that we appropriately adjusted for several of the potential confounding variables highlighted by Dr Aitchison in our statistical models, including rape, household income, and marital status.

Please see our response to another “Letter to the Editor” for further details.

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References

New Psychotherapies for Mood and Anxiety Disorders: Necessary Innovation or Waste of Resources?

Dear Editor:

With much interest we read the systematic review from Stirman et al1 about new psychotherapies for mood and anxiety disorders. Although the study has been well conducted, we think the authors have not sufficiently answered the question of whether we actually need new psychotherapies.

On the one hand, there is a clear need for better treatments, as mood and anxiety disorders constitute a considerable burden for patients and society. Further, modelling studies have shown that current treatments can reduce only one-third of the disease burden of depression and less than one-half of anxiety disorders, even in optimal conditions.2

However, there are already dozens of different types of psychotherapy for mood and anxiety disorders, and there is very little evidence that the effects of treatments differ significantly from each other. In depression, we found that interpersonal psychotherapy is somewhat more effective than other therapies,3 but differences were very small (Cohen’s d < 0.21) and the clinical relevance is not clear. In the field of anxiety disorders, there is evidence that relaxation is less effective than cognitive-behavioural therapy, but there is very little evidence for significant differences between other therapies.

We think that new therapies are only needed if the additional effect compared with existing therapies is at least d = 0.20. Larger effect sizes are not reasonable to expect as 0.20 is the largest difference between therapies found until now. Further, this effect needs to be empirically demonstrated in high-quality trials. However, to show such an effect of 0.20 we would need huge numbers. A simple power calculation shows that this would require a trial of about 1000 participants (STATA [Statacorp, College Station, TX] sampsi command). As a comparison, the large National Institute of Mental Health Treatment of Depression Collaborative Trial examining the effects of treatments of depression included only 250 patients.

We want to suggest, therefore, that the field stops with developing new psychotherapies for mood and anxiety disorders unless the developers can convince financiers of research to conduct a well-powered comparative study that shows that this therapy is indeed more effective than existing therapies. In the meantime, the field should focus on the real problems that limit the contribution of therapies to the reduction of disease burden, including the large number of patients who do not respond to any treatment, the patients who still have considerable residual symptoms after successful treatments, and patients who relapse.

References

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Reply

Re: New Psychotherapies for Mood and Anxiety Disorders: Necessary Innovation or Waste of Resources?

Dear Editor:

We certainly agree with Dr Cuijpers and Dr van Straten that to date there have not been many examples of clear successes in developing new psychotherapies that are measurably superior to existing psychotherapies.

But there are good reasons why the field should not stop attempting to develop new psychotherapies. As Dr Cuijpers and Dr van Straten make clear, we need ways to address lack of response, residual symptoms, and relapse rates associated with existing treatments. Other than sequencing or combined existing treatments, or attempting to match treatments to patient characteristics, the development of new psychotherapies that target nonresponders, residual symptoms, and (or) relapse is the