

Premature Conclusions About Psychotherapy for Dysthymia

To the Editor: In their meta-analysis of 30 randomized trials of treatments for adult major depression, Cuijpers et al¹ concluded that pharmacotherapy was more efficacious than psychotherapy for dysthymia. A meta-analysis by Imel et al² reached similar conclusions, but another by Pincus et al³ on later-life depression reported that pharmacotherapy was less effective than psychotherapy for dysthymia. The strength of conclusions derived from meta-analyses stems directly from the quality and quantity of data available to address the research question. Unfortunately, the scientific literature on comparative trials of psychotherapy for dysthymia is not well enough established at this point to answer this question.

Cuijpers and colleagues' conclusion about psychotherapy for dysthymic patients was based on just 5 clinical trials of psychological interventions that differed in content, length, and treatment setting. Two trials^{4,5} compared problem-solving therapy (PST) versus paroxetine for primary care patients with dysthymia. Psychotherapy in these trials consisted of just 4 to 6 sessions of PST delivered for 30 minutes each using a highly structured protocol that quite likely does not generalize well to psychotherapy delivered in the community. In the Williams et al⁴ study, patients receiving PST showed an increasing rate of improvement over the course of the 11-week trial. Thus, the length or frequency of PST may not have been adequate to determine its full benefits. Furthermore, as most primary care patients report a treatment preference for psychotherapy over antidepressants,⁶ medication trials in these settings may suffer from sample selection bias.

Two other trials^{7,8} reported that interpersonal psychotherapy (IPT) was significantly less effective than sertraline at posttreatment. The poorer outcomes for IPT may stem from the fact that IPT was originally designed for acute depressive illness and may require further adaptation for chronically depressed patients.⁸ The last trial⁹ included in the meta-analysis was the only one of cognitive-behavioral therapy (CBT) for dysthymia. Although the sample size was small and differences were not significant, retention in the CBT condition was 91% versus only 67% in the medication condition. If nonresponders are more likely than responders to drop out, the higher discontinuation rate in the medication arm may have made this condition appear more efficacious than it actually was.

Previous reports suggest that psychotherapy for dysthymia may require a greater number of sessions than typically used in acute depression treatment and specific adaptation for chronic illness.¹⁰ Adapted CBT appears effective: in another large trial,¹¹ the cognitive-behavioral analysis system of psychotherapy for chronic depression was found to be as effective as medication alone for patients with co-occurring major depression and dysthymia.

A more appropriate interpretation of the evidence to date is that comprehensive CBT adapted for chronic depression is a promising treatment for dysthymia and that brief psychotherapy or IPT specifically may be less effective than antidepressants during acute treatment. Further research is needed to determine the efficacy of different types of psychotherapy versus antidepressants for dysthymia, especially for longer-term outcomes. Until such trials are conducted, meta-analyses of these data are premature, and definitive conclusions about the efficacy of "psychotherapy" for dysthymia appear unwarranted.

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