Modular psychotherapy improves problems in youth with anxiety, depression or conduct disorder more rapidly than standard psychotherapy

QUESTION

Question: Is modular psychotherapy more effective than standard psychotherapy or usual care for depression, anxiety and conduct problems in youths?

Patients: 203 youths aged between 7 and 13 years who had primary Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV anxiety, depression or disruptive conduct disorders, or clinically elevated problem levels in these areas. All participants had sought outpatient care (mean age 10.59 years; 70% male; 45% white patients). *Exclusion criteria:* mental retardation, pervasive development disorder, psychotic symptoms, primary bipolar disorder or primary inattention or hyperactivity.

Setting: Ten outpatient clinical service organisations (clinic offices and schools) in Massachusetts and Hawaii, USA; January 2005 to May 2009.

Intervention: Modular psychotherapy, standard psychotherapy or usual care. Standard psychotherapy involved evidence-based manualised treatments: Coping Cat cognitive behavioural therapy (CBT) protocol for anxiety (16–20 sessions); Primary and Secondary Control Enhancement Training CBT protocol for depression (10–15 sessions); or Defiant Children behavioural parent training for conduct problems (10 steps). Modular psychotherapy was based on the Modular Approach to Therapy for Children with Anxiety, Depression or Conduct Problems (MATCH). Usual care involved the therapist's usual practices and continued until a normal end of treatment for the client.

Outcomes: *Primary outcomes:* Trajectory of change in problems assessed using standardised youth and parental measures of problems via telephone (Brief Problem Checklist (BPC) assessing internalising, externalising and total number of problems and Top Problems Assessment (TPA), assessing severity of top three problems). *Secondary outcome:* DSM-IV diagnoses.

Patient follow-up: 85.7%.

METHODS

Design: Cluster randomised controlled trial (therapists were the unit of randomisation).

Allocation: Concealed.

Blinding: Double blinded.

Follow-up period: One year (treatment period only, no post-treatment follow-up). Mean treatment period was: 201.15 days for modular psychotherapy; 196.24 days for standard psychotherapy; and 275.49 days for usual care.

MAIN RESULTS

Modular psychotherapy produced a significantly faster improvement (steeper trajectories) in overall parent-rated and youth-rated problems compared with standard psychotherapy or usual care. Modular psychotherapy significantly outperformed usual care on the pooled parent and youth rated: BPC total score (effect size 0.59, p=0.004), BPC internalising subscale (effect size 0.51, p=0.014), BPC externalising subscale (effect size 0.48, p=0.02) and TPA score (effect size 0.62, p=003). Modular therapy significantly outperformed standard treatment on the pooled parent and youth rated: BPC total score (effect size 0.71, p=0.001), BPC internalising subscale (effect size 0.55, p=0.007), BPC externalising subscale (effect size 0.65, p=0.002) and TPA score (effect size 0.50, p=0.014). Modular psychotherapy significantly reduced the mean number of clinical diagnoses compared with usual care at the end of treatment (1.23 with modular psychotherapy vs 1.86 with usual care; p=0.01).

CONCLUSIONS

In youths with anxiety, depression or conduct disorder, modular evidence-based psychotherapy reduces youth and parent-reported problems more rapidly than standard psychotherapy or usual care over a year's treatment.

ABSTRACTED FROM

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COMMENTARY

The quality gap between research and practice has led to efforts to move evidence-based treatments (EBTs), with documented efficacy in highly controlled research trials, into real-world practice settings.[1] Researchers are moving towards effectiveness and pragmatic trials to evaluate treatments in community settings with usual clinicians, patients, accountability and financing. Clinical organisations are working to bring EBTs into clinics and identify which services/treatments yield optimal outcomes.

Bridging these research and clinical perspectives, this pioneering study demonstrates the value of a modular treatment approach, with treatment elements sequenced to address youth/family needs, complex comorbid presentations, using clinical algorithms and feedback systems to guide clinical decision-making. Major study strengths include: the rigorous comparative effectiveness design, creativity of the modular approach, inclusion of usual care and active comparator conditions and documented feasibility across 10 clinics in diverse service systems.

Selection of a multiple-EBT approach, with clinicians required to learn three distinct manualised EBTs, may provide a weak 'active comparator' condition. Although the EBT movement has led to increasing use of this multiple-EBT approach, the finding that delivery of the modular treatment appeared less rigid, with more non-manual content in sessions, is consistent with our experience that clinicians find mastering multiple distinct manuals difficult, resulting in less personalised and effective treatment. The modular approach addressed only three problem areas, resulting in roughly a third of practice youth excluded based on the primary problem, and is supported by information technology, supervision and quality assurance protocols, which require organisational resources and may limit feasibility. These factors may limit generalisability, and the relatively small sample size limited analyses to primary outcomes, with no information on moderators. Further 'unpacking' of the modular approach to identify active components would be informative.

This potentially field-changing work merits further evaluation, as do alternative models, which support collaborative learning between researchers and clinicians.

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Notes