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Psychotherapy and Pharmacotherapy for Major Depressive Disorder and Generalized Anxiety Disorder: A Rapid Qualitative Review

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Abbreviations

BA	Behavioural Activation
CBT	Cognitive Behavioural Therapy
cCBT	Computerized, or Internet-based, Cognitive Behavioural Therapy
GAD	Generalized Anxiety Disorder
IPT	Interpersonal Psychotherapy

Context and Policy Issues

Depression and anxiety are two of the most common mental health conditions, and often first present in adolescence. If left untreated, both depression and anxiety can persist into adulthood in a more severe form. Further, untreated depression and anxiety have been found to be associated with an increased risk of developing a subsequent mental health condition, such as bipolar disorder or personality disorders. Early intervention is effective in preventing the progression of symptoms and the development of more severe mental health conditions later in life; however, diagnosis is challenging as patients often present with subthreshold symptoms during early phases.

Treatment for mental health conditions fall into two broad categories: pharmacotherapy, prescribed by family doctors or psychiatrists; and, psychotherapy (e.g., cognitive behavioral therapy [CBT], behavioural therapy [BA], interpersonal therapy [IPT]) typically offered through non-physician health professionals such as clinical psychologists. While pharmacotherapies may be covered through public or private insurance, psychotherapies are generally not funded and patients therefore must pay out-of-pocket.

To help ensure people living with depression and anxiety have access to appropriate care, some jurisdictions either have implemented, or are exploring, a stepped care approach to mental health care. In a stepped care approach, the intensity of the intervention is matched to the complexity of the condition. Interventions are classified as low intensity if they are less labour intensive for the provider, require fewer clinician hours to deliver, or can be delivered by providers with less intensive training and qualifications. Some examples are education and support, guided or unguided self-help, or computerized or internet based CBT (cCBT). In contrast, high intensity interventions are more labour intensive, require longer clinician hours and also potentially providers with more intensive training and qualifications. Face-to-face psychotherapy, either individual or in a group setting, and pharmacotherapy are examples of high intensity interventions.

Understanding how people living with depression and anxiety, and the people who care for them, experience mental health care can provide insight into an appropriate model of mental health care delivery, including a stepped care approach. The purpose of this review is to explore and describe patients', caregivers', and health care providers' experiences and perspectives with pharmacotherapy and psychotherapy for the treatment of major depressive disorder (MDD) and generalized anxiety disorder (GAD). For psychotherapy, there is a focus on CBT, IPT, and BA.

Research Questions

1. How have people living with major depressive disorder and/or generalized anxiety disorder experienced pharmacotherapy and psychotherapy? What are their perspectives on the various treatment approaches?
2. How have families, caregivers, and health care providers who care for people with MDD and/or GAD experienced pharmacotherapy and psychotherapy? What are their perspectives on the various treatment approaches?

Key Findings

This rapid review summarizes the results of 29 studies that relate to the experiences and perspectives of patients, providers, and caregivers in relation to different forms of treatment for major depressive disorder and/or generalized anxiety disorder, with a focus on a stepped care approach.

Across included studies, participants described a range of perceived benefits across a range of interventions. At the same time, experiences were varied across studies. Some interventions—or aspects of interventions—were perceived as more suitable and acceptable to some individuals, suggesting a need for the tailoring of mental health interventions to ensure individualized and patient-centered care. Tailoring would appear to help ensure that the right intervention is offered for the right individual in their particular circumstance. Aspects of tailoring may include consideration of patient-level characteristics—for example, age, disease severity and personal preferences; intervention-level characteristics—for example low versus high intensity interventions, therapist involvement and support; and organizational-level characteristics—for example clinical setting and consideration of competing life and work demands.

The need for therapist support emerged through conversations relating to both low and high intensity interventions, and was echoed by patients, parents and health care providers. While not universal, concerns were expressed when people did not feel consistently supported by a health care practitioner, often expressing a lack of confidence to engage in treatment independent of therapist support and unable or unwilling to take on the responsibility for their own treatment. For high intensity interventions in particular, the importance of a therapeutic relationship emerged as an important factor influencing people's experiences.

The role of parent as therapist emerged in studies describing parents' experiences supporting their child through care. Despite a desire to be included in the treatment process, parents also consistently expressed difficulties working alongside their child in this role. Parents described issues related to identity and role clarity, as they observed their role shifting from one of "parent" to one of "therapist". Some described feeling unqualified, without adequate resources, and inadequately trained to assist in implementation of treatment at home.

Hesitations to engage in treatment were described, in particular for high-intensity interventions. For psychotherapy, participants described being most influenced by how their therapist perceived them, how they treated them, and what they expected or asked of them. A safe, friendly environment where people can safely discuss their feelings may enhance the therapeutic relationship, and positive engagement with treatment. A range of hesitations to engage in pharmacological therapy were likewise reported, including fears around

addiction, a perceived inability to discontinue treatment due to the potential for relapse, and being perceived as “weak”.

Methods

Literature Search Methods

A limited literature search, with main concepts appearing in the title or major subject heading, was conducted on key resources including Ovid Medline, PsycINFO, the Cochrane Library, and CINAHL databases, Canadian and major international health technology agencies, as well as a focused Internet search. The search strategy was comprised of both controlled vocabulary, such as the National Library of Medicine’s MeSH (Medical Subject Headings), and keywords. The main search concepts were psychotherapy and Major Depressive Disorder (MDD) or Generalized Anxiety Disorder (GAD). A methodological filter was applied to limit retrieval to qualitative studies. The search was also limited to English language documents published between January 1, 2014 and April 9, 2019.

A limited, supplemental literature search, with main concepts appearing in the title or major subject heading, was conducted on key resources including Ovid Medline, PsycINFO, the Cochrane Library, and CINAHL databases only. The main search concepts were pharmacotherapy and MDD or GAD. A methodological filter was applied to limit retrieval to qualitative studies. The search was also limited to English language documents published between January 1, 2014 and May 6, 2019.

Selection Criteria and Methods

One reviewer independently screened citations and selected studies from the initial search. A second reviewer independently screened citations and selected studies identified through the supplemental literature search. For both sets of citations, during the first level of screening, titles and abstracts were reviewed. The full-text of potentially relevant articles was then retrieved and assessed for inclusion based on the inclusion criteria presented in Table 1.

Table 1: Inclusion Criteria

Population	Individuals aged years 6 and over with subthreshold or diagnosed MDD or GAD Families, caregivers and health care providers caring for individuals with subthreshold or diagnosed MDD or GAD
Intervention	Stepped-care treatment, or its components, with a focus on pharmacotherapy, cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), and behavioural activation (BA)
Context	Settings of interest include health care systems similar to the Canadian model, (i.e., member countries in the Organization for Economic Co-operation and Development [OECD], having universal (or near-universal) coverage for core-medical services), as well as the United States of America
Outcomes	Q1-2: Issues emerging from the literature that relate to the research questions including, but not limited to: perspectives on, expectations of, and experiences with a stepped-care treatment model, or its components, with a focus on pharmacotherapy, CBT, IPT, and BA; experiences accessing and engaging with these interventions. Q3-4: Issues emerging from the literature that relate to the research questions including, but not limited to: perspectives on, expectations of, and experiences with caring for the populations of interest; conversations

	and decision-making around a stepped-care treatment model, or its components, with a focus on pharmacotherapy, CBT, IPT, and BA; perspectives on features of therapies that may lead to better outcomes, and why.
Study Designs	Primary qualitative research of any design

BA = Behavioural Activation; CBT = Cognitive Behavioural Therapy; GAD = Generalized Anxiety Disorder; IPT = Interpersonal Psychotherapy; MDD = Major Depressive Disorder.

Exclusion Criteria

Articles were excluded if they did not meet the inclusion criteria outlined in Table 1 or if they were duplicate publications reporting identical data. Studies that were secondary analyses to another primary study, did not specify the type of diagnosis, or had a patient population with GAD or MDD and another co-morbidity (e.g., chronic pain, autism) were also excluded. Qualitative meta-syntheses or articles of mixed methods study designs that included both qualitative and quantitative components were also excluded.

Critical Appraisal of Individual Studies

One reviewer assessed the quality of all included studies. The ten components of the Critical Appraisal Skills Programme (CASP) Qualitative Tool[1] were used as prompts for reflection, and the appraisal was directed by three primary questions that aimed to assess if and how a study demonstrated richness of data, rigour in analysis, and the incorporation of reflexive practices: 1) Is it credible?; 2) Is it trustworthy?; 3) Are the results transferable? The results of the critical appraisal process were not used to exclude studies from this review; instead, they were used to understand the methodological and conceptual limitations of the included publications as they relate to the review objectives.

Data Analysis

Descriptive Analysis

A descriptive analysis was conducted to detail the study design and participant characteristics of each included study. Descriptive study data included author, publication year and country of publication, study objectives, study design, inclusion criteria, and data collection strategies. Participant characteristics included age range, proportion of males (%), sample size, and recruitment strategy.

Analytic Approach

One reviewer conducted all stages of the coding and analysis process, using NVivo12.[2] During initial coding, the reviewer worked line-by-line through one study to better understand the context. Following this, the same reviewer went through 10 more studies to develop a preliminary coding framework, with a particular focus on elements of acceptability, satisfaction, and barriers and facilitators to care. These codes reflected the most substantial components of analysis but also those that were identified as most relevant to the review objectives.

During focused coding, the same reviewer coded relevant data from the remaining studies. Data were coded through several iterative cycles where analysis remained open to new ideas, codes, and themes. Findings from the included studies were compared and contrasted to develop a cohesive interpretation of the phenomenon of interest. Brief analytic memos were maintained throughout the analytic process to maintain reflexivity. Themes

that were reiterated across numerous studies are emphasized in the summary, with attempts made to explain the thematic results that emerged.

Summary of Evidence

Quantity of Research Available

A total of 1,164 citations were identified in the literature search. Following screening of titles and abstracts, 1,098 citations were excluded and 66 potentially relevant reports were retrieved for full-text review. In total, 37 articles were excluded for various reasons and 29 were included in this review. Appendix 1 illustrates the complete PRISMA[3] diagram.

Summary of Study and Participant Characteristics

Characteristics of the included studies and their participants are summarized below, and additional details are available in Appendix 2 and Appendix 3.

Study Design, Data Collection and Data Analysis

As is frequently the case with published qualitative research, authors of some articles reported a study design, while some reported their analytic approach only. Among the 29 studies included in this review, 10 reported using grounded theory,[4-13] 10 reported using thematic analysis,[14-23] two each reported using constant comparative analysis,[24,25] content analysis,[26,27] and phenomenology,[28] and one each reported using systematic text condensation,[29] a general inductive approach,[30] and qualitative description.[31] All studies used individual interviews, focus groups or a combination of both approaches as data collection strategies.

Country of Origin

Of the 29 included studies, eight were conducted in the United States,[5-8,10,12,13,26] six in the United Kingdom,[4,16,18,20,21,25] and four were conducted in Canada.[9,11,19,31] Two studies were conducted in each of Australia [14,15] and Denmark,[28,32] and one was conducted in each of Ireland,[22] Norway,[23] Sweden ,[29] Austria,[17] Switzerland,[27] the Netherlands,[24] and New Zealand.[30]

Participant Population

The sample size of included studies ranged from two (detailed individual interview-based study)[7] to 119 (large community-based focus group).[26] The age range of patients ranged from a low of 13 years of age[21] to a maximum of 84 years of age.[14] The proportion of males ranged from 0%[7-9,11,15] to 100%.[16]

Among the 29 included studies, 28 were directly relevant to patients' experiences, three related to caregivers' experiences, and 10 related to health care providers' experiences. Further, 24 articles included perspectives related to MDD and 11 articles included perspectives related to GAD.

Interventions (and Comparators)

A range of mental health care interventions were explored across the included studies, although no articles were identified that assessed experiences specifically with or across a stepped care approach. All 29 included studies, however, explored experiences with a

range of components that could be considered within a stepped care model. Twenty studies explored experiences with CBT (including traditional, computerized, internet-based, or blended CBT), six with pharmacotherapy, two with BA, and one article explored experiences with both CBT and pharmacotherapy. No articles were identified that assessed experiences with IPT, and some articles included multiple stakeholder groups and their perspectives on and experiences with a range of diagnoses and therapies.

Summary of Critical Appraisal

Details of the critical appraisal of individual studies can be found in Appendix 4.

The criterion of credibility relates to the concept of whether the researchers were true to their participants' voices, and could be demonstrated through clear descriptions of data collection methodology, flexibility in data collection (e.g., via open-ended question, refining of interview guide, semi-structured approach) and supporting descriptive analyses. In total, 23 primary studies were assessed as credible, and six were assessed as partially credible.[7,10,13,16-18] The reasons for an assessment of partial credibility include lack of clarity on data analysis steps, lack of flexibility with the interview guide, and lack of clarity around what type of interview guide was used or what types of questions were asked.

The criterion of trustworthiness relates to ideas of dependability and confirmability of study results. The assessment explored whether the analysis was analytically consistent and included reflexive approaches. Factors related to trustworthiness include cross-checking codes, respondent validation approaches, member-checking, triangulation, maintaining memos and audit trails, and details around how saturation or information power was determined. In total, 21 studies were assessed as trustworthy, and eight were assessed as partially trustworthy.[7,15,17,18,24,25,32] The reasons for a partially trustworthy assessment include lack of methodological safeguards that may help to support respondent validation or lack of clarity in the write-up about how data trustworthiness was upheld or how sampling was achieved.

The final criterion for quality appraisal was transferability. This concept is related to how relevant each included study was to the objectives of this current review. The assessment was made by exploring the reporting of individual study participant demographics and contexts, and how relevant the study's findings were to the broader policy issue. In total, 18 studies were assessed as transferrable, and 11 were assessed as partially transferable.[5,7,8,10,14,16-18,20,23,32] The reasons for an assessment of partial transferability include lack of reporting of demographic or contextual details, limited data around satisfaction or acceptability of the therapy, and small sample sizes (e.g., n=2).

Summary of Findings

The following summary explores people's described experiences and perspectives with a range of interventions for the treatment of MDD and/or GAD. With a focus on acceptability, satisfaction, and barriers and facilitators to care, the summary also attempts to identify when patient-, intervention-, and organizational-level factors impact these experiences and perspectives. Although no studies were identified that explored experiences with stepped care specifically, the results of studies that were included and that explored experiences with components of stepped care were analyzed from the perspective of appropriateness within a stepped care model. Accordingly, the results are summarized by "low" and "high" intensity interventions, as they are commonly defined within stepped care, and further by

age and disease severity, which emerged as important determinants of experiences and perspectives.

Experiences with low intensity interventions among patients with MDD and/or GAD, and those who care for them

Low intensity interventions typically include guided self-help, participation in psychoeducational group therapy, and computerized, or internet-based, CBT (cCBT). Studies exploring perspectives relating to guided self-help and cCBT were identified and included in this review.

Five studies explored patients' (aged 15 years and older) or health care providers' perspectives in regards to cCBT for MDD[23,25,26,29,30] and one explored perspectives with cCBT for GAD.[22] Experiences were largely similar across conditions with cCBT overall being viewed as an acceptable and effective therapy for some, but not all, patients. Primarily, participants described cCBT as improving their depressive symptoms, leading to the acquisition of new skills and knowledge and as enhancing personal development through self-awareness and reflection.[22,30] Experiences, however, were varied with some people noting they felt worse, on occasion, after engaging with cCBT programs.[30] Positive aspects of cCBT that promoted engagement with treatment included the ability to monitor and track progress over time, reassurance provided by other users, and guidance provided by online support members.[22]

While many appealing aspects of cCBT were identified, it was also acknowledged that the treatment may not be appropriate for everyone. Some patients reported appreciating the anonymity, privacy, and accessibility of a computerized intervention, whereas others were not comfortable with the lack of interpersonal contact with a therapist and were left feeling alone.[22,25,26,29,30] Participants in these studies described appreciating programs that were flexible,[22] expressing the need to deeply tailor or personalize program content to remain engaged and experience positive effects.[25,26,30] The use of generic examples was experienced as frustrating, and inhibited engagement with treatment, suggesting a lack of personalized content may limit compliance and therefore positive outcomes.[25] In one study that explored LGBTQ+ youths' (aged 13 to 19 years) experiences with a customized cCBT program for MDD, for example, while the 'rainbow' content was described as making the program relevant and acceptable, many still suggested that more—and more diverse—'rainbow' content would enhance satisfaction and acceptability.[30] Similarly, in a study exploring experiences with cCBT in rural communities, participants expressed concern that vignettes used in the program were not relatable to their everyday experiences, which challenged their ability to engage with the content.[26]

Patient-, intervention-, and organizational-level factors appeared to impact on satisfaction and perceived acceptability of cCBT. At the patient-level, disease severity in particular influenced perceptions of acceptability and ability to engage with treatment—and patients expressed their feelings that cCBT would not be a suitable approach for patients undergoing more severe depressive episodes, or if patients had heightened feelings of loneliness.[25,29] Likewise, being goal-driven, conscientious, high-achieving or having a high-level of self-efficacy and motivation were also reported to impact patients' satisfaction with, acceptability of, and positive experiences with cCBT.[22] On the contrary, patient-level challenges to engaging with cCBT were reported to include competing external priorities (e.g., work, school exams) and lack of confidence using computers.[22,27] At the intervention-level, a lack of potential for follow-up care impeded satisfaction with cCBT, as did technical issues such as layout and accessibility issues (e.g., difficulty navigating larger modules,

heavy use of text), and lack of ability to customize content.[22,30] Organizational-level factors, such as lack of time on the part of a therapist or variations in practice settings, were described in relation to lower satisfaction and acceptability of cCBT.[23,25] While cCBT was broadly acknowledged as having several potential benefits for some patients, the lack of consistent practitioner support,[25] and a related lack of confidence amongst individual patients to take on the responsibility of treatment were identified as barriers to care.[29]

Concerns around a lack of therapist support, and a related lack of confidence to engage in treatment independent of therapist support, were likewise raised by parents caring for children with GAD. One study explored the perspectives of parents with young children (aged 8 to 13 years) with GAD in relation to parental use of bibliotherapy, with and without therapist support, in the home setting.[6] While some parents responded positively to the self-help model, many felt uncertain, citing that materials can be difficult to understand, or frustrating and overwhelming to implement with their children, because they would constantly be wondering if they were doing things correctly.[6] In the same study, health care providers also expressed unfavorable views around the self-directed model, advocating that it is difficult for families to engage if therapist support is lacking.[6]

Experiences with combined low and high intensity interventions among patients with MDD and/or GAD

One study explored the experiences of adult patients who received blended CBT, combining face-to-face CBT and cCBT.[27] In general, patients felt blended CBT was purposeful and effective in the treatment of depression, leading to changed perspectives on problematic situations, consideration of circumstances in a more positive way, and adapted behaviour including engaging more often in pleasant activities and reacting differently in difficult situations. Participants described combined treatment as complementary and emphasized the advantage of the constant availability of the online program.[27] Contact with a therapist was described as of therapeutic benefit, but also beneficial to have the ability to resolve technical challenges with the online program. Treatment was viewed as particularly effective when the online and face-to-face components were suitably integrated.

When explored by severity of MDD (mild, moderate, moderately severe and severe), it was found that different components of blended CBT were preferred.[27] Those with mild to moderate MDD consistently described the treatment as effective, and appreciated being able to discuss online content with their therapist, that their therapist was a support for the online tool, and that they had the possibility to monitor their improvement themselves and to reflect on their progress. No disadvantages were reported among these participants. Among those who were diagnosed with moderately severe to severe MDD, participants appreciated the ability to discuss personal issues and receive face-to-face feedback from a therapist, the constant availability of the online tool and having their symptoms monitored by a therapist. These people, however, noted that the lack of an additional contact possibility through the online tool was a challenge, as were a lack of computer skills in general.

Experiences with high intensity interventions among patients with MDD and/or GAD, and those who care for them

High intensity interventions typically include individual or group CBT, BA, individual or group IPT and pharmacotherapy. Studies addressing individual CBT, group CBT, BA and pharmacotherapy were identified and included in this review; however, no studies were

identified that explored experiences with either individual or group IPT. Experiences and perspectives are summarized separately for psychotherapies and pharmacotherapy.

Experiences with high intensity psychotherapies among patients with MDD and/or GAD, and those who care for them

Four studies explored patients' (aged 15 years and older) or health care providers' experiences with individual or group CBT for GAD,[5,7,8,13] and five studies explored experiences with psychotherapies for MDD, including CBT[17,18,32] and BA.[11,31]

Generally, experiences with psychotherapies were embedded within conversations around lack of access to, and hesitations (or other barriers) to engage in treatment. Accordingly, studies included in this review focused on identifying positive experiences with engagement,[7,17,32] understanding barriers to delivering and receiving treatment,[13] strategies to overcome ambivalence and resistance to engaging in treatment,[5,8] and experiences engaging with treatment in the long term.[18] Generally, it was acknowledged across the included studies that psychotherapies may offer positive experiences to patients with MDD and GAD, however also that experiences are typically characterized with initial hesitations, and are varied and individualized across patients, depending on a range of individual-, intervention- and organizational-level factors.

Some of the positive experiences that were described include positive shifts in mood and functioning,[7,31] learning about their diagnosis,[18] learning productive coping strategies,[17] gaining new perspectives and skills around self-identity,[17,18] gaining personal strength and self-confidence,[32] and increased agency in interpersonal relationships.[7]

Individual-level factors that contributed to challenges accessing or remaining engaged in treatment include competing priorities such as psychosocial stressors and other psychiatric disorders,[13] difficulty grasping CBT concepts,[13] an observed lack of improvement,[5] and perceptions of inappropriate tasks.[5]

The importance of a therapeutic relationship emerged as an important intervention-level factor influencing people's experiences. Participants described being most influenced by how their therapist perceived them, how they treated them, and what they expected or asked of them.[8] Whether positive or negative, patients' perceptions of these expectations appear related to resistance to engage in therapy. When resistance to engage in therapy is present, practitioner initiated strategies (e.g. motivational interviewing) appeared to strengthen a feeling of connectedness and to enhance the therapeutic relationship, and positive engagement with treatment.[8] Patients emphasized the importance of a friendly and safe environment, where they could safely discuss their feelings and experiences.[11,31] Other intervention-level factors that influenced experiences include the flexibility and comprehensiveness of programming that allowed for a patient-centred experience through an ability to integrate patient feedback and accordingly adapt treatment in an iterative manner.[11,31] The quality of practitioner training and supervision, time commitments and time constraints,[13] and whether practitioners were able to work at the same pace as the patient[20] also emerged as determinants of patients' experiences. For group therapies in particular, patients and practitioners described group based therapy as a useful component, in the right circumstance.[11,31] Participants described appreciating the ability to meet other people in similar circumstance, or of a similar culture, and the ability to develop social skills, team-building and accountability.[11,16,17]

The importance of tailoring, or personalizing interventions, for a particular patient also emerged.[11,16,31] For example, in one study that explored experiences with adaptations to CBT for Armed Forces Veterans, participants described an appreciation of the focus on activities that are familiar to Veterans, the use of lay and easy to understand terminology, and the use of visual images. Participants further suggested that for enhanced acceptability, practitioners may avoid the use of images that accentuated physical injuries.[16]

We retrieved four studies exploring parent or provider experiences related to the delivery of individual or group CBT for youth with GAD, aged 6 to 14 years.[6,9,10,28] Across studies, parents described appreciating the steady steps inherent in CBT to help their child confront their condition, as they worried that more dramatic changes would be challenging to understand and could lead to worsening of symptoms. They likewise appreciated an intervention that focuses on skill-building. Generally, there was an appreciation for the parent(s) to be included in the intervention, as the role of parent was seen as linked to one of protector and supporter,[9] and being included allowed the opportunity to experiment with different strategies in the home and to learn new skills on their own time and schedule.[6]

Despite a desire to be included in the treatment process, parents also consistently expressed difficulties working alongside their child in the context of CBT. Parents described challenges understanding their child's condition and the root of their symptoms, and consequently were challenged to support homework assignments, in particular when their child demonstrated resistance to engage in treatment.[28] Challenges emerged as related to individual-level factors, such as feeling unqualified and without adequate resources to support their child, and intervention-level factors such as feeling inadequately trained by a therapist to assist in implementation at home.[28] Parents also described experiencing issues related to identity and role clarity, describing that assisting their child in treatment requires a shifting of roles from "parent" to "therapist", and their preference to remain in their parenting role. A role of "therapist" or "co-therapist" was experienced as unnatural and felt to require going against "motherly instincts"[9] and accompanied an insecurity and fear of pushing their child too far, and causing worsening of symptoms.[9,10,28] It is possible that challenges may be exacerbated in working with younger children, as in one study younger children were portrayed as being more challenging to work with.[10]

Parents described intervention-level factors, such as lack of in-person contact with a therapist, and organizational-level factors, such as competing work and life demands as barriers to care. These challenges were similarly echoed by health care providers who described inflexible structures and time-related constraints of preparing intervention materials as barriers to care and administrative supports and provider autonomy as satisfactory elements of delivering CBT to youth.[6,10]

Experiences of pharmacological interventions among patients with severe GAD or MDD and those who care for them

Experiences with pharmacological interventions as a treatment for GAD and/or MDD were typically described as being both related to improvements in symptoms and also met with hesitations, and for a variety of reasons. Some of the more commonly reported reasons for hesitations included fears around addiction, a perceived inability to discontinue treatment due to the potential for relapse,[14,15,19] being perceived as "weak",[14,15] or feeling embarrassed or guilty.[19] These hesitations were described as unique to treatment for GAD and MDD from the perspective of health care providers, who observed differing experiences treating people with other chronic disease with pharmacological treatments.

Across studies, adults and adolescents described experiences with the use of pharmacological treatments as moving through common stages including: an initial hesitation or a need to survive a crisis; acceptance that medication is a sign of severity, but not a solution; engaging with medication with the hope that it may "level the playing field" or lead to a regain of autonomy; experiencing a trial and error period to find an optimal dosage, type, and frequency; and wishing to discontinue for a range of reasons.[4,12,14,15,19,21,24] Pharmacists within included studies and who work with patients on pharmacological treatment expressed that they often witness a similar process as they are often faced with convincing patients to start treatment despite initial hesitations, moving to support patients through side effects, and subsequently helping to monitor adherence and effectiveness.[19]

The notion of discontinuation emerged as a strong theme across included studies. For some, considerations of the potential for discontinuation appeared early in the treatment trajectory and acted as a barrier to treatment initiation, as ultimately discontinuation was their treatment goal.[19] For others discontinuation was a challenge to ongoing treatment as—while guidelines guide against long term use—discontinuation was challenging to enact due to factors such as a perceived lack of support, observed positive effects and dependence, concern due to potential or realized relapse,[15,24] and a desire to not become a burden on social networks.[24] Patients and their health care providers agreed that there is a strong role for a range of health care providers (e.g., doctors, mental health assistants, psychiatrists, and psychologists) and members of a patient's social network (e.g., relatives or friends) during the discontinuation process.[24]

Fears around long term side effects of pharmacologic treatment use were also commonly expressed,[24] and appeared to be related to a desire to discontinue treatment, which may or may not be possible with other described challenges to discontinuation.[24] While hesitations around the use of pharmacotherapy were weaved throughout the included studies, this is by no means a universal experience. Health care providers in one study, for example, described their experiences of some parents' disappointment if medication was not prescribed, as they felt parents were hoping for the "quick results" they anticipated pharmacotherapy to bring.[6]

For many individuals—including adolescents, adults and parents of younger children—the use of pharmacological treatments was described in relation to a perceived severity of the mental health condition. People appeared more commonly willing to try pharmacological treatment if their condition was perceived as more severe.[15,21] For example, in one study that assessed Latino parent's perspectives around their children using pharmacological interventions for anxiety,[6] acceptability of medication use was described in relation to a described severity of the condition. Despite described hesitations, including a fear of side effects, parents were typically more willing to try medications if their child's anxiety was perceived as severe.[6] In this study, parents described preferring psychotherapy over pharmacotherapy, viewing pharmacological interventions as a 'last resort', as they were man-made and perhaps may accompany negative side effects as a result.

One included study explored adult patients' experiences with CBT and concurrent medication use for depression.[4] In this study, it was clear that pharmacotherapy and CBT were perceived and experienced quite differently: CBT was typically viewed as an alternative to medication, and sometimes as an approach to help support discontinuation of medication.[4] Further, very few patients reported that they discussed their pharmacological therapies in CBT sessions.[4] While experienced as separate treatments, patients also

described the complementary effects of CBT and pharmacotherapy. For example, some described their feelings that their medication used increased their motivation to partake in CBT, as it increased their energy levels, or helped to maintain concentration.[4] Patients also reported feeling less passive and more autonomous in managing their pharmacological therapy when concurrently engaging in CBT, feeling as though they were being listened to during CBT sessions, and that the underlying causes of their challenges were being tackled.[4] Of note, many patients described gaining access to CBT as a result of learning about the treatment through media and other health care providers. Because health care providers are often the gatekeepers to therapy, patients often described the felt the need to 'badger' them for a referral to CBT.[4]

Limitations

A key limitation of qualitative synthesis is that the results are limited to the topics examined and constructs identified in the existing literature. The included publications addressed a range of experiences with interventions for the treatment of MDD and/or GAD; however, no studies were identified that explored experiences with stepped care specifically.

To address this limitation, and where possible, experiences with components of stepped care were considered throughout the analysis through a focus on "low" and "high" intensity interventions. Moreover, data were likewise examined through emergent determinants of experiences with these interventions, such as age and disease severity. It is important to note, however, that gaps in the focus of the included studies limited such explorations, namely, the lack of studies addressing experiences with education, unguided self-help, or IPT; the absence of studies examining the perspectives of youths (aged 6 to 14 years) related to guided self-help, psychoeducational group therapy, behavioural activation, or cCBT for MDD. Finally, perspectives of people identifying as from typically marginalized populations, including Indigenous Peoples living in Canada, refugees, immigrants, and substance users were not explored (or not explored in great detail) in the included studies, limiting our understanding of any unique policy implications for these groups.

Finally, given the sampling strategies employed across the included studies, which focused on people's experiences with interventions for the treatment of MDD and/or GAD, experiences related to access were not explored. Perspectives of people who wanted to access care, but did not or could not for whatever reason, are missing. This omission limits the ability to consider related equity concerns, which are important, particularly given the out-of-pocket costs associated with most therapies in Canada.

Conclusions and Implications for Decision or Policy Making

This rapid review summarized the results of 29 studies that relate to the experiences and perspectives of patients, providers, and caregivers in relation to different forms of treatment for MDD and/or GAD, with a focus on a stepped care approach.

Across included studies, participants described a range of perceived benefits across a range of interventions. At the same time, experiences were varied across studies with some interventions—or aspects of interventions—perceived as more suitable and acceptable to some individuals. Where possible, these factors are described as individual-level factors, intervention-level factors, or organizational-level factors that impact on perspectives and experiences and that indicate a need for the tailoring of mental health interventions to ensure individualized and patient-centered care. For cCBT, for example, patients explicitly acknowledged that the treatment may not be appropriate for everyone. Some patients

reported appreciating the anonymity, privacy, and accessibility of a computerized intervention, whereas others were not comfortable with the lack of interpersonal contact with a therapist and the perceived burden of responsibility for their own care. Disease severity likewise influenced perceptions of acceptability and ability to engage with treatment: patients expressed their feelings that cCBT would not be a suitable approach for patients undergoing more severe depressive episodes, while perceived disease severity may be associated with increased acceptance of pharmacological therapy. The need for tailoring interventions is further highlighted through conversations with people from socially or economically marginalized communities (e.g., LGBTQ+, rural populations, Veterans), who indicated a need to contextualize interventions to ensure that they are engaging and relatable to their particular circumstance.

The need for therapist support emerged through conversations relating to both low and high intensity interventions, and was echoed by patients, parents and health care providers. While not universal, concerns were expressed when people did not feel consistently supported by a health care practitioner, often expressing a lack of confidence to engage in treatment independent of therapist support and unable or unwilling to take on the responsibility for their own treatment. Indeed, some patients reported feeling offended when offered cCBT, because it was perceived as a sign that their needs were not a priority. For high intensity interventions in particular, the importance of a therapeutic relationship emerged as an important intervention-level factor influencing people's experiences. The role of parent as therapist emerged in studies describing parents' experiences supporting their child through care. Despite a desire to be included in the treatment process, parents also consistently expressed difficulties working alongside their child in this role. Parents described issues related to identity and role clarity, as they observed their role shifting from one of "parent" to one of "therapist". They described feeling unqualified, without adequate resources, and inadequately trained to assist in implementation of treatment at home.

Hesitations to engage in treatment were described, in particular for high-intensity interventions. For psychotherapy, participants described being most influenced by how their therapist perceived them, how they treated them, and what they expected or asked of them. A safe, friendly environment where people can safely discuss their feelings may enhance the therapeutic relationship, and positive engagement with treatment. A range of hesitations to engage in pharmacological therapy were likewise reported, including fears around addiction, a perceived inability to discontinue treatment due to the potential for relapse, and being perceived as "weak".

When evaluating appropriate models of mental health care delivery, the results of this review suggest that a stepped care model that matches interventions to the complexity of a person's condition is appropriate. However, further tailoring is required to ensure that the right intervention is offered for the right individual in their particular circumstance. Aspects of tailoring may include consideration of patient-level characteristics—for example, age, disease severity and personal preferences; intervention-level characteristics—for example low versus high intensity interventions, therapist involvement and support; and organizational-level characteristics—for example clinical setting and consideration of competing life and work demands.

References

1. Critical Appraisal Skills Programme. CASP Qualitative checklist. Oxford (GB): CASP-UK; 2019: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf. Accessed 2019 May 18.
2. QSR International Pty Ltd. NVivo qualitative data analysis software. 2019; https://www.qsrinternational.com/nvivo/home. Accessed 2019 May 24.
3. Liberati A, Altman DG, Tetzlaff J, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *J Clin Epidemiol.* 2009;62(10):e1-e34.
4. Bayliss P, Holttum S. Experiences of antidepressant medication and cognitive-behavioural therapy for depression: a grounded theory study. *Psychology & Psychotherapy: Theory, Research & Practice.* 2015;88(3):317-334.
5. Button ML, Norouzian N, Westra HA, Constantino MJ, Antony MM. Client reflections on confirmation and disconfirmation of expectations in cognitive behavioral therapy for generalized anxiety disorder with and without motivational interviewing. *Psychother Res.* 2018:1-14.
6. Chavira DA, Bustos CE, Garcia MS, Ng B, Camacho A. Delivering CBT to Rural Latino Children with Anxiety Disorders: A Qualitative Study. *Community Ment Health J.* 2017;53(1):53-61.
7. Khattra J, Angus L, Westra H, Macaulay C, Moertl K, Constantino M. Client perceptions of corrective experiences in cognitive behavioral therapy and motivational interviewing for generalized anxiety disorder: An exploratory pilot study. *J Psychother Integr.* 2017;27(1):23-34.
8. Morrison NR, Constantino MJ, Westra HA, Kertes A, Goodwin BJ, Antony MM. Using interpersonal process recall to compare patients' accounts of resistance in two psychotherapies for generalized anxiety disorder. *J Clin Psychol.* 2017;73(11):1523-1533.
9. Pishva R. Becoming Therapeutic Agents: A Grounded Theory of Mothers' Process When Implementing Cognitive Behavioural Therapy at Home with an Anxious Child. *Clin Psychol Psychother.* 2017;24(3):766-784.
10. Ringle VA, Read KL, Edmunds JM, et al. Barriers to and Facilitators in the Implementation of Cognitive-Behavioral Therapy for Youth Anxiety in the Community. *Psychiatr Serv.* 2015;66(9):938-945.
11. Samaan Z, Dennis BB, Kalbfleisch L, et al. Behavioral activation group therapy for reducing depressive symptoms and improving quality of life: a feasibility study. *Pilot feasibility stud.* 2016;2:22.
12. Vargas SM, Cabassa LJ, Nicasio A, et al. Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy. *Transcult Psychiatry.* 2015;52(2):244-273.
13. Wolitzky-Taylor K, Fenwick K, Lengnick-Hall R, et al. A Preliminary Exploration of the Barriers to Delivering (and Receiving) Exposure-Based Cognitive Behavioral Therapy for Anxiety Disorders in Adult Community Mental Health Settings. *Community Ment Health J.* 2018;54(7):899-911.
14. Brijnath B, Antoniades J. Playing With Antidepressants: Perspectives From Indian Australians and Anglo-Australians Living With Depression. *Qual Health Res.* 2017;27(13):1970-1981.
15. Cartwright C, Gibson K, Read J. Personal agency in women's recovery from depression: The impact of antidepressants and women's personal efforts. *Clin Psychol.* 2018;22(1):72-82.
16. Farrand P, Mullan E, Rayson K, Engelbrecht A, Mead K, Greenberg N. Adapting CBT to treat depression in Armed Forces Veterans: qualitative study. *Behav Cogn Psychother.* 2019:1-11.
17. Fathi A, Renner W, Juen B. A qualitative study of cognitive-behavioral therapy for Iranian migrants with mild/moderate depression in Austria. *Bull Menninger Clin.* 2016;80(2):166-186.
18. French LR, Thomas L, Campbell J, et al. Individuals' Long Term Use of Cognitive Behavioural Skills to Manage their Depression: A Qualitative Study. *Behav Cogn Psychother.* 2017;45(1):46-57.
19. Guillaumie L, Moisan J, Gregoire JP, et al. Perspective of community pharmacists on their practice with patients who have an antidepressant drug treatment: findings from a focus group study. *Res Social Adm Pharm.* 2015;11(2):e43-56.
20. Kahlon S, Neal A, Patterson TG. Experiences of cognitive behavioural therapy formulation in clients with depression. *the Cognitive Behaviour Therapist Vol 7 2014, ArtID e8.* 2014;7.
21. Maroun RA, Thackeray LA, Midgley N. Meaning and medication: A thematic analysis of depressed adolescents' views and experiences of SSRI antidepressants alongside psychological therapies. *BMC Psychiatry.* 2018;18:ArtID 374.
22. Walsh A, Richards D. Experiences and engagement with the design features and strategies of an internet-delivered treatment programme for generalised anxiety disorder: a service-based evaluation. *Br J Guid Counc.* 2017;45(1):16-31.
23. Wilhelmsen M, Hoifodt RS, Kolstrup N, et al. Norwegian general practitioners' perspectives on implementation of a guided web-based cognitive behavioral therapy for depression: a qualitative study. *J Med Internet Res.* 2014;16(9):e208.
24. Bosman RC, Huijbregts KM, Verhaak PF, et al. Long-term antidepressant use: a qualitative study on perspectives of patients and GPs in primary care. *Br J Gen Pract.* 2016;66(651):e708-719.
25. Knowles SE, Lovell K, Bower P, Gilbody S, Littlewood E, Lester H. Patient experience of computerised therapy for depression in primary care. *BMJ Open.* 2015;5(11):e008581.

26. Schure MB, Howard M, Bailey SJ, Bryan B, Greist J. Exploring perceptions of a computerized cognitive behavior therapy program in a U.S. rural western state. *J Rural Ment Health.* 2018;42(3-4):174-183.

27. Urech A, Krieger T, Moseneder L, et al. A patient post hoc perspective on advantages and disadvantages of blended cognitive behaviour therapy for depression: A qualitative content analysis. *Psychother Res.* 2018:1-13.

28. Lundkvist-Houndoumadi I, Thastum M, Nielsen K. Parents' difficulties as co-therapists in CBT among non-responding youths with anxiety disorders: Parent and therapist experiences. *Clin Child Psychol Psychiatry.* 2016;21(3):477-490.

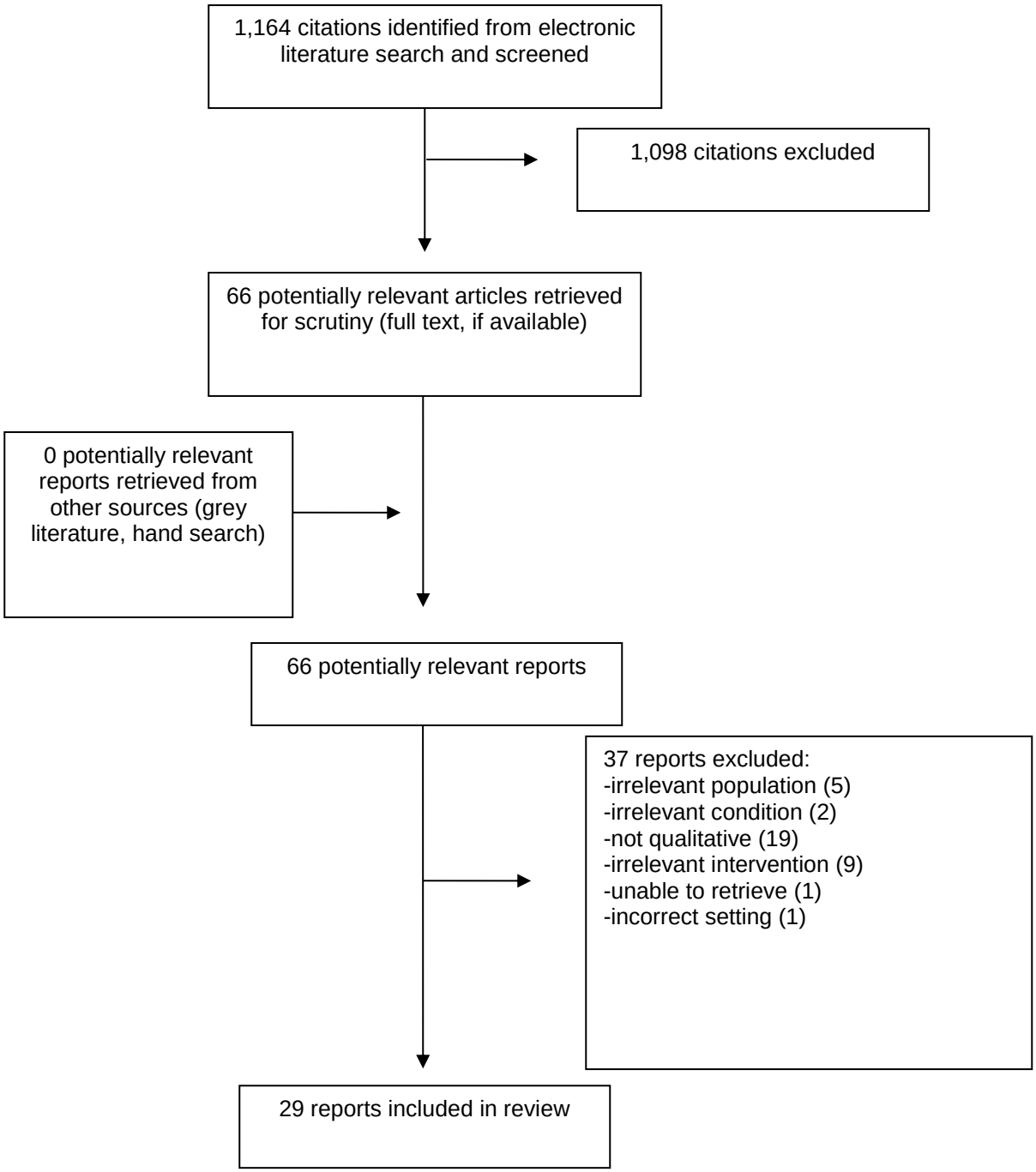
29. Holst A, Nejati S, Bjorkelund C, et al. Patients' experiences of a computerised self-help program for treating depression - a qualitative study of Internet mediated cognitive behavioural therapy in primary care. *Scand J Prim Health Care.* 2017;35(1):46-53.

30. Lucassen MF, Hatcher S, Fleming TM, Stasiak K, Shepherd MJ, Merry SN. A qualitative study of sexual minority young people's experiences of computerised therapy for depression. *Australas.* 2015;23(3):268-273.

31. O'Neill L, Samaan Z, McCabe K, et al. Patient Experiences and Opinions of a Behavioral Activation Group Intervention for Depression. *Research on Social Work Practice.* 2019;29(1):10-18.

32. Straarup NS, Poulsen S. Helpful aspects of metacognitive therapy and cognitive behaviour therapy for depression: A qualitative study. *Cogn Behav Therap.* 2015;8:e22.

Appendix 1: Selection of Included Studies



Appendix 2: Characteristics of Included Publications

Table 2: Characteristics of Included Publications

First Author, Publication Year, Country	Study Design	Study Objectives	Sample Size	Inclusion Criteria	Data Collection Strategy
Farrand, 2019, UK	Thematic Analysis	To gain a better appreciation of factors that inform the type of adaptations to CBT interventions for depression and mainstream service promotion materials to enhance acceptability for Armed Forces Veterans	5 Armed Forces Veteran service users 3 mental health providers 4 non-clinical welfare staff	NR	Focus groups
Button, 2018, USA	Grounded Theory	To examine client process expectations following treatment, including differences between clients receiving CBT versus motivational interviewing integrated with CBT (MI-CBT)	10 adult patients	Completed treatment for a principal diagnosis of GAD	Pre-treatment questionnaire and post-treatment semi-structured interviews
Cartwright, 2018, Australia	Thematic Analysis	To examine women's experiences of using antidepressant treatment along with other activities and practices to support their recovery from depression, to understand how these experiences promote or diminish their sense of agency in regard to their recovery.	50 female patients	Females who were prescribed and used antidepressants in the past five years	Semi-structured telephone interviews
Maroun, 2018, UK	Thematic Analysis	To explore adolescents' views and experiences of selective serotonin uptake inhibitors within their accounts of engaging in a psychological therapy for depression, particularly focusing on meanings they attached to medication-use	12 adolescent patients	Adolescents (13-18 years of age) who met the diagnostic criteria for moderate-to-severe depression and received pharmacotherapy for depression	Semi-structured interviews
O'Neill, 2019, Canada	Qualitative Description	To explore the effectiveness, acceptability, and feasibility of providing BA treatment in a group format	18 adult patients	Adults with a primary diagnosis of MDD	Focus groups and individual interviews

First Author, Publication Year, Country	Study Design	Study Objectives	Sample Size	Inclusion Criteria	Data Collection Strategy
Schure, 2018, USA	Content Analysis	To conduct an exploratory examination of the acceptability of an interactive computerized CBT program to reduce depressive symptoms for adults in a rural Western state	119 mental health professionals	Adults who are speakers of fluent English	Focus groups and individual interviews
Urech, 2018, Switzerland	Content Analysis	To explore perceived advantages and disadvantages of blended CBT from the patients' perspective in specialized mental health care	15 adult patients	Adults meeting diagnostic criteria for MDD with a score of 5 or higher on the Patient Health Questionnaire-9 (PHQ-9)	Semi-structured interviews
Wolitzky-Taylor, 2018, USA	Grounded Theory	To understand the barriers associated with CBT for anxiety disorders	1 policy expert in community mental health 5 clinic administrators 30 providers 10 adult patients	NR	Focus groups and individual interviews
Brijnath, 2017, Australia	Thematic Analysis	To see how the play instinct asserts itself vis-à-vis the meaning and experience of antidepressant use from the patient perspective	58 adult patients	Adults of Indian Australian or Anglo Australian background living with depression currently under medical treatment for depression	Semi-structured interviews
Chavira, 2017, USA	Grounded Theory	To gather community feedback regarding to assess the acceptability of mental health interventions to Latino mental health providers and rural Latino parents and patients	15 parents 28 mental health professionals	Parents of a Latino child diagnosed with a clinical level of anxiety Mental health professionals who: self-identify as Latino	Semi-structured interviews
French, 2017, UK	Thematic Analysis	To explore whether individuals who had attended at least 12 sessions of CBT continued	20 adult patients	Adults who had completed a follow-up in the primary trial	Semi-structured interviews

First Author, Publication Year, Country	Study Design	Study Objectives	Sample Size	Inclusion Criteria	Data Collection Strategy
		to use and value the CBT skills they had learnt during therapy			
Holst, 2017, Sweden	Systematic text condensation	To explore primary care patients' experiences of iCBT for depression treatment	13 adult patients	Adults diagnosed with mild to moderate depression by their primary care doctor	Semi-structured interviews
Khattra, 2017, USA	Grounded Theory	To investigate clients' post-therapy accounts of corrective experiences after completion of either a brief CBT or MI–CBT for GAD.	2 female patients	Adults with principal diagnosis of GAD	Semi-structured interviews
Morrison, 2017, USA	Grounded Theory	To explore patients' experiences of CBT and MI-CBT	10 adult patients	Adults who exhibited a notable change ambivalence in language during CBT sessions	Interpersonal process recall interviews
Pishva, 2017, Canada	Constructivist Grounded Theory	To examine patterns of action and interaction involved in the complex process of carrying out CBT with one's child in one's home	19 mothers	Mother of a child with a diagnosed primary anxiety disorder	Semi-structured interviews
Walsh, 2017, Ireland	Thematic Analysis	To understand the user experience of iCBT amongst those with GAD	7 adult patients	Adult students with GAD	Semi-structured interviews
Bosman, 2016, Netherlands	Constant Comparative Analysis	To unravel the motivations of patients and GPs causing long-term antidepressant use and to gain insight into possibilities to prevent unnecessary long-term use	38 adult patients 26 GPs	Adults prescribed antidepressants for anxiety and/or depressive disorder(s) for >6 months and in remission, and their general practitioners	Semi-structured interviews
Fathi, 2016, Austria	Thematic Analysis	To reveal the basic reasons for immigrants' depression and also the failures and successes regarding the effectiveness of Group-CBT	23 adult patients	NR	Structured interviews

First Author, Publication Year, Country	Study Design	Study Objectives	Sample Size	Inclusion Criteria	Data Collection Strategy
Lundkvist-Houndoumadi, 2016, Denmark	Interpretive Phenomenology	To explore parents' and therapists' experiences of CBT among non-responding youths with anxiety disorders, with a primary focus on parent involvement in therapy	24 families	Families with a non-responder youth to CBT who has a primary anxiety disorder	Semi-structured interviews
Samaan, 2016, Canada	Grounded Theory	To provide an in-depth analysis of the acceptability of BA for patients with depression	9 adult patients 12 clinicians	Adult patients with a confirmed clinical diagnosis of MDD, and the clinicians who care for them	Focus groups
Bayliss, 2015, UK	Grounded Theory	To develop a preliminary model of the experiences of people undergoing combined treatment with antidepressant medication and CBT for depression	12 adult patients	Adults diagnosed with depression and those who have experienced CBT and anti-depressant medication	Semi-structured interviews
Guillaumie, 2015, Canada	Thematic Analysis	To describe pharmacists' perceptions with respect to their practices related to patients receiving antidepressant drug treatment	43 community pharmacists	Community pharmacists who worked at least 20 hours per week in the month prior to recruitment	Focus groups
Knowles, 2015, UK	Constant Comparative Analysis	To explore patients' experience of cCBT for depression	36 adult patients	Adults with clinical depression and who are willing to try cCBT	Semi-structured interviews
Lucassen, 2015, New Zealand	General Inductive Approach	To describe the experiences of lesbian, gay, bisexual or sexual minority youth who used a form of computerized therapy for depression	25 adolescent patients	Youth with significant depressive symptoms and who identify as lesbian, gay or bisexual and who have trialed the Rainbow SPARX cCBT program	Semi-structured interviews
Ringle, 2015, USA	Grounded Theory	To examine, from the perspective of therapists, the barriers to and facilitators in implementing CBT for anxious youths in community settings	50 therapists	NR	Semi-structured interviews

First Author, Publication Year, Country	Study Design	Study Objectives	Sample Size	Inclusion Criteria	Data Collection Strategy
Straarup, 2015, Denmark	Interpretive Phenomenological Analysis	To explore clients' experiences of the mechanisms of change in CBT and MCT for depression	6 adult patients	Adult patients who have tried the intervention within the larger trial	Semi-structured interviews
Vargas, 2015, USA	Grounded Theory	To explore the views around depression and pharmacology among Latinos seeking outpatient care	30 adult patients	Latino adults with MDD	Semi-structured interviews
Kahlon, 2014, UK	Thematic Analysis	To explore experiences of CBT formulation in clients with depression	7 adult patients	Adults who had been referred to psychological services for treatment of depression, and who had not previously received a formulation	Semi-structured interviews
Wilhelmsen, 2014, Norway	Thematic Analysis	To explore aspects perceived by GPs to affect the implementation of guided iCBT in daily practice	11 GPs	GPs who had enrolled voluntarily in a guided iCBT course	Semi-structured interviews

BA = Behavioural Activation; CBT = Cognitive Behavioural therapy; cCBT = computerized CBT; GAD = Generalized Anxiety Disorder; GP = General Practitioner; iCBT = internet-based CBT; MDD = Major Depressive Disorder; MI-CBT = Motivational Interviewing CBT; NR = Not Reported; PHQ-9 = Patient Health Questionnaire; RCT = Randomized Controlled Trial; UK = United Kingdom; USA = United States of America

Appendix 3: Characteristics of Study Participants

Table 3: Characteristics of Study Participants

First Author, Publication Year, Country	Sample Size	Recruitment Strategy	Sex (%male)	Age range in years
Farrand, 2019, UK	5 Armed Forces Veteran service users 3 mental health providers, 4 non-clinical welfare staff	Advertisements on a closed Facebook page Purposive sample consisting of the first 12 participants drawn from three groups	Armed Forces Veteran service users: 100% Mental health providers: 33% Non-clinical welfare staff: 45%	NR
Button, 2018, USA	10 adult patients	Participants were randomly selected from a larger client pool, which was part of a broader study	10%	20-51
Cartwright, 2018, Australia	50 female patients	Participants in an online survey who were also interested in participating in an interview	0%	27-62
Maroun, 2018, UK	12 adolescent patients	Participants were recruited as part of a RCT	17%	13-18
O'Neill, 2019, Canada	18 adult patients	Participants in a mood disorders program were approached by their clinicians	NR	NR
Schure, 2018, USA	119 mental health professionals	Participants were selected based on their interest in the subject of mental health issues in their respective communities	NR	NR
Urech, 2018, Switzerland	15 adult patients	Participants were recruited as part of a RCT, through private psychotherapy practices, licensed outpatient clinics, a website and mass media	47%	20-67
Wolitzky-Taylor, 2018, USA	1 policy expert in community mental health 5 clinic administrators 30 providers 10 adult patients	Participants were recruited from clinics that serve low-income patients	Policy expert: NR Clinic administrators: 33% Providers: 20% Patients: 30%	NR
Brijnath, 2017, Australia	58 adult patients	Participants were recruited from the community	40%	19-84

First Author, Publication Year, Country	Sample Size	Recruitment Strategy	Sex (%male)	Age range in years
Chavira, 2017, USA	15 parents 28 mental health professionals	Mental health professionals were recruited from community mental health agencies and a regional Latino professional group. Parents were recruited from primary care clinic waiting rooms	Parents: 7% Providers: 22%	NR
French, 2017, UK	20 adult patients	Participants in a trial were invited to participate Purposive sampling through measurement of depression severity using the PHQ-9	45%	28-65
Holst, 2017, Sweden	13 adult patients	Participants were recruited as part of a trial	46%	27-68
Khattra, 2017, USA	2 female patients	Participants were recruited as part of a larger trial	0%	28-53
Morrison, 2017, USA	10 adult patients	Participants were recruited as part of a larger trial	0%	18-57
Pishva, 2017, Canada	19 mothers	Purposeful sample of mothers who took part in a CBT group for parents of anxious children and youth	0%	NR
Walsh, 2017, Ireland	7 adult patients	Completers and non-completers of an online iCBT program were invited to participate	29%	18-34
Bosman, 2016, Netherlands	38 adult patients 26 GPs	Patients were recruited via websites of patient associations for anxiety and depression GPs were recruited by telephone and email via the recruited patients or via an academic affiliated GP network When GPs agreed to participate, they were asked to contact one to two eligible patients	Patients: 10% GPs: 11%	Patients: 30-68 GPs: 30-64
Fathi, 2016, Austria	23 adult patients	Snowball sampling techniques using previously recruited participants	35%	NR
Lundkvist-Houndoumadi, 2016, Denmark	24 families	Families self-referred from a University clinic	38% of youth	NR

First Author, Publication Year, Country	Sample Size	Recruitment Strategy	Sex (%male)	Age range in years
Samaan, 2016, Canada	9 adult patients 12 clinicians	Purposive sample of participants (patients and clinicians) in a mood disorders program	Patients: 0% Clinicians: 0%	Patients: 18-65 Clinicians: 25-64
Bayliss, 2015, UK	12 adult patients	Participants were recruited through their therapists	58%	22-58
Guillaumie, 2015, Canada	43 community pharmacists	Convenience sample recruited through advertisements, newsletters and by phone	47%	NR
Knowles, 2015, UK	36 adult patients	Participants were recruited as part of a larger trial	28%	29-69
Lucassen, 2015, New Zealand	25 adolescent patients	Participants were recruited from high schools, a youth-led organization for sexual minority youth and advertisements	52%	13-19
Ringle, 2015, USA	50 therapists	Providers, who were part of an original cohort of CBT training, were invited to participate	8%	23-75
Straarup, 2015, Denmark	6 adult patients	Participants were recruited as part of a larger trial	NR	20-35
Vargas, 2015, USA	30 adult patients	Participants were recruited as part of an RCT	37%	NR
Kahlon, 2014, UK	7 adult patients	NR	43%	19-54
Wilhelmsen, 2014, Norway	11 GPs	GPs who had participated in a guided iCBT course, in addition to two GPs who had attended a related presentation and who were included for comparative purposes	NR	NR

GP = General Practitioner; NR = Not Reported; UK = United Kingdom; USA = United States of America

Appendix 4: Critical Appraisal of Included Studies

Table 4: Strengths and Limitations of Included Studies

First Author, Publication Year, Country	Is the study credible?	Is the study trustworthy?	Is the study transferable?
Farrand, 2019, UK	Partially. The study uses cited focus group methodology, where the procedures and code of conduct are described. Not enough details are provided about how data analysis was carried out.	Yes. Inductive thematically-oriented approach was used to data analysis. Two researchers worked independently to aggregate similar coded groups into sub-themes. Discussions were held to achieve refinement.	Partially. Limited demographic details provided, however interview questions and prompts were related to user and provider experiences of BA therapy that is relevant for this review. Although this sample covers a sub-set of the population, it is an important component of those who receive psychological treatment.
Button, 2018, USA	Yes. Model developed was grounded in participant data (including in vivo descriptions and terminology). Lots of data and context provided.	Yes. Triangulation used while developing and reviewing the model. Lead author completed all coding, which was audited by the third author. Discussions were used to resolve any discrepancies.	Partially. Beyond age and sex, little demographic features or descriptions are provided.
Cartwright, 2018, Australia	Yes. Developed semi-structured interview guide was facilitated using telephone interviews by experienced students. Lots of participant data and context incorporated into the analysis and reporting of findings.	Partially. Data analysis was conducted with consultation and consensus amongst the research team. Unclear if and how triangulation or confidence in data analysis was determined.	Yes. Diverse demographic details and context provided about the sample.
Maroun, 2018, UK	Yes. Participant data and voices could be seen coming through the findings via the quotes and well-defined model.	Yes. Guidelines for conducting rigorous thematic analysis were followed with a particular emphasis on trustworthiness, credibility, transferability, dependability, and confirmability. This was achieved through reflexivity, maintaining a journal to document and review thought progression, and an audit trail on how codes were grouped into themes.	Yes. Demographic details support transferability. Interview context and results are relevant to the review's objectives.
O'Neill, 2019, Canada	Yes. Semi-structured focus groups were conducted to gather information about the group experience and individual	Yes. Field notes were kept to document group dynamics, body language, and other visual components that may	Yes. Demographic details, including Canadian context, and content of interviews and their analysis support the

First Author, Publication Year, Country	Is the study credible?	Is the study trustworthy?	Is the study transferable?
	interviews were offered to provide a venue to discuss more personal matters. Focus groups provided participants with the opportunity to build off each other's ideas and respond to ideas. Participant data provided to support major themes.	not come through in the audio-recording.	transferability to this review.
Schure, 2018, USA	Yes. A predetermined list of semi-structured questions was used during the interview. It is unclear if or how these questions were modified during the research process. Questions appear to be flexible enough to solicit responses from diverse participants.	Yes. Transcribed data were analyzed shortly after completion of each focus group and interview. Saturation of content was reached well before all the focus groups and interviews were completed. However, team members continued to conduct focus groups and interviews in order to reach a representation from all areas of the state.	Yes. The focus areas of the interviews and focus groups parallel the objectives of this review. The diversity in the participants appears to support transferability to other contexts.
Urech, 2018, Switzerland	Yes. Interview guide was adapted from previous literature and built upon open-ended questions. Interviewers were trained before data collection and analysis.	Yes. Data were tested for discrepancies. Disagreements between two researchers were discussed and regrouped until consensus was achieved. In addition to the content analysis, an explorative post hoc segment analysis was conducted to categorize all the advantages and disadvantages named by the patients in specific groups with respect to the severity of their depression at baseline.	Yes. Perceptions of CBT obtained relate to suitability and acceptability, and are relevant to the review objectives. Ample details around demographics and context was provided.
Wolitzky-Taylor, 2018, USA	Partially. Unclear how the interview guide was developed or whether it was subject to change depending on pilot interviews. Questions were open-ended and flexible enough to encourage discussions.	Yes. Two experienced researchers independently reviewed each transcript and developed a codebook. All data were coded independently and in-duplicate. Coding decisions were discussed to resolve any discrepancies. Memos and audit trails were maintained throughout the methodological process.	Yes. Results are related to the objectives of the review. Demographic factors appear to be more relevant for US populations (due to ethnicity), however, the context and focus of the findings as they relate to CBT is likely to transcend geographical borders.

First Author, Publication Year, Country	Is the study credible?	Is the study trustworthy?	Is the study transferable?
Brijnath, 2017, Australia	Yes. Semi-structured interviews were undertaken by two members of the research team. Lots of connections made to direct participant data. Use of large sample size.	Yes. Codes were cross-checked by an independent colleague and interpretive differences were resolved by consensus.	Partially. Basic demographic features such as age, sex, ethnicity, and antidepressant use are provided. Results are somewhat relevant to the objectives of this review as the analysis does not incorporate, to a great extent, issues related to satisfaction and acceptability.
Chavira, 2017, USA	Yes. Semi-structured interview guide used; sample of neutral prompts and questions are provided.	Yes. Data analyzed by a team of expert researchers. Disagreements were addressed via discussion and consensus was reached. Data was analysed iteratively and five extra interviews were conducted to support that saturation was achieved.	Yes. Demographic details and parent perceptions and experiences of and with CBT components were obtained within the interviews.
French, 2017, UK	Partially. Topic guide used to conduct interviews and to maintain consistency across them. Sufficient details not provided about interview conduct.	Partially. Transcripts were independently read by two members of the research team to develop a coding framework. Unclear how further levels of trustworthiness was upheld (e.g., triangulation, member-checking, sustaining integrity in analysis)	Partially. The content area of the interviews included longer-term implications and experiences of CBT No focus on factors related to acceptance of therapy.
Holst, 2017, Sweden	Yes. A semi-structured interview guide was developed from a previous guide for iCBT research. A sample of open-ended questions are provided. Participant data and context provided within the analysis, which was described to be “data-driven”.	Yes. Data analyzed by a researcher with expertise in iCBT and who has worked previously with CBT therapists. Transcripts were read several times. Some interviews were coded in duplicate to enhance dependability and trustworthiness.	Yes. Content area of the interviews are related to the topic area of this report, focusing on experiences related to iCBT and specifically acceptability, preferences, and suitability to the condition.
Khattra, 2017, USA	Partially. Unclear what kind of interview guide was used or if was modified to account for diverse participants’ needs. Lots of contextual data and participant quotes are used to supplement themes and sub-	Partially. Only two patients were included in this grounded theory analysis. This questions information power and reaching of saturation. Transcripts were coded by a single coder into meaning	Partially. Because this study has only included the experiences of two participants with GAD and focuses more on perceptions and experiences of corrective experiences as they relate to CBT, it is only slightly related

First Author, Publication Year, Country	Is the study credible?	Is the study trustworthy?	Is the study transferable?
	categories and to provide first hand explanations of meaning.	units and properties before being clustered into categories. The coding was verified by a senior researcher.	to the objectives of this review, which is to look more broadly at patients' experiences with CBT.
Morrison, 2017, USA	Yes. Participants were interviewed by an experienced student. Lots of context and data incorporated into the write-up.	Yes. Multiple experienced coders were used. Each coder's biases and expectations were reviewed and reflexively discussed in advance of analysis. Their potential influence on study findings were monitored.	Partially. Demographic features beyond age, sex, and race are not provided in detail so it is difficult to assess transferability. Some of the results related to CBT experiences are related to the context of this review and thus can be applied.
Pishva, 2017, Canada	Yes. The interview guide was developed by the primary investigator and focused on elements such as expectations, knowledge, and challenges. The guide was modified based on initial and subsequent interviews to support the iterative process that is inherent to grounded theory construction. In vivo codes or verbatim labels were used to encapsulate the main themes.	Yes. Data collection was terminated when saturation was reached. Theoretical sorting, diagramming, and integration were used to construct a cohesive theory. Detailed memos were maintained throughout the methodological process. Constant comparison methods and a research steering committee, for member-checking, were utilized to ensure resonance, referring to the researcher's responsibility to seek variations in the codes and ensure that categories are fully saturated and clearly defined, all the while representing the meaning of participants' experience. Reflexivity was upheld using memos.	Yes. Results are relevant to the objectives of this review. Lots of context provided about participants to help support the transferability, including the Canadian context.
Walsh, 2017, Ireland	Yes. A semi-structured interview guide was developed based on pilot interview data. Open-ended questions allowed for participants to discuss their experiences and what was important to them.	Yes. Inter-rater reliability was used to ensure reliability of the defined themes. The primary supervisor of the study cross checked and examined the identified themes from a sample interview. An	Yes. Results are relevant to this review as they relate to experiences with program completion, online interventions, and suitability of online therapy.

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		independent researcher also analyzed and coded extracts from five randomly selected interviews using the same framework.	
Bosman, 2016, Netherlands	Yes. In-depth semi-structured interviews were conducted with all participants by experienced students. Analysis conducted with clear and detailed connections to participant data.	Partially. Two researchers coded the initial interview and consensus was reached with an initial framework before coding all subsequent interviews. No member-checking or respondent validation approaches were used.	Yes. Context and patient population reported in sufficient detail (e.g., age, sex, urban or rural living, ethnicity, diagnosis, type of antidepressant used) to support transferability of results to this review.
Fathi, 2016, Austria	Partially. Structured interviews were used to collect data. GABEK method was used as a comprehensive approach to evaluate measures. Procedures seem to rely on formulating a tree structure to elicit themes and sub-themes.	Partially. Not enough details are provided to make an accurate assessment of how data trustworthiness was maintained or upheld.	Partially. Various validated scales used to determine clinical status to include those with mild to moderate depression and exclude those with severe depression. Some demographic details are provided, and content areas relate to the subject of this review. Not certain how participant population might relate to those who seek care within a Canadian context.
Lundkvist-Houndoumadi, 2016, Denmark	Yes. Interview questions are provided for families and therapists. Lots of participant data is used to support major themes and ideas.	Yes. Reflexive thinking used by researchers. Themes were repeatedly cross-referenced with the transcripts to ensure that ideas were grounded within the data. Two researchers worked together to determine consistency in findings and reporting.	Yes. Interviews focus on families' and therapists' experiences with the provision of CBT, which is of relevance to this review. Demographic details are provided and support transferability.
Samaan, 2016, Canada	Yes. Flexible and open-ended questions were asked during the interview. Lots of participant data provided to support major themes.	Yes. Three members of the research team individually reviewed the transcripts of the focus group to inductively identify themes before further analysis of the data. After coding of the identified themes, they created an inclusive master list of themes. To ensure categories were comprehensive and relevant, all data were re-read	Yes. Demographic details, including Canadian context, and participant context provided to determine transferability. Content and context of data is relevant to this review.

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		and re-analyzed. Analysis was initiated at the time of the first interview, allowing any emerging themes to inform and guide future data collection.	
Bayliss, 2015, UK	Yes. Use of a semi-structured interview guide informed by preliminary consultation with patient partners. Lots of contextual elements are considered with data grounded within the voices of the participants. A well-developed model brings the findings together.	Yes. Data supplied and methods are described in sufficient details. Respondent validation was used to gauge the credibility of the results to the participants.	Yes. Context and patient population reported in sufficient detail (e.g., age, time since diagnosis, diagnosis, current medication, stage of CBT) to support transferability to this review.
Guillaumie, 2015, Canada	Yes. Interviews were conducted by an experienced researcher. A pilot-tested topic guide was developed in consultation with the literature. Focus of the guide is discussed and is relevant to pharmacists' experiences.	Yes. Field notes were kept. The three researchers who were involved in data collection debriefed post-interview to discuss preliminary ideas and emerging themes. Codebook was developed in consultation with the research team and used for the duration of the data analysis process.	Yes. Topic area ,and Canadian context, is relevant to the focus of this review as it relates to the experiences, perceptions, barriers, and facilitators faced by pharmacists who care for patients taking antidepressant drugs.
Knowles, 2015, UK	Yes. Semi-structured interviews were conducted by experienced associates. Within the interview, topic guides were used to facilitate open-ended conversations. Lots of participant data used to support main ideas	Partially. Transcripts were independently analyzed and consensus meetings were held to resolve any discrepancies.	Yes. Topic areas were directly related to the focus area of this review. Demographic characteristics are also provided about each participant and support transferability.
Lucassen, 2015, New Zealand	Yes. Participant views were obtained using a semi-structured interview guide focusing on suitability and acceptability of the cCBT platform. Lots of participant data in the form of quotes are incorporated as a way to support each major theme and associated sub-themes.	Yes. Transcripts were read and re-read several times by the research team. Interviews were coded independently and in duplicate. An accuracy check was performed to determine discrepancies. Data was shared with participants for feedback.	Yes. This cCBT platform was modified to suit the needs of the patient population and areas of focus included those relevant to the objectives of this review.

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Ringle, 2015, USA	Partially. Details about the interview guide and modifications made throughout the methodological process are unclear. More participant data could have been incorporated into the write-up to support main themes.	Yes. Research team collaborated to determine an initial list of codes. Two raters independently identified themes. Each reviewer produced memos, including examples and commentary, to reach consensus regarding newly derived, emergent themes	Partially. More demographic and contextual details could have been provided to help assess transferability. Barriers and facilitators are related to the objectives of this review.
Straarup, 2015, Denmark	Yes. The interview was semi-structured in order to help clients express their experiences as freely as possible. Thus, the interviewer was allowed to change the order of the questions; however, in each interview all themes in the interview guide had to be covered. Themes are supported by participant voices through quotes.	Partially. All coding was done by a single author. Not enough detail is provided about how trustworthiness was upheld.	Partially. Lots of data provided around patients' experiences with CBT; however, only a small amount relates to satisfaction and suitability of the intervention.
Vargas, 2015, USA	Yes. A semi-structured interview guide was used was to explore participants' experiences around domains such as health treatments and logistical issues related to engagement. Participant data used to support themes.	Yes. Two authors independently reviewed transcripts to develop a "living" codebook. Regular meetings were held to discuss interpretations, resolve disagreements, and refine/identify new codes.	Yes. Various measures such as the results of acculturation, clinical characteristics, and demographics are provided. Interview questions and context are relevant to this review.
Kahlon, 2014, UK	Yes. A semi-structured interview guide was developed in collaboration with a multi-disciplinary team. Key themes and focus areas of the interview are provided. Participant data and context incorporated with detail.	Partially. An independent audit of the coding procedures was conducted. Discussions were used to support quality control and the researcher's position was reported with transparency. Sampling approach not reported.	Partially. Limited reporting of demographic data and focus area is only partially relevant to the context of this review.
Wilhelmsen, 2014, Norway	Yes. Semi-structured interview guide was used to gather information. The guide was developed by an	Yes. Field notes were made immediately after the interview. Throughout the analytical process, all findings	Partially. Content and context of interview and subject matter relates directly to the objectives of this review. Due

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	interdisciplinary team of researchers. Interview domains related to experiences and implications of working with patients in the context of iCBT.	were discussed and validated with an experienced qualitative researcher and two GPs. Inconsistencies were resolved through discussion and further reflection. All transcripts were checked against the audio recordings. Findings were discussed in light of existing literature.	to a lack of provided details in the write-up, it is difficult to determine if GPs experiences would be similar to those in Canadian context.

BA = Behavioural Activation; CBT = Cognitive Behavioural Therapy; cCBT = computerized CBT; GAD = Generalized Anxiety Disorder; US = United States