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Knowledge Service

Literature Search

Interpersonal therapy, depression and physical health conditions

Requester:	Toni Baker
Purpose:	Therapist Accreditation
KS Specialist:	Laura Jeffreys
Date:	21 October 2019

Contents

Search Request

"pain(or any health condition) , depression and interpersonal therapy"

Knowledge Specialist Comments

There is very limited evidence on interpersonal psychotherapy with long term conditions.

Search Limits

Publication Date:	Past 20 years
Language:	English only
Article Type:	All
Gender:	All
Age Group:	Adults (16+)

Results sorted by:	Condition; then Date (newest first)
Results filtered:	Yes

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To evaluate the impact this service has on both the learning and development of staff at the Trust and ultimately, on patient care. We would be very interested to know if this information has been of use to you in your daily practice. Please feel free to contact us with your comments. Receiving your comments will help towards the continuous improvement of this service.

Results

Paper already identified

1. **Interpersonal Psychotherapy for Co-occurring Depression and Chronic Pain**.

Poleshuck EL, Gamble SA, Cort N, et al.

2010

Professional psychology, research and practice. 41/ 4 (pp. 312–8)

Up to 37% of individuals experience chronic pain during their lifetimes. Approximately one-fourth of primary care patients with chronic pain also meet criteria for major depression. Many of these individuals fail to receive psychotherapy or other treatment for their depression; moreover when they do, physical pain is often not addressed directly. Women, socioeconomically disadvantaged individuals, African Americans and Latinos all report higher rates of pain and depression compared to other groups. This article describes a version of Interpersonal Psychotherapy tailored for patients with comorbid depression and chronic pain, Interpersonal Psychotherapy for Depression and Pain (IPT-P). While IPT-P potentially could be delivered to many different patient populations in a range of clinical settings, this article focuses on its delivery within primary care settings for socioeconomically disadvantaged women. Adaptations include a brief 8-session protocol that incorporates strategies for anticipating barriers to psychotherapy, accepting patients' conceptualization of their difficulties, encouraging patients to consider the impact of their pain on their roles and relationships, emphasizing self-care, incorporating pain management techniques, and flexible scheduling. In addition, IPT-P is designed as an adjunct to usual medical pain treatment, and seeks to engage non-treatment seeking patients in psychotherapy by focusing on accessibility and relevance of the intervention to concerns common among patients with pain. Identifying patients with comorbid depression and chronic pain and offering IPT-P as a treatment option has the potential to improve clinical outcomes for individuals with depression and chronic pain.

Document:

https://www.ncbi.nlm.nih.gov/pubmed/21191470

Cancer

2. **A randomized trial of interpersonal psychotherapy, problem solving therapy, and supportive therapy for major depressive disorder in women with breast cancer**.

Blanco C, Markowitz JC, Hellerstein DJ, et al.

2019

Breast cancer research and treatment. 173/ 2 (pp. 353-64)

PURPOSE: Breast cancer (BC) is a risk factor for major depressive disorder (MDD), yet little research has tested the efficacy of different psychotherapies for depressed women with BC. This study, the largest to date, compared outcomes of three evidence-based, 12-week therapies in treating major depressive disorder among women with breast cancer.

METHODS: This randomized trial compared interpersonal psychotherapy (IPT), problem

solving therapy (PST), and brief supportive psychotherapy (BSP). Conducted at the outpatient clinic of the New York State Psychiatric Institute/Columbia University, the trial offered bilingual treatment by treatment-specific psychotherapists supervised by treatment experts. The primary outcome was change in the Hamilton Depression Rating Scale (HAM-D) at 12 weeks. Secondary outcomes included other validated patient-reported outcomes for depression and quality of life.

RESULTS: Of 179 women with breast cancer screening positive for depression at the Columbia Cancer Center, 134 eligible patients signed informed treatment consent. Half of patients were Hispanic and economically disadvantaged. Most women had stage I (35.2%) or II (36.9%) BC; 9% had stage IV. The three brief psychotherapies showed similar improvements on the HAM-D, with large pre-post effect sizes (d ~ 1.0); a priori defined response rates were 35% for IPT, 50% for PST and 31% for BSP, and remission rates 25%, 30% and 27%, respectively. The three treatments also showed similar improvements in the Quality of Life Enjoyment and Satisfaction Questionnaire. Dropout was high, ranging from 37 to 52% across treatments. Predictors of dropout included having < 16 years of education and annual family income < $20,000.

CONCLUSIONS: Among patients who completed treatment, all three psychotherapies were associated with similar, meaningful improvements in depression. Physical distance between the oncology and psychiatric treatment sites might have contributed to high dropout. This study suggests various psychotherapy approaches may benefit patients with breast cancer and major depression.

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3. **Interpersonal-Relational-Existential Therapy in Oncology Settings**.

Taylor N, Newman E

2014

Psycho - Oncology. 23 (p.] 74)

From a conference presentation [THIS IS THE FULL TEXT] In this presentation, we will discuss how utilizing an integrative theoretical approach that draws upon interpersonal, relational, and existential theories can be beneficial with cancer patients. The use of empirically supported treatments and cognitive-behavioral therapy are well established in health settings, however in practice, many clinicians adhere to a more integrative model of conducting psychotherapy. We will discuss how to balance the demands for empirically supported treatments within a health setting with relational approaches that are especially necessary and beneficial in working with cancer patients. Drawing upon common factors research (e.g. Wampold), interpersonal psychotherapy (e.g. Teyber), existential therapy (e.g. Yalom), and relational psychotherapy (e.g. Wachtel), we will share a new model for integrating theory in oncology settings. Common factors research has shown that the relationship between therapist and client is the most important predictor of outcome in psychotherapy. In addition, the trans-theoretical tenets of symptom explanation and confrontation of negative emotions are particularly important in working with cancer patients. We will share our clinical experiences working with cancer patients in both inpatient and outpatient settings. Since the traditional therapeutic " frame " is often not present in oncology settings and therapy can be done " chair-side " while patients are receiving chemotherapy, waiting for an appoint- ment, or bedside in hospital rooms, the unique factors in applying these theories to work in psychosocial oncology will be emphasized. We have found that taking a more relational approach can occur even with time and space constraints placed on psychotherapy. The research implications of a more inter- personal-relational approach in health settings, especially as managed care and medical centers place restrictions on time spent with patients,

will be discussed. Additionally, research ideas for testing this theory will be explored. This presentation will be relevant to psychologists, social workers, and other clinicians who provide counseling to cancer patients. Some specific techniques we will describe include: using the here-and-now to process both physiologi cal and emotional changes, utilizing the therapeutic relationship to understand relational themes, discussing how cancer treatments and medications have impacted relationships, showing unconditional positive regard for patients through potentially disfiguring treatments, and creating a space to discuss existential and mortality-related concerns.

Cardiac Problems

4. **Psychological and pharmacological interventions for depression in patients with coronary artery disease**.

Baumeister H, Hutter N, Bengel J

2011

Cochrane Database of Systematic Reviews. / 9

Background: Depression occurs frequently in patients with coronary artery disease (CAD) and is associated with a poor prognosis.

Objectives: To determine the effects of psychological and pharmacological interventions for depression in CAD patients with comorbid depression.

Search methods: CENTRAL, DARE, HTA and EED on The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL, ISRCTN Register and CardioSource Registry were searched. Reference lists of included randomised controlled trials (RCTs) were examined and primary authors contacted. No language restrictions were applied.

Selection criteria: RCTs investigating psychological and pharmacological interventions for depression in adults with CAD and comorbid depression were included. Primary outcomes were depression, mortality and cardiac events. Secondary outcomes were healthcare costs and health-related quality of life (QoL).

Data collection and analysis: Two reviewers independently examined the identified papers for inclusion and extracted data from included studies. Random effects model meta-analyses were performed to compute overall estimates of treatment outcomes.

Main results: The database search identified 3,253 references. Sixteen trials fulfilled the inclusion criteria. Psychological interventions show a small beneficial effect on depression compared to usual care (range of SMD of depression scores across trials and time frames: -0.81;0.12). Based on one trial per outcome, no beneficial effects on mortality rates, cardiac events, cardiovascular hospitalizations and QoL were found, except for the psychosocial dimension of QoL. Furthermore, no differences on treatment outcomes were found between the varying psychological approaches. The review provides evidence of a small beneficial effect of pharmacological interventions with selective serotonin reuptake inhibitors (SSRIs) compared to placebo on depression outcomes (pooled SMD of short term depression change scores: -0.24 [-0.38,-0.09]; pooled OR of short term depression remission: 1.80 [1.18,2.74]). Based on one to three trials per outcome, no beneficial effects regarding mortality, cardiac events and QoL were found. Hospitalization rates (pooled OR of three trials: 0.58 [0.39,0.85] and emergency room visits (OR of one trial: 0.58 [0.34,1.00]) were reduced in trials of

pharmacological interventions compared to placebo. No evidence of a superior effect of Paroxetine (SSRI) versus Nortriptyline (TCA) regarding depression outcomes was found in one trial.

Authors' conclusions: Psychological interventions and pharmacological interventions with SSRIs may have a small yet clinically meaningful effect on depression outcomes in CAD patients. No beneficial effects on the reduction of mortality rates and cardiac events were found. Overall, however, the evidence is sparse due to the low number of high quality trials per outcome and the heterogeneity of examined populations and interventions.

Document:
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008012.pub3/full

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5. **Remission from depression comorbid with chronic illness and physical impairment**.

Turvey CL, Klein DM

2008

The American Journal of Psychiatry. 165/ 5 (pp. 569-74)

This case presentation describes psychotherapy for depression in a man suffering multiple chronic illnesses and severe functional impairment. The psychotherapy described herein occurred in the context of a treatment development research project that aims to develop new methods to treat depression in heart failure patients. The treatment used in this case study is novel in three ways that may enhance the efficacy of psychosocial interventions in patients with chronic cardiac conditions. First, in light of the considerable research demonstrating the relation between functional impairment and depression, strategies that address specifically the connection between impairment and mood are being developed. Comparable to prior treatment development in pain or bereavement, we aim to identify common problems among chronically ill elder patients that contribute to or exacerbate major depression. Second, the therapy uses a hybrid model combining techniques from interpersonal psychotherapy and behavioral activation. The treatment development will test whether combining the two models to address both the emotional and behavioral sequelae of impairment will improve efficacy. The third unique aspect of the therapy is that it is conducted primarily by telephone. Many chronically ill patients are homebound and are not able or not willing to make weekly visits to a geographically remote medical center.

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6. **Citalopram, but not interpersonal psychotherapy, improves major depression in people with coronary artery disease**.

Parashar S, Rumsfeld JS

2007

Evidence Based Mental Health. 10/ 3 (pp. 80-)

Are citalopram or interpersonal psychotherapy more effective than placebo or clinical management for major depression in people with coronary artery disease?METHODSDesign: Randomised controlled 2x2 factorial trial.Allocation: Concealed.Blinding: Double blind for citalopram and placebo; single blind for interpersonal psychotherapy (IPT) or clinical management (assessors blind).Follow-up period: Twelve weeks (treatment period only).Setting: Nine academic centres, Canada; May 2002 to March 2006.Patients: 284

outpatients (>/= 18 years old) with DSM-IV major depression for >/=4 weeks, Hamilton Depression rating scale (HAM-D) score >/= 20, and established coronary artery disease (previous myocardial infarction or revascularisation; or angiographic evidence of >/= 50% stenosis in >/=1 major coronary artery). Main exclusions: depression with psychotic features; bipolar disorder; substance abuse; serious suicidal risk; taking antidepressants, anticonvulsants, lithium, or undergoing psychotherapy; previous non-response to citalopram or IPT; >/= 2 unsuccessful treatments for current depressive episode; previous early discontinuation of SSRIs due to adverse events; Mini-Mental State Examination score <24; worsening angina or congestive heart failure symptoms in previous week; severely limiting angina; cardiac admission within past week; or coronary artery bypass graft planned in next 4 months.Intervention: Citalopram (up to 40 mg daily) or placebo, plus IPT and clinical management or clinical management alone for 12 weeks (provided by trained IPT therapists). Clinical management sessions lasted 20-25 min and included information about depression and encouragement to comply with medication.Outcomes: Depression symptoms (24-item Hamilton Depression rating scale (HAM-D)), remission (HAM-D score </=8), response (>/= 50% reduction from baseline in HAM-D).Patient follow-up: 81% completed treatment; 100% included in last observation carried forward analyses.MAIN RESULTSCitalopram significantly improved symptoms of depression, and increased response and remission, compared with placebo at 12 weeks (mean difference in change in HAM-D score from baseline: 3.33, 95% CI 0.80 to 5.85; p = 0.005; remission: OR 1.93, 95% CI 1.14 to 3.25; response: OR 1.67, 95% CI 1.04 to 2.67). IPT added no benefit to clinical management alone in symptoms of depression, response, or remission at 12 weeks (mean difference in change in HAM-D score from baseline: -2.26, 95% CI -4.78 to +0.27; p = 0.06; remission: OR 0.90, 95% CI 0.54 to 1.51; response: OR 0.75, 95% CI 0.47 to 1.20).CONCLUSIONS:When given in combination with clinical management, citalopram is more effective than placebo for treating depression in people with coronary artery disease. However, adding interpersonal psychotherapy to clinical management does not improve depressive symptoms.

Document:
https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Febmh.bmj.com%2Flookup%2Fdoi%2F10.1136%2Febmh.10.3.80

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7. **Effects of citalopram and interpersonal psychotherapy on depression in patients with coronary artery disease: the Canadian Cardiac Randomized Evaluation of Antidepressant and Psychotherapy Efficacy (CREATE) trial**.

Lespérance F, Frasure-Smith N, Koszycki D, et al.

2007

JAMA: Journal of the American Medical Association. 297/ 4 (pp. 367-79)

Context: Few randomized controlled trials have evaluated the efficacy of treatments for major depression in patients with coronary artery disease (CAD). None have simultaneously evaluated an antidepressant and short-term psychotherapy.Objective: To document the short-term efficacy of a selective serotonin reuptake inhibitor (citalopram) and interpersonal psychotherapy (IPT) in reducing depressive symptoms in patients with CAD and major depression.Design, Setting, and Participants: The Canadian Cardiac Randomized Evaluation of Antidepressant and Psychotherapy Efficacy, a randomized, controlled, 12-week, parallel-group, 2 x 2 factorial trial conducted May 1, 2002, to March 20, 2006, among 284 patients with CAD from 9 Canadian academic centers. All patients met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria for diagnosis of major depression of 4 weeks' duration or longer and had baseline 24-item Hamilton Depression Rating Scale (HAM-D) scores of 20 or higher.Interventions: Participants underwent 2 separate randomizations: (1) to

receive 12 weekly sessions of IPT plus clinical management (n = 142) or clinical management only (n = 142) and (2) to receive 12 weeks of citalopram, 20 to 40 mg/d (n = 142), or matching placebo (n = 142).Main Outcome Measures: The primary outcome measure was change between baseline and 12 weeks on the 24-item HAM-D, administered blindly during centralized telephone interviews (tested at alpha = .033); the secondary outcome measure was self-reported Beck Depression Inventory II (BDI-II) score (tested at alpha = .017).Results: Citalopram was superior to placebo in reducing 12-week HAM-D scores (mean difference, 3.3 points; 96.7% confidence interval [CI], 0.80-5.85; P = .005), with a small to medium effect size of 0.33. Mean HAM-D response (52.8% vs 40.1%; P = .03) and remission rates (35.9% vs 22.5%; P = .01) and the reduction in BDI-II scores (difference, 3.6 points; 98.3% CI, 0.58-6.64; P = .005; effect size = 0.33) also favored citalopram. There was no evidence of a benefit of IPT over clinical management, with the mean HAM-D difference favoring clinical management (-2.26 points; 96.7% CI, -4.78 to 0.27; P = .06; effect size, 0.23). The difference on the BDI-II did not favor clinical management (1.13 points; 98.3% CI, -1.90 to 4.16; P = .37; effect size = 0.11).Conclusions: This trial documents the efficacy of citalopram administered in conjunction with weekly clinical management for major depression among patients with CAD and found no evidence of added value of IPT over clinical management. Based on these results and those of previous trials, citalopram or sertraline plus clinical management should be considered as a first-step treatment for patients with CAD and major depression.

Document:
http://search.ebscohost.com/login.aspx?direct=true&scope=site&site=ehost-live&db=mdc&AN=17244833

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8. **Depression after cardiac transplant treated with interpersonal psychotherapy and paroxetine: Case study**.

Miller M
2002
American Journal of Psychotherapy. 56/ 4 (pp. 555-61)

Discusses the treatment of a 67-yr-old man with no prior history of psychiatric illness diagnosed with major depression following cardiac transplantation. Shortly after surgery, the patient demonstrated depressive symptoms, including weight loss, emotional instability, and social isolation. Psychiatric consultation revealed that the patient first experienced these symptoms after learning that the donor heart he had received belonged to a woman. The patient had preconceived, stereotypical ideas that a woman's heart would inhibit his physical recovery and transform him into a more emotional man. The patient was prescribed the selective serotonin reuptake inhibitor paroxetine and began interpersonal psychotherapy. Results from this case study indicate that treatment with paroxetine, combined with interpersonal psychotherapy, may be successful in treating patients who had transplants and suffer from postsurgical depression.

Document:
https://psychotherapy.psychiatryonline.org/doi/pdf/10.1176/appi.psychotherapy.2002.56.4.555

COPD

9. **Psychological therapies for the treatment of depression in chronic obstructive pulmonary disease**.

Pollok J, van Agteren JE, Esterman AJ, et al.

2019

Cochrane Database of Systematic Reviews. / 3

Background: Chronic obstructive pulmonary disease (COPD) has been recognised as a global health concern, and one of the leading causes of morbidity and mortality worldwide. Projections of the World Health Organization (WHO) indicate that prevalence rates of COPD continue to increase, and by 2030, it will become the world's third leading cause of death. Depression is a major comorbidity amongst patients with COPD, with an estimate prevalence of up to 80% in severe stages of COPD. Prevalence studies show that patients who have COPD are four times as likely to develop depression compared to those without COPD. Regrettably, they rarely receive appropriate treatment for COPD-related depression. Available findings from trials indicate that untreated depression is associated with worse compliance with medical treatment, poor quality of life, increased mortality rates, increased hospital admissions and readmissions, prolonged length of hospital stay, and subsequently, increased costs to the healthcare system. Given the burden and high prevalence of untreated depression, it is important to evaluate and update existing experimental evidence using rigorous methodology, and to identify effective psychological therapies for patients with COPD-related depression.

Objectives: To assess the effectiveness of psychological therapies for the treatment of depression in patients with chronic obstructive pulmonary disease.

Search methods: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (2018, Issue 11), and Ovid MEDLINE, Embase and PsycINFO from June 2016 to 26 November 2018. Previously these databases were searched via the Cochrane Airways and Common Mental Disorders Groups' Specialised Trials Registers (all years to June 2016). We searched ClinicalTrials.gov, the ISRCTN registry, and the World Health Organization International Clinical Trials Registry Platform (ICTRP) to 26 November 2018 to identify unpublished or ongoing trials. Additionally, the grey literature databases and the reference lists of studies initially identified for full-text screening were also searched.

Selection criteria: Eligible for inclusion were randomised controlled trials that compared the use of psychological therapies with either no intervention, education, or combined with a co-intervention and compared with the same co-intervention in a population of patients with COPD whose depressive symptoms were measured before or at baseline assessment.

Data collection and analysis: Two review authors independently assessed the titles and abstracts identified by the search to determine which studies satisfied the inclusion criteria. We assessed two primary outcomes: depressive symptoms and adverse events; and the following secondary outcomes: quality of life, dyspnoea, forced expiratory volume in one second (FEV1), exercise tolerance, hospital length of stay or readmission rate, and cost-effectiveness. Potentially eligible full-text articles were also independently assessed by two review authors. A PRISMA flow diagram was prepared to demonstrate the decision process in detail. We used the Cochrane 'Risk of bias' evaluation tool to examine the risk of bias, and assessed the quality of evidence using the GRADE framework. All outcomes were continuous, therefore, we calculated the pooled standardised mean difference (SMD) or mean difference (MD) with a corresponding 95% confidence interval (CI). We used a random-effects model to calculate treatment effects.

Main results: The findings are based on 13 randomised controlled trials (RCTs), with a total of

1500 participants. In some of the included studies, the investigators did not recruit participants with clinically confirmed depression but applied screening criteria after randomisation. Hence, across the studies, baseline scores for depressive symptoms varied from no symptoms to severe depression. The severity of COPD across the studies was moderate to severe.

Primary outcomes: There was a small effect showing the effectiveness of psychological therapies in improving depressive symptoms when compared to no intervention (SMD 0.19, 95% CI 0.05 to 0.33; P = 0.009; 6 studies, 764 participants), or to education (SMD 0.23, 95% CI 0.06 to 0.41; P = 0.010; 3 studies, 507 participants).

Two studies compared psychological therapies plus a co-intervention versus the co-intervention alone (i.e. pulmonary rehabilitation (PR)). The results suggest that a psychological therapy combined with a PR programme can reduce depressive symptoms more than a PR programme alone (SMD 0.37, 95% CI -0.00 to 0.74; P = 0.05; 2 studies, 112 participants).

We rated the quality of evidence as very low. Owing to the nature of psychological therapies, blinding of participants, personnel, and outcome assessment was a concern.

None of the included studies measured adverse events.

Secondary outcomes: Quality of life was measured in four studies in the comparison with no intervention, and in three studies in the comparison with education. We found inconclusive results for improving quality of life. However, when we pooled data from two studies using the same measure, the result suggested that psychological therapy improved quality of life better than no intervention. One study measured hospital admission rates and cost-effectiveness and showed significant reductions in the intervention group compared to the education group. We rated the quality of evidence as very low for the secondary outcomes.

Authors' conclusions: The findings from this review indicate that psychological therapies (using a CBT-based approach) may be effective for treating COPD-related depression, but the evidence is limited. Depressive symptoms improved more in the intervention groups compared to: 1) no intervention (attention placebo or standard care), 2) educational interventions, and 3) a co-intervention (pulmonary rehabilitation). However, the effect sizes were small and quality of the evidence very low due to clinical heterogeneity and risk of bias. This means that more experimental studies with larger numbers of participants are needed, to confirm the potential beneficial effects of therapies with a CBT approach for COPD-related depression.

New trials should also address the gap in knowledge related to limited data on adverse effects, and the secondary outcomes of quality of life, dyspnoea, forced expiratory volume in one second (FEV1), exercise tolerance, hospital length of stay and frequency of readmissions, and cost-effectiveness. Also, new research studies need to adhere to robust methodology to produce higher quality evidence.

Document:
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012347.pub2/abstract

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10. **Psychological therapies for the treatment of anxiety disorders in chronic**

obstructive pulmonary disease.

Usmani ZA, Carson KV, Heslop K, et al.

2017

Cochrane Database of Systematic Reviews. / 3

Background: Chronic obstructive pulmonary disease (COPD) (commonly referred to as chronic bronchitis and emphysema) is a chronic lung condition characterised by the inflammation of airways and irreversible destruction of pulmonary tissue leading to progressively worsening dyspnoea. It is a leading international cause of disability and death in adults. Evidence suggests that there is an increased prevalence of anxiety disorders in people with COPD. The severity of anxiety has been shown to correlate with the severity of COPD, however anxiety can occur with all stages of COPD severity. Coexisting anxiety and COPD contribute to poor health outcomes in terms of exercise tolerance, quality of life and COPD exacerbations. The evidence for treatment of anxiety disorders in this population is limited, with a paucity of evidence to support the efficacy of medication-only treatments. It is therefore important to evaluate psychological therapies for the alleviation of these symptoms in people with COPD.

Objectives: To assess the effects of psychological therapies for the treatment of anxiety disorders in people with chronic obstructive pulmonary disease.

Search methods: We searched the specialised registers of two Cochrane Review Groups: Cochrane Common Mental Disorders (CCMD) and Cochrane Airways (CAG) (to 14 August 2015). The specialised registers include reports of relevant randomised controlled trials from The Cochrane Library, MEDLINE, Embase, and PsycINFO. We carried out complementary searches on PsycINFO and CENTRAL to ensure no studies had been missed. We applied no date or language restrictions.

Selection criteria: We considered all randomised controlled trials (RCTs), cluster-randomised trials and cross-over trials of psychological therapies for people (aged over 40 years) with COPD and coexisting anxiety disorders (as confirmed by recognised diagnostic criteria or a validated measurement scale), where this was compared with either no intervention or education only. We included studies in which the psychological therapy was delivered in combination with another intervention (co-intervention) only if there was a comparison group that received the co-intervention alone.

Data collection and analysis: Two review authors independently screened citations to identify studies for inclusion and extracted data into a pilot-tested standardised template. We resolved any conflicts that arose through discussion. We contacted authors of included studies to obtain missing or raw data. We performed meta-analyses using the fixed-effect model and, if we found substantial heterogeneity, we reanalysed the data using the random-effects model.

Main results: We identified three prospective RCTs for inclusion in this review (319 participants available to assess the primary outcome of anxiety). The studies included people from the outpatient setting, with the majority of participants being male. All three studies assessed psychological therapy (cognitive behavioural therapy) plus co-intervention versus co-intervention alone. We assessed the quality of evidence contributing to all outcomes as low due to small sample sizes and substantial heterogeneity in the analyses. Two of the three studies had prespecified protocols available for comparison between prespecified methodology and outcomes reported within the final publications.

We observed some evidence of improvement in anxiety over 3 to 12 months, as measured by the Beck Anxiety Inventory (range from 0 to 63 points), with psychological therapies performing better than the co-intervention comparator arm (mean difference (MD) -4.41 points, 95% confidence interval (CI) -8.28 to -0.53; P = 0.03). There was however, substantial heterogeneity between the studies (I2 = 62%), which limited the ability to draw reliable conclusions. No adverse events were reported.

Authors' conclusions: We found only low-quality evidence for the efficacy of psychological therapies among people with COPD with anxiety. Based on the small number of included studies identified and the low quality of the evidence, it is difficult to draw any meaningful and reliable conclusions. No adverse events or harms of psychotherapy intervention were reported.

A limitation of this review is that all three included studies recruited participants with both anxiety and depression, not just anxiety, which may confound the results. We downgraded the quality of evidence in the 'Summary of findings' table primarily due to the small sample size of included trials. Larger RCTs evaluating psychological interventions with a minimum 12-month follow-up period are needed to assess long-term efficacy.

Document:
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010673.pub2/full

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11. **Advances in Psychotherapy for Depressed Older Adults**.

Raue PJ, McGovern AR, Kiosses DN, et al.

2017

Current Psychiatry Reports. 19/ 9 (p.] 57)

Purpose of ReviewWe review recent advances in psychotherapies for depressed older adults, in particular those developed for special populations characterized by chronic medical illness, acute medical illness, cognitive impairment, and suicide risk factors. We review adaptations for psychotherapy to overcome barriers to its accessibility in non-specialty settings such as primary care, homebound or hard-to-reach older adults, and social service settings.Recent FindingsRecent evidence supports the effectiveness of psychotherapies that target late-life depression in the context of specific comorbid conditions including COPD, heart failure, Parkinson's disease, stroke and other acute conditions, cognitive impairment, and suicide risk. Growing evidence supports the feasibility, acceptability, and effectiveness of psychotherapy modified for a variety of health care and social service settings.SummaryResearch supports the benefits of selecting the type of psychotherapy based on a comprehensive assessment of the older adult's psychiatric, medical, functional, and cognitive status, and tailoring psychotherapy to the settings in which older depressed adults are most likely to present.

Document:
http://search.ebscohost.com/login.aspx?direct=true&AuthType=athens&db=mdc&AN=28726061&site=ehost-live

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12. **Treatments for anxiety and depression in patients with chronic obstructive pulmonary disease: A literature review**.

Cafarella PA, Effing TW, Usmani Z-A, et al.

2012
Respirology. 17/ 4 (pp. 627–38)

Chronic obstructive pulmonary disease (COPD) is a serious contemporary health issue. Psychological co-morbidities such as anxiety and depression are common in COPD. Current evidence for treatment options to reduce anxiety and depression in patients with COPD was examined. There is evidence available for the efficacy of pharmacological treatments, cognitive behavioural therapy, pulmonary rehabilitation, relaxation therapy and palliative care in COPD. Therapeutic modalities that have not been proven effective in decreasing anxiety and depression in COPD, but which have theoretical potential among patients, include interpersonal psychotherapy, self-management programmes, more extensive disease management programmes, supportive therapy and self-help groups. Besides pulmonary rehabilitation that is only available for a small percentage of patients, management guidelines make scant reference to other options for the treatment of mental health problems. The quantity and quality of research on mental health treatments in COPD have historically been insufficient to support their inclusion in COPD treatment guidelines. In this review, recommendations regarding assessment, treatment and future research in this important field were made.

Document:
https://doi.org/10.1111/j.1440-1843.2012.02148.x

Diabetes

13. **Treatment Response in Type 2 Diabetes Patients with Major Depression**.

Gois C, Dias VV, Carmo I, et al.
2014
Clinical Psychology & Psychotherapy. 21/ 1 (pp. 39-48)

Aims Major depression is more prevalent in patients with type 2 diabetes mellitus (T2DM) than in general population. Comparing psychotherapeutic and pharmacological treatment responses could help to inform the choice between available treatment options. Method Thirty-four patients with T2DM and major depression detected by using the Hospital Anxiety-Depression Scale (HADS), the Montgomery-Äsberg Depression Rating Scale (MADRS) and a structured interview (Mini-International Neuropsychiatric Interview) were randomized to undergo Interpersonal Psychotherapy (IPT) or treatment with sertraline in a 3-month acute intervention course in addition to a 3-month continuation format. Provided that the initial MADRS score was not reduced ≥25% at week 6, these early non-responding patients continued treatment in a sequential add-on combined format. Psychological adjustment to diabetes, attachment style, diabetes self-efficacy, quality of life and HbA1c were also evaluated along intervention. Results Out of 22 early-responding patients (11 for each treatment type), 16 had clinically significant improvements (<50% initial MADRS score) at endpoint with 11 reaching remission (MADRS scores ≤8), and with no significant differences between IPT and sertraline. Within sequential add-on treatment, out of eight patients, only three of them achieved a clinically significant improvement and only one reached remission. Conclusions These preliminary results suggested that IPT may be an option to treat major depression in T2DM against medical care with sertraline. Early non-responding patients likely need alternative or longer treatment interventions. Limitations of this study relate to small sample and absence of a control group, which was difficult to implement due to ethical restrictions.

Key Practitioner Message: Findings suggest that Interpersonal Psychotherapy is a useful tool to treat major depression in type 2 diabetes patients., A significant number of type 2 diabetes patients with major depression do not achieve depression remission irrespective of the type of treatment., Further clinical research should focus on addictive effects of psychotherapy and psychopharmacology in the treatment of depressed patients with chronic somatic diseases.

Document:
http://openurl.ebscohost.com/linksvc/linking.aspx?authtype=athens&genre=article&issn=1063-3995&volume=21&issue=1&spage=39&date=2014

HIV

14. **A Randomized Clinical Trial Showing Persisting Reductions in Depressive Symptoms in HIV-Infected Rural Adults Following Brief Telephone-Administered Interpersonal Psychotherapy**.

Heckman TG, Markowitz JC, Heckman BD, et al.

2018

Annals of Behavioral Medicine. 52/ 4 (pp. 299-308)

Background: Rural areas account for 5% to 7% of all HIV infections in the USA, and rural people living with HIV (PLHIV) are 1.3 times more likely to receive a depression diagnosis than their urban counterparts. A previous analysis from our randomized clinical trial found that nine weekly sessions of telephone-administered interpersonal psychotherapy (tele-IPT) reduced depressive symptoms and interpersonal problems in rural PLHIV from preintervention through postintervention significantly more than standard care but did not increase perceived social support compared to standard care.Purpose: To assess tele-IPT's enduring effects at 4- and 8-month follow-up in this cohort.Methods: Tele-IPT's long-term depression treatment efficacy was assessed through Beck Depression Inventory self-administrations at 4 and 8 months. Using intention-to-treat and completer-only approaches, mixed models repeated measures, and Cohen's d assessed maintenance of acute treatment gains.Results: Intention-to-treat analyses found fewer depressive symptoms in tele-IPT patients than standard care controls at 4 (d = .41; p < .06) and 8-month follow-up (d =.47; p < .05). Completer-only analyses found similar patterns, with larger effect sizes. Tele-IPT patients used crisis hotlines less frequently than standard care controls at postintervention and 4-month follow-up (ps < .05).Conclusions: Tele-IPT provides longer term depression relief in depressed rural PLHIV. This is also the first controlled trial to find that IPT administered over the telephone provides long-term depressive symptom relief to any clinical population.

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15. **Metacognitive Interpersonal Therapy Improves Adherence to Antiretroviral Therapies in a Man with a Severe Personality Disorder: A Case Report**.

Sofia S, Lysaker P, Dimaggio G

2017

Journal of Contemporary Psychotherapy. 47/ 4 (pp. 223-32)

Treatment adherence by patients with HIV ensures they gain the full benefit of antiretroviral medications and extend their lives. One problem which may contribute to poor adherence is deficits in metacognition or the capacity to make sense of mental states. In particular, persons who struggle to notice and think about their thoughts and feelings may be less able to direct

their own recovery by taking advantage of effective treatments. This raises the possibility that treatments which lead to improved metacognitive function may enhance treatment adherence. We describe the case of a man in an advanced stage of AIDS with Kaposi's sarcoma. The patient was treated with Metacognitive Interpersonal Therapy combined with psychoeducation about pharmacological treatment for HIV. Primary medical outcomes were suppression of viral load, increase of CD4 count and control of AIDS related conditions such as Kaposi's sarcoma. The primary psychological outcome was reduction of personality disorders criteria. The patient was able to understand what led him to discontinue medication and then later regain full adherence. He achieved suppression of viral load and restore of CD4 count. As regard severity of personality disorder, he achieved reliable change. Interventions such as Metacognitive Interpersonal Therapy may assist patients with HIV to gain the metacognitive capacities to make sense of their medical and psychological challenges and adhere to antiretroviral therapies leading to enhanced levels of health. Future studies are needed to explore these findings in larger controlled studies.

Document:
http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48104&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=0022-0116&volume=47&issue=4&spage=223

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16. **Reauthoring one's own life in the face of being HIV+: Promoting healthier narratives with metacognitive interpersonal therapy**.

Dimaggio G, Conti C, Lysaker PH, et al.

2017

Journal of Constructivist Psychology. 30/ 4 (pp. 388-403)

We describe here a narrative-based psychotherapy for a woman in her 40s who had been HIV+ since the age of 21 and who suffered from posttraumatic symptoms related to having received the diagnosis. She had also suffered from self-stigma and had lost the capacity to envision a future filled with hope. Treating individuals with HIV who face posttraumatic symptoms and stigma can be challenging for the clinician. A narrative approach to therapy can be helpful for these persons, in order to overcome symptoms, build a more benevolent self-image, feel accepted by society, and promote posttraumatic growth. Current evidence indicates that such an approach is mostly lacking. We describe how we applied metacognitive interpersonal therapy—an approach rooted in narrative constructivism. By using this treatment, the patient could overcome posttraumatic symptoms, participate in social activities after years of avoidance and isolation, and recover her sense of being a person able to make plans for the future with strength and dignity. Discussion includes ideas of how to generalize some of the mechanisms that have likely been effective in this therapy to other individuals with HIV.

Document:
http://openurl.ebscohost.com/linksvc/linking.aspx?authtype=athens&genre=article&issn=1072-0537&volume=30&issue=4&spage=388&date=2017

Irritable Bowel Syndrome

17. **Psychological treatments for the management of irritable bowel syndrome**.

Zijdenbos IL, de Wit NJ, van der Heijden GJ, et al.

2009
Cochrane Database of Systematic Reviews. / 1
Plain language summary:

Psychological treatments for the management of irritable bowel syndrome

In this review, the effectiveness of psychological therapies for adult patients with irritable bowel syndrome was evaluated. Studies involving cognitive behavioural therapy, interpersonal psychotherapy and relaxation therapy or stress management were reviewed. Although it is difficult to draw conclusions because of differences between studies and quality issues, the results suggest that cognitive behavioural therapy and interpersonal psychotherapy may be effective immediately after finishing treatment. It is unclear whether the effects of these therapies are sustained thereafter. These results have to be interpreted with caution as the quality of the studies was sub-optimal. Physicians should be aware of the limitations of these therapies and should choose an appropriate therapy based on the individual patient's characteristics.

Document:
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006442.pub2/full

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18. **Psychodynamic interpersonal therapy and improvement in interpersonal difficulties in people with severe irritable bowel syndrome**.

Hyphantis T, Guthrie E, Tomenson B, et al.
2009
Pain (03043959). 145/ 1/2 (pp. 196-203)

The aim of the present study was to assess the relationship between change in interpersonal difficulties with change in chronic pain, health status and psychological state in 257 irritable bowel syndrome (IBS) patients in a randomized control trial comparing psychotherapy, antidepressant and usual care. We assessed at three time points interpersonal problems (IIP-32), abdominal pain and bowel symptoms, psychological distress (SCL-90), and health status (SF-36). Analysis included repeated measures (ANOVA) to assess change over time and multiple regressions to identify whether change in IIP was associated with outcome after controlling for psychological status. The main findings were: (1) difficulties with social inhibition and dependency were associated with longer disease duration; (2) change in mean IIP-32 over 15 months was significantly correlated with changes in pain, but these relationships were mediated by change in psychological distress; (3) change in IIP-32 was an independent predictor of improved health status at 15 months only in the psychotherapy group. These results indicate that improvement in interpersonal problems in IBS patients appear to be primarily associated with reduced psychological distress but, in addition, the association with improved health status following psychotherapy suggests that specific help with interpersonal problems may play a role in improving health status of patients with chronic painful IBS.

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19. **The relationship between somatisation and outcome in patients with severe irritable bowel syndrome**.

Creed F, Tomenson B, Guthrie E, et al.
2008
Journal of Psychosomatic Research. 64/ 6 (pp. 613-20)

Objective: This study aimed to assess the relationship between somatisation and outcome in patients with severe irritable bowel syndrome (IBS). Method: Two hundred fifty-seven patients with severe IBS included in a randomised controlled trial were assessed at baseline and divided into four quartiles on the basis of their somatisation score. The patients were randomised to receive the following over 3 months: brief interpersonal psychotherapy, 20 mg daily of the SSRI antidepressant paroxetine, or treatment as usual. Outcome 1 year after treatment was assessed using the Short Form-36 physical component summary (PCS) score and total costs for posttreatment year. Results: The patients in the quartile with the highest baseline somatisation score had the most severe IBS, the most concurrent psychiatric disorders, and the highest total costs for the year prior to baseline. At 1 year after the end of treatment, however, the patients with marked somatisation, who received psychotherapy or antidepressant, had improved health status compared to those who received usual care: mean (S.E.) PCS scores at 15 months were 36.6 (2.2), 35.5 (1.9), and 26.4 (2.7) for psychotherapy, antidepressant, and treatment-as-usual groups, respectively (adjusted P=.014). Corresponding data for total costs over the year following the trial, adjusted for baseline costs, were pound 1092 (487), pound 1394 (443), and pound 2949 (593) (adjusted P=.050). Conclusions: Patients with severe IBS who have marked somatisation improve with treatment like other IBS patients and show a greater reduction of costs. Antidepressants and psychotherapy are cost-effective treatments in severe IBS accompanied by marked somatisation.

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20. **An experimental study of determinants of group judgments in clinical guideline development**.

Raine R, Sanderson C, Hutchings A, et al.

2004

The Lancet. 364/ 9432 (pp. 429-37)

Clinical guidelines for improving the quality of care are a familiar part of clinical practice. Formal consensus methods such as the nominal group technique are often used as part of guideline development, but little is known about factors that affect the statements produced by nominal groups, and on their consistency with the research evidence. Cognitive behavioural therapy, behavioural therapy, brief psychodynamic interpersonal therapy, and antidepressants for irritable bowel syndrome, chronic fatigue syndrome, and chronic back pain were selected for study. 16 nominal groups in a factorial design allowed comparison of GP-only with mixed groups of GPs and specialists, provision of a literature review with no provision, and ratings made in the context of realistic or ideal levels of health-care resources. Participants rated appropriateness independently, and again after a facilitated meeting. Audiotapes of four group discussions were analysed. There was agreement with the research evidence for 51% of 192 scenarios. Agreement was more likely if the group was GP-only, if a literature review was provided, or if the evidence was in accordance with clinicians' beliefs. Assumptions about the level of resources available had no impact. Clinical and social cues had mixed effects, irrespective of the research evidence. Qualitative analysis showed the modifying effect of clinical experience and beliefs about research evidence. Guidelines cannot be based on data alone; judgment is unavoidable. The nominal group technique is a method of eliciting and aggregating judgments in a transparent and structured way. It can provide important information on levels of agreement between experts. However, conclusions can be at odds with the published literature. If they are, reasons need to be explicit.

Document:

http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=48104&rft_val_fmt=ori/fmt:kev:mtx:journal

&genre=article&issn=0140-6736&volume=364&issue=9432&spage=429

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21. **Review: cognitive behavioural interventions may be effective for chronic fatigue syndrome and chronic back pain**.

Hofmann SG

2003

Evidence Based Mental Health. 6/ 2 (pp. 55-)

QUESTION: Are mental health interventions for people with common somatic conditions effective? Can results from secondary care be extrapolated to primary care?Design:Systematic review with metes-analysis.Data sources:Studies were identified using PubMed, the Cochrane Library, PsychLit and Embase (1966 - September 2001); reference lists; key texts, and citations from experts.Study selection:Narrative systematic reviews, metes-analyses and randomised trials published in English were eligible if they assessed the effectiveness of primary or secondary care mental health interventions for chronic fatigue syndrome, irritable bowel syndrome or chronic back pain (where no physical cause was established). Eligible interventions included cognitive behavioural, cognitive, behaviour, brief interpersonal psychodynamic and antidepressant therapies. The authors identified 20 studies in primary care, 41 studies in secondary care and 2 metes-analyses.Data extraction:Reviewers extracted data on participant characteristics, sample size, sample source, intervention, outcomes, study dropouts and reasons for withdrawal. Main outcome measures were reported health status and functional outcomes, treatment effect size and disease severity. The authors calculated treatment effects using fixed and random effects models.Main results:Chronic fatigue syndrome: There is some evidence that cognitive behavioural therapy and behavioural therapy are effective in chronic fatigue syndrome. The authors found no evidence that brief psychodynamic interpersonal therapy or antidepressants improve symptoms in chronic fatigue syndrome.Irritable bowel syndrome: There is some evidence that antidepressants and brief interpersonal therapy are effective in irritable bowel syndrome. There is limited evidence for the effectiveness of relaxation training and mixed evidence about the benefits of cognitive behaviour therapy.Back Pain: There is some evidence that cognitive behaviour therapy and behaviour therapy are effective for people with back pain. The authors found insufficient evidence on antidepressants or brief interpersonal therapy.For all 3 syndromes, treatment effect sizes were largest in secondary care.Conclusions:Mental health interventions may be effective for chronic fatigue syndrome, irritable bowel syndrome and chronic back pain. There is more evidence for the effectiveness of secondary care interventions than interventions in primary care.

Document:

https://ebmh.bmj.com/content/6/2/55.full.pdf

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22. **Systematic review of mental health interventions for patients with common somatic symptoms: can research evidence from secondary care be extrapolated to primary care?**

Raine R, Haines A, Sensky T, et al.

2002

BMJ : British Medical Journal. 325/ 7372 (p.] 1082)

Objectives: To determine the strength of evidence for the effectiveness of mental health interventions for patients with three common somatic conditions (chronic fatigue syndrome, irritable bowel syndrome, and chronic back pain). To assess whether results obtained in

secondary care can be extrapolated to primary care and suggest how future trials should be designed to provide more rigorous evidence. Design: Systematic review. Data sources: Five electronic databases, key texts, references in the articles identified, and citations from expert clinicians. Study selection: Randomised controlled trials including participants with one of the three conditions for which no physical cause could be found. Two reviewers screened sources and independently extracted data and assessed quality. Results: Sixty one studies were identified; 20 were classified as primary care and 41 as secondary care. For some interventions, such as brief psychodynamic interpersonal therapy, little research was identified. However, results of meta-analyses and of randomised controlled trials suggest that cognitive behaviour therapy and behaviour therapy are effective for chronic back pain and chronic fatigue syndrome and that antidepressants are effective for irritable bowel syndrome. Cognitive behaviour therapy and behaviour therapy were effective in both primary and secondary care in patients with back pain, although the evidence is more consistent and the effect size larger for secondary care. Antidepressants seem effective in irritable bowel syndrome in both settings but ineffective in chronic fatigue syndrome. Conclusions: Treatment seems to be more effective in patients in secondary care than in primary care. This may be because secondary care patients have more severe disease, they receive a different treatment regimen, or the intervention is more closely supervised. However, conclusions of effectiveness should be considered in the light of the methodological weaknesses of the studies. Large pragmatic trials are needed of interventions delivered in primary care by appropriately trained primary care staff. What is already known on this topic Patients with functional somatic symptoms are common in primary care and may not receive effective mental health interventions What this study adds Research in secondary and primary care shows that cognitive behaviour therapy and behaviour therapy help patients with back pain and that antidepressants benefit patients with irritable bowel syndrome Effect sizes are larger in secondary care than in primary care Patients in secondary care with chronic fatigue syndrome may benefit from cognitive behaviour therapy Future research should focus on large pragmatic trials with longer term follow up and economic evaluation

Document:
https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Fwww.bmj.com%2Flookup%2Fdoi%2F10.1136%2Fbmj.325.7372.1082

Pain

23. **Integration of cognitive-behavioral and interpersonal therapies in treating depression with concurrent relational distress and chronic pain**.

Wischkaemper KC, Gordon KC

2015

Clinical Case Studies. 14/ 5 (pp. 357-73)

This is a single-case study of a middle-aged man presenting with relationship distress and simultaneous major depressive disorder with chronic back pain and a physical tic. Treatment was informed by cognitive-behavioral therapy (CBT), interpersonal psychotherapy (IPT), and psychodynamic principles. Over the course of treatment, a variety of techniques were utilized, including progressive muscle relaxation training, behavioral monitoring, cognitive restructuring, and interpersonal principles to address somatic complaints and underlying feelings of helplessness and inadequacy. Symptoms including general distress, frustration, back pain, worry about his wife's mental illness, and amount of negative thinking were tracked on a daily basis over three assessment periods. In addition, clinically significant change was

assessed using a comparison of baseline and follow-up results from the patient's Outcome Questionnaire–45 (OQ-45.2). Evidence for symptomatic and characterological change is outlined, and treatment implications are discussed.

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24. **Interpersonal psychotherapy for late-life depression**.

Raue PJ

2015

Treatment of late-life depression, anxiety, trauma, and substance abuse. (pp. 71-323)

Interpersonal psychotherapy (IPT) is a user-friendly psychotherapy that was developed as a treatment for reducing depressive symptoms no matter what their cause (e.g., genetics, emotional strain, medical disease, pain). As we discuss in this chapter, IPT was developed by Klerman and Weissman for the New Haven–Boston Collaborative Depression Research Project (Klerman, Weissman, Rounsaville, & Chevron, 1984) and was later expanded for older adults with depression (Hinrichsen & Clougherty, 2006). IPT draws on psychodynamic theory and uses specific therapeutic techniques from a variety of approaches, including psychodynamic, supportive, and behavioral therapy. It has been widely studied in older adults with depression and in general is an effective intervention for late-life depression. In this chapter, we review the theoretical underpinnings of IPT, as well as cultural, disability, and cognitive impairment considerations, after introducing our illustrative patient, Susan.

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25. **Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults**.

van Dessel N, Boeft Md, van der Wouden JC, et al.

2014

Cochrane Database of Systematic Reviews. / 11

Background: Medically unexplained physical symptoms (MUPS) are physical symptoms for which no adequate medical explanation can be found after proper examination. The presence of MUPS is the key feature of conditions known as 'somatoform disorders'. Various psychological and physical therapies have been developed to treat somatoform disorders and MUPS. Although there are several reviews on non-pharmacological interventions for somatoform disorders and MUPS, a complete overview of the whole spectrum is missing.

Objectives: To assess the effects of non-pharmacological interventions for somatoform disorders (specifically somatisation disorder, undifferentiated somatoform disorder, somatoform disorders unspecified, somatoform autonomic dysfunction, pain disorder, and alternative somatoform diagnoses proposed in the literature) and MUPS in adults, in comparison with treatment as usual, waiting list controls, attention placebo, psychological placebo, enhanced or structured care, and other psychological or physical therapies.

Search methods: We searched the Cochrane Depression, Anxiety and Neurosis Review Group's Specialised Register (CCDANCTR) to November 2013. This register includes relevant randomised controlled trials (RCTs) from The Cochrane Library, EMBASE, MEDLINE, and PsycINFO. We ran an additional search on the Cochrane Central Register of Controlled Trials and a cited reference search on the Web of Science. We also searched grey literature, conference proceedings, international trial registers, and relevant systematic reviews.

Selection criteria: We included RCTs and cluster randomised controlled trials which involved adults primarily diagnosed with a somatoform disorder or an alternative diagnostic concept of

MUPS, who were assigned to a non-pharmacological intervention compared with usual care, waiting list controls, attention or psychological placebo, enhanced care, or another psychological or physical therapy intervention, alone or in combination.

Data collection and analysis: Four review authors, working in pairs, conducted data extraction and assessment of risk of bias. We resolved disagreements through discussion or consultation with another review author. We pooled data from studies addressing the same comparison using standardised mean differences (SMD) or risk ratios (RR) and a random-effects model. Primary outcomes were severity of somatic symptoms and acceptability of treatment.

Main results: We included 21 studies with 2658 randomised participants. All studies assessed the effectiveness of some form of psychological therapy. We found no studies that included physical therapy.

Fourteen studies evaluated forms of cognitive behavioural therapy (CBT); the remainder evaluated behaviour therapies, third-wave CBT (mindfulness), psychodynamic therapies, and integrative therapy. Fifteen included studies compared the studied psychological therapy with usual care or a waiting list. Five studies compared the intervention to enhanced or structured care. Only one study compared cognitive behavioural therapy with behaviour therapy.

Across the 21 studies, the mean number of sessions ranged from one to 13, over a period of one day to nine months. Duration of follow-up varied between two weeks and 24 months. Participants were recruited from various healthcare settings and the open population. Duration of symptoms, reported by nine studies, was at least several years, suggesting most participants had chronic symptoms at baseline.

Due to the nature of the intervention, lack of blinding of participants, therapists, and outcome assessors resulted in a high risk of bias on these items for most studies. Eleven studies (52% of studies) reported a loss to follow-up of more than 20%. For other items, most studies were at low risk of bias. Adverse events were seldom reported.

For all studies comparing some form of psychological therapy with usual care or a waiting list that could be included in the meta-analysis, the psychological therapy resulted in less severe symptoms at end of treatment (SMD -0.34; 95% confidence interval (CI) -0.53 to -0.16; 10 studies, 1081 analysed participants). This effect was considered small to medium; heterogeneity was moderate and overall quality of the evidence was low. Compared with usual care, psychological therapies resulted in a 7% higher proportion of drop-outs during treatment (RR acceptability 0.93; 95% CI 0.88 to 0.99; 14 studies, 1644 participants; moderate-quality evidence). Removing one outlier study reduced the difference to 5%. Results for the subgroup of studies comparing CBT with usual care were similar to those in the whole group.

Five studies (624 analysed participants) assessed symptom severity comparing some psychological therapy with enhanced care, and found no clear evidence of a difference at end of treatment (pooled SMD -0.19; 95% CI -0.43 to 0.04; considerable heterogeneity; low-quality evidence). Five studies (679 participants) showed that psychological therapies were somewhat less acceptable in terms of drop-outs than enhanced care (RR 0.93; 95% CI 0.87 to 1.00; moderate-quality evidence).

Authors' conclusions: When all psychological therapies included this review were combined they were superior to usual care or waiting list in terms of reduction of symptom severity, but

effect sizes were small. As a single treatment, only CBT has been adequately studied to allow tentative conclusions for practice to be drawn. Compared with usual care or waiting list conditions, CBT reduced somatic symptoms, with a small effect and substantial differences in effects between CBT studies. The effects were durable within and after one year of follow-up. Compared with enhanced or structured care, psychological therapies generally were not more effective for most of the outcomes. Compared with enhanced care, CBT was not more effective. The overall quality of evidence contributing to this review was rated low to moderate.

The intervention groups reported no major harms. However, as most studies did not describe adverse events as an explicit outcome measure, this result has to be interpreted with caution.

An important issue was that all studies in this review included participants who were willing to receive psychological treatment. In daily practice, there is also a substantial proportion of participants not willing to accept psychological treatments for somatoform disorders or MUPS. It is unclear how large this group is and how this influences the relevance of CBT in clinical practice.

The number of studies investigating various treatment modalities (other than CBT) needs to be increased; this is especially relevant for studies concerning physical therapies. Future studies should include participants from a variety of age groups; they should also make efforts to blind outcome assessors and to conduct follow-up assessments until at least one year after the end of treatment.

Document:
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011142.pub2/full

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26. **Randomized controlled trial of interpersonal psychotherapy versus enhanced treatment as usual for women with co-occurring depression and pelvic pain**.

Poleshuck EL, Gamble SA, Bellenger K, et al.

2014

Journal of Psychosomatic Research. 77/ 4 (pp. 264-72)

Objective: Our study assessed the effectiveness of Interpersonal Psychotherapy (IPT) tailored for biomedical patients with depression and pain. IPT was compared to enhanced treatment as usual (E-TAU) among women with co-occurring depression and chronic pain presenting for care at a women's health or family medicine practice. We hypothesized that women presenting to urban medical practices with depression and chronic pain would benefit from IPT tailored to address their needs to a greater degree than from E-TAU.Methods: We conducted a randomized controlled psychotherapy trial of 61 women from 2 urban medical practices who met criteria for major depressive disorder and chronic pelvic pain. Participants were assigned to receive either 8 sessions of IPT or a facilitated psychotherapy referral to a community mental health center, and assessed for depression, social interactions, and pain at 0-, 12-, 24-, and 36-weeks, with score on the Hamilton Rating Scale for Depression as the primary outcome. Both intent-to-treat (ITT) and causal modeling analyses correcting for treatment attendance were conducted.Results: ITT analyses were not significant. In causal modeling analyses, participants assigned to IPT showed significantly more improvement for depression and social interactions, but not for pain.Conclusion: IPT may be a viable option as part of a comprehensive treatment program for women in medical practices with depression and chronic pain.

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27. **Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder: randomised controlled trial**.

Sattel H, Lahmann C, Gündel H, et al.

2012

The British journal of psychiatry : the journal of mental science. 200/ 1 (pp. 60-7)

BACKGROUND: Multisomatoform disorder is characterised by severe and disabling bodily symptoms, and pain is one of the most common and impairing of these. Furthermore, these bodily symptoms cannot be explained by an underlying organic disorder. Patients with multisomatoform disorder are commonly found at all levels of healthcare and are typically difficult to treat for physicians as well as for mental health specialists.

AIMS: To test whether brief psychodynamic interpersonal therapy (PIT) effectively improves the physical quality of life in patients who have had multisomatoform disorder for at least 2 years.

METHOD: We recruited 211 patients (from six German academic outpatient centres) who met the criteria for multisomatoform disorder for a randomised, controlled, 12-week, parallelgroup trial from 1 July 2006 to 1 January 2009 (International Standard Randomised Controlled Trial Number ISRCTN23215121). We randomly assigned the patients to receive either 12 weekly sessions of PIT (n = 107) or three sessions of enhanced medical care (EMC, n = 104). The physical component summary of the Short Form Health Survey (SF-36) was the pre-specified primary outcome at a 9-month follow-up.

RESULTS: Psychodynamic interpersonal therapy improved patients' physical quality of life at follow-up better than EMC (mean improvement in SF-36 score: PIT 5.3, EMC 2.2), with a small to medium between-group effect size (d = 0.42, 95% CI 0.15-0.69, P = 0.001). We also observed a significant improvement in somatisation but not in depression, health anxiety or healthcare utilisation.

CONCLUSIONS: This trial documents the long-term efficacy of brief PIT for improving the physical quality of life in patients with multiple, difficult-to-treat, medically unexplained symptoms.

Document:
https://www.cambridge.org/core/product/identifier/S0007125000257267/type/journal_article

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28. **Psychological therapies for the management of chronic pain (excluding headache) in adults**.

de C. Williams AC, Eccleston C, Morley S

2012

Cochrane Database of Systematic Reviews. / 11

Background: Psychological treatments are designed to treat pain, distress and disability, and are in common practice. This review updates and extends the 2009 version of this systematic review.

Objectives: To evaluate the effectiveness of psychological therapies for chronic pain (excluding headache) in adults, compared with treatment as usual, waiting list control, or placebo control,

for pain, disability, mood and catastrophic thinking.

Search methods: We identified randomised controlled trials (RCTs) of psychological therapy by searching CENTRAL, MEDLINE, EMBASE and Psychlit from the beginning of each abstracting service until September 2011. We identified additional studies from the reference lists of retrieved papers and from discussion with investigators.

Selection criteria: Full publications of RCTs of psychological treatments compared with an active treatment, waiting list or treatment as usual. We excluded studies if the pain was primarily headache, or was associated with a malignant disease. We also excluded studies if the number of patients in any treatment arm was less than 20.

Data collection and analysis: Forty-two studies met our criteria and 35 (4788 participants) provided data. Two authors rated all studies. We coded risk of bias as well as both the quality of the treatments and the methods using a scale designed for the purpose. We compared two main classes of treatment (cognitive behavioural therapy(CBT) and behaviour therapy) with two control conditions (treatment as usual; active control) at two assessment points (immediately following treatment and six months or more following treatment), giving eight comparisons. For each comparison, we assessed treatment effectiveness on four outcomes: pain, disability, mood and catastrophic thinking, giving a total of 32 possible analyses, of which there were data for 25.

Main results: Overall there is an absence of evidence for behaviour therapy, except a small improvement in mood immediately following treatment when compared with an active control. CBT has small positive effects on disability and catastrophising, but not on pain or mood, when compared with active controls. CBT has small to moderate effects on pain, disability, mood and catastrophising immediately post-treatment when compared with treatment as usual/waiting list, but all except a small effect on mood had disappeared at follow-up. At present there are insufficient data on the quality or content of treatment to investigate their influence on outcome. The quality of the trial design has improved over time but the quality of treatments has not.

Authors' conclusions: Benefits of CBT emerged almost entirely from comparisons with treatment as usual/waiting list, not with active controls. CBT but not behaviour therapy has weak effects in improving pain, but only immediately post-treatment and when compared with treatment as usual/waiting list. CBT but not behaviour therapy has small effects on disability associated with chronic pain, with some maintenance at six months. CBT is effective in altering mood and catastrophising outcomes, when compared with treatment as usual/waiting list, with some evidence that this is maintained at six months. Behaviour therapy has no effects on mood, but showed an effect on catastrophising immediately post-treatment. CBT is a useful approach to the management of chronic pain. There is no need for more general RCTs reporting group means: rather, different types of studies and analyses are needed to identify which components of CBT work for which type of patient on which outcome/s, and to try to understand why.

Document:
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD007407.pub3/full

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29. **Interpersonal psychotherapy for women with comorbid depression and chronic pain**.

Poleshuck EL, Talbot NE, Zlotnick C, et al.
2010
Journal of Nervous & Mental Disease. 198/ 8 (pp. 597-600)

Chronic pain is prevalent among patients with depression and a risk factor for poor depression treatment outcomes. No known psychotherapy approaches have been developed to target the needs of patients with comorbid depression and chronic pain. This study's goals were to evaluate feasibility, acceptability, and initial effects of interpersonal psychotherapy adapted for women with depression and chronic pain. Seventeen women with major depression and chronic pelvic pain were offered 8 sessions of individual treatment, interpersonal psychotherapy for depression and pain (IPT-P). Participants were recruited from a women's health clinic, were predominantly low-income and minority, and generally did not initially self-identify as depressed. Large effect sizes with significant improvements were found for depression severity and social adjustment; pain interference remained unchanged. Most enrolled patients reported a high level of satisfaction with IPT-P. This pilot study provides preliminary support for the use of IPT-P for patients with comorbid depression and chronic pain.

Document:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6217818

Renal

30. **Chronic Kidney Disease: Depression in Chronic Kidney Disease** Unruh M
2017
Renal and Urology News.

Document:
https://www.renalandurologynews.com/home/decision-support-in-medicine/nephrology-hypertension/chronic-kidney-disease-depression-in-chronic-kidney-disease
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Search Information

Strategy

(*"INTERPERSONAL PSYCHOTHERAPY"/ OR ("interpersonal psychotherap*" OR "interpersonal therap*").ti,ab)

[DT FROM 2000] [Human age groups Adulthood 18 Yrs + Older OR Young Adulthood 18-29 Yrs OR Thirties 30-39 Yrs OR Middle Age 40-64 Yrs OR Aged 65 Yrs + Older OR Very Old 85 Yrs + Older] [Languages English]

Sources and Databases

AMED
Allied and Complementary Medicine
1985 to present
Allied health professions, complementary medicine

BNI
British Nursing Index
1992 to present
Nursing, midwifery, health visitors

CINAHL
Cumulative Index to Nursing and Allied Health Literature
1981 to present
Nursing, allied health professions

HMIC
Health Management Information Consortium
1979 to present
Records from King's Fund and Department of Health

Medline
1946 to present
General medical database

NHS Evidence
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PsycINFO
1806 to present
Psychology and allied fields