Stepped Care Treatment for Depression and Anxiety in Primary Care

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2011

document version
Publisher's PDF, also known as Version of record

Link to publication in VU Research Portal

citation for published version (APA)
Seekles, W. M. (2011). *Stepped Care Treatment for Depression and Anxiety in Primary Care*. Ipskamp Drukkers.

Summary

Chapter 1 presents the general introduction of this dissertation. In summary, depressive and anxiety disorders are both highly prevalent and can cause serious impairment and reduction in quality of life. They also lead to huge economic costs due to health care utilization and especially due to productivity losses. Although evidence-based treatments and clinical guidelines are available for the treatment of depression and anxiety disorders in primary care, initiation of and adherence to effective treatment is usually poor. To optimize the treatment of anxiety and depression in primary care several care models are developed. One of these care models is the stepped care model. This model applies effective, evidence-based care for depression and anxiety by initiating interventions at the right time and as adequately as possible. All patients start with an evidence-based treatment of low intensity as a first step. Progress is monitored and patients who do not respond adequately can 'step up' to a subsequent treatment of higher intensity. This dissertation describes a study of the effectiveness of (guided) self-help in a stepped care model and the overall effectiveness of the stepped care model in for the treatment of anxiety and depression in general practice. Furthermore, it describes what should be offered in stepped care and how. The effectiveness of psychological treatment of anxiety disorders in primary care is examined and finally, the influence of personality traits on the perceived need for care in primary care is assessed.

Chapter 2 describes the design of the randomized controlled trial in which we compare a stepped care model with care as usual for the treatment of anxiety and/or depression in primary care. The stepped care program consists of four evidence-based interventions: (1) *watchful waiting*, (2) *bibliotherapy*, (3) *Problem-solving Treatment* and (4) *pharmacotherapy and/or specialized mental health care*. The study population consists of primary care attendees aged 18-65 years who are recruited via screeners that are sent to all individuals who consulted their general practitioner during the past two months. Individuals with a Diagnostic and Statistical Manual of mental disorders (DSM-IV) diagnosis of major depression, dysthymia, panic disorder (with or without agoraphobia), generalized anxiety disorder, or social phobia are included, as well as individuals with minor depression and anxiety disorders. Primary outcome is the reduction of depressive (IDS) and anxiety (HADS) symptoms. Both conditions are monitored at 8, 16 and 24 weeks. Strengths and limitations of this study are discussed.

Chapter 3 describes what should be offered in stepped care and how. We propose a stepped care model for patients with sub-threshold, mild and moderate depressions. The first step of this model consists of psycho-education and 'watchful waiting' since half of all depressions recover spontaneously within a limited period of time. The second step, self-help, is considered to be the key element of the stepped care model. Its effectiveness for depression has been proven, the accessibility of self-help is high, especially when offered through the Internet, and costs are relatively low. As a third step, short-term face-to-face psychotherapy is offered and as a last step antidepressants or referral can be considered. An essential element in a stepped care model is the monitoring of progress of the patients. One person, a care manager, is responsible for this monitoring, the decision to step up to a next treatment and the continuity of care. This creates the self-correcting character of stepped care: patients only step up when necessary.

Chapter 4 provides the results of (guided) self-help, the second step of the stepped care program after a watchful waiting period. We compared patients who received (guided) self-help to care as usual for patients with depression and/or anxiety in primary care. The study population

consisted of 120 (screened) primary care attendees aged 18-65 years with at least one depressive and/or anxiety disorder. The primary outcome was the reduction of depressive and anxiety symptoms. In this study we offered two different self-help interventions. The first was a generic intervention based on problem solving treatment (PST) and the second self-help intervention was specifically aimed at patients with phobias and was based on exposure therapy (Phobias). Both self-help courses took 6 weeks to complete. The self-help group reported slightly better outcomes than care as usual but these results were not significant: d = -0.18 (95% CI = -2.29 to 7.31) for symptoms of depression and d = -0.20 (95% CI = -0.74 to 2.29) for symptoms of anxiety. For patients with pure anxiety the anxiety symptoms decreased significantly compared to the care as usual (d = -0.68; 95% CI = 0.25 to 4.77). Self-help seems only slightly superior to care as usual and therefore might not be an effective tool in general practice. However, the lack of results could also be caused by recruitment of patients (screening) or the selection of GPs (with interest in psychiatric disorders).

Chapter 5 describes the results of the randomized controlled trial testing the effectiveness of stepped care for depression and anxiety in primary care. The study protocol itself is described in chapter 2. We recruited (via screening) 120 primary care attendees aged 18-65 years with at least one minor or major DSM-IV depressive and/or anxiety disorders. We randomized 60 patients to stepped care and 60 patients to care as usual. Symptoms of anxiety and depression decreased significantly over time for both groups, however there was no statistical significant difference between both groups (IDS: P = 0.35 and HADS: P = 0.64). The largest, but not significant, effect (d = -0.21) was found for anxiety symptoms on the last assessment (6 months). In both groups approximately 48% of the patients were recovered from their DSM-IV diagnosis at the final 6 months assessment. We could not demonstrate that stepped care for depression and anxiety in general practice was more effective than care as usual.

Chapter 6 describes a meta-analysis on the effectiveness of psychological treatment of anxiety disorders in primary care. In addition, we examine several aspects of treatment (*e.g.*, type of treatment or treatment provider) that can be related to effect sizes. The databases of Cochrane (central register of controlled trials), EMBASE, Medline, PsycINFO and Pubmed were searched in July 2010. Manuscripts were included if they: 1) described psychological treatment for anxiety in primary care, 2) if the research design was a randomized controlled trial and 3) if the psychological treatment was compared to a waiting list, placebo or care as usual. In total 1343 abstracts were identified. Of these, 12 manuscripts described a randomized controlled trial comparing psychological treatment for anxiety with a control group in primary care. The pooled standardized-effect size for reduced symptoms of anxiety at post-intervention was d = 0.57 (95% CI: 0.29 - 0.84; P = 0.00; the number needed to treat (NNT): 3.18). Heterogeneity was not significant among the studies (I^2 = 58.55, Q: 26.54; P < 0.01). We found a moderate effect size for the psychological treatment of anxiety disorders in primary care. This effect remains after imputation for the 'missing' studies. Several aspects of treatment are related to effect-size. More studies are needed to evaluate long-term effects given the chronicity and recurrent nature of anxiety.

Chapter 7 examines the influence of personality traits on perceived need for care in primary care patients. Cross-sectional data were derived from the Netherlands Study of Depression and Anxiety (NESDA). A total of 762 patients, with one or more DSM-IV diagnoses, were recruited

from primary Outcomes were adjusted for the severity of the disorders. We found indications that personality traits, in particular neuroticism and openness to experience, have impact on care needs regardless of the symptom severity. Patients who had higher levels of neuroticism were more likely to perceive a need for care, irrespective whether this was met (odds ratio (OR) = 1.06; 95% CI = 1.01 to 1.10; P = 0.01) or not (OR = 1.05; 95% CI = 1.01 to 1.09; P = 0.01). Patients with higher levels of openness to experience were also more likely to perceive a need for care (OR = 1.04; 95% CI = 1.01 to 1.08; P = 0.02). We found the risk of having *met need* or being *in need* (relative to *no need*) to be unrelated to extraversion, agreeableness and conscientiousness. When patients have higher levels of neuroticism or higher levels of openness to experience counseling is most likely to be perceived a as needed. Many patients, for comorbid disorders up to 70%, expressed an unmet need for care. Future research should point out whether perceived unmet need is justified: is perceived need also necessarily need?

Chapter 8 is the general discussion of this dissertation. It summarizes the main results of the described studies and links them to previous, relevant, findings. Clinical implications and recommendations are presented, based on the main findings. The main limitations of the studies are discussed and recommendations for future research are provided.