

University of Groningen

Re

Coyne, James C.

Published in:
 JOURNAL OF THE NATIONAL CANCER INSTITUTE

DOI:
[10.1093/jnci/djs408](https://doi.org/10.1093/jnci/djs408)

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
 Publisher's PDF, also known as Version of record

Publication date:
 2012

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Coyne, J. C. (2012). Re: Meta-analysis of Efficacy of Interventions Elevated Depressive Symptoms in Adults Diagnosed With Cancer. *JOURNAL OF THE NATIONAL CANCER INSTITUTE*, 104(22), 1770-1770. <https://doi.org/10.1093/jnci/djs408>

Copyright

Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

The publication may also be distributed here under the terms of Article 25fa of the Dutch Copyright Act, indicated by the "Taverne" license. More information can be found on the University of Groningen website: <https://www.rug.nl/library/open-access/self-archiving-pure/taverne-amendment>.

Take-down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): <http://www.rug.nl/research/portal>. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.

Re: Meta-analysis of Efficacy of Interventions Elevated Depressive Symptoms in Adults Diagnosed With Cancer

Despite the fundamental importance of the question of whether interventions can reduce depressive symptoms among cancer patients, Hart and colleagues (1) had to contend with a literature that is limited in both quality and quantity of studies in their effort to establish basic effect sizes. With few studies to begin with, they had to eliminate four studies because of incomplete data, and they eliminated another study as an extreme outlier in effect size. They were left with five studies they classified as psychotherapeutic and four studies as pharmacologic.

Three of the studies classified as psychotherapeutic were complex collaborative care interventions for depression with medication management components as well as psychotherapy components plus additional components addressing patient education and adherence (2,3). These studies should not have been included if the intent was to establish the effect size of psychotherapeutic interventions. Whether patients received psychotherapy was not determined by randomization and so any evaluation of the specific contribution of psychotherapy was not possible. However, these three studies provided the bulk ($n = 527$) of the patients for the authors' calculation of the effect size for psychotherapeutic intervention. Of the two remaining studies, one randomly assigned 45 patients to either problem-solving or waitlist control groups and retained only 37 patients for analyses (4). The final study (5) contributed two effect sizes based on comparisons of 29 patients receiving cognitive behavior therapy and 23 receiving supportive therapy with the same 26-patient no-treatment control group, thus violating the assumption of independence of effect sizes. In sum, the authors identified only weak evidence for the efficacy of psychotherapeutic interventions from two small studies with no control group for minimal attention and support.

Of the four pharmacologic studies, one (6) substantially differed from the others in inadequacies in both its determination of depression and its medication management by mail, and reduction in depressive symptoms was not its primary outcome. Of the 163 patients randomized to either treatment or control group, only 93 were available at follow-up. The other three studies also involved substantial loss of patients to follow-up; one of these studies (7) began with a total of 35 patients randomized to active medication or placebo and retained only 21 at follow-up.

Overall, effect sizes for psychotherapeutic and pharmacologic interventions generated by this meta-analysis are misleading as estimates of the efficacy of intervention for depressive symptoms among cancer patients. Any verdicts on the efficacy of interventions for depressive symptoms or calls for these interventions to be disseminated and implemented and integrated into routine care are premature. What would seem most appropriate is acknowledgment of the weakness of available data and the need for more and better quality research with more appropriate control groups.

JAMES C. COYNE

References

- Hart SL, Hoyt MA, Diefenbach M, et al. Meta-analysis of efficacy of interventions elevated depressive symptoms in adults diagnosed with cancer. *J Natl Cancer Inst.* 2012;104(13):990–1004.
- Dwight-Johnson M, Ell K, Lee P-J. Can collaborative care address the needs of low-income Latinas with comorbid depression and cancer? Results from a randomized pilot study. *Psychosomatics.* 2005;46(3):224–232.
- Ell K, Xie B, Quon B, et al. Randomized controlled trial of collaborative care management of depression among low-income patients with cancer. *J Clin Oncol.* 2008;26(10):4488–4496.
- Strong V, Waters R, Hibberd C, et al. Management of depression for people with cancer (SMaRT oncology 1): a randomised trial. *Lancet.* 2008;372(9632):40–48.
- Evans RL, Connis RT. Comparison of brief group therapies for depressed cancer patients receiving radiation treatment. *Public Health Rep.* 1995;110(3):306–311.
- Savard J, Simard S, Giguere I, et al. Randomized clinical trial on cognitive therapy for depression in women with metastatic breast cancer:

psychological and immunological effects. *Palliat Support Care.* 2006;4(3):219–237.

- Fisch MJ, Loehrer PJ, Kristeller J, et al. Fluoxetine versus placebo in advanced cancer outpatients: a double-blinded trial of the Hoosier Oncology Group. *J Clin Oncol.* 2003;21(10):1937–1943.

Notes

Affiliations of author: Health Psychology Section, Department of Health Sciences, University Medical Center Groningen, University of Groningen, Groningen, the Netherlands; Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

Correspondence to: James C. Coyne, PhD, Department of Psychiatry, University of Pennsylvania School of Medicine, 3535 Market St, Rm 676, Philadelphia, PA 19104 (e-mail: jcoyne@mail.med.upenn.edu).

DOI: 10.1093/jnci/djs408

©The Author 2012. Published by Oxford University Press. All rights reserved. For Permissions, please e-mail: journals.permissions@oup.com.

Response

We appreciate Coyne highlighting several of our original points, including the fundamental importance of the research question and the strikingly small body of relevant randomized controlled trials (RCTs). We agree that each included RCT had limitations. We concur that dissemination into routine care requires additional carefully formulated research.

Two primary points of disagreement with Coyne remain. First, we contend that including collaborative care RCTs and trials with relatively small samples was well reasoned. Our goal (p. 991) was to examine the efficacy of RCTs testing various therapeutic approaches rather than specific psychotherapies. Collaborative care (CC) interventions are well suited for primary care (1) and are gaining traction in oncology (2). Secondary processes in CC, such as education about depression, are common components of psychotherapy (3). In the three CC trials, patients were randomly assigned to CC or usual care. We emphasized (p. 1000) that patients do not invariably receive psychotherapy in a CC model but rather can receive psychotherapy, medication, or both. Most CC patients