

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[i] International Statistical Classification of Diseases – 10th revision (ICD-10)
[ii] Structural Clinical Interview for Depression (SCID)
[iii] Internet-based Cognitive Behavioural Therapy (iCBT)
[iv] Self-reported Montgomery-Asperg Depression Rating Scale (MADRS-S)
[v] Research Diagnostic Criteria (RDC)
[vi] Face-to-face therapy (FTF)
[vii] Center for Epidemiologic Studies Depression Scale (CES-D)
[viii] Diagnostic and Statistical Manual of Mental Disorders (DSM)
[ix] Hamilton Rating Scale for Depression (HAMD)
[x] Geriatric Depression Scale (GDS)
[xi] Computerized Cognitive Behavioural Therapy (cCBT)
[xii] Beck Depression Inventory (BDI)
[xiii] Post-cycle therapy (PCT)
[xiv] Hopkins Symptom Checklist for Depression revised (SCL-90-D)
[xv] Minnesota Multiphasic Personality Inventory (MMPI)
[xvi] Profile of Mood States (PMS)
[xvii] Zung Self-Rating Depression Scale (SDS)
[xviii] Residual depressive symptoms (RDS)
[xix] Edinburgh Postnatal Depression Score (EPDS)