Medication or psychotherapy in the treatment of depression and anxiety ?

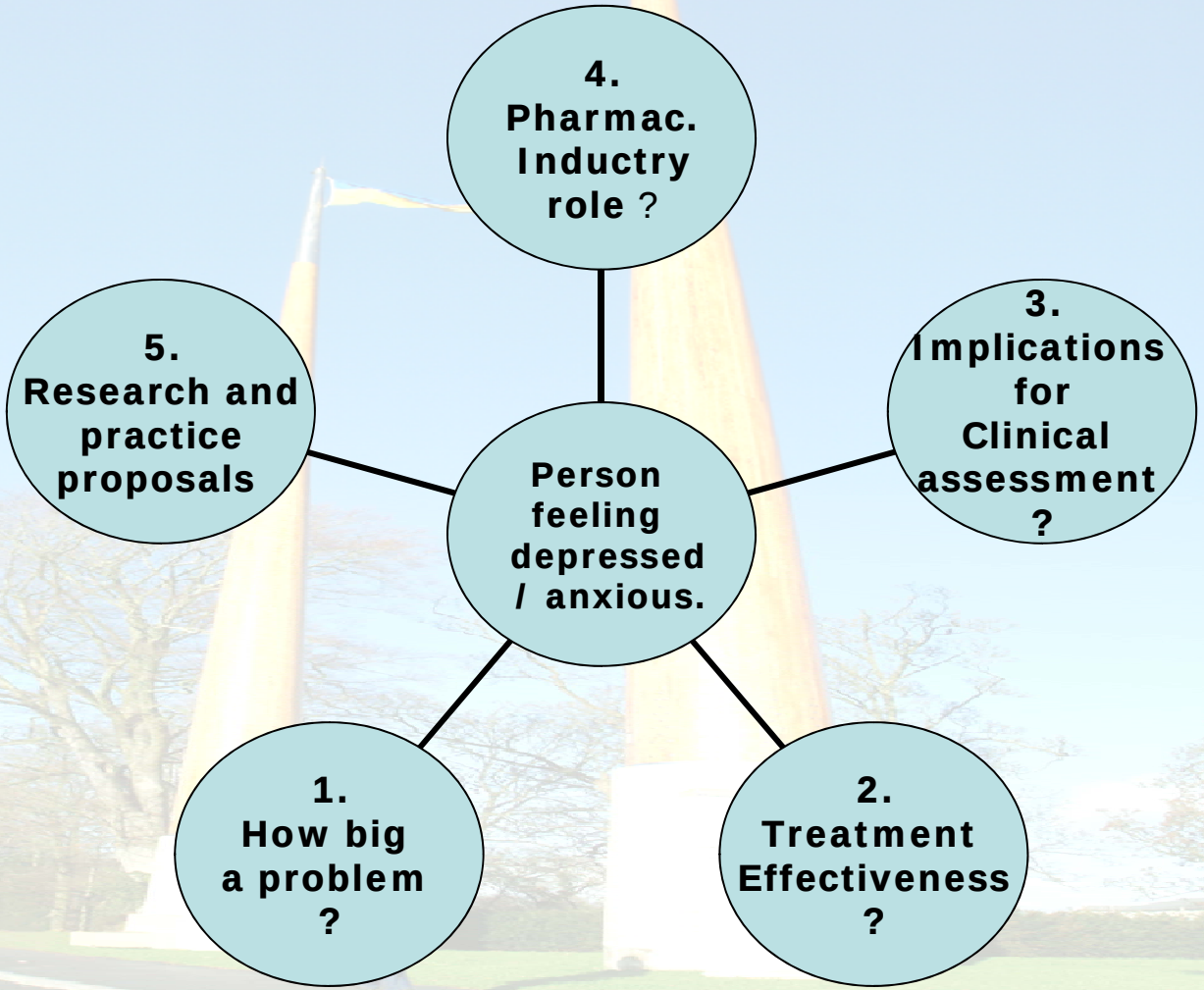
by

Dr. Declan Aherne

Clinical Psychologist and Psychotherapist

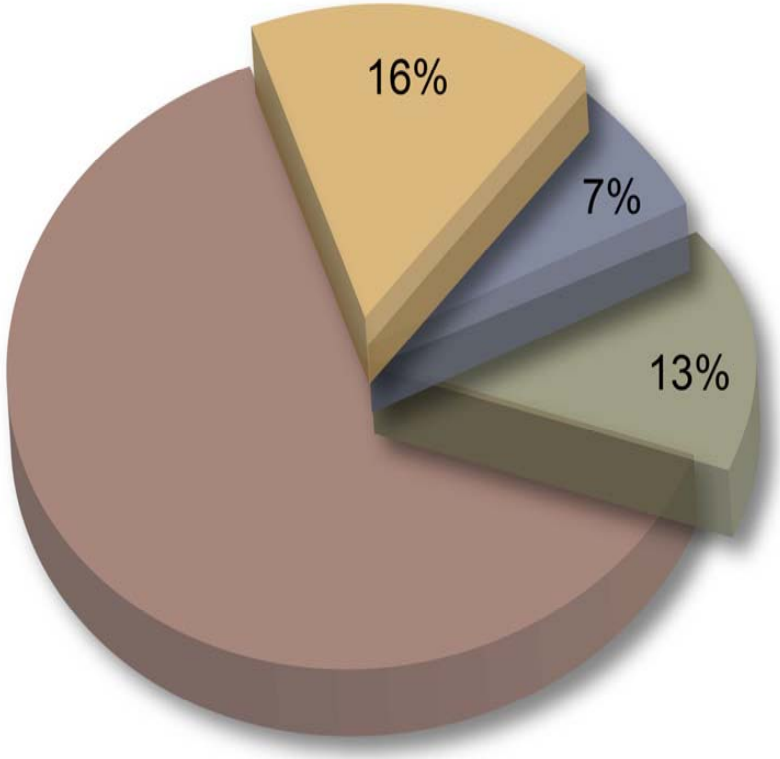
UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

Summary of presentation



Total Mental health difficulties in Europe: 36%

EU POP: 400 million approx



	Other
30.8 million	Depression
66 million	Anxiety

Wittchen et al, 2011

- **W.H.O. 2000 reports depression as the largest non-fatal ‘burden of disease’.**

- **More than 80% managed in primary care. (NICE 2004.)**

Recommended Treatment

- **Standard treatment guidelines, (NICE), recommend combining psychotherapy and medication for moderate to severe depression and psychotherapy for sub-threshold and mild depression.**

However, there is compelling evidence that combined treatments are not as effective as psychotherapy on its own, except for severe depression.

Furthermore, there is no evidence based rationale for combined treatments

- **Psychotherapy may be considered the treatment of first choice for depression, based on equivalence of treatment outcome and coupled with greater risks associated with medication.**

- **Antonuccia et al (1995)**
  Professional psychology: research and practice

- **Meta-analysis of studies found no evidence of long term benefit for combined treatment of depression over psychotherapy alone.**

- **Friedman et al 2004 ,**
  Clinical psychology: science and practice.

.

- **Psychotherapy and medication are equally effective in treatment of mood disorders and anxiety, but the long term benefits of psychotherapy outweigh those of medication.**

- **Combined treatment should not be considered the default treatment for mood and anxiety disorders.**

Otto et al 2005,
Clinical Psychology: science and practice

Also
Wurz and Sungur, 2009,

- **Combination treatment for acute depression is superior only when psychotherapy is added to medication. Combination treatment does not have an advantage over psychotherapy alone.**

- **Bloma et al . (2007)**
  Psychotherapy and psychosomatics

- **Meta-analytic study found that active medication has a 'small but significant contribution' to the overall efficacy of combined treatments for depression i.e. 1 in 7 patients has a positive outcome which can be attributed to active medication.**

The effect size is .25, yet clinically relevant effect size is .50.

- **Cuijpers et al, 2010**
  Archives of General Psychiatry

- **The lack of a definite additive effect justifies selection of the monotherapies first, based on availability and patient preference, with the alternative strategy considered in sequence or in combination for those who are less responsive to treatment for depression.**

- **Bergin and Garfield, 2004**

Supporting evidence:

Positive antidepressant drug effects only apply in cases of severe depression.

The magnitude of benefit of antidepressant medication compared with placebo increases with severity of depression symptoms and may be minimal or nonexistent, on average, in patients with mild or moderate symptoms.

For patients with very severe depression, the benefit of medications over placebo is substantial.

- **Fournier et al., 2010, JAMA**

Based on the evidence , it is critical that we know how to establish patients severity of depression as a first step in choosing treatment choice at the primary care level.

DSMIV-TR criteria for Severe depression:

has most symptoms, with a marked interference in functioning (7+).

2 Key symptoms:

- **Depressed mood**
- **Markedly diminished interest or pleasure in almost all daily activities.**

7 Ancillary symptoms:

1. **Fatigue or loss of energy**
2. **Change in appetite or weight(increased or decreased)**
3. **Insomnia or hyper-somnia**
4. **Psychomotor retardation or agitation**
5. **Low self esteem or excessive guilt**
6. **Poor concentration or indecisiveness**
7. **Recurrent thoughts of death, suicidal ideation or suicidal attempt.**

How many patients are severely depressed ?

- **A survey of depressed, treatment-seeking outpatients found that 29% of the 503 patients assessed were very severely depressed.**
  Zimmerman, 2002.

- **In a major US study 30% of sample with major depression, were considered 'serious' cases.**
  Kessler, 2005. Amer. J. Psychiatry.

- **We can conclude that medication ought only to be prescribed in the main to the 30% approx. of people presenting with severe depression and the mild and moderately depressed people ought to be availing of psychotherapy.**

- **Is this what is happening ?**

GP initiate antidepressants more frequently than any other treatment for depression.

52% medication only.
27% combination
4% psychotherapy only.

Robinson et al (2005)
Journal American Board Family Practice

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

Worrying trends in the use of psychotherapy and medication in U.S.

Between 1998 and 2007:

- **Use of psychotherapy alone decreased from 15.9% to 10.5%.**
- **Use of combined treatment decreased from 40% to 32.1%.**
- **Use of psychothropic medication increased from 44.1% to 57.4%.**

- Olfson, 2002, 2010.
  American Journal of Psychiatry

The use of psychotropic drugs is widespread in Europe, and is markedly more common in France than elsewhere

- **During the 1990s, the sales of psychotropic medications in France increased, antidepressants +70%.**

  International Journal for equity in Health, 2008.

Portugese Regulatory Agency for Medicines,Infarmed, 2002-2011

- Reports 52% increase in use of psychotropic medication.
- 177% increase in the use of antidepressants.

<u>Great business !</u>

Increase in prescribing medication due to :

1. Less side effects of meds.
2. Aggressive marketing by pharma.co.
3. Research errors
4. Increased screening.
5. Third party reimbursements.
6. GP's more willing to treat depression.
7. GP's defensive practice.
8. Lack of resources.
9. Patient preference.

Increase in prescribing ? contd.

- Selective publication of antidepressant trials distorts the facts and influences prescribing practices.

- **Studies judged positive by the FDA were 12 times more likely to be published.**

- Turner et al 2008
  The New England Journal of Medicine.

- **Gotzsche and Jorgensen, 2011 describe efforts to get access to unpublished trial reports from the European Medicines Agency (EMA).**

- **The EMA replied 'documents could not be released because it would undermine commercial interests'.**
- **the EMA put the interests of drug companies 'ahead of protecting the lives and welfare of patients'.**

- BMJ

- **Institute for Quality and Efficiency in Health Care in Germany accused pfizer of concealing data on its depression treatment of reboxetin and refused to rule on drug's benefits until Pfizer disclosed all trial results.**

- **Had access to results on only 1600 of 4600 patients tested.**

Stafford, 2009
BMJ

- **There is something fundamentally wrong with our priorities in healthcare if commercial success depends on withholding data that are important for rational decision making by doctors and patients.**

Is it a case of

……

Antidepressants:

A triumph of marketing over science !

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

For patients, the extensive marketing structure for pharmacotherapy has no counterpart for psychotherapies

- **Druss,*2010;***
  Am J Psychiatry

Why not anti-depressants – sure they'll 'do no harm'

- Ineffective
- Costly
- Damaging side effects.
- Contraindicated in conjunction with psychotherapy, interfering with psychotherapeutic gains.
- Perpetuating an 'illness' model for dealing with life's problems.

In conclusion

- What is the gap between best practice and what is currently delivered ?

Current treatment of depression

Mild Moderate Severe

10%

Recieving psychoth-erapy alone

Recieving medication with limited psychotherapy usage

Recommended treatment of depression

Subthreshold

Mild | Moderate | Severe

70% | 30%

Recommended - Psychotherapy

Recommended - Psychotherapy + medication

Over 4 million (and up to 17 million) depressed people in EU taking anti-depressant medication inappropriately, when psychosocial interventions are what are needed.

<u>This is a political matter.</u>

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

Practice -Key Recommendations

1. **Psychotherapy as first option in a stepped care program – with non-medical point of entry.**

2. **Assessing levels of depression need to be improved at primary care.**

3. **Patients responsibility for choice of treatment is crucial.**

4. **The burden of responsibility on physicians for dealing with patients psychological problems removed.**

5. **Psychotherapy profession in EU needs to be far more unified**

Contd.

6. Service users charter needed.

7. Pharmaceuticals companies need to be informed as to what is needed. Rigorous monitoring required.

8. A joint European forum be established between medicine / psychiatry and psychology / psychotherapy.

9. Psychological interventions needed as agents of social change.

10. Significant public funding and resources needed to implement a primary care psychological service.

Research - Key points

1. **Relevant psychotherapy research in EU needs adequate funding.**
2. **Trends in psychotherapy usage in Europe to be studied.**
3. **Guidelines and rationale for combined treatments need to be developed e.g. NICE.**
4. **Publications of trials to be made public, commercial interests are not the priority.**
5. **Psychotherapy effectiveness is not amenable to double blind RCT type studies.**
6. **Appropriate and relevant research designs need to be utilised and published.**
7. **Do GP's want to treat depressed patients ?**
8. **Evidence practice needs to be informed by practice based evidence and vice versa.**

The End

Thank You

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH