Moderators of remission with interpersonal counselling or drug treatment in primary care patients with depression: randomised controlled trial

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Background
Despite depressive disorders being very common there has been little research to guide primary care physicians on the choice of treatment for patients with mild to moderate depression.

Aims
To evaluate the efficacy of interpersonal counselling compared with selective serotonin reuptake inhibitors (SSRIs), in primary care attenders with major depression and to identify moderators of treatment outcome.

Method
A randomised controlled trial in nine centres (DEPICS, Australian New Zealand Clinical Trials Registry number: ACTRN12608000479303). The primary outcome was remission of the depressive episode (defined as a Hamilton Rating Scale for Depression score ≤7 at 2 months). Daily functioning was assessed using the Work and Social Adjustment Scale. Logistic regression models were used to identify moderators of treatment outcome.

Results
The percentage of patients who achieved remission at 2 months was significantly higher in the interpersonal counselling group compared with the SSRI group (58.7% vs. 45.1%, P = 0.021). Five moderators of treatment outcome were found: depression severity, functional impairment, anxiety comorbidity, previous depressive episodes and smoking habit.

Conclusions
We identified some patient characteristics predicting a differential outcome with pharmacological and psychological interventions. Should our results be confirmed in future studies, these characteristics will help clinicians to define criteria for first-line treatment of depression targeted to patients' characteristics.

Declaration of interest
None.

Major depression is an important public health problem, associated with high levels of functional impairment and impairment in quality of life.1,2 Moreover, depression is related to high health service utilisation, work absenteeism and decreased performance at work with elevated direct and indirect social costs.3,4 The most authoritative guidelines basically agree on first-line treatments for individuals with moderate to severe depression; however, they differ on recommendations for ‘mild major’ depression, because few data exist on this condition.5 The American Psychiatric Association practice guidelines for the treatment of major depression recommend either psychotherapy or antidepressant monotherapy for mild depression.6 Only two criteria for the choice were proposed: patient preference and previous treatment response. The National Institute for Health and Care Excellence (NICE) guidelines recommend that for mild major depression a range of low-intensity psychosocial interventions and a stepped-care approach should be used.7 Anti-depressants should not be used routinely because the risk–benefit ratio is poor and limited to specific situations, for example mild persistent depressive symptoms or a history of severe depression. Mild depression is the most prevalent form of depression in the community8 and its management involves mainly primary healthcare services. It is therefore important to improve the selection of first-line treatments available to primary care settings. However, to date, there is a lack of evidence from studies comparing the efficacy and effectiveness of pharmacotherapy vs. psychotherapy that may serve as a guide for primary care practitioners when choosing between treatments for patients with mild depression. Given that antidepressant medication and psychotherapies have comparable response rates and that different antidepressants have similar efficacy, the treatment choice should be based ideally on patient characteristics and treatment preference.9 This personalised approach takes advantage of the identification of patient characteristics that predict a differential response to alternative treatments (the so-called moderators of treatment response, or effect modifiers).10 We therefore carried out a large multicentre randomised controlled trial (RCT) comparing a brief structured psychological intervention, interpersonal counselling, with selective serotonin reuptake inhibitor (SSRI) use for patients with mild to moderate major depression. The primary and secondary objectives of the study were: (a) to compare the efficacy of interpersonal counselling with SSRIs in primary care attenders; and (b) to identify moderators of treatment outcome at 2 months. We examined both demographic and baseline clinical characteristics as potential moderators of treatment outcome. Based on evidence from previous studies conducted in the mental health setting11–14 and on NICE guidelines,2 we hypothesised that patients with more severe depression, previous depressive episodes and comorbid anxiety disorder would have a better response to drug treatment than to the psychological intervention. We also hypothesised, as suggested by Fournier et al.,15 that married and unemployed patients would exhibit a better response to the psychological intervention than to the drug treatment.
Method

The full protocol for the DEPICS study is described elsewhere.16 Briefly, this multicentre RCT comparing interpersonal counselling and SSRI pharmacotherapy took place between May 2006 and May 2008 at nine academic centres located in Northern, Central and Southern Italy (the final follow-up was completed in July 2009). In each centre the research project was conducted by specific psychiatric consultation-liaison services collaborating with primary care physicians working in the catchment area to improve the quality of treatment for patients with depression and to promote enrolment in the trial. Patients identified by primary care physicians as depressed were referred to the consultation-liaison service and seen by a psychiatrist and a research assistant to determine their eligibility for the study. Eligible patients signed a written informed consent after an explanation of the study procedures and an opportunity to ask questions. The study was approved by the ethics committee of the Bologna University Hospital Authority Sant’Orsola-Malpighi and registered with the Australian New Zealand Clinical Trials Registry (ACTRN12608000479303).

Inclusion criteria were: age ≥18 years, meeting DSM-IV criteria17 for major depression, confirmed with the Mini-International Neuropsychiatric Interview (MINI),18 treatment for either a first or second depressive episode and a score ≥13 on the Hamilton Rating Scale for Depression (HRSD, 21-item version).19 Exclusion criteria were: ongoing effective treatment with antidepressants or psychotherapy, moderate to high suicide risk, more than two treated episodes of major depression, current/past episodes of mania or hypomania, current/past psychotic symptoms, borderline or antisocial personality disorder, substance use disorder, cognitive impairment, pregnancy or breastfeeding, poor knowledge of the Italian language. Those patients who met all inclusion/exclusion criteria but had an HRSD score <13 at baseline were reassessed after 1 month to establish their eligibility for the study; if their HRSD score was ≥13 after 1 month they were enrolled and randomised to interpersonal counselling or SSRIs.

Randomisation sequences, derived from a computer random number generator, were delivered to each centre by the coordinating centre. In each centre, allocation to treatment group was made by dedicated research personnel outside the consultation-liaison service where the patients were recruited, assessed and treated. After baseline assessment and consent to participate in the study was obtained, the researcher was contacted via telephone by clinicians and disclosed the assignment.

Interventions

Interpersonal counselling is a brief structured psychological intervention derived from interpersonal psychotherapy, a time-limited evidence-based psychotherapy for major depression.20 As with interpersonal psychotherapy, interpersonal counselling focuses on patients’ current interpersonal problems and social functioning in four problem areas: complicated grief, interpersonal disputes, role transitions and interpersonal deficits. It consisted of six 30 min sessions, with the initial session lasting 1 h. The therapist could evaluate if one or two additional sessions were needed. Originally designed for distressed patients with symptoms relating to current life stressors in primary care,21 interpersonal counselling has subsequently been tested as a stand-alone intervention in patients with mild or subthreshold depression.22,23 More details about the intervention are given in the online supplement.

Regarding drug treatment, the protocol allowed the use of two SSRIs (sertraline or citalopram) on the basis of the study psychiatrists’ clinical judgement. At the first treatment visit, the psychiatrists provided education about antidepressants and their side-effects. Two or three subsequent visits with the psychiatrist were planned at 2- to 3-week intervals in order to evaluate patients’ adherence to treatment, clinical response and initial side-effects.

Baseline assessment and outcome measure

Demographic characteristics and medical history, including both significant current and past physical illnesses and depressive episodes were collected. Severity of depression was evaluated with the 21-item HRSD. An HRSD score from 8 to 17 indicates mild depression, from 18 to 24 moderate depression and a score ≥25 indicates severe depression. Daily functioning was assessed using the Work and Social Adjustment Scale (WSAS).24 This self-report scale consists of five items exploring work functioning, home management, social leisure, private leisure and relationships on an eight-point ordinal scale. A score from 11 to 20 denotes mild functional impairment, whereas a score higher than 20 denotes severe functional impairment.25 Raters who administered the assessment instruments were different from the clinicians who provided psychiatric consultation to the primary care physicians and delivered the pharmacological or psychological interventions. Efforts were made to keep raters masked to randomisation assignment. The primary end-point was remission of depressive symptoms, defined as an HRSD ≤7 at the 2-month follow-up visit.

Sample size calculation

A meta-analysis of RCTs on major depression estimated a 35% remission rate with SSRI treatment.25 Studies conducted in primary care reported higher remission rates with SSRIs, ranging from 52 to 67%.26,27 No data are available for interpersonal counselling for depression in primary care as a stand-alone therapy. We based the sample size calculation on a critical difference in remission rates between the two treatments of 15%. We calculated that a sample size of 274 (137 per arm, 15.2 per site per arm) would result in a power of 80% at a 0.05 alpha level. To protect against a drop-out rate of about 10% at the first 2-month follow-up, we planned to enrol 300 patients (150 per arm, 16.6 per site per arm).

Statistical analysis

All analyses were carried out using an intention-to-treat approach. Patients who dropped out from the study were considered to be ‘non-remitters’. Moderators analyses were carried out using the approach of Kraemer et al28 and the methodological criteria set by Pincus et al29 and Sun et al30 (see online supplement).

We computed three equivalent measures of treatment effect size: the success rate difference (SRD), that is the difference between the proportions of patients remitting with interpersonal counselling and with SSRIs, the number needed to treat (NNT), where NNT = 1/SDR, and the area under the curve (AUC), defined as the probability that a patient randomly assigned to interpersonal counselling will have a better outcome than a patient randomly assigned to SSRIs. The AUC ranges from 0 to 1, with a value of 0.5 if there is no difference between interpersonal counselling and SSRIs (the probability of the toss of a coin). The higher the AUC, the greater the advantage of interpersonal counselling over SSRIs, and the lower the AUC, the greater the advantage of SSRIs over interpersonal counselling. As a rule of thumb, small, medium and large effect sizes correspond to AUCs of 0.556, 0.638 and 0.714, to a NNT of about 9, 4 and 2 and SRDs of 0.1, 0.3 and 0.5.31
The moderator effect size is computed as the difference between the SRD in patients with and without the characteristics of interest.

Results

Primary analyses

The study sample included 287 patients (Fig. 1) with a mean age of 44.9 years; 73.5% were female and 49.1% were married or living with a partner (Table 1). The proportion of patients who achieved remission at 2 months was significantly higher in the interpersonal counselling group compared with the SSRI group (intention-to-treat sample: 58.7% vs. 45.1%, $\chi^2 = 5.3$, d.f. = 1, $P = 0.021$). This corresponds to an SRD = 0.136 (95% CI 0.021–0.251), an NNT = 7.3 (95% CI 4–46.5) and an AUC = 0.568 (95% CI 0.502–0.634). Of the patients who received the allocated intervention, 6/136 (4.4%) assigned to interpersonal counselling and 13/139 (9.3%) assigned to SSRIs discontinued treatment. Reasons for treatment discontinuation are shown in Fig. 1. In the course of the trial no severe side-effects were recorded.

Next we examined whether the sites differed in the overall proportion of individuals who remitted and treatment effect. Preliminary analyses were carried out including site and the interaction treatment site. Although one site proved to perform better than the others, no interaction effect was found (i.e. site was not a moderator of treatment effect). After these preliminary analyses, one of the nine research sites was excluded because the proportion of individuals who remitted was extremely low compared with the other sites and none of the patients recruited had remitted with interpersonal counselling, leading to problems in the estimation of the coefficients in the logistic regression models. This site had recruited a larger proportion of patients with moderate to severe physical illness (56%) compared with the others ($\leq 34%$). Therefore, we carried out the subsequent secondary analyses on eight sites and 264 patients.

Secondary analyses

Potential moderators of remission were then examined in 13 separate logistic regression models. Five significant moderators of treatment outcome were found (Table 2). The strongest moderator was being in a first episode of depression, with an effect size of 0.38, which corresponds to a medium effect size according to Cohen’s standards.

Patients in their first episode were more likely to remit with interpersonal counselling, whereas those in a second episode were more likely to remit with SSRIs. The other four moderators were: baseline HRSD score, baseline WSAS score, comorbidity with anxiety disorder and smoking status. Patients with a baseline HRSD score $\leq 18$, a WSAS score $\leq 21$, without an anxiety disorder and who smoked were more likely to remit with interpersonal counselling than with SSRIs. On the contrary those with a baseline HRSD score $> 18$, a WSAS score $> 21$, anxiety comorbidity and who did not smoke experienced a better outcome when treated with SSRIs compared with interpersonal counselling.
Two characteristics were identified as non-specific predictors of outcome: unmarried patients and those with no or mild comorbid physical illness were more likely to remit regardless of treatment assignment. Specifically, the percentage of remitters among unmarried patients was 73% vs. 57% with interpersonal counselling and 65% vs. 42% with SSRIs, and the percentage of remitters among patients without v. with comorbid physical illness was 70% v. 40% with interpersonal counselling and 56% v. 48% with SSRIs.

To examine the extent to which the clinical moderators identified represent alternative indicators of severity, we analysed their bivariate correlations. Spearman’s correlation coefficients

### Table 1 Baseline characteristics of randomised patients

<table>
<thead>
<tr>
<th></th>
<th>Interpersonal counselling group (n = 143)</th>
<th>Selective serotonin reuptake inhibitor group (n = 144)</th>
<th>Total (n = 287)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic</strong> characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender, female: n (%)</td>
<td>107 (74.8)</td>
<td>104 (72.2)</td>
<td>211 (73.5)</td>
</tr>
<tr>
<td>Age, years: mean (s.d.)</td>
<td>42.8 (13.1)</td>
<td>46.9 (14.8)</td>
<td>44.9 (14.1)</td>
</tr>
<tr>
<td>Education, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 8 years</td>
<td>52 (36.4)</td>
<td>75 (52.1)</td>
<td>127 (44.3)</td>
</tr>
<tr>
<td>High school diploma</td>
<td>70 (49.0)</td>
<td>46 (31.9)</td>
<td>116 (40.4)</td>
</tr>
<tr>
<td>University degree</td>
<td>21 (14.7)</td>
<td>19 (13.2)</td>
<td>40 (13.9)</td>
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<tr>
<td>Unknown</td>
<td>0 (0.0)</td>
<td>4 (2.8)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td>Marital status, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>42 (29.4)</td>
<td>39 (27.1)</td>
<td>81 (28.2)</td>
</tr>
<tr>
<td>Married</td>
<td>64 (44.8)</td>
<td>73 (50.7)</td>
<td>137 (47.7)</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>25 (17.5)</td>
<td>19 (13.2)</td>
<td>44 (15.3)</td>
</tr>
<tr>
<td>Widowed</td>
<td>10 (7.0)</td>
<td>8 (5.6)</td>
<td>18 (6.3)</td>
</tr>
<tr>
<td>Living with partner</td>
<td>2 (1.4)</td>
<td>2 (1.4)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0 (0.0)</td>
<td>3 (2.1)</td>
<td>3 (1.0)</td>
</tr>
<tr>
<td>Occupation, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>84 (58.7)</td>
<td>82 (56.9)</td>
<td>166 (57.8)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>16 (11.2)</td>
<td>5 (3.5)</td>
<td>21 (7.3)</td>
</tr>
<tr>
<td>Homemaker</td>
<td>18 (12.6)</td>
<td>22 (15.3)</td>
<td>40 (13.9)</td>
</tr>
<tr>
<td>Retired</td>
<td>15 (10.5)</td>
<td>25 (17.4)</td>
<td>40 (13.9)</td>
</tr>
<tr>
<td>Student</td>
<td>10 (7.0)</td>
<td>9 (6.3)</td>
<td>19 (6.6)</td>
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<tr>
<td>Unknown</td>
<td>0 (0.0)</td>
<td>1 (0.7)</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td><strong>Clinical</strong> characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HRSD score, mean (s.d.)</td>
<td>17.1 (3.4)</td>
<td>17.5 (3.3)</td>
<td>17.3 (3.4)</td>
</tr>
<tr>
<td>WSAS score, mean (s.d.)</td>
<td>18.3 (8.8)</td>
<td>19.8 (8.7)</td>
<td>19.0 (8.6)</td>
</tr>
<tr>
<td>First depressive episode, n (%)</td>
<td>59 (41.3)</td>
<td>51 (35.4)</td>
<td>110 (38.3)</td>
</tr>
<tr>
<td>Comorbid anxiety disorder, n (%)</td>
<td>28 (19.6)</td>
<td>29 (20.1)</td>
<td>57 (19.9)</td>
</tr>
<tr>
<td>Physical illness, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>54 (37.8)</td>
<td>56 (38.9)</td>
<td>110 (38.3)</td>
</tr>
<tr>
<td>Mild</td>
<td>50 (35.0)</td>
<td>48 (33.3)</td>
<td>98 (34.1)</td>
</tr>
<tr>
<td>Moderate to severe</td>
<td>39 (27.3)</td>
<td>40 (27.8)</td>
<td>79 (27.5)</td>
</tr>
</tbody>
</table>
| **HRSD, Hamilton Rating Scale for Depression; WSAS, Work and Social Adjustment Scale.**

### Table 2 Moderators of remission by 2 months of treatment

<table>
<thead>
<tr>
<th></th>
<th>Total, n</th>
<th>Interpersonal counselling group</th>
<th>SSRI group</th>
<th>NNTa</th>
<th>SRD (95% CI)</th>
<th>Moderator effect sizeb</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRSD, baseline score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 18</td>
<td>153</td>
<td>83 (0.75)</td>
<td>70 (0.56)</td>
<td>5.22</td>
<td>0.19 (0.04 to 0.34)</td>
<td>0.25</td>
</tr>
<tr>
<td>≥ 18</td>
<td>111</td>
<td>60 (0.40)</td>
<td>51 (0.46)</td>
<td>17.26</td>
<td>−0.06 (−0.24 to 0.12)</td>
<td></td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>209</td>
<td>105 (0.67)</td>
<td>104 (0.46)</td>
<td>4.9</td>
<td>0.21 (0.04 to 0.38)</td>
<td>0.25</td>
</tr>
<tr>
<td>Yes</td>
<td>55</td>
<td>28 (0.56)</td>
<td>27 (0.70)</td>
<td>19.32</td>
<td>−0.05 (−0.33 to 0.23)</td>
<td></td>
</tr>
<tr>
<td>Depressive episode</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First</td>
<td>110</td>
<td>59 (0.73)</td>
<td>51 (0.39)</td>
<td>2.98</td>
<td>0.34 (0.16 to 0.51)</td>
<td>0.38</td>
</tr>
<tr>
<td>Second</td>
<td>154</td>
<td>74 (0.53)</td>
<td>80 (0.59)</td>
<td>24</td>
<td>−0.04 (−0.20 to 0.12)</td>
<td></td>
</tr>
<tr>
<td>WSAS score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 21</td>
<td>148</td>
<td>83 (0.74)</td>
<td>65 (0.56)</td>
<td>5.54</td>
<td>0.18 (0.03 to 0.33)</td>
<td>0.24</td>
</tr>
<tr>
<td>≥ 21</td>
<td>109</td>
<td>49 (0.53)</td>
<td>60 (0.59)</td>
<td>15.61</td>
<td>−0.06 (−0.25 to 0.12)</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>127</td>
<td>69 (0.51)</td>
<td>58 (0.58)</td>
<td>14.14</td>
<td>−0.07 (−0.24 to 0.1)</td>
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</tr>
<tr>
<td>Yes</td>
<td>122</td>
<td>58 (0.74)</td>
<td>64 (0.50)</td>
<td>4.26</td>
<td>0.24 (0.07 to 0.40)</td>
<td>0.30</td>
</tr>
</tbody>
</table>

SSRI, selective serotonin reuptake inhibitor; SRD, standardised rate difference; HRSD, Hamilton Rating Scale for Depression; WSAS, Work and Social Adjustment Scale.
a. The number needed to treat (NNT) is computed as 1/SRD. For instance, the NNT for patients with an HRSD <18 indicates that one would expect to treat 5 individuals with interpersonal counselling to have one more success (or one less failure) than if the same number were treated with SSRIs. Similarly, the NNT for patients with an HRSD ≥18 indicates that one would expect to treat 17 individuals with SSRIs to have one more success (or one less failure) than if the same number were treated with interpersonal counselling.
b. The moderator effect size is computed as the difference between the SRD in patients with and without the characteristics of interest. For instance, the moderator effect size for the HRSD score is 0.19 − (−0.06) = 0.25. An effect size of 0.1, 0.3, 0.5 correspond to a d of 0.2, 0.5, 0.8 respectively, i.e. small, medium and large effect sizes by Cohen’s standards (see Kraemer & Kupfer).31
Interpersonal counselling proved to be more efficacious than SSRIs in primary care patients with mild to moderate depression in their first or second depressive episode. About 59% of participants achieved symptom remission in 2 months with interpersonal counselling compared with 45% with SSRIs. The NNT with interpersonal counselling to have one more remission than with SSRIs was seven, which corresponds to a moderate effect size.

We identified five clinical moderators of treatment outcome, including depression severity, functional impairment, anxiety comorbidity, previous depressive episodes and smoking habit. Specifically, mild depression, low functional impairment, being in a first depressive episode, having no comorbid anxiety disorder and being a smoker predicted a better outcome with interpersonal counselling. Whereas, moderate to severe depression, moderate to severe functional impairment, being in a second depressive episode, comorbid anxiety and not being a smoker predicted a better outcome with SSRIs. In addition, being unmarried and having no or mild comorbid physical illness proved to be two predictors of better outcome regardless of treatment assignment.

The role of pharmacological and psychological interventions for mild depression is uncertain. There are very few trials in the literature that have compared brief psychological interventions with antidepressant treatment for depression in primary care. In three out of four of these studies tricyclic antidepressants were prescribed and nowadays these are used infrequently in clinical practice. They all found no difference between the two approaches, in part because of low statistical power. In contrast, our adequately powered study found a higher efficacy of interpersonal counselling compared with SSRIs, thus suggesting that many patients with depression in primary care would benefit from structured and focused psychological interventions.

Although it is crucial to identify the characteristics of patients who respond favourably to psychological interventions, available data on moderators of outcome on this topic are still lacking. There are few studies in the literature that have examined potential moderators of treatment effects in patient populations recruited from psychiatric settings and with moderate to severe and/or recurrent depression. These studies identified moderators of differential response to antidepressants vs. psychotherapy, by testing the interaction (moderator treatment) effect in mixed-effect models or in survival models. To our knowledge, only one primary care study has been conducted that examines which patient characteristics predict a differential response to psychological and pharmacological treatments, but the use of stratified analyses did not allow the identification of moderators of outcome. Our study is the first to investigate this issue in primary care using a large sample and an adequate methodological approach. Comparison of previous studies with our findings should be made keeping in mind differences in the clinical population examined.

Our data may suggest that patients experiencing mild and non-chronic depression could be initially treated with a psychological intervention. This approach is consistent with the NICE clinical guidance, which recommends a stepped-care model for the management of depression and differentiate treatment options according to the severity and course of depressive symptoms. A previous study comparing paroxetine with cognitive therapy found that the presence of a life event associated with depression predicted a better response to the psychological intervention compared with antidepressants. We did not assess life events but they are often detectable in the first episode of depression, especially in women. We could hypothesise that psychological interventions actively work on the ability to manage stressful circumstances and may confer an advantage compared with drugs in new and mild cases associated with recent life events.

The role of comorbid anxiety as a moderator of remission was evaluated in two studies. Brown et al in a sample of primary care patients with depression found that patients without a history of comorbid anxiety were significantly more likely to recover with interpersonal psychotherapy compared with those on nortriptyline. On the other hand, Frank et al, in an out-patient psychiatric setting, found that the absence of comorbid anxiety disorder was a non-specific predictor of better outcome with SSRIs and interpersonal psychotherapy, but not a moderator. In that study, 69.3% of the patients had recurrent depression and 48.5% had lifetime comorbid anxiety disorder. It is possible that anxiety is a moderator only in patients with mild to moderate depression, where recurrence and comorbidity are less frequent. Thus, moderators of outcome should be confirmed in studies conducted in primary and secondary care settings.

**Strengths and limitations of the study**

The strengths of the present study are the relatively large sample size and the inclusion of patients with mild and non-chronic depression who are representative of the primary care setting, a group that are usually excluded from RCTs. Primary care is the health service entry point for the majority of people experiencing depressive disorders and therefore it is essential to collect data in this area. In addition, our attrition rate was very low (13.7%). The discontinuation rates of antidepressant or psychological treatments in primary care trials carried out in Germany and Finland were higher, ranging from 22 to 33%. In these trials the mean HRSD score at baseline was equal or lower than in our sample, suggesting that patients with milder symptomatology might be less motivated to complete treatment. Moreover, evidence from a multicentre study comparing SSRIs with interpersonal psychotherapy in patients with moderate to severe depression, indicates a higher retention rate in Italy compared with the USA at 3 months (81.2% vs. 73.9%).

Several potential limitations of our study need to be acknowledged. First, interpersonal counselling might have been delivered in a different way at the study sites. In order to minimise site differences, we employed trained clinicians similar in background and years of experience and who attended a specific training programme. In addition, we addressed this point in the analytical strategy, by including site and site treatment effects in the models. This procedure makes it possible to estimate the treatment effect adjusted for differences in the case mix among sites and for possible site-specific factors, including beliefs about the effectiveness of the treatment strategies and clinical expertise. However, this strategy forced us to exclude one site.

Our results should be interpreted keeping in mind that patients with more than two treated depressive episodes in their personal history were excluded. Our findings are not generalisable to patients with chronic or more recurrent mood disorders. However, because response to treatment may vary across episodes, our inclusion of homogeneous patients in their first or second episode allowed us to exclude a possible source of variability related to their previous treatment experience.
Moreover, our moderator analyses should be considered as exploratory and aimed at contributing useful information for designing future clinical studies. The effect size measures provided for the moderators identified in the present paper may serve as a guidance to researchers for estimating the sample size needed in confirmation studies. The design of these confirmation studies implies the selection of a group with the characteristic of interest and the comparison of outcomes in patients receiving different treatments.

Finally, we emphasise that the sample size of the present study was determined anticipating a difference of 15% in the response to the two study treatments at 2 months, whereas the detection of moderator effects requires larger sample sizes. Therefore, if the moderator analyses had been planned as the primary aim of the study then a broader recruitment would have been carried out. However, a less conservative criterion for the moderator analysis, set by Pincus et al.53 prescribes at least 20 people in the smallest subgroup of the moderator, and this criterion is met for each of the moderators identified in the present study.

Implications for research

The therapists delivering interpersonal counselling were recruited to work in the primary care psychiatric consultation-liaison services for the research study. At present, similar therapists do not exist in primary care services in Italy and further research evaluating both the feasibility and cost-effectiveness of interpersonal counselling in comparison with SSRIs is needed.

In contrast to findings in the literature,15,41 we found that being unmarried was a predictor of remission regardless of treatment assignment. Treatment preference was not a moderator of treatment outcome. Another study carried out on patients with chronic major depression found an interactive effect of preference and treatment outcome, this was particularly apparent for those who expressed a preference for one of the monotherapies. Therefore, if the moderator analyses had been planned as the primary aim of the study then a broader recruitment would have been carried out. However, a less conservative criterion for the moderator analysis, set by Pincus et al.53 prescribes at least 20 people in the smallest subgroup of the moderator, and this criterion is met for each of the moderators identified in the present study.

References


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Interpersonal counselling is a manualised, briefer version of interpersonal psychotherapy. Interpersonal counselling posits that patients’ symptoms occur in a social and interpersonal context, and that interpersonal relations influence symptom onset and treatment response. In the first longer session, the counsellor explores the patient’s current interpersonal and social situation (interpersonal diagnosis). In the second session, the counsellor and patient identify specific current stress areas that are contributing to symptoms (interpersonal formulation). The four focal stress areas are grief, interpersonal disputes, role transition and social isolation. Subsequent sessions focus on dealing more positively with the stress area, add homework to accelerate improvement and discuss termination of the interpersonal counselling relationship (session 6).

In the present study, interpersonal counselling was delivered by 18 therapists (resident psychiatrists, clinical psychologists, counsellors) with at least 2 years of clinical experience. They attended a 3-day residential teaching seminar and monthly group supervisions with one of the authors (P.S.) in order to review videotaped cases and to ensure consistency of the intervention.

More detailed information about interpersonal counselling is included in the following publications.


Drug treatment

Citalopram was initially administered at a dosage of 10 mg and titrated if needed to 60 mg and sertraline was administered at 25 mg and then titrated up to 200 mg. The pharmacological treatment was followed up by the primary care physician and continued for at least 4–6 months after the patients had responded.

Moderator analyses

A moderator is an attribute that the participant must already have at study entry (such as gender, age, severity of illness), should be clinically plausible and measured with adequate quality. Such an attribute is by definition unrelated to treatment because in a randomised clinical trial (RCT), when randomisation is successful, the two treatment arms are balanced for demographic and clinical characteristics.

To assess potential moderators of treatment response, the optimal study design is a RCT comparing two active treatments. If a study does not include a direct comparison of alternative treatments, it cannot identify moderators of differential treatment response. For example, in the multicentre RCT ‘Depression: the search for treatment-relevant phenotypes study’, in which patients were randomly assigned to selective serotonin reuptake inhibitors (SSRIs) or interpersonal psychotherapy, need for medical reassurance (coded as low–high) proved to be a moderator of treatment outcome.11 Need for medical reassurance indicates the patient propensity to request frequent diagnostic procedures or medical visits including use of emergency services and are probably related to the risk of treatment discontinuation. Patients with high need for medical reassurance exhibited a faster remission with interpersonal psychotherapy than with SSRI pharmacotherapy, whereas the opposite was found for patients with a low need for medical reassurance. This suggests that, if there are two patients who are identical in all respects except that the first has a high need for medical reassurance and the second a low need for medical reassurance, offering the first an antidepressant as a first-line treatment would result in a poor outcome and offering the second the same treatment would give a substantial benefit.

We selected a priori as potential moderators, based on a literature review and clinical relevance: age (<45 years v. ≥45 years), gender (male v. female), education (≤8 years v. >8 years), marital status (unmarried v. married), work status (not employed v. employed), severity of depression (mild v. moderate to severe), level of functional impairment (mild v. moderate to severe), duration of depressive episode (<6 months v. ≥6 months), previous episodes of depression (no previous episode v. one previous episode), comorbid anxiety disorder (no v. yes), comorbid physical illness (no v. yes), smoking (no v. yes), patient’s treatment preference (antidepressants v. psychological interventions).

As to the analytical model to be used to identify moderators of treatment outcome, the criteria proposed by Kraemer et al28 and Pinxus et al29 prescribe an explicit test of the interaction between moderator and treatment. Our analytical strategy incorporates such a test and is based on logistic regression models. Each potential moderator was explored in a separate model. Each model included as independent variables treatment T (interpersonal counselling v. SSRI), site (S), one moderator (M) and their two- and three-way interactions (T × S, T × M, T × S × M). When the main effect of M was significant but the interactions T × M and/or T × M × S were not, the variable was considered a non-specific predictor of outcome. This means that patients with the characteristics M were less likely to respond to any treatment. When the interactions were significant, regardless of a significant main effect, the variable was considered a moderator. Dichotomous variables were coded as −1/2, +1/2 to be centred around the mean, and site was included in the models using 7 dummies coded as 7/8, −1/8.
Moderators of remission with interpersonal counselling or drug treatment in primary care patients with depression: randomised controlled trial

Marco Menchetti, Paola Rucci, Biancamaria Bortolotti, Annarosa Bombi, Paolo Scocco, Helena Chmura Kraemer, Domenico Berardi and the DEPICS group

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