Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial

Article

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Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial

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Summary

Background Psychological treatments for adolescents with unipolar major depressive disorder are associated with diagnostic remission within 28 weeks in 65–70% of patients. We aimed to assess the medium-term effects and costs of psychological therapies on maintenance of reduced depression symptoms 12 months after treatment.

Methods We did this multicentre, pragmatic, observer-blind, randomised controlled superiority trial (IMPACT) at 15 National Health Service child and adolescent mental health service (CAMHS) clinics in three regions in England. Adolescent patients (aged 11–17 years) with a diagnosis of DSM IV major depressive disorder were randomly assigned (1:1:1), via a web-based randomisation service, to receive cognitive behavioural therapy (CBT) or short-term psychoanalytical therapy versus a reference brief psychological intervention. Randomisation was stochastically minimised by age, sex, self-reported depression sum score, and region. Patients and clinicians were aware of group allocation, but allocation was concealed from outcome assessors. Patients were followed up and reassessed at weeks 6, 12, 36, 52, and 86 post-randomisation. The primary outcome was self-reported depression symptoms at weeks 36, 52, and 86, as measured with the self-reported Mood and Feelings Questionnaire (MFQ). Because our aim was to compare the two psychological therapies with the brief psychosocial intervention, we first established whether CBT was inferior to short-term psychoanalytical psychotherapy for the same outcome. Primary analysis was by intention to treat. This trial is registered with Current Controlled Trials, number ISRCTN83033550.

Findings Between June 29, 2010, and Jan 17, 2013, we randomly assigned 470 patients to receive the brief psychosocial intervention (n=158), CBT (n=155), or short-term psychoanalytical therapy (n=157); 465 patients comprised the intention-to-treat population. 392 (84%) patients had available data for primary analysis by the end of follow-up. Treatment fidelity and differentiation were established between the three interventions. The median number of treatment sessions differed significantly between patients in the brief psychosocial intervention group (n=6 [IQR 4–11]), CBT group (n=9 [5–14]), and short-term psychoanalytical therapy group (n=11 [5–23]; p=0.0001), but there was no difference between groups in the average duration of treatment (27·5 [SD 21·5], 24·9 [17·7], 27·9 [16·8] weeks, respectively; Kruskal–Wallis p=0.238). Self-reported depression symptoms did not differ significantly between patients given CBT and those given short-term psychoanalytical therapy at weeks 36 (treatment effect −0.179, 95% CI −3·731 to 4·088; p=0.929), 52 (0·307, −3·161 to 3·774; p=0.862), or 86 (0·578, −2·948 to 4·104; p=0.748). These two psychological treatments had no superiority effect compared with brief psychosocial intervention at weeks 36 (treatment effect −3·234, 95% CI −6·611 to 0·143; p=0.061), 52 (−2·806, −5·790 to 0·177; p=0·065), or 86 (−1·898, −4·922 to 1·126; p=0.219). Physical adverse events (self-reported breathing problems, sleep disturbances, drowsiness or tiredness, nausea, sweating, and being restless or overactive) did not differ between the groups. Total costs of the trial interventions did not differ significantly between treatment groups.

Interpretation We found no evidence for the superiority of CBT or short-term psychoanalytical therapy compared with a brief psychosocial intervention in maintenance of reduced depression symptoms 12 months after treatment. Short-term psychoanalytical therapy was as effective as CBT and, together with brief psychosocial intervention, offers additional patient choice for psychological therapy, alongside CBT, for adolescents with moderate to severe depression who are attending routine specialist CAMHS clinics.

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Introduction

Unipolar major depression is a clinically significant mental illness affecting a substantial proportion of adolescents worldwide.1 Although evidence exists for the effectiveness of treatments in the short term, data are scarce for whether one or more of the available psychological treatments is also able to maintain reduced depressive symptoms a year after the end of therapy.1,3 This issue is not trivial, because maintenance of depressive symptoms below a clinical threshold 12 months after the end of treatment is associated with reduced risk for diagnostic relapse into the adult years.2 Cognitive behavioural therapy (CBT) offers plausible long-term benefits for adolescents with depression, and is recommended as such by the National Institute for Health and Care Excellence (NICE).1 Short-term psychoanalytical psychotherapy also shows preliminary promise as a treatment for adolescents with depression. CBT has established clinical effectiveness and relapse prevention, and short-term psychoanalytical psychotherapy has shown similar clinical effectiveness in adults with depression and some clinical effectiveness in adolescents.1,3

We did the IMPACT trial to assess the medium-term effects and costs of psychological therapies on maintenance of reduced depression symptoms 12 months after treatment. We tested a primary superiority hypothesis that CBT and short-term psychoanalytical psychotherapy would be more likely to maintain significantly lower depressive symptoms 1 year after treatment than would a reference brief psychosocial intervention. Because our aim was to compare two psychological therapies with a brief psychosocial intervention, we first established whether CBT was inferior to short-term psychoanalytical psychotherapy for the same outcomes.

Findings from previous studies5 of psychological treatment in adolescents with depression have shown reductions in anxiety symptoms even despite no reductions in depressive symptoms. Therefore, we tested a secondary hypothesis that, compared with participants assigned to receive brief psychosocial intervention, those assigned to receive CBT or short-term psychoanalytical psychotherapy would be more likely to maintain significantly lower self-reported anxiety symptoms, but significantly higher research interviewer-evaluated psychosocial function, 1 year after treatment. Finally, a cost-effectiveness hypothesis tested whether the additional costs of CBT and short-term psychoanalytical psychotherapy could be justified by improvements in clinical effectiveness or decreased use of health and social care services compared with brief psychosocial intervention.

Evidence before this study

Unipolar major depression emerges with the highest incidence risk rate in the second decade of life, affecting a substantial proportion of the adolescent population worldwide. Good evidence exists for psychological treatments being associated with clinical remission in about 70% of cases. By contrast, data are scarce for whether one or more of the available therapies is associated with maintenance of reduced depressive symptoms 1 year after the end of treatment. This issue is not trivial, because maintenance of depressive symptoms below a clinical threshold 12 months after the end of treatment is associated with reduced risk for diagnostic relapse into the adult years. We searched PubMed between Aug 1, 1990, and Aug 31, 2016, with the search terms “adolescence”, “depression”, “psychological treatments”, “randomised controlled trials”, “remission”, “relapse”, “relapse prevention”, and “adverse effects”. This search identified three trials of school population-based interventions, a small (n=43) feasibility study of a social media intervention for relapse prevention in patients recovered from depression, and a Cochrane database review of relapse prevention in children and adolescents with depression. No identified psychological treatments are currently recommended as effective in maintaining reduced depressive symptoms in the year after successful treatment.

Added value of this study

Our findings show that short-term psychoanalytical psychotherapy and CBT, delivered by highly trained therapists over 28 weeks and 20 weeks, respectively, were not superior to a reference brief psychosocial intervention delivered over 12 weeks by child and adolescent psychiatrists and mental health nurses. All three psychological treatments were associated with an average 49–52% reduction in depression symptoms 1 year after treatment. Prescribing of an SSRI during therapy or follow-up, as per National Institute for Health and Care Excellence guidelines, did not differ between the treatment groups and so did not mediate the outcome. Suicide and self-harm attempts over the follow-up period were lower than at baseline, as were physical side-effects. Furthermore, total costs and quality-of-life scores did not differ between treatment groups by the end of the study.

Implications of all the available evidence

To our knowledge, this is the only high-quality, fully powered, superiority and cost-effectiveness study assessing the medium-term effects and costs of psychological treatments on maintenance of reduced depression symptoms 12 months after treatment. Short-term psychoanalytical psychotherapy is as effective as CBT and, together with brief psychosocial intervention, offers an additional patient choice for psychological therapy, alongside CBT, for adolescents with moderate to severe depression who are attending routine specialist child and adolescent mental health service clinics.
Method
Study design and participants
We did this multicentre, pragmatic, single-blind, randomised controlled superiority trial in three regions of England: East Anglia, a largely rural area of 3 million people with four urban areas each containing about 100,000 people; North London, a densely populated urban area with around 4 million people; and the North West of England, covering roughly 4 million people of whom about 1 million live in rural surroundings and 3 million live in the city of Manchester. Adolescents (aged 11–17 years) with a diagnosis of DSM IV unipolar major depressive disorder were recruited from 15 routine National Health Service (NHS) child and adolescent mental health service (CAMHS) clinics (n=5 in each region).11,12 In the UK NHS, adolescents who do not respond to community-based treatments might be sent to specialist outpatient CAMHS. Therefore, the adolescents entered into this trial had high numbers of symptoms and concurrent personal impairments.

Exclusion criteria were generalised learning difficulties, pervasive developmental disorder, pregnancy, current use of another medication that could interact with an SSRI, current substance or alcohol abuse disorders, previous completion of one of the study treatments, and a primary diagnosis of bipolar disorder, schizophrenia, or eating disorders. The study was approved by the Cambridgeshire 2 Research Ethics Committee (reference 09/H0308/137) and local NHS provider trusts. The protocol has been previously published.13 All patients and their parents gave written informed consent.

Randomisation and masking
Patients were randomly assigned (1:1:1), via a web-based randomisation service, to receive either CBT or short-term psychoanalytical therapy versus the brief psychological intervention. Randomisation was done by the trial coordinator, with stochastic minimisation by age (11–13 years vs 14–15 years vs 16–17 years), sex, self-reported depression sum score (≥29 vs 30–39 vs 40–49 vs ≥50),8 and region (East Anglia vs North London vs North West England). In view of the nature of the interventions, patients and clinicians were aware of group allocation, but allocation was concealed from outcome assessors.

Procedures
All treatments were manualised; the appendix provides a full description of the treatment manuals, including theoretical and operational differences, and the manuals are available online. Short-term psychoanalytical psychotherapy comprised a planned programme of 28 sessions over 30 weeks, with parents or carers offered up to seven additional sessions by a separate parent worker. The techniques of this intervention are based on close and detailed observation of the relationship the child or young person makes with their therapist. The therapist introduces the therapeutic task to the young person as one of understanding feelings and difficulties in their life. The therapist is non-judgmental and enquiring, and conveys the value of self-understanding. Therapists were CAMHS clinicians with child and adolescent psychoanalytical psychotherapy training. Short-term psychoanalytical psychotherapy has been shown to be reliably and effectively delivered.9

CBT was based on the classic form originally developed for adults with depression.10 We adapted the intervention to include parental involvement, focused on engagement in therapy, and emphasised the use of behavioural techniques. The focus of CBT is to identify the behaviours and information processing biases that maintain depression and low mood, and to amend these through a process of collaborative empiricism between the therapist and patient. CBT comprised a planned programme of up to 20 sessions over 30 weeks. CBT therapists were routine CAMHS clinicians and were either clinical psychologists or other clinicians who had received post-qualification training in CBT.

The brief psychosocial intervention was derived from the routine specialist clinical care delivered in the ADAPT trial, and reformulated on the basis of findings suggesting this intervention might be clinically effective.11 Emphasis in the brief psychosocial intervention programme is on the importance of psychoeducation about depression, in addition to action-oriented, goal-focused, and interpersonal activities as therapeutic strategies. Neither self-understanding nor cognition change are components of the programme. The programme consists of 12 individual sessions, including up to four family or marital sessions delivered over 20 weeks. Therapists were drawn from routine CAMHS clinics.

For all three groups, liaison with external agencies and personnel (e.g., teachers, social care) and peer group was commonly done. All therapy sessions were audiotaped. A computerised randomisation procedure was used to select tapes stratified by age, treatment, and whether obtained early (two to four sessions) or later (after four sessions) in the therapy. Randomisation was done with the Comparative Psychotherapy Process Scale and the Brief Psychosocial Intervention scale.12 Independent raters rated each treatment session from the three treatment modalities to assess treatment fidelity and differentiation (appendix). In accordance with NICE guidelines, fluoxetine could be added if clinicians deemed that combination therapy might accelerate the time to remission.13 A test dose of 10 mg was given for 48 h, followed by 20 mg as a single dose. If no improvement was shown within 2–4 weeks, the dose could be adjusted upwards to a maximum of 60 mg.

Outcomes
The primary outcome was self-reported depression symptoms at weeks 36, 52, and 86 post-randomisation (i.e., end of treatment), as measured with the Mood and Feelings

See Online for appendix
For the treatment manuals see http://dev.psychiatry.cam.ac.uk/projects
Methods of the economic evaluation have been applied previously and are shown in the appendix and available online. In brief, cost-effectiveness was explored at the 86 week follow-up point, with outcomes expressed as QALYs and costs assessed from a service perspective (health, social care, and education). Unit costs were for the financial year 2011–12, and costs and QALYs were discounted at a rate of 3·5% as recommended by NICE. Differences in mean costs were tested with linear regression models, with validity of the results confirmed with bias-corrected, non-parametric bootstrapping (5000 resamples). For the cost-effectiveness analysis, we calculated incremental cost-effectiveness ratios (the difference in mean cost divided by the difference in mean effect) and explored uncertainty with cost-effectiveness acceptability curves, which show the probability that each of the treatments is the optimum choice, for a range of possible values of willingness to pay for additional QALYs. All economic analyses were adjusted for the prespecified covariates and for baseline utility and cost, as appropriate. Complete case analysis was used, with the effect of missing data and sessions offered but not attended explored in sensitivity analyses.

We did analysis by intention to treat, subject to the availability of data. Analyses were done with Stata (version 12.0). This trial is registered with Current Controlled Trials, number IsrCTN83033550.

Role of the funding source
The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results
Between June 29, 2010, and Jan 17, 2013, we randomly assigned 470 patients to receive the brief psychosocial intervention (n=158), CBT (n=155), or short-term psychoanalytical therapy (n=157; figure). Five patients withdrew before starting treatment and requested data be deleted; the remaining 465 participants comprised the intention-to-treat population (figure). The patient recruitment rate was 40% in East Anglia, 33% in the

For methods of the economic evaluation see http://dev.psychiatry.cam.ac.uk/projects
North West, and 27% in North London (table 1). 63 therapists delivered the brief psychosocial intervention, 44 therapists delivered CBT, and 38 therapists delivered short-term psychoanalytical therapy. Most (n=53) brief psychosocial intervention therapists were either psychiatrists who had passed postgraduate general training (ie, obtained membership of the Royal College of Psychiatrists) and subsequently entered specialist CAMHS psychiatry training or consultants. The primary analysis population comprised 392 (84%) patients who provided one or more self-reported depression symptom scores at weeks 36, 52, and 86 (figure). 39 (10%) patients had one MFQ score, 90 (23%) had two MFQ scores, and 263 (67%) had three MFQ scores. The number of patients with follow-up data for secondary outcomes was similar between treatment groups. The data available were within the margins suggested by the power calculation. Baseline characteristics were similar between groups (table 1).

The appendix shows the full profile of depression symptoms at baseline (appendix). The mean number of symptoms was 8·4 (SD 2·5) in patients undergoing brief psychosocial intervention, 8·7 (2·3) in patients undergoing CBT, and 8·3 (2·5) in patients undergoing short-term psychoanalytical therapy (appendix). The most prevalent symptom was sleep disturbance (n=427 [92%]) followed by depressed mood (n=390 [84%]; appendix). Psychotic symptoms were uncommon (n=48 [10%]), but a notable number of patients had current suicidal ideas (n=284 [61%]) and lifetime suicide attempts (n=177 [38%]; appendix). Symptom prevalence rates were similar between treatment groups (appendix). 225 (48%) patients had concurrent comorbid psychiatric disorders: 71 (46%) in the brief psychosocial intervention group, 80 (52%) in the CBT group, and 74 (47%) in the short-term psychoanalytical therapy group (appendix). Overall, 134 (29%) patients had one comorbidity, 60 (13%) patients had two comorbidities, and 31 (7%) patients had three or more comorbidities, with no marked differences between groups. Non-suicidal self-injury in the previous 2 weeks was reported in 85 (18%) patients: 26 (17%) assigned to the brief psychosocial intervention, 25 (16%) assigned to CBT, and 34 (22%) assigned to short-term psychoanalytical...
therapy; lifetime non-suicidal self-injury was reported in 246 (53%) participants: 87 (56%), 75 (49%), and 84 (54%), respectively.

The number of patients starting therapy was 147 (93%) in the brief psychosocial intervention group, 142 (92%) in the CBT group, and 136 (87%) in the short-term psychoanalytical therapy group, with no differences in proportions between groups ($\chi^2$ p=0.729; appendix). The number of individual treatment sessions given per group was less than planned (median six [IQR four to 11] in the brief psychosocial intervention group, nine [five to 14] in the CBT group, and 11 [five to 23] in the short-term psychoanalytical therapy group), but differed significantly between groups (Kruskal–Wallis p<0.0001; appendix). Of patients assigned to receive the brief psychosocial intervention, 24 (17%) had more sessions than the manual specified, compared with five (3%) assigned to receive CBT and three (2%) assigned to receive short-term psychoanalytical therapy. Mean duration of therapy did not differ significantly between treatment groups (27.5 weeks [SD 21.5] in the brief psychosocial intervention group, 24.9 weeks [SD 17.7] in the CBT group, 27.9 weeks [IQR 20.5 to 31.7] in the short-term psychoanalytical therapy group; Kruskal–Wallis p=0.238).

Raters assessed treatment fidelity by use of 232 audio tapes: 75 tapes for brief psychosocial intervention sessions, 76 tapes for CBT sessions, and 81 tapes for short-term psychoanalytical therapy sessions. Overall, 60 (81%) brief psychosocial intervention sessions, 61 (80%) short-term psychoanalytical therapy sessions, and 60 (74%) CBT sessions met treatment fidelity criteria (appendix). Treatment differentiation was good: the mean cognitive behavioural subscale score on the Comparative Psychotherapy Process Scale was 1·91 (95% CI 1·73–2·09) higher for CBT sessions than for short-term psychoanalytical therapy sessions (p<0.0001), whereas the mean psychodynamic interpersonal subscale score was 1·18 (1·01–1·30) higher for short-term psychoanalytical therapy sessions than for CBT sessions (p<0.0001). Patients attending brief psychosocial intervention sessions had a significantly lower mean score on the cognitive behavioural subscale than did those attending CBT sessions (mean difference −0·93, 95% CI −1·2 to −0·75; p=0.0001) and a significantly lower mean score on the psychodynamic interpersonal subscale than did those attending short-term psychoanalytical therapy sessions (−1·30, −1·48 to −1·11; p<0.0001).

The number of patients receiving an SSRI before randomisation was 29 (19%) in the brief psychosocial intervention group, 32 (21%) in the CBT group, and 28 (18%) in the short-term psychoanalytical therapy group; by the end of study, the number of patients who reported having received an SSRI at any time over the course of the trial (randomisation up to 86 weeks) was 56 (41%), 55 (40%), and 50 (36%), respectively (p=0·729; appendix). Behavioural disorder at baseline was found to predict non-response. Because this was not a prespecified baseline covariate, it was added to all models of outcome to support the missing-at-random assumption. The appendix provides data for time from randomisation to assessment and estimates of the main effect and time with treatment interaction.

The primary outcome of self-reported depression symptoms (MFQ) at weeks 36, 52, and 86 did not differ significantly between patients in the CBT group and those in the short-term psychoanalytical therapy group, nor between those in the CBT or short-term psychoanalytical therapy groups combined versus the brief psychological intervention group (table 2). With a lower score representing improved outcome, we recorded a larger difference in favour of combined established treatments at weeks 36 and 52 (table 2), but these reductions were not statistically significant, less than the five unit difference prespecified as clinically meaningful, and not accompanied by differences in psychosocial impairment. The secondary outcomes of anxiety and obsessional symptoms were significantly reduced after the psychological treatments combined versus brief psychosocial therapy at week 36 only (table 2). The therapist intracluster correlation coefficient for therapy outcomes was calculated as the
proportion of the random intercept variance, and was negligible (<10⁻⁷) for all the models (data not shown). Study power was therefore at the upper end of the range, because the sample size calculation included a range of values of the intracluster correlation coefficient, from 0 to 0.05.

Table 3 shows findings for the secondary binary outcomes of patients who self-reported no or one or more antisocial behaviour symptoms and patients who met clinical diagnostic criteria for major depressive disorder. Compared with brief psychosocial intervention, CBT and short-term psychoanalytical therapy led to significantly lower self-reported ABQ scores at week 36, but this difference was not maintained at week 52.

Over the follow-up period, recent suicide attempts were reported in three (3%) of 279 patients at 36 weeks (n=1 per group), two (6%) of 201 patients at 52 weeks (n=1 in the brief psychosocial intervention group, n=1 in the short-term psychoanalytical therapy group), and no patients at 86 weeks, compared with 12 (3%) of 465 patients at baseline (table 1). Similarly, non-suicidal self-injury attempts were reported in 19 (7%) of 268 patients at 36 weeks (n=10 in the brief psychosocial intervention group, n=6 in the CBT group, n=3 in the short-term psychoanalytical therapy group), 14 (4%) of 234 patients at 52 weeks (n=6, n=2, n=6, respectively), and 16 (5%) of 257 at 86 weeks (n=7, n=5, n=4,

![Table 2: Primary and secondary outcomes](http://www.thelancet.com/psychiatry/appendix)

![Linear mixed model estimates of the treatment effect at weeks 36, 52, and 86 post-randomisation. Data were missing for some participants. The model was based on data for 392 (84%) of 465 patients who provided one or more self-reported depression symptom scores over the 36, 52, or 86 week assessment points. The analysis used time since randomisation as a continuous variable, with therapist, participant and slope random effects, treatment, treatment by time interaction, and other prespecified baseline covariates (appendix). BPI=brief psychological intervention. CBT=cognitive behavioural therapy. STPP=short-term psychoanalytical psychotherapy. MFQ=Mood and Feelings Questionnaire. RCMAS=Revised Children’s Manifest Anxiety Scale. LOI=Leyton Obsessional Inventory–adolescent version. HoNOSCA=Health of the Nation Outcome Scale for Children and Adolescents. *The marginal mean difference at a given timepoint, with negative effects indicating treatment benefit. †To control for two comparisons, we used a 2.5% significance level to maintain a 5% significance level for any measure and timepoint combination.)
respectively), which compares favourably with self-harm attempts reported at baseline (n=85 [18%]; table 1). On the basis of our physical adversities score, we recorded a decline in the self-reporting of adverse physical events over the course of the study, with no observable differences between treatment groups (table 4).

The proportion of patients in diagnostic remission by 36, 52, or 86 weeks did not differ significantly between groups (data not shown). Because the present study is pragmatic, with no control group, we did a comparison of the 12 week remission rate with the rate in the TADS study, which included a pill placebo control group (n=111): 145 (48%) of 305 patients were in remission at 12 weeks in our study compared with 37 (34%) placebo patients in the TADS study. Additionally, in the treatment trial of resistant depression in adolescents, 203 (61%) of 334 patients were in diagnostic remission by week 72 compared with 221 (77%) of 286 by week 86 in this study. Finally, 15 (11%) of the 140 patients in remission at week 36 had relapsed by week 86 (n=5/48 [10%] in the brief psychosocial intervention group, n=2/48 [4%] in the CBT group, and n=2/48 [4%] in the short-term psychoanalytical therapy group; p=0·149).

The cost of the trial interventions was lowest for CBT (mean £904·57 [SD 607·25]) and highest for short-term psychoanalytical therapy (£1396·72 [1133·41]), with CBT (mean £904·57 [SD 607·25]) and highest for short-term psychoanalytical therapy (£1396·72 [1133·41]): 145 (48%) of 305 patients were in remission at baseline (n=85 [18%]; table 1). On treatment, we found no evidence for the superiority of CBT or short-term psychoanalytical therapy compared with a brief psychosocial intervention for maintenance of reduced depression symptoms 12 months after treatment. To our knowledge, this is the first trial to show that short-term psychoanalytical therapy and brief psychosocial intervention are as clinically effective as CBT for the treatment of adolescents with depression. We note the continuing decline of symptoms and further increase in remission, which are not explained by any marked differences in post-treatment service use, costs between therapies, or reported SSRI use. However, caution is required with the findings for remission because the study was not powered for treatment group comparisons, interview data were missing at each

### Table 3: Patients with an MDD diagnosis and one or more antisocial behaviour symptoms

<table>
<thead>
<tr>
<th></th>
<th>BPI (n=155)</th>
<th>CBT (n=154)</th>
<th>STPP (n=156)</th>
<th>CBT vs STPP</th>
<th>STPP vs BPI</th>
<th>CBT plus STPP vs BPI</th>
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<tbody>
<tr>
<td>MDD</td>
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<td></td>
<td></td>
<td>Treatment effect (95% CI)</td>
<td>p value</td>
<td>Treatment effect (95% CI)</td>
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<td>Baseline</td>
<td>155 (100%)</td>
<td>154 (100%)</td>
<td>156 (100%)</td>
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<td>...</td>
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<tr>
<td>6 weeks</td>
<td>63/143 (44%)</td>
<td>57/95 (60%)</td>
<td>62/99 (63%)</td>
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<td>...</td>
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<tr>
<td>12 weeks</td>
<td>57/105 (54%)</td>
<td>46/98 (47%)</td>
<td>54/99 (55%)</td>
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<tr>
<td>36 weeks</td>
<td>42/95 (44%)</td>
<td>28/83 (31%)</td>
<td>35/98 (36%)</td>
<td>-0·064 (-0·206 to 0·078)</td>
<td>0·375</td>
<td>-0·043 (-0·160 to 0·073)</td>
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<td>52 weeks</td>
<td>27/92 (29%)</td>
<td>23/90 (26%)</td>
<td>23/87 (27%)</td>
<td>-0·018 (-0·120 to 0·084)</td>
<td>0·727</td>
<td>-0·053 (-0·142 to 0·035)</td>
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<td>86 weeks</td>
<td>27/99 (27%)</td>
<td>24/95 (25%)</td>
<td>14/92 (15%)</td>
<td>0·057 (-0·043 to 0·157)</td>
<td>0·261</td>
<td>-0·065 (-0·152 to 0·022)</td>
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<tr>
<td>ABQ</td>
<td></td>
<td></td>
<td></td>
<td>Treatment effect (95% CI)</td>
<td>p value</td>
<td>Treatment effect (95% CI)</td>
</tr>
<tr>
<td>Baseline</td>
<td>121 (78%)</td>
<td>124/152 (82%)</td>
<td>128/154 (83%)</td>
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<td>...</td>
</tr>
<tr>
<td>6 weeks</td>
<td>75/98 (77%)</td>
<td>71/102 (70%)</td>
<td>73/107 (68%)</td>
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<td>12 weeks</td>
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<td>36 weeks</td>
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<td>45/101 (45%)</td>
<td>55/107 (51%)</td>
<td>-0·068 (-0·186 to 0·051)</td>
<td>0·263</td>
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<td>52 weeks</td>
<td>47/99 (47%)</td>
<td>43/107 (40%)</td>
<td>41/102 (40%)</td>
<td>-0·040 (-0·132 to 0·055)</td>
<td>0·408</td>
<td>-0·074 (-0·163 to 0·015)</td>
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<tr>
<td>86 weeks</td>
<td>39/107 (36%)</td>
<td>49/115 (43%)</td>
<td>43/106 (41%)</td>
<td>0·018 (-0·083 to 0·120)</td>
<td>0·725</td>
<td>0·040 (-0·051 to 0·131)</td>
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</table>

Data are n (%) or n/N (%), unless otherwise specified. Logistic generalised estimated equation model estimates of the treatment effect at weeks 36, 52, and 86 post-randomisation. The model was based on data from 36 weeks post-randomisation, with therapist, participant and slope random effects, treatment, treatment by time interaction, and other prespecified baseline covariates. BPI=brief psychological intervention. CBT=cognitive behavioural therapy. STPP=short-term psychoanalytical psychotherapy. MDD=major depressive disorder. ABQ=Antisocial Behaviour Questionnaire. *The marginal mean difference at a given timepoint, with negative effects indicating treatment benefit. The study was not powered to test for treatment differences in clinical diagnostic relapse. †To control for two comparisons, we used a 2·5% significance level to maintain a 5% significance level for any measure and timepoint combination.
trial patients are also consistent with these results. 3,11,28–30 the same outcome or even to no eff  ect, with the decline
explanations, including three unique eff ects leading to
eff ect, but could also be a result of alternative
present study might be due to a putative shared common
difference between the three treatments assessed in the
across diff erent treatment modalities. The absence of
diff erence in cost between the available treatment options
improve the precision of the ability to select the best
therapy, or to prediction of the likelihood of non-
lack of resistance to a given treatment early in
Such non-response might be due to issues of selection of
the right treatment for the right patient, noting the
likelihood of resistance to a given treatment early in
therapy, or to prediction of the likelihood of non-
compliance. One challenge for further research is to
improve the precision of the ability to select the best
treatment for a given patient with depression. Despite
the planned differences in treatment intensity, in
practice, young people attended a median of six to 11
sessions over 25–28 weeks across all three treatment
groups. A first course of therapy for adolescents with
depression could be brief (six to 11 sessions) and at no
difference in cost between the available treatment options
assessed in this trial. The reasons for non-attendance
deserve further investigation.

Our study had various strengths, including that
participants were representative of the population with
moderate to severe depression, with self-harm,
suicidality, and non-depressive comorbid disorders at


Table 4: Adverse event scores

<table>
<thead>
<tr>
<th>BPI</th>
<th>CBT</th>
<th>STPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>Median (min–max range)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Baseline</td>
<td>155</td>
<td>5.0 (1.1)</td>
</tr>
<tr>
<td>6 weeks</td>
<td>99</td>
<td>4.4 (1.5)</td>
</tr>
<tr>
<td>12 weeks</td>
<td>112</td>
<td>4.2 (1.6)</td>
</tr>
<tr>
<td>36 weeks</td>
<td>105</td>
<td>4.1 (1.6)</td>
</tr>
<tr>
<td>52 weeks</td>
<td>105</td>
<td>3.5 (1.8)</td>
</tr>
<tr>
<td>86 weeks</td>
<td>116</td>
<td>3.3 (1.8)</td>
</tr>
</tbody>
</table>

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psychoanalytical therapy and brief psychosocial interventions offer additional patient choice, alongside CBT, for depressed adolescents attending routine specialist CAMHS clinics.

Contributors
IMG, SR, SB, BD, JH, RK, CR, MT, and PF were responsible for the original proposal, securing funding, for the trial, and for drafting the original protocol. IMG as chief investigator had overall responsibility for the management of the study, SR, RK, and IMG had responsibility for the East Anglia site; JH and BD for the North West site; and RS, NM, MT, and PF for the North London site. RK, BD, PW, and IMG were responsible for the development of the brief psychosocial intervention manual and provided training and supervision for the therapists in East Anglia. Medical leadership and supervision for the brief psychosocial intervention was provided by RK in East Anglia, RS in North London, and BD and JH in the North West. NM, MT, and PF developed the short-term psychoanalytical therapy manual and ensured and coordinated short-term psychoanalytical therapists for the study, together with JH in the North West. SR developed the CBT manual and coordinated the therapists’ election, training, and supervision for the study; BD and JH coordinated CBT therapy in the North West. BW was project manager throughout the trial, developed and coordinated the randomisation and minimisation protocol with IMG and CR. BW set up and coordinated the database, with all data held in a single repository on the Cambridge site. NM, SR, RK, and BD coordinated and supervised the treatment fidelity project and analysed the data with randomisation and minimisation protocol with IMG and CR. BW set up the study; BD and JH coordinated CBT therapy in the North West. BW worked with JH in the North West. SR, RK, and IMG had responsibility for the development of the brief psychosocial intervention manual and provided training and supervision for the therapists in East Anglia. Medical leadership and supervision for the brief psychosocial intervention was provided by RK in East Anglia, RS in North London, and BD and JH in the North West. NM, MT, and PF developed the short-term psychoanalytical therapy manual and ensured and coordinated short-term psychoanalytical therapists for the study, together with JH in the North West. SR developed the CBT manual and coordinated the therapists’ election, training, and supervision for the study; BD and JH coordinated CBT therapy in the North West. BW was project manager throughout the trial, developed and coordinated the randomisation and minimisation protocol with IMG and CR. BW set up and coordinated the database, with all data held in a single repository on the Cambridge site. NM, SR, RK, and BD coordinated and supervised the treatment fidelity project and analysed the data with CR. FH, CR, BB, and SB wrote the statistical analysis plan and did the analyses. BW and FH were responsible for data cleaning. IMG wrote the initial draft of the manuscript. All authors contributed to and approved the final manuscript.

Declaration of interests
All authors declare no competing interests.

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