Updating the Evidence and Recommendations for Short-Term Psychodynamic Psychotherapy (STPP) in the Treatment of Major Depressive Disorder in Adults: The Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Guidelines

Joel M. Town [1, 2)], Allan Abbass [2)], Ellen Driessen [3, 4)], Patrick Luyten [5, 6)], Priyanthy Weerasekera [7)]

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[1)] Plymouth University Peninsula Schools of Medicine and Dentistry, Plymouth, UK

[2)] Centre for Emotions and Health, Dalhousie University, Nova Scotia, Canada

[3)] Department of Clinical, Neuro and Developmental Psychology, Faculty of Behavioural and Movement Sciences, VU University Amsterdam, The Netherlands

[4)] EMGO Institute for Health and Care Research, VU University and VU University Medical Center Amsterdam, The Netherlands

[5)] Faculty of Psychology and Educational Sciences, University of Leuven, Belgium

[6)] Research Department of Clinical, Educational, and Health Psychology, University College London, UK

[7)] Psychiatry and Behavioral Neurosciences, McMaster University, Canada

We welcome the revised CANMAT guidelines for psychological treatments in depression. We understand that the updated guidelines are based on a thorough literature search focusing on systematic reviews and meta-analyses, thus we seek to highlight the omission of key findings from 2 recent meta-analyses of STPP for depression (1, 2).

First, while the guideline authors identified the meta-analysis of 54 STPP studies (33 RCTs) for depression (2) as evidence of effectiveness of this approach, it would have been informative to note that analyses adequately powered to detect clinically significant differences found no such differences between STPP delivered in individual format and other psychotherapies at post-treatment or at follow-up for depression. Moderator analyses clearly showed that the observation of non-equivalence between STPP versus other psychotherapies at post-treatment was explained by the inclusion of 2 STPP studies applying group format. Adjustment for publication bias also indicated no difference between STPP and other psychotherapies even when individual and group was combined. If the complete meta-analytic results are taken into consideration, it appears that the authors' conclusion that, "STPP compared to other types of psychotherapy resulted in slightly worse outcomes on some measures of depression at the end of treatment" might not be correct.

Since the methods for determining Line of Treatment used by CANMAT state, "a first line treatment recommendation indicates good-quality evidence (Level 1 or 2

Evidence)" (3) (p. 2), it would be helpful if the authors can clarify that these findings are consistent with the criteria for meta-analytic data used by CANMAT (4) (Table 1, p. 3) for Level 1 or 2 Evidence.

While meta-analyses of STPP include different models, this is also the case for those cited as evidence(5) for the effectiveness of other psychotherapies (e.g., Cognitive Behavioural Therapies, CBT). CBT approaches employ broad definitions and include different treatment manuals but are equally considered a family of therapies that share common features.(6) Furthermore, models of STPP for depression were recently shown to overlap to a high degree having most treatment elements in common.(7)

Second, the guidelines address whether, "co-occurring psychiatric conditions affect the efficacy of psychological treatments?" The authors determined that there is insufficient evidence on anxiety disorders and personality disorders. We noticed that select individual studies are subsequently discussed and only statements about the likely effectiveness of CBT are given. A new finding of potential significance that was overlooked by the authors, despite being derived from meta-analytic data, showed significant superiority of STPP over other psychotherapies in 5 studies which reported anxiety measures in patients with depression; a significant small differences at post-treatment became a medium to large difference at follow-up. Similarly, data from another meta-analysis found that STPP is likely effective for depression and comorbid personality disorder.(1) According to the dearth of

alternative meta-analytic studies around treating comorbid psychiatric conditions, these findings warrant referencing. The guidelines could state that as an effective treatment for MDD, STPP may remain effective in comorbid personality disorders and can improve symptoms of anxiety to a greater extent than other psychotherapies for depression.

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