Behavioral Activation and Problem Solving Treatment in Primary Care Bibliography

Behavioral Activation


- Participants in this study (aged 18-60) met the criteria for major depressive disorder. Participants were randomly assigned to CT, BA, ADM, or pill placebo. Three therapists provided CT and BA for a maximum of 24 50-minute sessions over 16 weeks, with sessions generally held twice weekly for the first 8 weeks and once weekly for the next 8 weeks. A subset of patients treated with CT showed a pattern of extreme non-response (ENR) on self-reports of depression not found among patients treated with BA (or medications).


- Authors conducted a meta-analysis of randomized effect studies of activity scheduling. Sixteen studies with 780 subjects were included. The pooled effect size indicating the difference between intervention and control conditions at post-test was 0.87 (95% CI: 0.60 - 1.15). Heterogeneity was low in all analyses. The comparisons with other psychological treatments at post-test resulted in a non-significant pooled effect size of 0.13 in favor of activity scheduling. In ten studies activity scheduling was compared to cognitive therapy, and the pooled effect size indicating the difference between these two types of treatment was 0.02. Activity scheduling is an attractive treatment for depression, not only because it is relatively uncomplicated, time-efficient and does not require complex skills from patients or therapist, but also because this meta-analysis found clear indications that it is effective.

- The comparison involved randomly assigning 150 outpatients with major depression to a treatment focused exclusively on the behavioral activation (BA) component of CT, a treatment that included both BA and the teaching of skills to modify automatic thoughts (AT), but excluding the components of CT focused on core schema, or the full CT treatment. Four experienced cognitive therapists conducted all treatments. Despite excellent adherence to treatment protocols by the therapists, a clear bias favoring CT, and the competent performance of CT, there was no evidence that the complete treatment produced better outcomes, at either the termination of acute treatment or the 6-month follow-up, than either component treatment. Furthermore, both BA and AT treatments were just as effective as CT at altering negative thinking as well as dysfunctional attributional styles. Finally, attributional style was highly predictive of both short- and long-term outcomes in the BA condition, but not in the CT condition.

**Problem-Solving Treatment in Primary Care**


- The data from the IMPACT study, which compared collaborative care within a primary care clinic to care as usual in the treatment of 1,801 primary care patients, 60 years of age or older, with major depression or dysthymia. This study is a secondary data analysis (n = 433) of participants who received either Problem-Solving Treatment (PST-PC) by means of collaborative care or community-based psychotherapy by means of usual care. Older adults who received PST-PC had more depression-free days at both 12 and between 12 and 24 months (beta = 47.5, p <.001; beta = 47.0, p <.001), and they had fewer depressive symptoms and better functioning at 12 months (beta(dep) = -0.36, p <.001; beta(func) = -0.94, p <.001), than those who received community-based psychotherapy. Differences were not found at 24 months.


- Authors conducted a systematic literature search and identified 13 randomized studies examining the effects of PST, with a total of 1133 subjects. The mean standardized effect size was 0.34 in the fixed effects model and 0.83 in the random effects model, with very high heterogeneity. Subgroup analyses indicated significantly lower effects for individual interventions in studies with subjects who met criteria for major depression, studies in which intention-to-treat analyses were conducted instead of completers-only analyses, and studies with pill placebo and care-as-usual control groups. Heterogeneity was high, and the subgroup analyses did not result in clear indications of what caused
this high heterogeneity. This indicates that PST has varying effects on depression, and that it is not known to date what determines whether PST has larger or smaller effects.

• This case study described the application of problem-solving treatment for a person with complicated depression.

• IMPACT’s treatment manual for PST-PC.

• This paper describes a meta-analysis of 31 studies that examined the efficacy of problem solving therapy (PST). The meta-analysis, encompassing 2895 participants, showed that PST is significantly more effective than no treatment (d=1.37), treatment as usual (d=0.54), and attention placebo (d=0.54), but not significantly more effective than other bona fide treatments offered as part of a study (d=0.22). Significant moderators included whether the PST included problem-orientation training, whether homework was assigned, and whether a developer of PST helped conduct the study.

• Randomized controlled trial of problem solving treatment, amitriptyline plus standard clinical management, and drug placebo plus standard clinical management. Each treatment was delivered in six sessions over 12 weeks. 91 patients in primary care who had major depression. At six and 12 weeks the difference in score on the Hamilton rating scale for depression between problem solving and placebo treatments was significant (5.3 (95% confidence interval 1.6 to 9.0) and 4.7 (0.4 to 9.0) respectively), but the difference between problem solving and amitriptyline was not significant (1.8 (-1.8 to 5.5) and 0.9 (-3.3 to 5.2) respectively). At 12 weeks 60% (18/30) of patients given problem solving treatment had recovered on the Hamilton scale compared with 52% (16/31) given amitriptyline and 27% (8/30) given placebo.

- 415 elderly primary care patients (mean age 71), in four geographically and clinically diverse practices, with either minor depression (n=204) or dysthymia (n=211), and with a Hamilton Depression Rating Score (HDRS) of 10 or higher. 311 (75%) completed all study visits. Patients were randomized to receive paroxetine (generic name for Paxil) (n=137), placebo (n=140), or Problem-Solving Treatment-Primary Care psychotherapy (PST-PC)(n=138). Overall, patients receiving paroxetine showed greatest improvement. PST-PC intervention improved symptoms more rapidly than placebo in the end stages of the experiment. Both PST-PC and paroxetine improved function for those with minor depression at low baseline function.