Non-pharmacological treatment for depressed older patients in primary care: A systematic review and meta-analysis

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Abstract

Background

Late-life depression is most often treated in primary care, and it usually coincides with chronic somatic diseases. Given that antidepressants contribute to polypharmacy in these patients, and potentially to interactions with other drugs, non-pharmacological treatments are essential. In this systematic review and meta-analysis, we aimed to present an overview of the non-pharmacological treatments available in primary care for late-life depression.

Method

The databases of PubMed, PsychINFO, and the Cochrane Central Register of Controlled Trials were systematically searched in January 2017 with combinations of MeSH-terms and free text words for “general practice,” “older adults,” “depression,” and “non-pharmacological treatment”. All studies with empirical data concerning adults aged 60 years or older were included, and the results were stratified by primary care, and community setting. We narratively reviewed the results and performed a meta-analysis on cognitive behavioral therapy in the primary care setting.

Results

We included 11 studies conducted in primary care, which covered the following five treatment modalities: cognitive behavioral therapy, exercise, problem-solving therapy, behavioral activation, and bright-light therapy. Overall, the meta-analysis showed a small effect for cognitive behavioral therapy, with one study also showing that bright-light therapy was effective. Another 18 studies, which evaluated potential non-pharmacological interventions in the community suitable for implementation, indicated that bibliotherapy, life-review, problem-solving therapy, and cognitive behavioral therapy were effective at short-term follow-up.
We conclude that the effects of several treatments are promising, but need to be replicated before they can be implemented more widely in primary care. Although more treatment modalities were effective in a community setting, more research is needed to investigate whether these treatments are also applicable in primary care.

**Trial registration**

PROSPERO CRD42016038442.

Introduction

Depression is a common disorder among older adults, with an estimated one-year prevalence of 10% in primary care [1,2]. These older patients are most often treated in primary care [3], and only a few are referred to specialist mental healthcare services [4,5]. This is consistent with research indicating that older adults prefer to consult their general practitioner for mental health problems [6,7]. If depression is treated, most of these patients will be treated with an antidepressant [4]. However, depression in older adults often co-occurs with chronic somatic disease [8] and in the context of polypharmacy [9]. Prescribing antidepressants therefore increases the risk of adverse drug-related events [10], as evidenced by the fact that two-thirds of elderly antidepressant users receive drugs that are either contraindicated or have the potential for moderate to major interactions [11,12]. Moreover, tricyclic antidepressants, and to a minor degree newer agents like SSRIs, often have anticholinergic and sedative effects that are associated with physical and cognitive impairment [13–15].

Evidence-based non-pharmacological treatment options are needed for the treatment of depression in older adults, particularly in primary care. Despite this, the most recent systematic review focusing on the treatment for late-life depression in primary care was performed more than 15 years ago [16]. Although other systematic reviews and meta-analyses focusing on the psychological treatment of late-life depression have concluded that psychological therapies seem effective [17–20], these had limitations precluding the generalization of their results to primary care settings. First of all, all reviews included studies conducted in clinical settings. Moreover, the most recently conducted review included only six RCTs. Three of these six RCTs were conducted in a primary care setting, with even two of them relying on an academic team to provide the intervention at home [18]. Furthermore, two previously conducted reviews also included middle-aged adults (50+) [17,19]. Since, depression may be more heterogeneous in primary care, and treatment may be less structured, this precludes generalizability of the results of these previous systematic reviews to primary care. Given that primary care is the predominant setting in which depression in older adults is treated, it is essential that an up-to-date summary is available to inform practitioners of the evidence base for non-pharmacological treatments in this setting.

We aimed to present an overview of the evidence for non-pharmacological treatment options for depression in older adults (60+) within primary care, to provide up-to-date, evidence-based information to inform primary care physicians about possible alternatives for antidepressant treatment with its side-effects, interactions and contribution to polypharmacy.
Methods

Search strategy

The protocol for this systematic review was registered at PROSPERO (CRD42016038442). We performed an extensive search in the databases of PubMed, PsychINFO, and the Cochrane Central Register of Controlled Trials. We used the following search terms: (general practice OR synonym) AND (depressive disorder OR synonym) AND (aged OR synonym) AND (non-pharmacological treatment OR synonym). Free text words and index terms were used (MeSH for PubMed and Thesaurus for PsychINFO). We searched for articles until the January 2nd, 2017. The full search strategies for the three databases are presented in S1 Appendix.

Identification and selection of studies

To be as comprehensive as possible, we decided not to restrict the searches to randomized controlled trials (RCTs). Results of other study types (e.g. cohort studies) were used to identify promising therapeutic strategies subject to future research. Therefore, we included all empirical studies that met the following criteria: (a) sample sizes ≥5 patients; (b) depression as the primary outcome; (c) a study population of adults aged ≥60 years at the moment of inclusion (or there were adequately reported sub-analyses of adults ≥60 years); (d) was conducted in a primary care or community setting; and (e) reported non-pharmacological treatments applicable in these settings. We set no language or date restrictions.

Depression was defined as either an identified depressive disorder according to DSM or ICD criteria determined by a validated diagnostic interview or instrument, or as an elevated score on a screening tool. Since there is no known golden standard for the identification of depression in later life, we decided to include all studies focusing on depression, regardless of their depression inclusion criterion. The age cut-off of 60 was used, because this is the mostly used cut-off for late-onset depression [21]. In addition, the earlier review regarding treatment of depression in primary care [16] also included studies focusing on adults aged 60+.

Studies were excluded if they met the following criteria: (a) included bipolar disorder, psychotic depression, or depression with suicide ideation, which are considered indicative for referral to secondline treatment [22]; (b) focused on caregivers instead of patients; (c) studied the effect of a non-pharmacological intervention as an adjunct to pharmacotherapy; (d) studied the effect of service-level intervention, such as collaborative or stepped care; or (e) studied the effect of an intervention to prevent depression.

Studies were independently screened and selected for inclusion by two authors (FH and BM). First, titles were screened to exclude irrelevant papers, and the remaining abstracts were then scrutinized in detail. Of the potentially relevant papers, full texts were retrieved to determine whether the inclusion criteria were met. In cases of disagreement, consensus was reached based on discussion and, if necessary, consultation with a third author (PV). We searched for additional articles by studying published study protocols lacking published follow-up data, by checking the reference lists of the included publications and of relevant systematic reviews and meta-analyses [17–20], and by screening conference abstracts. If necessary, corresponding authors of possible relevant papers were contacted.

Analysis

Quality assessment. The Cochrane risk of bias tool was used for the quality assessment of included RCTs [23]. This was done independently by two authors (FH and BM). Studies were not excluded based on the quality assessment, but the quality was considered when comparing
the different studies, when interpreting the results, and when recommendations for future studies were formulated.

**Data extraction.** Two authors (FH and BM) independently extracted data from all included studies. The following data were extracted: year of study, study design, sample size, setting (primary care, community), population characteristics (age, gender, comorbidity), treatment type and characteristics (e.g. individual/group, number of sessions), diagnosis at baseline and diagnostic tool, main result, percentage that declined participation, duration of follow-up, percentage lost to follow-up, and percentage that adhered to treatment. Included studies were classified to the setting in which they were conducted, namely primary care setting or community setting. Studies were considered primary care studies if the study recruited participants in primary care and the intervention was delivered in that setting. Studies were considered community studies when participants were recruited from the community, for example, by means of self-referral.

The results were then summarized into the following three categories: (1) mean change, defined as the difference in depressive symptoms between baseline and follow-up measurement; (2) responders, defined as a ≥50% symptom reduction in the outcome measure between baseline and follow-up (unless stated otherwise); and (3) remission from depression at follow-up measurement. The definition of remission differed between studies. The mean change in depressive symptom scores was the primary outcome of this review.

**Analysis.** We narratively reviewed the included studies by type of treatment, with the results stratified by setting (primary care or community). Given that most studies in primary care have focused on the effect of cognitive behavior therapy (CBT), we chose to perform a meta-analysis for the effect of this intervention in the primary care setting. Because of expected heterogeneity of the studies, a random-effects model was used to pool the effect of CBT on depression. We calculated the standardized mean differences (SMD) using the mean scores and standard deviations immediately after treatment and at long-term follow-up for the intervention and control groups in the studies included in the meta-analysis. If these data were not available in the original articles, they were calculated by the researchers, using the published data. If studies varied in measurement time points during long-term follow-up, we calculated the SMDs for the points closest to 6 months. Statistical heterogeneity was evaluated by the chi-square and I^2 tests. Inter-study heterogeneity was considered significant for p < 0.1 and I^2 > 50%. The meta-analysis was conducted using Review Manager (Version 5.3. Copenhagen: The Nordic Cochrane Centre, The Cochrane Collaboration, 2014).

**Results**

**Selection of studies and characteristics of included studies**

Fig 1 summarizes the process of study inclusion. In total, 4027 references were screened and 273 full text papers were retrieved, of which 17 were identified through cited reference search. Of these, 31 were included that consisted of 29 different studies (27 RCTs, two cohort studies). Of two RCTs two references of each were included, one reporting short-term follow-up and the other long-term follow-up. Eleven primary care studies and 18 community studies were included.

Table 1 shows the characteristics of the 11 included studies that were conducted in primary care settings (10 RCTs, 1529 patients; 1 cohort study, 14 patients). The interventions studied included CBT (n = 5), exercise (n = 2), problem-solving therapy (PST; n = 1), a combination of CBT and bibliotherapy (n = 1), behavior activation (BA; n = 1), and bright-light therapy (n = 1). Follow-up ranged from 1 week up to 12 months.
Table 2 shows the characteristics of the 18 studies recruiting in the community, most of which depended on self-referral by participants (17 RCTs, 1041 patients; 1 cohort study, 22 patients). The studied treatment modalities were CBT (n = 3), bibliotherapy (n = 4), life-review (n = 3), exercise (n = 4), PST (n = 3), and receiving postcards (n = 1). In addition, 1 study compared cognitive therapy, behavioral therapy, and brief psychodynamic therapy with patients on a waiting list. Follow-up period ranged from 4 weeks to 2 years.

Outcome data of primary care studies

The outcome data for studies conducted in a primary care setting are presented in Table 3, and the quality assessments with corresponding scores on the subscales are presented in Fig 2. The results of the meta-analysis are summarized in Fig 3.

Cognitive behavioral therapy. Five studies assessed the effect of CBT on depression in older adults: three assessed the effect of CBT alone [25,28,31], one assessed its use in combination with self-management [29], and one compared CBT with clinical case-management [24]. CBT was delivered individually in three out of the five studies [28,29,31], and as a group therapy in the other two [24,25].

CBT delivered as individual therapy was more effective in reducing depressive symptoms at 4 and 12 months’ follow-up compared with both control groups (talking control and care as usual) [31]. In a study where CBT was delivered by individual therapy, CBT was not effective at reducing depressive symptoms immediately after treatment or at 3 and 6 months’ follow-up [28]. Equally, in another study where CBT was delivered by group therapy, it was no more effective in achieving response (determined by a decrease of ≥5 points in the PHQ-9 [Patient Health Questionnaire]) compared with care as usual at 12 weeks’ follow-up [25]; however, this
<table>
<thead>
<tr>
<th>Study year</th>
<th>Design</th>
<th>Setting (country)</th>
<th>Diagnostic inclusion criterion</th>
<th>Intervention</th>
<th>N</th>
<th>Control (if applicable)</th>
<th>N</th>
<th>Mode of therapy</th>
<th>Age mean (min)</th>
<th>Female (%)</th>
<th>Antidepressant therapy</th>
<th>Specific baseline characteristics</th>
<th>Declined participation (%)</th>
<th>Follow-up period</th>
<th>Loss to follow-up (%)</th>
<th>Adherence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aman (2008) [24]</td>
<td>RCT</td>
<td>Primary care and community (USA)</td>
<td>Major depression and dysthymia (SCID)</td>
<td>CBT</td>
<td>20</td>
<td>1.CCM; 2. CCM + CBT</td>
<td>1. 27; 2. 25</td>
<td>Group therapy, by psychologist or social worker, 18 sessions/week for 16 weeks, 2 h</td>
<td>65.3 (60+)</td>
<td>64.3%</td>
<td>AD use was an exclusion criterion; and 11 (22%) started AD immediately after treatment</td>
<td>&lt;$15,000 household income</td>
<td>14%</td>
<td>Post-treatment 6 months; 12 months</td>
<td>30.9%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Garcia-Pena (2013) [25]</td>
<td>RCT</td>
<td>Primary care (Mexico)</td>
<td>Depressive symptoms (PHQ-9 cut-off of 6-9)</td>
<td>CBT</td>
<td>41</td>
<td>CAU</td>
<td>41</td>
<td>Group therapy by a nurse with 10 group, 12-15 h; 4 weeks</td>
<td>70.8 (60+)</td>
<td>83%</td>
<td>Not reported</td>
<td>–</td>
<td>–</td>
<td>Not reported</td>
<td>12 weeks</td>
<td>1.2%</td>
</tr>
<tr>
<td>Gum (2016) [26]</td>
<td>Pilot Cohort</td>
<td>Primary care (USA)</td>
<td>Mild to moderate depressive symptoms (PHQ-9 cut-off of 14)</td>
<td>Behavioral activation</td>
<td>14</td>
<td>n.a.</td>
<td>n.a.</td>
<td>Individual, 1 session, 90 min, by psychologist, identifying life values, select activities, and establish weekly goals. FU by 3 phone calls</td>
<td>70.2 (60+)</td>
<td>71.4%</td>
<td>Baseline: 35.7%</td>
<td>psychotropic medication</td>
<td>–</td>
<td>47.6%</td>
<td>4 weeks</td>
<td>33.3%</td>
</tr>
<tr>
<td>Joling (2011) [27]</td>
<td>RCT</td>
<td>Primary care (Netherlands)</td>
<td>Subthreshold depression (CES-D cut-off of 6)</td>
<td>CBT-based, bilateral therapy</td>
<td>86</td>
<td>CAU</td>
<td>84</td>
<td>Individual therapy, 3 nurse visits max 1 h, 2 phone calls</td>
<td>81.5 (75+)</td>
<td>73.5%</td>
<td>Not reported</td>
<td>–</td>
<td>15.4%</td>
<td>2 months</td>
<td>14.1%</td>
<td>41% completed full intervention</td>
</tr>
<tr>
<td>Lastrow (2008) [28]</td>
<td>RCT</td>
<td>Primary care (Yorkshire, UK)</td>
<td>MDD (SADS-L, HDRS &gt;7–24, BDI-II ≥13–23)</td>
<td>CBT</td>
<td>21</td>
<td>CAU</td>
<td>23</td>
<td>Individual, by psychologist, mean 8 sessions (range 3–17)</td>
<td>74 (60+)</td>
<td>65.9%</td>
<td>2 CBT participants on AD. CAU could include AD</td>
<td>–</td>
<td>24.3%</td>
<td>Post-treatment; 3 months, 6 months</td>
<td>13.6%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Lammers (2010) [29]</td>
<td>RCT</td>
<td>Primary care (Netherlands)</td>
<td>MDD (moderate to severe), minor depression, dysthymia (MINI)</td>
<td>Self-management + CBT</td>
<td>183</td>
<td>CAU</td>
<td>178</td>
<td>Individual therapy, 10–15 sessions during 3 months (mean 8), 1 h each</td>
<td>70.7 (60+)</td>
<td>46.5%</td>
<td>AD exclusion criterion. CAU could include AD. 2 participants started during follow-up</td>
<td>165 DM and 176 COPD patients</td>
<td>Not reported</td>
<td>1 week; 3 months, 9 months</td>
<td>36.9%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Lavers (2011) [30]</td>
<td>RCT</td>
<td>Outpatient clinics and case-finding via GP offices (Netherlands)</td>
<td>MDD (SADS-L, BDI-II ≥13–23)</td>
<td>Bright-light therapy</td>
<td>42</td>
<td>Dim red light</td>
<td>47</td>
<td>Individual, 60 min during early morning, for 3 weeks</td>
<td>69.3 (60+)</td>
<td>65.2%</td>
<td>Randomization stratified for AD: IG 53.3%; CG 53%</td>
<td>–</td>
<td>11.7%</td>
<td>3 weeks; 6 months</td>
<td>5.6%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Safery (2009) [31]</td>
<td>RCT</td>
<td>Primary care (UK)</td>
<td>Depressive disorder (Geriatric Mental Health and History and Staging Schedule; BDI-II ≥14)</td>
<td>CBT + CAU</td>
<td>70</td>
<td>1. Talking control + CAU; 2. CAU</td>
<td>1. 67; 2. 67</td>
<td>Group therapy, mean 12 sessions, 30 min each. As adj: &quot;Feeling Good&quot; handbook</td>
<td>74.1 (65+)</td>
<td>79.4%</td>
<td>Inclusion: stable dose for ≥4 weeks. Baseline: IG 25.75% TC 33.91%; CAU 37.3% could include AD</td>
<td>–</td>
<td>19.9%</td>
<td>4 months; 10 months</td>
<td>13.2%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Sims (2011) [32]</td>
<td>Pilot RCT</td>
<td>Primary care (Australia)</td>
<td>Depressive symptoms (GDS cut-off ≥10)</td>
<td>Progressive Resistance Training</td>
<td>14</td>
<td>Advice</td>
<td>18</td>
<td>Group (individual not reported; 3 week for 10 weeks, max. 30 sessions) + weekly phone monitoring</td>
<td>74.3 (65+)</td>
<td>65.6%</td>
<td>AD withdrawal criterion</td>
<td>–</td>
<td>Not reported</td>
<td>10 weeks; 6 months</td>
<td>15.8%</td>
<td>58% met adherence criterion of 60%</td>
</tr>
<tr>
<td>Singh (2005) [33]</td>
<td>RCT</td>
<td>Primary care (Australia)</td>
<td>Major/minor depression, dysthymia (instrument not reported; GDS cut-off ≥5)</td>
<td>1. High-intensity training: 2. Low-intensity training</td>
<td>1. 20; 2. 20</td>
<td>CAU</td>
<td>20</td>
<td>Groups of 1-4 participants; 3 week during 8 weeks, sessions of 60 min. High: 80% of max load; LOW: 20% of max load</td>
<td>69.3 (60+)</td>
<td>50%</td>
<td>Indication: No AD prescription within last 3 months</td>
<td>–</td>
<td>Not reported</td>
<td>8 weeks</td>
<td>10.0%</td>
<td>HIGH: 90%–100%; LOW: 99%–100%</td>
</tr>
<tr>
<td>Williams (2000) [34]</td>
<td>RCT</td>
<td>Primary care (USA)</td>
<td>Minor depression and dysthymia (PRIME-AD)</td>
<td>PST</td>
<td>138</td>
<td>1 placebo; 2. paroxetine</td>
<td>1. 140; 2. 137</td>
<td>Individual, by psychologist, social worker, or counselor 6 sessions for 11 week; first 1 h then 30 min each</td>
<td>71 (60+)</td>
<td>41.5%</td>
<td>AD prohibited in PST</td>
<td>–</td>
<td>3.9%</td>
<td>11 weeks</td>
<td>25.1%</td>
<td>8.1% attended ≥4 sessions; 74.9% completed all sessions</td>
</tr>
</tbody>
</table>

AD, Antidepressant; BDI, Beck Depression Inventory; CAU, Care as Usual; CBT, Cognitive Behavior Therapy; CCM, Clinical Case-Management; CES-D, Center for Epidemiologic Studies Depression Scale; CG, Control Group; COPD, Chronic Obstructive Pulmonary Disease; DM, Diabetes Mellitus; FU, follow-up; GDS, Geriatric Depression Scale; GP, General Practitioner; HDRS, Hamilton Depression Rating Scale; IG, Intervention Group; MDD, Major Depressive Disorder; MINI, Mini International Neuropsychiatric Interview; n.a., not applicable; PHQ-9, Patient Health Questionnaire; RCT, Randomized Controlled Trial; SCID, Structured Clinical Interview for DSM Disorders; SADS-L, Schedule for Affective Disorders and Schizophrenia–Lifetime version; UK, United Kingdom; USA, United States of America.
Table 2. Characteristics of included studies conducted in community settings.

<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Design</th>
<th>Setting (country)</th>
<th>Diagnostic inclusion criterion</th>
<th>Intervention</th>
<th>N</th>
<th>Control (if applicable)</th>
<th>N</th>
<th>Mode of therapy</th>
<th>Age (min)</th>
<th>Female (%)</th>
<th>Antidepressant therapy</th>
<th>Specific baseline characteristics</th>
<th>Declined participation (%)</th>
<th>Follow-up period</th>
<th>Loss to follow-up (%)</th>
<th>Adherence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chen (2013)</td>
<td>RCT</td>
<td>Community (Singapore)</td>
<td>Mild to moderate depressive symptoms (GDS &lt;= 14)</td>
<td>Life review</td>
<td>14</td>
<td>None</td>
<td>12</td>
<td>Creating a life-story book, including personal photos. 5 sessions; 30–60 min each</td>
<td>69.7 (63)</td>
<td>80.8</td>
<td>Not reported</td>
<td>20.7%</td>
<td>8 weeks</td>
<td>0%</td>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Ciechanowski (2004)</td>
<td>RCT</td>
<td>Community senior service agencies (USA)</td>
<td>Minor depression and dysthymia (SCID)</td>
<td>PST + Social activities to Moderate physical activity</td>
<td>72</td>
<td>CAU</td>
<td>66</td>
<td>Individual, by social worker, 8 sessions during 16 weeks, 30 min. Followed by brief phone contact</td>
<td>73 (60)</td>
<td>79%</td>
<td>Baseline: IG 40%; COG 40%</td>
<td>During study: started IG 7; COG 4</td>
<td>8%</td>
<td>0 months; 12 months</td>
<td>5.1%</td>
<td>8.6</td>
</tr>
<tr>
<td>Foyle (2004, 2006)</td>
<td>RCT</td>
<td>Community (USA)</td>
<td>Minor and major depression, dysthymia (HRDS out of 15)</td>
<td>1. Bibliotherapy, 2. Cognitive psychotherapy</td>
<td>1.16</td>
<td>Waiting list (4 weeks)</td>
<td>14</td>
<td>1. Book “Finding Good” read + homework exercises, &lt;6 month. Weekly phone calls. 2. Individual, by clinical psychology graduate students, 12–20 sessions, 1–2 weeks</td>
<td>68.0 (65)</td>
<td>76.1</td>
<td>Inclusion, stable dose for &lt;3 months Baseline: 26%</td>
<td>Self-referral</td>
<td>12.6% Post-treatment: 3 months/IG only 2 years (IG only)</td>
<td>30.4%</td>
<td>43.5%</td>
<td>Median: 8.0 visits</td>
</tr>
<tr>
<td>Imai (2015)</td>
<td>RCT</td>
<td>Community (Taiwan)</td>
<td>Depressive symptoms (GDS out of -5)</td>
<td>Receiving postal</td>
<td>93</td>
<td>None</td>
<td>91</td>
<td>Receiving postal, 1/ month during 8 months. Handwritten message + computer printed general message</td>
<td>81 (68)</td>
<td>73.4</td>
<td>Baseline: IG 65%; COG 62%</td>
<td>At least mild cognitive deficit (DRS ≤ 7) &amp; impairment iADL &lt; 1</td>
<td>Not reported</td>
<td>12 weeks</td>
<td>14.9%</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Kiosses (2010)</td>
<td>RCT</td>
<td>Community (USA)</td>
<td>MDD (GDS, HAM-D out of 17)</td>
<td>Problem Adaptation Therapy</td>
<td>15</td>
<td>Supportive therapy</td>
<td>15</td>
<td>PST modified for cognitive impaired. Individual, during 12 weeks, home-delivered, by therapist</td>
<td>79.4 (65)</td>
<td>70.0%</td>
<td>Inclusion: Psychotropic medication stable dose for &lt;8 weeks. Baseline: 78.7% on AD in both groups</td>
<td>Cognitive impairment deficit (DRS 30) &amp; impairment iADL &lt; 1</td>
<td>Self-referral</td>
<td>13.5%</td>
<td>6 weeks; 12 weeks (post-treatment)</td>
<td>10.0%</td>
</tr>
<tr>
<td>Kiosses (2015)</td>
<td>RCT</td>
<td>Community agencies (USA)</td>
<td>Major depression symptoms (SCID)</td>
<td>Problem Adaptation Therapy</td>
<td>37</td>
<td>Supportive therapy</td>
<td>37</td>
<td>Problem-solving approach, individual, by psychologist/social worker/M. 12 sessions</td>
<td>80.9 (65)</td>
<td>74.3%</td>
<td>Inclusion, stable dose for 6 weeks Baseline: IQ 65%; AD 62%</td>
<td>At least mild cognitive deficit (DRS ≤ 7) &amp; impairment iADL &lt; 1</td>
<td>Not reported</td>
<td>12 weeks</td>
<td>14.9%</td>
<td>Not applicable</td>
</tr>
<tr>
<td>McNeil (1991)</td>
<td>RCT</td>
<td>Community (Canada)</td>
<td>Moderate depression (BDI out of 12–26)</td>
<td>Exercise</td>
<td>?</td>
<td>Social contact control</td>
<td>?</td>
<td>Walking at vigorous pace, 3x/week, 20–40 min, during 6 weeks. 2x/week accompanied with undergraduate psychologist</td>
<td>72.5 (7)</td>
<td>?</td>
<td>Not reported</td>
<td>–</td>
<td>Not reported</td>
<td>10 weeks</td>
<td>0%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Moses (2012)</td>
<td>RCT</td>
<td>Community (USA)</td>
<td>Depressive symptoms (GDS out of -5)</td>
<td>Behavioral Activation Therapy</td>
<td>13</td>
<td>Waiting list (4 weeks)</td>
<td>13</td>
<td>Individual, self-study workbook, weekly phone calls</td>
<td>77.5 (65)</td>
<td>76.9%</td>
<td>Inclusion, stable dose for &lt;1 month</td>
<td>–</td>
<td>–</td>
<td>5.5%</td>
<td>8 weeks</td>
<td>30.8%</td>
</tr>
<tr>
<td>Presch (2012)</td>
<td>RCT</td>
<td>Community (Switzerland)</td>
<td>Subsyndromic and minimal depression (HRSD out of 10–28)</td>
<td>Life review</td>
<td>21</td>
<td>Waiting list (6 weeks)</td>
<td>19</td>
<td>Individually, by psychologists, 6 sessions, 1 week during 6 weeks. Face to face and computer intervention</td>
<td>70 (65)</td>
<td>66.7%</td>
<td>Baseline: IG 36.8%; COG 41.2%</td>
<td>Self-referral</td>
<td>Not reported</td>
<td>6 weeks; 3 months/IG only</td>
<td>10.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Rosenbaum (2010)</td>
<td>RCT</td>
<td>Pilot Cohort</td>
<td>Senior centers/retirement communities</td>
<td>Subsyndromic depression (MINI)</td>
<td>Exercise (Niralee Wii gaming)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>Group/individual not reported first by physical trainer, subsequently by staff member, 3x/3min each week, during 12 weeks</td>
<td>78.7 (65)</td>
<td>68.4%</td>
<td>AD exclusion criterion</td>
<td>–</td>
<td>–</td>
<td>Not reported</td>
<td>12 weeks; 24 weeks</td>
<td>13.6%</td>
</tr>
<tr>
<td>Szocik (1987)</td>
<td>RCT</td>
<td>Community (USA)</td>
<td>Mild to moderate depression (HRBD out of 10)</td>
<td>1. Cognitive bibliotherapy. 2. Control bibliotherapy (Attention Control)</td>
<td>1.10</td>
<td>Waiting list (4 weeks)</td>
<td>11</td>
<td>1. Book “Finding good” read &lt;6 month, weekly, weekly phone calls 2. Book “Man’s search for meaning” weekly phone calls</td>
<td>71.0 (65)</td>
<td>79.3%</td>
<td>Baseline: 20.7%</td>
<td>Psychotropic med CB 33.3% AC 25.0% Waiting list 9.7%</td>
<td>Self-referral</td>
<td>Not reported</td>
<td>10.3%</td>
<td>31.0%</td>
</tr>
<tr>
<td>Study (year)</td>
<td>Design</td>
<td>Setting (country)</td>
<td>Diagnostic inclusion criterion</td>
<td>Intervention</td>
<td>N</td>
<td>Control (if applicable)</td>
<td>N</td>
<td>Mode of therapy</td>
<td>Age (mean)</td>
<td>Female (%)</td>
<td>Antidepressant therapy</td>
<td>Specific baseline characteristics</td>
<td>Declined participation (%)</td>
<td>Follow-up period</td>
<td>Loss to follow-up (%)</td>
<td>Adherence (%)</td>
</tr>
<tr>
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</tr>
<tr>
<td>Scogin (1989, 1990) [48,49]</td>
<td>RCT</td>
<td>Community (USA)</td>
<td>Mild to moderate depressive symptoms (HRSD cut-off ≥16)</td>
<td>1. Behavioral bibliotherapy; 2. Cognitive bibliotherapy</td>
<td>1.23 2.22</td>
<td>Waiting list (4 weeks)</td>
<td>22</td>
<td>1.Book &quot;Control Your Depression,&quot; read &lt;1month, weekly phone calls, 2.Book &quot;Feeling Good,&quot; read &lt;1month, weekly phone calls</td>
<td>69.3 (65±)</td>
<td>85.1%</td>
<td>Inclusion: stabilized on psychotropics, Baseline: 34.3%</td>
<td>Self-referral</td>
<td>Not reported</td>
<td>Post-treatment: 6 month (IG only); 2 years (IG only)</td>
<td>72.5% 33.3%</td>
<td>31.8% (eligible N = 44)</td>
</tr>
<tr>
<td>Serrano (2004) [50]</td>
<td>RCT</td>
<td>Community (Spain)</td>
<td>Clinically significant depressive symptoms (CES-D cut-off ≥17)</td>
<td>Life-review</td>
<td>25</td>
<td>CAU (by social services)</td>
<td>25</td>
<td>Individual, by therapist, 4 sessions, 1/week</td>
<td>77.2 (65±)</td>
<td>76.7%</td>
<td>AD exclusion criterion</td>
<td>Self-referral</td>
<td>18.4%</td>
<td>8 weeks</td>
<td>14%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Singh (1997) [51]</td>
<td>RCT</td>
<td>Community (USA)</td>
<td>Mild depressive symptoms (BDI cut-off ≤18)</td>
<td>Exercise</td>
<td>17</td>
<td>Health education program</td>
<td>15</td>
<td>Group (1–8 individuals), high intensity progressive resistance training, during 10 weeks, 3 days/week, 45 min per session, by principal investigator</td>
<td>71 (60±)</td>
<td>62.5%</td>
<td>Exclusion if an AD within last 3 months</td>
<td>Self-referral</td>
<td>Not reported</td>
<td>10 weeks</td>
<td>0%</td>
<td>IG: 93%, CG: 95%</td>
</tr>
<tr>
<td>Thompson (1997) [53]</td>
<td>RCT</td>
<td>Community (USA)</td>
<td>Major depression (Research Diagnostic Criteria: BDI cut-off ≥17, HRSD cut-off ≥14)</td>
<td>1.Cognitive therapy; 2. Behavioral therapy; 3.Brief psychodynamic therapy</td>
<td>1.27 2.25 3.24</td>
<td>Waiting list (6 weeks)</td>
<td>30</td>
<td>All 3 interventions: Individual therapy, by psychologist, 16–20 sessions, 1/week</td>
<td>67.0 (60±)</td>
<td>67.4%</td>
<td>Inclusion stabilized for ≥3-month, Baseline: % unclear</td>
<td>Self-referral</td>
<td>Not reported</td>
<td>Mid-treatment: Post-treatment (IG only)</td>
<td>Unclear</td>
<td>Not reported</td>
</tr>
<tr>
<td>Titov (2015) [54]</td>
<td>RCT</td>
<td>Community (Australia)</td>
<td>Depressive feelings</td>
<td>ICBT</td>
<td>29</td>
<td>Waiting list (8 weeks)</td>
<td>25</td>
<td>Individual, 5 lessons during 8 weeks + weekly contact with therapist by phone or e-mail</td>
<td>65 (60±)</td>
<td>74.1%</td>
<td>Not reported</td>
<td>Self-referral</td>
<td>Not reported</td>
<td>Post-treatment: 3 months (IG only); 12 months (IG only)</td>
<td>13.0% 31.0% 34.5%</td>
<td>70% completed treatment within the 8 wk course</td>
</tr>
<tr>
<td>Wuthrich (2013) [66]</td>
<td>RCT</td>
<td>Community (Australia)</td>
<td>DSM-IV (sub) clinical criteria for both anxiety and mood disorder (ADIS ≥3)</td>
<td>CBT</td>
<td>27</td>
<td>Waiting list (12 weeks)</td>
<td>35</td>
<td>Group therapy, 12 weekly sessions, 2 h each, 6-8 participants per group, by psychologist + homework</td>
<td>67.4 (60±)</td>
<td>64.5%</td>
<td>Baseline: 21.0% on psychotropic medication; IG: 22.2% CG:20.0%</td>
<td>Participants were asked not to change medication during trial</td>
<td>Control: anxiety disorder: Self-referral</td>
<td>Not reported</td>
<td>Post-treatment: 3 months (IG only)</td>
<td>24.2% 25.9%</td>
</tr>
</tbody>
</table>

AD, Antidepressant; AC, Attention Control; ADIS, Anxiety Disorder Interview Schedule; BDH, Beck Depression Inventory; Bib, Bibliotherapy; CB, Cognitive bibliotherapy; CBT, Cognitive Behavior Therapy; CES-D, Center for Epidemiologic Studies Depression Scale; CG, Control Group; CP, Cognitive Psychotherapy; DRS, Dementia Rating Scale; GDS, Geriatric Depression Scale; IADL, instrumental Activities of Daily Life; HAM-D Hamilton Rating Scale for Depression; HRSD, Hamilton Rating Scale for Depression; iCBT, Individual Cognitive Behavior Therapy; IG, Intervention Group; MINI, International Neuropsychiatric Interview; PFE, Physical Fitness Exercise; PST, Problem-Solving Therapy; RCT, Randomized Controlled Trial; SCID, Structured Clinical Interview for DSM Disorders; USA, United States of America.

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later study did not report the mean change in depressive symptoms. In other research, clinical case-management was more effective than CBT at 12 months’ follow-up [24]. By contrast, CBT in combination with self-management was shown to reduce depressive symptoms at 3 and 9 months’ follow-up [29].

Fig 3 shows the results of the meta-analysis. Four out of the five studies focusing on CBT in primary care could be included in the meta-analysis; the fifth study could not be included because it did not report continuous baseline and follow-up data [25], and because the authors

Table 3. Outcomes by intervention and control groups (if applicable) for studies conducted in primary care.

<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Treatment</th>
<th>Outcome measure</th>
<th>Follow-up</th>
<th>Mean change*</th>
<th>Responders**</th>
<th>Remission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arean (2005) [24]</td>
<td>1. CBT; 2. CCM; 3. CBT+CCM</td>
<td>HDRS</td>
<td>Post-treatment (6 months); 6 months FU; 12 months FU</td>
<td>CBT -1.71 CCM -3.84 CBT+CCM -2.77; n.s.; CBT -1.50 CCM -4.37 CBT+CCM -4.81; n.s.; CBT +1.97 CCM -5.10 CBT +CCM -8.49; CBT vs other p &lt; .01</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Garcia-Pena (2015) [25]</td>
<td>CBT</td>
<td>PHQ-9</td>
<td>12 weeks FU</td>
<td>Not reported</td>
<td>IG 56.1% and CG 30%; n.s.*</td>
<td>Not reported</td>
</tr>
<tr>
<td>Gum (2016) [26]</td>
<td>Behavioral Activation</td>
<td>PHQ-9</td>
<td>4 weeks FU</td>
<td>-4.28; p = .002</td>
<td>Not reported</td>
<td>57.1%b</td>
</tr>
<tr>
<td>Joling (2011) [27]</td>
<td>CBT-based bibliotherapy</td>
<td>CES-D</td>
<td>2 months FU</td>
<td>IG -4.57 and CG -4.78; p = .73</td>
<td>IG 46.9% and CG 43.6; p = .70f</td>
<td>IG 36.4% and CG 30%; p = .46d</td>
</tr>
<tr>
<td>Laidlaw (2008) [28]</td>
<td>CBT</td>
<td>HRSD</td>
<td>Post-treatment (18 weeks); 3 months FU; 6 months FU</td>
<td>HRDS: IG -6.15 and CG -4.05; p = .15; BDI-II: IG -10.2 and CG -6.25; p = .21; HDRS: IG -6.25 and CG -5.1; p = .38; BDI-II: IG -10.6 and CG -6.6; p = .17; HDRS: IG -4.7 and CG -4.25; p = .63; BDI-II: IG -9.05 and CG -4.4; p = .18</td>
<td>Not reported</td>
<td>IG 70% and CG 40%; p = .06; IG 80% and CG 50%; p = .047; IG 55% and CG 40%; p = .34</td>
</tr>
<tr>
<td>Lamers (2010) [29]</td>
<td>Self-management + CBT</td>
<td>BDI</td>
<td>1 week FU; 3 months FU; 9 months FU</td>
<td>IG -0.92 and CG -0.53; p = .19; IG -1.22 and CG -0.21; p &lt; .05; IG -1.19 and CG -0.30; p = .03</td>
<td>IG 6.3% and CG 7.4%; n.s.; IG 12.4% and CG 8.7%; n.s.; IG 17.5% and CG 7.3%; p = .02</td>
<td>Not reported</td>
</tr>
<tr>
<td>Lieverse (2011) [30]</td>
<td>Bright-Light therapy</td>
<td>HAM-D</td>
<td>Post-treatment (3 weeks); 6 weeks FU</td>
<td>IG -8.5 and CG -5.8; p = 0.03; IG -10.0 and CG -5.4; p = .001</td>
<td>IG 50% and CG 41%; p = .20; IG 58% and CG 34%; p = .05</td>
<td>Not reported</td>
</tr>
<tr>
<td>Serfaty (2009) [31]</td>
<td>CBT</td>
<td>BDI-II</td>
<td>4 months FU; 10 months FU</td>
<td>CBT -8.9 TC -6.2 CAU -7.4; CBT vs other p &lt; .05; TC vs CAU n.s.; CBT -9.0 TC -6.1 CAU -6.9; CBT vs other p &lt; .05; TC vs CAU n.s.</td>
<td>CBT 33% and TC 21% and CAU 23%; p-value not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Sims (2006) [32]</td>
<td>Progressive Resistance Training</td>
<td>GDS</td>
<td>10 weeks FU; 6 months FU</td>
<td>IG -0.41 and CG -0.22; n.s.; IG -1.14 and CG -0.34; n.s.</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Singh (2005) [33]</td>
<td>1. High intensity training; 2. Low intensity training</td>
<td>HRSD/GDS</td>
<td>8 weeks FU</td>
<td>HRSD: HIGH -9.5 LOW -7.1 GP -5.3; p = .14; GDS: HIGH -11.6 LOW -8.7 GP -4.7; p = .006</td>
<td>HRSD: HIGH 61% LOW 29% GP 21%; HIGH vs LOW p = .05; HIGH vs GP p &lt; .02; LOW vs GP p = .56</td>
<td>Not reported</td>
</tr>
<tr>
<td>Williams (2000) [34]</td>
<td>PST</td>
<td>HSCL-D-20</td>
<td>Post-treatment (11 weeks)</td>
<td>PST -0.52 paroxetine -0.61 placebo -0.40; PST vs paroxetine p = .17; PST vs placebo p = .13</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

BDI, Beck Depression Inventory; CAU, Care as Usual; CBT, Cognitive Behavior Therapy; CCM, Clinical Case-Management; CES-D, Center for Epidemiologic Studies Depression Scale; CG, Control Group; FU, Follow-Up; GDS, Geriatric Depression Scale; HAM-D Hamilton Rating Scale for Depression; HDRS, Hamilton Depression Rating Scale; HSCL-D, Hopkins Symptom Checklist for Depression; IG, Intervention Group; n.s., not significant; PHQ-9, Patient Health Questionnaire.

* Difference between baseline measurement and follow-up measurement;
**Defined as ≥50% reduction in outcome measure unless stated otherwise;
*a Defined as a decrease of ≥5 points on the PHQ-9 after 12 weeks;
*b Defined as a PHQ-9 score ≤4;
*c Defined as a decrease of ≥5 points on the CES-D;
*d Defined as a decrease of ≥5 points or more on the CES-D and a post-test score <16;
*e Defined by RDC (Research Diagnostic Categorization as <4 symptoms of depression)
Fig 2. Risk of bias assessment for the included randomized controlled trials. Based on the Cochrane Collaboration’s tool for assessing risk of bias, + indicates low risk of bias, — indicates high risk of bias, and ? indicates unclear risk of bias.

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could not be reached by e-mail. The meta-analysis demonstrated that CBT had no effect on depression immediately after treatment (SMD -0.16 [-0.34–0.02], \(I^2=0\%\), \(Z=1.69, p = 0.09\)). A statistical significant effect was found at 6 months' follow-up, but the effect size was only small (SMD -0.21 [-0.40–-0.03], \(I^2=0\%\), \(Z=2.23, p = 0.03\)). No statistically significant heterogeneity was found between the studies (\(\chi^2=1.58\) [p = 0.66] and 1.13 \(\chi^2\) = [p = 0.77], respectively; \(I^2=0\%\) in both analyses).

To summarize, CBT was effective in two of the five studies, of which one was assessed to have the lowest risk of bias. This effect was confirmed in the meta-analysis at six months' follow-up. The two studies demonstrating a beneficial effect of CBT used individually delivered treatment rather than group therapy.

**Exercise.** Two studies assessed the effect of exercise [32,33]. Compared to a control group receiving information about exercise and local exercise options, progressive resistance training was not more effective in reducing depressive symptoms at 10 weeks’ and 6 months’ follow-up [32]. But, high and low intensity training were both more effective in reducing depressive symptoms at 8 weeks’ follow-up based on self-reported, but not observer-rated, measures [33]. The risk of bias was assessed as moderate for both studies.

**Other.** Treatment modalities in the “other” category included PST, CBT-based bibliotherapy, behavioral activation, and bright-light therapy; all four were delivered individually. Of the two studies with a low risk of bias, bright-light therapy was effective [30], whereas PST was not [34]. In a study of moderate quality, CBT-based bibliotherapy was shown to be no more effective than care as usual [27]. Behavioral activation, which was only studied in a pilot cohort, was found to reduce symptoms of depression at 4 weeks’ follow-up [26].

**Outcome data of studies in community settings**

Outcome data for studies conducted in the community are presented in Table 4, and the quality assessment with corresponding scores on the subscales is presented in Fig 2.

**Cognitive behavioral therapy.** Three RCTs [39,53,54] studied the effect of CBT on depressive symptoms. One RCT demonstrated that CBT group therapy was more effective than remaining on a waiting list, but found no difference between the effects of CBT and exercise [39]. Another RCT showed that, after treatment, CBT group therapy was effective at reducing depressive symptoms among participants suffering from depression with comorbid

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**Fig 3. Forrest plot of the meta-analysis for studies of cognitive behavioral therapy in primary care.**

Control condition entered in meta-analyses specified by study: Arean (2005) [24] used clinical case-management; but, Laidlaw (2008) [28], Lamers (2010) [29], Serfaty (2009) [31] used care as usual. One of the two reported outcome measurements by Laidlaw was used in the meta-analyses, namely HRSD.

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<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Treatment</th>
<th>Outcome measure</th>
<th>Follow-up</th>
<th>Mean change*</th>
<th>Responders **</th>
<th>Remission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chan (2013) [35]</td>
<td>Life-review</td>
<td>GDS</td>
<td>8 weeks</td>
<td>IG -5.4 CG -1.0; p &lt; .001</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Ciechanowski (2004) [36]</td>
<td>PST; Social activities; Moderate physical activity</td>
<td>HSCL-20</td>
<td>6 months FU; 12 months FU</td>
<td>IG -0.59 and CG -0.03; p &lt; .001; IG -0.48 and CG -0.19; p = .03</td>
<td>IG 54% and CG 8%; P &lt; .001; IG 43% and CG 15%; p &lt; .001</td>
<td>IG 44% and CG 10%; p &lt; .001* IG 36% and CG 12%; p = .0028</td>
</tr>
<tr>
<td>Huang (2015) [39]</td>
<td>Exercise (PFE); 2. CBT</td>
<td>GDS</td>
<td>Post-treatment (3 months FU); 3 months FU</td>
<td>PFE -4.0 CBT -3.5 CG -2.0; p = .012; PFE -4.21 CBT 2.61 CG -2.45; p = .12; PFE -3.84 CBT -3.0 CG -2.1; p = .20</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Imai (2015) [40]</td>
<td>Receiving postcards</td>
<td>GDS</td>
<td>12–14 months FU</td>
<td>IG 0.5 and CG 0.7; n.s.</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Kiosses (2010) [41]</td>
<td>Problem Adaptation Therapy</td>
<td>HAM-D</td>
<td>6 weeks FU; 12 weeks FU</td>
<td>IG -11.33 and CG -7.65; IG -13.48 and CG 8.65; p = .03</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Kiosses (2015) [42]</td>
<td>Problem Adaptation Therapy</td>
<td>MADRS</td>
<td>12 weeks FU</td>
<td>Baseline scores IG 21.08; CG 21.41; p = .58; IG lower scores at week 12; p &lt; .001 (no mean difference reported)</td>
<td>IG 66.7% and CG 32.3%; p = .007</td>
<td>IG 37.8% and CG 13.5%; p = .026</td>
</tr>
<tr>
<td>McNeil (1991) [43]</td>
<td>Exercise</td>
<td>BDI</td>
<td>10 weeks FU</td>
<td>IG -5.5; Attention Control -4.2; CG -0.5; IG vs Attention Control p &gt; .05; IG vs CG p &lt; .05; Attention Control vs CG p &lt; .05</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Moss (2012) [44]</td>
<td>Behavioral Activation</td>
<td>HRSD</td>
<td>Post-treatment (4 weeks)</td>
<td>IG -5.77 and CG -1.15; p = .004</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Preschil (2012) [45]</td>
<td>Life-review</td>
<td>BDI</td>
<td>Post-treatment (8 weeks); 3 months FU</td>
<td>IG -9.0 and CG -1.4; p &lt; .01; IG -10.3; p &lt; .01</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Rosenberg (2010) [46]</td>
<td>Exercise (Nintendo Wii gaming)</td>
<td>QIDS</td>
<td>Post-treatment (12 weeks); 24 weeks FU</td>
<td>-2.7; p = .004; -4.07; p &lt; .001</td>
<td>(24 weeks FU) 53%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Scogin (1987) [47]</td>
<td>Cognitive bibliotherapy</td>
<td>HRSD/GDS/BDI</td>
<td>Post-treatment (4 weeks); 1 month FU IG Only</td>
<td>HRSD: CB -8.5 AC -2.5 CG 1.1; p &lt; .05; GDS: CB -5.8 AC -0.6 CG 0.0; p &lt; .05; BDI CB -3.4 CA -1.7 CG -0.7; n.s.; HRSD: -6.3; GDS: -5.2; BDI: -0.7; No change compared with post-treatment; p &gt; .05</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Scogin (1989, 1990) [48,49]</td>
<td>1. Behavioral bibliotherapy; 2. Cognitive bibliotherapy</td>
<td>HRSD/GDS</td>
<td>Post-treatment (4 weeks); 6 months FU IG only; 2 years FU IG combined</td>
<td>HRSD: BB -8.1 CB -8.8 CG -0.5; p &lt; .05; GDS: BB -2.7 CB -5.6 CG -0.5; p &lt; .05; HRSD/BD: -8.7 CB -7.4; GDS: BB -5.2 CB -6.6; No change compared with post-treatment; p &gt; .05; HRSD: -0.7; GDS: -3.2; HRSD: no change compared with post-treatment; GDS: further improvement in bibliotherapy conditions (p &lt; .05)</td>
<td>HRSD: IG 66% (completers only) CG 19%**</td>
<td>Not clearly reported</td>
</tr>
<tr>
<td>Serrano (2004) [50]</td>
<td>Life-review</td>
<td>CES-D</td>
<td>Post-treatment (8 weeks)</td>
<td>IG -10.25 and CG 0.0; p &lt; .0001</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Singh (1997) [51]</td>
<td>High intensity progressive resistance training</td>
<td>BDI/HRSD/GDS</td>
<td>Post-treatment (10 weeks)</td>
<td>BDI: IG -11.5 and CG -4.6; p = .002; HRSD: IG -7.0 and CG -2.5; p = .008; GDS: IG -8.3 and CG -1.9; p = .0004</td>
<td>HRSD: IG 59% and CG 26%; p = .067</td>
<td>n.s.1</td>
</tr>
</tbody>
</table>

(Continued)
anxiety [54]. Individual CBT delivered through the internet was also more effective at reducing depressive symptoms after treatment than care as usual [53]. In the latter RCT, this effect was maintained at 3 months’ follow-up, although this was not compared to a control condition. In summary, individual CBT tended to be an effective treatment for reducing depressive symptoms compared with inactive control conditions among older adults, but the risk of bias ran ged from low to moderate in the included studies.

**Bibliotherapy.** Four RCTs investigated the effect of individual bibliotherapy [37,44,47,48], and had low to moderate risk of bias. All RCTs showed that bibliotherapy was effective at reducing depressive symptoms at 4 weeks’ follow-up compared with remaining on a waiting list and being given a control form of bibliotherapy.

**Life-review.** All three RCTs investigating the effect of individual life-review on depression in older adults found a positive effect on depressive symptoms from 2 to 8 weeks’ follow-up [35,45,50]. One RCT [45] also reported a further improvement of depressive symptoms at 3 months’ follow-up, but did not compare this with a control condition. The risk of bias did differ a little between the included studies, ranging from high to moderate.

**Exercise.** Three RCTs [39,43,51] investigated the effect of exercise on depressive symptoms, with risk of bias assessments ranging from high to moderate. Compared with an active control group, one RCT did demonstrate an effect of exercise on depressive symptoms [51].

### Table 4. (Continued)

<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Treatment</th>
<th>Outcome measure</th>
<th>Follow-up</th>
<th>Mean change*</th>
<th>Responders**</th>
<th>Remission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thompson (1987) [52]</td>
<td>1. Cognitive therapy (CT); 2. Behavioral therapy (BT); 3. Brief Psychodynamic therapy (BPT)</td>
<td>BDI/HRSD; Diagnostic status (SADS-change)</td>
<td>Mid-treatment (6 weeks); Post-treatment (16 weeks)</td>
<td>BDI: IG (combined) -6.1 CG +1.2; p &lt; .001; HRSD: IG (combined) -5.1 CG -0.3; p &lt; .001; BDI: CT -11.7 BT -10.1 BPT -9.2; n.s.; HRSD: CT -8.7 BT -10.4 BPT -9.0; n.s.</td>
<td>Not reported</td>
<td>(Post-treatment) CT 52%, BT 57% BPT 47%; n.s.</td>
</tr>
<tr>
<td>Titov (2015) [53]</td>
<td>iCBT</td>
<td>PHQ-9</td>
<td>Post-treatment (8 weeks); 3 months FU (IG only); 12 months FU (IG only)</td>
<td>IG -9.46 and CG -0.25; p &lt; .001; -8.05; no change compared with post-treatment; -8.02; no change compared with post-treatment</td>
<td>IG 68.7% and CG 5.8%; p &lt; .001**</td>
<td>IG 68.7% and CG 0%; p &lt; .001**</td>
</tr>
<tr>
<td>Wuthrich (2013) [54]</td>
<td>CBT</td>
<td>GDS/CES-D</td>
<td>Post-treatment (12 weeks); 3 months FU (IG only)</td>
<td>GDS: IG -8.93 CG -1.97; p = .004; CES-D: IG -13.03 CG -1.45; p = .007; GDS: -8.3; CES-D -12.98; GDS and CES-D: no change compared with post-treatment</td>
<td>Unclear</td>
<td>Not reported for depression separately</td>
</tr>
</tbody>
</table>

AC, Attention Control; BDI, Beck Depression Inventory; CBT, Cognitive Behavior Therapy; CES-D, Center for Epidemiologic Studies Depression Scale; CG, Control Group; FU, Follow-Up; GDS, Geriatric Depression Scale; HAM-D Hamilton Rating Scale for Depression; iCBT, Individual Cognitive Behavior Therapy; IG, Intervention Group; MADRS, Montgomery Asberg Depression Rating Scale; n.s., not significant; PFE, Physical Fitness Exercise; PHQ-9, Patient Health Questionnaire; PST, Problem Solving Therapy; QIDS, Quick Inventory of Depressive Symptomatology; SADS, Schedule for Affective Disorders and Schizophrenia.

* Difference between baseline and follow-up measurements; ** Defined as a ≥50% reduction in outcome measures, unless stated otherwise

* Defined as a HSCL-20 score <0.5;  
* Defined as a reduction of the HRSD ≤11 and no longer having a major depressive episode, or as a HRDS <10;  
* Defined as the absence of depressive symptoms;  
* Remission defined as a MADRS score <7;  
* Defined as scores outside the range of the dysfunctional population, and a change according to the reliable change index;  
* Defined as change in diagnostic category;  
* Defined as scores outside the range of the dysfunctional population, and scores with a reliable change from Time 1;  
* Defined as a change in diagnostic category;  
* Defined as a >5.20 reduction on the PHQ-9;  
* Defined as reliable improvement and a score below the clinical cut-off (PHQ-9 <10)

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However, although two other RCTs did find that exercise had an effect compared with inactivity, no difference was observed between the exercise group and the active controls in each study (e.g., CBT [39] and social contact control [43]). In addition, one cohort study [46] studied the effect of exercise on depressive symptoms. It was not reported whether the intervention was delivered as group or as individual therapy, but showed reduced depression scores at 12 and 24 weeks' follow-up compared with baseline.

**Problem-solving therapy.** Three RCTs studied the effect of individually delivered PST [36,41,42]. They all demonstrated that PST reduced depressive symptoms. Two of these RCTs [36,42] delivered PST in community agencies, and one combined PST with engagement in social activities [36]. The risk of bias varied from low to moderate.

**Other.** One RCT investigated the effect of receiving postcards on depressive symptomatology [55], but showed no effect at follow-up. Another RCT showed that three interventions (cognitive therapy, behavioral therapy, and brief psychodynamic therapy) had beneficial effects compared with controls (waiting list) [52] at 6 weeks (mid-treatment), but showed no differences between these three interventions after treatment (16 weeks). However, the effects of the three interventions were not compared with the control group after treatment, because those on the waiting list had started treatment.

**Discussion**

**Summary of main findings**

Of the five treatments studied in primary care, a meta-analysis on CBT yielded a significant result, indicating its potential benefit in primary care settings. There was also a positive effect with bright-light therapy, and although this is promising, it needs replication in a second trial in primary care before recommendations for implementation can be made. Unfortunately, we did not find convincing evidence in favor of exercise, PST, or behavioral activation for the treatment of depressive symptomatology in primary care, but better quality research is needed before we can reach any definitive conclusions. In addition, community-based studies showed promising short-term results for bibliotherapy, life-review, PST, behavioral therapy, brief psychodynamic therapy, and cognitive therapy, which might, therefore, be suitable for use as treatment strategies in primary care.

**Comparison with existing literature**

Previous systematic reviews and meta-analyses focusing on the use of non-pharmacological treatment for depression in older patients have reported different findings to those in our review [17–20]. Two recent systematic reviews [18,20], for example, concluded that psychological treatments may be feasible for late-life depression (65+), but they did not perform formal meta-analyses. However, both of these reviews questioned the generalizability and efficacy because of the wide diversity of interventions, the low number of studies per intervention, and the poor quality of studies included. Moreover, neither review was limited to the primary care setting, and studies were excluded if they had a low quality assessment, leading to the exclusion of 73.9% [18] and 36.4% [20] of the identified studies, respectively. To be more comprehensive, we decided not to restrict ourselves to RCTs and not to exclude studies based on the quality assessment. This not only ensured that we could summarize all available evidence but also enabled us to formulate explicit targets for future research, such as instances where an included study was of poor quality but focused on a promising intervention.

Another two reviews included formal meta-analyses of the research [17,19], and they indicated that psychological treatments were moderately effective in the treatment of late-life depression. Specifically, one showed that CBT, life-review, and PST [17] were effective, while
the other showed that CBT was more effective than a non-active control group [19]. However, these meta-analyses included studies conducted in clinical settings and with middle-aged participants (50/55+). These differences might explain why we could not replicate the finding that PST was an effective treatment for late-life depression in primary care; also, it should be noted that life-review therapy has been studied as treatment for late-life depression in primary care to date. Nonetheless, we confirmed the positive results for life-review and PST on depressive symptoms in community settings. We could also replicate the finding that CBT was an effective treatment modality for late-life depression at 6 months' follow-up, though with a small effect size (SMD -0.21 [-0.40 to -0.03]) comparable to that reported in one of the previous studies [17]. The other meta-analysis demonstrated a much larger effect size (-1.35) when CBT was compared with inactive controls, but did not find an effect when comparing CBT to active controls [19]. The fact that we analyzed the effect of CBT compared with both active and inactive controls might explain this difference. Although one might question the clinical relevance of this small effect of CBT, it might be partly caused by a floor-effect of treatment associated with milder forms of depression as seen and treated within primary care.

Another systematic review found that physical exercise may be effective for late-life depression [56]. We could not replicate this finding, irrespective of the quality assessments of these studies, but it should be noted that the previously conducted review included studies recruiting non-depressed adults, and that none of the studies included in the earlier review [56] was conducted in a primary care setting.

Several differences can be seen when comparing the studies conducted in primary care with those conducted in the community. First, although more treatment modalities have been studied in community settings, it is questionable whether these treatment modalities are applicable in general practice. For example, creating a life-story book with personalized pictures [35] is overly time-consuming for most GPs or practice nurses. Second, the follow-up periods of the community-based studies were shorter than those conducted in primary care. Because none of the studies included a control condition beyond the assessment when treatment ended, no data is available on the sustainability of the effects. Third, most of the community studies only included self-referred participants, thereby introducing selection bias. Self-referred participants show the initiative to seek out interventions targeting depression, whereas in general, depressed older adults are more likely to be reluctant to seek help [57]. This purported selection bias might also explain some of the low percentages lost to follow-up in the self-referral studies performed in the community. Although it is conceivable that community-based interventions would also be effective in primary care, further research is needed to confirm this assumption. Finally, among the therapist-guided interventions, almost half were delivered by a postgraduate therapist or clinical psychologist in the community studies, while only one-third included a psychologist in the primary care studies. Because it is questionable whether clinical psychology services could be successfully embedded in general practice, due for example to higher costs for patients and/or insurances, future research should determine whether these interventions can be successfully given by a practice nurse or other allied healthcare professionals.

Several non-pharmacological treatments for late-life depression studied a community setting seem promising for implementation in primary care. First of all, PST demonstrated a beneficial effect in the community [36,41,42], but the only RCT conducted in primary care demonstrated no effect on depressive symptoms [34]. However, the risk of bias was lower in two of the community studies [36,42] compared with the study conducted in primary care [34], and among middle-aged adults the effectiveness of PST in primary care has been confirmed [58]. Due to the positive results of PST in the community setting and among middle-aged adults, we recommend a second RCT in primary care focusing on PST with a longer
follow-up duration than the study included in our review (11 weeks) [34]. Moreover, the
control group in this primary care study [34] existed of paroxetine or a placebo, while an attention
control form of therapy would have been more adequate. Furthermore, bibliotherapy
[37,44,47,48] and life-review [35,45,50] have demonstrated beneficial effects in community set-
tings, although follow-up duration was short (maximum of 8 weeks). Before implementation
in primary care, life-review and bibliotherapy need to be studied among primary care patients
with a longer follow-up duration. Furthermore, these studies had some issues regarding their
risk of bias, with a high risk of bias for the bibliotherapy studies [37,44,47,48] and a moderate
risk of bias for two of the life-review studies [35,45], and these concerns need to be addressed
in a future RCT conducted in primary care. Finally, the effect of behavioral activation therapy
seems promising in a pilot cohort study conducted in primary care [26], and is currently being
investigated in a well-designed RCT in primary care [59]. In addition to this latter RCT,
also PST, bibliotherapy, and life-review should be studied in a RCT in primary care among
depressed patients confirmed by a diagnostic interview and with at least a one-year follow-up.

Limitations
First, although we decided to review the results narratively, we did diverge from the published
protocol to perform a meta-analysis concerning the effect of CBT in primary care. This was
because most of the included studies in primary care focused on CBT and the combined results
of the individual studies were inconclusive. Although only two of the five individual studies
indicated a beneficial effect of CBT, the meta-analysis confirmed a small but beneficial effect.
Too few studies focusing on other non-pharmacological treatment options were conducted to
perform a meta-analysis for these interventions; for example, two studies focused on exercise
and both concluded that it was ineffective at follow-up, whereas only single studies were con-
ducted for the other treatment modalities. Since we aimed to present an overview of the evi-
dence for non-pharmacological treatments for late-life depression within primary care, we
decided not to perform meta-analyses of studies conducted in the community, but to narra-
tively review these studies in order to identify promising non-pharmacological treatments.
Second, one of the search terms was “general practice OR synonym,” so we only found a few
studies that were conducted in the community in the primary search. Although these settings
were not the focus of our review, we wanted to include all studies that focused on non-pharma-
cological treatment options in primary care. Due to careful selection of studies from previous
systematic reviews and meta-analyses, we could find and included more studies conducted in
a community (n = 15) setting, consistent with the aim of our review (Fig 1). However, we can-
not ignore the possibility that we did not include all studies focusing on non-pharmacological
interventions for late-life depression conducted in a community setting. Third, included stud-
ies differed in their depression inclusion criterion, which may have introduced heterogeneity
and thus may have affected the results of this review. However, the observed heterogeneity in
our meta-analysis was small (I² = 0%). Finally, limitations of included studies should also be
acknowledged; such as the low number of included participants in primary care studies and
the short follow-up period in community studies.

Conclusion
Through this systematic review and meta-analysis, we aimed to provide general practitioners
with a comprehensive summary of the available evidence for non-pharmacological treatments
in late-life depression in primary care. We found a limited amount of studies studying a wide
variety of non-pharmacological interventions. Moreover, these studies differed in their defini-
tion of depression, definition of remission, and follow-up duration. Although this limits the
evidence for specific interventions, it does give merit for several promising therapeutic options for treatment of late-life depression within primary care. CBT was the only treatment option meeting the highest level of evidence according to the GRADE (Grading of Recommendations Assessment, Development and Evaluation) criteria, with a small but beneficial effect after meta-analysis. However, a wealth of alternative options were identified that could be delivered by well-trained nurses based on evidence that exists from studies in a community setting. This review indicates that bibliotherapy, life-review, PST, and behavioral activation therapy are the options most likely to be of benefit in primary care settings, but the paucity of high-quality research means that we can only conclude that these options warrant further investigation in RCTs performed in primary care.

Supporting information

S1 Appendix. Search strategy for different databases. Search strings for each part were combined using the “AND” Boolean statement.

S1 PRISMA Checklist. PRISMA checklist.

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Writing – review & editing: Floor Holvast, Btissame Massoudi, Richard C. Oude Voshaar, Peter F. M. Verhaak.

References


