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Use of psychotherapy in a representative adult community sample in São Paulo, Brazil

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Abstract

Little is known about the use of psychotherapy to treat common mental disorders in a major city in a middle income country. Data come from in-home interviews with a stratified random sample of 2,000 community residents age 18–65 in the city of São Paulo, Brazil. The information obtained included sociodemographic characteristics; psychotropic drugs; mental status; and lifetime, previous 12 months, and current use of psychotherapy. Logistic regression was used to examine determinants of use of psychotherapy. Of the sample, 22.7% met General Health Questionnaire-12 criteria for common mental disorders. Lifetime, previous 12 months, and current use of psychotherapy were reported by 14.6%, 4.6%, and 2.3% of the sample respectively. Users were typically women, more educated, higher income, not married, unemployed, with common mental disorders. Further analysis found that 47% (with higher education and income) paid out-of-pocket, and 53% used psychotropic medication. Psychotherapy does not appear to be the preferred treatment for common mental disorders.

Keywords

prevalence; common mental disorders; psychotropic medications; epidemiological survey; community sample; Brazil

Introduction

The symptoms of common mental disorders, can lead to clinically significant impairment or distress (Alonso et al., 2004a; Vos et al., 2012), which can be alleviated by a variety of treatments, including, possibly, psychotherapy (Wampold et al., 1997; Roth and Fonagy, 2006; van't Hof et al., 2011; Leichsenring and Rabung, 2011; Vos et al., 2012; van Hees et

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Conflicts of Interest

No conflicts of interest.

al., 2013). Several controlled studies (Freedland et al., 2009), meta-analyses (Westen et al., 2004; Mitte, 2005; Driessen et al., 2010), and guidelines (National Institute for Health and Clinical Excellence, 2011; Jonas et al., 2013; Parikh et al., 2009), have indicated the efficacy of psychotherapy for different mental health problems, both when used alone (Jonas et al., 2013; Parikh et al., 2009; Barth et al., 2013; Gibbons et al., 2008), or in combination with psychotropic medications (Parikh et al., 2009; Keller et al., 2000). There remains, however, debate on methodological issues regarding assessment of psychotherapy efficacy and effectiveness (Cuijpers et al., 2009; Gerber et al., 2011; Wampold et al., 1997).

While psychotherapy has a long history, there are few reports, which come primarily from developed countries [e.g., US, UK, continental Europe] (Alonso et al., 2004b; Jokela et al., 2013; McManus et al., 2009; Singleton et al., 2001; Da Silva and Blay 2010), of the prevalence with which psychotherapy is used, and the characteristics of users. Greater use has consistently been reported among women, the middle-aged, persons reporting more education and higher income, and the unemployed. Information for developing (lower and middle income) countries is largely absent. To help address this lack, we present here information from a sample of representative community residents age 18–65 in the city of São Paulo. Our focus is the prevalence of psychotherapy use, treatment duration, how paid for, association with common mental disorders, additional use of psychotropic medication, and the characteristics of users. Such information is critical to advising the ongoing debate in Brazil on reimbursement of such treatment and the recipients it should target.

METHODS

Sample

A stratified random survey of 2,000 community residents of the city of São Paulo, aged 18–65 was carried out in May–June 2002. To obtain a representative sample we identified the districts constituting São Paulo, and determined the population of each using year 2000 census data. Within each district we randomly selected census tracts, within which we randomly selected two blocks, and then households, following a systematic procedure. In each household, one resident aged 18–65 was selected based on the birthday closest to the date of interview. Five interviews (with replacement) were conducted within each block, yielding groups of 10 subjects. The resulting distribution was proportional to the populations of the districts.

This study was approved by the Ethics Committee of the Federal University of São Paulo (UNIFESP). All participants signed informed consent forms. Information was gathered in person, in the home, by trained interviewers using structured questionnaires, which included inquiry into demographic, health, and treatment characteristics.

Assessment of psychotherapy use

After being asked (translated) “Did anyone close to you, such as family members or friends, ever participate in treatment or in psychotherapy, such as a professional consultation in which the patient talks with a psychologist or therapist about problems and concerns?” participants were asked: “Did you ever participate in treatment or in psychotherapy, such as

a professional consultation in which the patient talks with a psychologist or therapist about problems and concerns?” Response categories: Yes/ No/ Do not know/ No response

Those responding “yes” (indicating any lifetime use), were then asked whether treatment was within the previous 12 months, treatment duration, whether currently undergoing treatment, and if so, anticipated duration. Duration was classified as 4, 5–12, >12 months.

Primary source of payment

Participants reported whether the primary source of payment was from the public health system, coded as public, or covered by separate insurance or out-of-pocket (coded as private).

Assessment of psychotropic medication use

Each participant was asked “Have you ever used a medication for anxiety, tension, problems sleeping, depression, mental problem or nervousness?” If “yes”, they were asked whether there had been use in the last 12 months, and to name the medications based on free recall. Psychotropic medications were grouped by therapeutic class as: anxiolytics, antidepressants, hypnotics, antipsychotics, and mood stabilizers. Anticonvulsants (carbamazepine, oxcarbazepine, valproate/divalproex, gabapentin, topiramate, lamotrigine) were considered mood stabilizers when participants indicated use in relation to a psychiatric condition. Teas, phytotherapy, and homeopathic preparations were classified as ‘alternative medicine’.

Identification of common mental disorders

Common mental disorders were identified by response to the 12-item General Health Questionnaire (GHQ-12) (Aalto, et al., 2012; Goldberg and Williams 1988) which has been used in other major epidemiological surveys of mental health (Jokela et al., 2013). Evaluation of the Brazilian Portuguese translation indicated that performance was unaffected by demographic characteristics, and that it could identify common mental disorders in primary care and community populations. Each of the 12 items addresses personal status in the last 30 days, and is answered on a 4-point scale. For summary purposes, scores of 0 and 1 were recoded to 0, scores of 2 and 3 were recoded to 1, resulting in a potential scoring range of 0–12. For Brazil, a score of 4 or more indicated the presence of depression or anxiety with a sensitivity of 82% and specificity of 77% (Mari and Williams, 1984;1985).

Covariates

Covariates, selected because of their association with psychotherapy use in previous studies (Briffault et al., 2008; Da Silva and Blay, 2010; Olfson and Marcus; 2010), included sex; age; education (0–7, 8+ years); income status, i.e., higher economic class (>U.S.\$200/month) vs. lower economic class (U.S.\$200/month) based on Brazilian Association of Market Research Institutes (ABEP) guidelines; marital status (married, never married, previously married); and whether currently employed (yes, no).

Statistical procedures

The sample was divided into three groups, which could overlap: lifetime users, previous 12-month users, and current users. For each group, the data were first described by percentages. Chi-square was used to examine bivariate differences in psychotherapy use as a function of sociodemographic characteristics and GHQ-12 score (0–3/ 4) for lifetime, previous 12 months, and current psychotherapy use. All variables were then entered into separate logistic regression models for lifetime and 12-month psychotherapy users, while a restricted set of variables was included for current users because of their small sample size. Additional descriptive statistics and logistic regressions focused on 12-month psychotherapy users since some information was available only for this group. These analyses examined psychotropic drug use, duration of therapy and source of funding. All analyses used SPSS-20. An α -level of .05 indicated statistical significance.

RESULTS

Sample

Lifetime use of psychotherapy was reported by 14.6% of the sample, previous 12 months use by 4.6%, and current use by 2.3%. Table 1 reports descriptive characteristics. Gender differences in psychotherapy use appear to have changed when different time frames were considered, with a significantly larger proportion of women reporting lifetime use, a lesser (but still significant) proportion reporting use in the previous 12 months, and no gender difference among current users. Age did not distinguish among lifetime users, suggesting lower use in the older population. Those in the 35–49 year age category were more likely to report receiving psychotherapy in the previous 12 months, but while this trend continued for current users, it did not reach statistical significance.

For all time intervals considered, participants with more education, higher income, who were no longer or had never been married, the currently unemployed, and those with common mental disorders were more likely to report use of psychotherapy. Of the lifetime, 12-month, and current psychotherapy users, 31.8%, 42.9%, and 48.9% respectively, met criteria for common mental disorders.

Adjusted analyses (Table 2) provided a more nuanced picture. All variables were entered into logistic regression analyses for lifetime and 12-month use of psychotherapy, but only gender, age (in continuous form), income, and presence of common mental disorders were entered for current users because of their smaller sample size ($N = 45$). Adjusted analyses confirmed that lifetime and 12-month users were more likely to be women, but that gender differences were not present among current users. Among lifetime users, both 35–49 year olds, and 50–65 year olds were more likely than the youngest (reference) group (age 18–34) to report psychotherapy, but among 12-month users the 35–49 year olds were the most likely users. As in the unadjusted analyses, among current psychotherapy users, age did not differentiate users. Increased education and higher income identified lifetime users, but neither of these characteristics distinguished 12-month users. While income did not identify current users, a separate analysis, in which education was substituted for income, showed greater odds of use (OR 2.60, 95% CI 1.24–5.46, $p=0.012$) with more education.

For lifetime users, both the never married and the previously married were more likely to report use of psychotherapy, but for previous 12-month users this held only for the never married (marital status was not examined for current users because of small sample size). Employment status lost relevance in adjusted analyses, but presence of common mental disorders was significantly associated with lifetime, 12-month, and current psychotherapy use.

Additional information on past 12-month psychotherapy users

Of the 91 participants reporting psychotherapy in the past 12 months, 46 no longer received psychotherapy. For 52%, their duration of treatment was four months; for 28%, 5–12 months; and for 20%, >12 months. Among those currently in therapy (N=45), 36% expected treatment to last four months, 18% expected duration of 5–12 months, and 47% expected psychotherapy to last more than a year.

Psychotropic drug use

Of those reporting psychotherapy use in the previous 12 months, 48 (53%) also reported using psychotropic medication, while 47% did not. The psychotropic medications taken were primarily antidepressants (19%) and anxiolytics (17%), with antipsychotics (7%), mood stabilizers (6%), hypnotics (3%), and alternative medicine (4%) reported to a lesser extent. Some took multiple medications, and psychotropic medications in more than one therapeutic class.

Payment for psychotherapy

For recent 12-month users, psychotherapy was paid by private insurance for 16.5% and out-of-pocket by 30.8%, and by public coverage for 53%. Adjusted analyses (Table 3), indicated that people with less education and lower income had a three to four times greater odds of using psychotherapy paid for by public means, while the inverse was true for psychotherapy paid by private insurance or out-of-pocket.

DISCUSSION

Findings on use of psychotherapy from this survey of 2,000 representative community residents of São Paulo age 18–65, indicated lifetime use by 14.6%, past 12 months use by 4.6%, and current use of psychotherapy by 2.3%. This is in line with, or somewhat greater than findings from developed countries. For current use: 1.1%–1.9% (Da Silva and Blay, 2010), and 2.3% in a nationally representative survey in the year 2000 of community residents age 16–74 in the UK (Singleton et al., 2001), increasing to approximately 3% in 2007, when there was no upper age limit in the UK survey (McManus et al., 2009). For 12-month use: 3.1%–3.6% (Da Silva and Blay, 2010); 2.3% averaged across the six countries of the ESEMeD project [Belgium, France, Germany, Italy, The Netherlands, Spain, years 2001–2003] (Alonso et al., 2004b); 3.2% in the US in 1987 and 2007, with variation in the intervening years (Olfson and Marcus, 2010; Olfson et al., 2002). For lifetime use: 1.2%–11.5% (Da Silva and Blay, 2010), lifetime use in France, however, was 11.8%, based on health insurance data (Briffault et al., 2008), and excludes privately paid psychotherapy.

Our finding that 53% of psychotherapy recipients also use psychotropic medications is within the reported range of 32%–71% (McManus et al., 2009; Singleton et al., 2001; Olfson and Marcus, 2010; Olfson et al., 2002; Kovess et al., 2007). Further, in agreement with other studies, the psychotropic medications most used were antidepressants and anxiolytics (Olfson and Marcus, 2010; Olfson et al., 2002).

In general, adjusted analyses indicated that use of psychotherapy was more likely for women, those with more education, those not married, and those who had depression and/or anxiety. Except for employment status, which was nonsignificant in adjusted analyses, these findings are in agreement with reports from previous studies. While lifetime use by those with more education or higher income was greater than for those with less education or income, income was no longer relevant for 12-month users (although this might not hold in a larger sample), and for current users; only education remained relevant. Changes in Brazil, as proposed by the 1988 Federal Constitution of Brazil (Constituição da República Federativa do Brasil de 1988), in its Article 196, recognizes that: “Health is a right of all and a duty of the State, calling for social and economic policies that involve reduction of the risk of disease and of other aggravations and universal and egalitarian access to actions and services for its promotion, protection and recovery.” Established in 1988, the Sistema Único de Saúde (SUS -Single Health System) was created to ensure universal, free, and equal access to health care. The principles of SUS, established in 1990 in the Lei Orgânica de Saúde (Organic Health Law), espoused universality, completeness, and equality. These laws, designed to increase access to health care, appear to have facilitated use of psychotherapy by those who might not otherwise have had the means to do so. This differs from findings of greater use by the better educated and more affluent for the US (Mojtabai and Olfson 2008), where higher income improves access. However, newer studies with larger samples are needed to determine whether access to psychotherapy is no longer restricted to those subjects with higher incomes.

Adjusted analyses indicated that over their lifetime people 35–65 years of age were more likely to have used psychotherapy than 18–34 year olds, a reasonable finding given that they had more years in which to use this service. Assuming, however, that use of psychotherapy parallels lifetime report of mental disorders, this finding may be conservative, since there is empirical evidence that report of mental disorder, and also of health service use, and underestimates prior occurrence (Patten, 2009; Streiner et al., 2009). Unlike lifetime use, previous 12-month use indicated greater use by the young middle-aged (ages 35–49), with a nonsignificant tendency in this direction among current users, suggesting that psychotherapy is either better accepted (or needed) in this age group, or that use reflects improved health care access. Other studies also report that this group and those slightly older are the most likely users (Alonso et al., 2004b; Olfson and Marcus, 2010), and view treatment for mental health problems most favorably (Mojtabai, 2007).

Duration of treatment varied from 4 months (28%), to >12 months (20%). Those currently in treatment seem to anticipate a yet longer duration. While there may be misreporting and misunderstanding by patients, the duration of therapy reported suggests that closer consideration be given to effective, evaluated brief psychotherapies, which may be less onerous for patients (and possibly also providers), and which could be offered to more

patients within the current healthcare budget. In the U.K., by training additional therapists, providing guidelines that specify effective approaches, and increasing access with an emphasis on the underserved, the costs of treatment appear to have been more than covered because improved mental health has resulted in reduced unemployment with associated unemployment insurance expenses, reduced days off work, and higher income taxes paid (McManus et al., 2009; Department of Health IAPT, 2013).

While common mental disorders are more prevalent among psychotherapy users than in the general population, the majority of past or present psychotherapy users did not meet criteria for common mental disorders. There may be various reasons for this. For past users, psychotherapy may have worked as desired, alleviating mental disorders; some users may have recognized the development of a problem, and successfully taken precautionary action; psychotherapy may have been used for conditions or circumstances not identified by GHQ-12; the GHQ-12 may have misclassified some people. Some people may have received treatment other than psychotherapy. Here, just over half of those who reported using psychotherapy, also used psychotropic medications.

Probably of greater concern to the health care provider community is the proportion with common mental disorders who do not receive treatment, in this case psychotherapy. In the current study, of those meeting criteria for common mental disorders, 20.4% reported lifetime use of psychotherapy, 8.6% reported use in the previous 12 months, and 4.8% reported current use. Absence of treatment for mental disorders is a common finding, reported by nearly every study on need for mental health services.

We may be under-estimating treatment. There are providers of mental health services other than those included in the current enquiry (e.g., practitioners of alternative and complementary medicine), and there are effective nonpsychotherapeutic, nonpharmacologic treatments that may be more relevant for certain patients (e.g., exercise, electroconvulsive and related therapies). While there are studies that have examined the effectiveness of alternate treatments (Gaynes et al., 2011), we do not know, and we may not be able to judge from current studies, how many persons with common mental disorders are being treated, how many have been treated to no avail, and how many who might be able to benefit lack access to, or never sought treatment.

Use of psychotherapy for treatment may be affected by a number of conditions, including the density of providers (Briffault et al., 2008), restrictions imposed by health insurance, ability to pay privately, concern regarding possible stigma, and lack of awareness that psychotherapy can be an effective treatment. In addition, it has been suggested that, with increased use of psychotropic medication, in particular antidepressants, some persons who might have been better treated by psychotherapy are being inappropriately treated by antidepressants prescribed by less knowledgeable primary care physicians, and pushed by the pharmaceutical industry (Kessler et al., 2007; Editorial, 2012). Dezzetter et al. (2013) showed that 1€ spent by the community for psychotherapy would result in a saving to the community of 1.95€ (95% CI 1.30–2.60) for depressive disorders, and 1.14€ (95% CI 0.76–1.52) for anxiety disorders, suggesting that coverage for psychotherapies would have a

positive impact for the community as a whole, not only in terms of quality-of-life, health and absenteeism, but also as a cost-effective investment.

Limitations

We cannot be sure that our definition of psychotherapy was understood as intended. Different studies have defined psychotherapy in different ways, included different therapies, used different durations, and identified as providers people with different training backgrounds. There appears to be little uniformity in this area.

Information on use was self-reported, and medical records were unavailable for confirmation. While we gathered information on self-reported duration of treatment, we did not ask for type, frequency of treatment, outcome, or information on the provider. Our enquiry emphasized provision by psychologists and therapists, trained providers who, in Brazil, are the more common providers of care to persons with common mental disorders. The phrasing of enquiry disregarded psychiatrists, who in Brazil are more likely to be referred patients with serious mental health problems, and alternative providers, so we may not have identified persons receiving psychotherapy from these providers.

The GHQ-12 is a valid screen for common mental disorders, and has been used in major epidemiological surveys (Jokela et al., 2013). It does not provide a psychiatric diagnosis, or indicate severity of disorder. GHQ-12 is one of multiple screens used in epidemiological surveys to identify mental health problems, agreement among only some of which has been determined, which complicates further the extent to which findings from different studies can be compared.

Data were collected in 2002. Although major health policies have not changed since then, there have been major improvements in level of education, reduction of illiteracy, increased spending on health (particularly by the public health sector), increase in life expectancy, and improved housing (Paim et al., 2011). Such changes may have modified and likely improved access to, and acceptance and use of psychotherapy. At the same time, there has been modification of the manner in which some therapeutic approaches are provided, specifically, placing greater emphasis on electronic resources, although it is unclear to what extent this approach has been used in São Paulo. Finally, this is a cross-sectional study. While appropriate to assess the prevalence of a condition, a longitudinal study is necessary to assess the impact of psychotherapy, and so to determine whether use, and absence of use, affects personal well-being.

Conclusions

Information from a representative sample of 2,000 community residents age 18–65 of the city of São Paulo, Brazil, indicated that residents who used psychotherapy, and the extent to which psychotherapy was used was comparable to, or sometimes higher, than that reported for developed countries. Specifically, 14.6% reported lifetime use, 4.6% reported use in the previous 12 months, and 2.3% were current users. Users were more likely to be women, not married, and who met criteria for common mental disorders. With improved access to health care, those with lower education or less income no longer appear to be differentially restricted from psychotherapy. Fifty three percent who used psychotherapy also used

psychotropic medications, primarily antidepressants and anxiolytics. Psychotherapy was available through both privately paid sources (used by 47% of psychotherapy users, who had higher education and income), and by public coverage (used by 53% of users, with lower education and income). Duration of use was variable, and in some cases lengthy, raising question regarding selection of efficient interventions.

As in other studies, only a small proportion of the sample that met criteria for common mental disorders received psychotherapy. The proportion receiving other forms of treatment, and the proportion untreated, is unclear. A longitudinal study is needed to ascertain the impact of psychotherapy. Alternative, brief, tested forms of psychotherapy could increase access within the current budget, and facilitate personal and societal well-being.

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REFERENCES

- Aalto A-M, Elovainio M, Kivimäki M. The Beck Depression Inventory and General Health Questionnaire as measures of depression in the general population: a validation study using the Composite International Diagnostic Interview as the gold standard. *Psych Res.* 2012; 197:163–171.
- Alonso J, Angermeyer MC, Bernert S, Bruffaerts R, Brugha TS, Bryson H, de Girolamo G, Graaf R, Demyttenaere K, Gasquet I, Haro JM, Katz SJ, Kessler RC, Kovess V, Lépine JP, Ormel J, Polidori G, Russo LJ, Vilagut G, Almansa J, Arbabzadeh-Bouchez S, Autonell J, Bernal M, Buist-Bouwman MA, Codony M, Domingo-Salvany A, Ferrer M, Joo SS, Martínez-Alonso M, Matschinger H, Mazzi F, Morgan Z, Morosini P, Palacín C, Romera B, Taub N, Vollebergh WA. ESEMeD/MHEDEA 2000 Investigators, European Study of the Epidemiology of Mental Disorders (ESEMeD) Project. Disability and quality of life impact of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatr Scand.* 2004a; 109(Suppl. 420):38–46. [PubMed: 14674957]
- Alonso J, Angermeyer MC, Bernert S, Bruffaerts R, Brugha TS, Bryson H, de Girolamo G, Graaf R, Demyttenaere K, Gasquet I, Haro JM, Katz SJ, Kessler RC, Kovess V, Lépine JP, Ormel J, Polidori G, Russo LJ, Vilagut G, Almansa J, Arbabzadeh-Bouchez S, Autonell J, Bernal M, Buist-Bouwman MA, Codony M, Domingo-Salvany A, Ferrer M, Joo SS, Martínez-Alonso M, Matschinger H, Mazzi F, Morgan Z, Morosini P, Palacín C, Romera B, Taub N, Vollebergh WA. ESEMeD/MHEDEA 2000 Investigators, European Study of the Epidemiology of Mental Disorders (ESEMeD) Project. European Study of the Epidemiology of Mental Disorders (ESEMeD) Project. Use of mental health services in Europe: Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) Project. *Acta Psychiatr Scand.* 2004b; 109(Suppl. 420):47–54.
- Barth J, Munder T, Gerger H, Nüesch E, Trelle S, Znoj H, Jüni P, Cuijpers P. Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. *PLoS Med.* 2013; 10(5):e1001454. [PubMed: 23723742]
- Briffault X, Sapinho D, Villamaux M, Kovess V. Factors associated with use of psychotherapy. *Soc Psychiatr Psychiatr Epidemiol.* 2008; 43:165–171.
- Constituição da República Federativa do Brasil de. [Accessed January 21, 2014] 1988. Available at: http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm
- Cuijpers P, van Straten A, van Schaik A, Andersson G. Psychological treatment of depression in primary care: a meta-analysis. *Br J Gen Pract.* 2009; 59(559):e51–e60. [PubMed: 19192368]

- Da Silva PFR, Blay SL. Prevalence and characteristics of outpatient psychotherapy use: a systematic review. *J Nerv Ment Dis.* 2010; 198:783–789. [PubMed: 21048467]
- Department of Health IAPT. IAPT three-year report: the first million patients. 2012 Nov. Available at: <http://www.iapt.nhs.uk/>.
- Dezetter A, Briffault X, Lakhdar CB, Kovess-Masfety V. Costs and benefits of improving access to psychotherapies for common mental disorders. *J Ment Health Policy Econ.* 2013; 16:151–159. [PubMed: 24526584]
- Driessen E, Cuijpers P, de Maat SC, Abbass AA, de Jonghe F, Dekker JJ. The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clin Psychol Rev.* 2010; 30:25–36. [PubMed: 19766369]
- Editorial. Therapy deficit. Studies to enhance psychological treatments are scandalously under-supported. *Nature.* 2012; 489:473–474.
- First, MB.; Spitzer, RL.; Gibbon, M.; William, JBW. Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP). New York: Biometry Research, New York State Psychiatric Institute; 2002.
- Freedland KE, Skala JA, Carney RM, Rubin EH, Lustman PJ, Dávila-Román VG, Steinmeyer BC, Hogue CW Jr. Treatment of depression after coronary artery bypass surgery: A randomized controlled trial. *Arch Gen Psychiatr.* 2009; 66:387–396. [PubMed: 19349308]
- Gaynes, BN.; Lux, L.; Lloyd, S.; Hansen, RA.; Gartlehner, G.; Thieda, P.; Jonas, D.; Brode, S.; Swinson Evans, T.; Crotty, K.; Viswanathan, M.; Lohr, KN. AHRQ Publication No. 11-EHC056-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2011. Nonpharmacologic interventions for treatment-resistant depression in adults. Comparative effectiveness review No. 33. Available at www.effectivehealthcare.ahrq.gov/reports/finalcfm
- Gerber AJ, Kocsis JH, Milrod BL, Roose SP, Barber JP, Thase ME, Perkins P, Leon AC. A quality-based review of randomized controlled trials of psychodynamic psychotherapy. *Am J Psychiatr.* 2011; 168:19–28. [PubMed: 20843868]
- Gibbons MB, Crits-Christoph P, Hearon B. The empirical status of psychodynamic therapies. *Annu Rev Clin Psychol.* 2008; 4:93–108. [PubMed: 17716035]
- Goldberg, D.; Williams, P. A user's guide to the General Health Questionnaire. Windsor, UK.: NFER-Nelson; 1988.
- Jokela M, Batty GD, Vahtera J, Elovainio M, Kivimäki M. Socioeconomic inequalities in common mental disorders and psychotherapy treatment in the UK between 1991 and 2009. *Brit J Psychiatr.* 2013; 202:115–120.
- Wilkins, MT.; Sonis, J.; Middleton, JC.; Feltner, C.; Meredith, D.; Cavanaugh, J.; Brownley, KA.; Olmsted, KR.; Greenblatt, A.; Weil, A.; Gaynes, BN. AHRQ Publication Number 13-EHC011-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2013. Psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD). Comparative Effectiveness Review No. 92. Available at: www.effectivehealthcare.ahrq.gov/reports/final.cfm
- Keller MB, McCullough JP, Klein DN, Arnow B, Dunner DL, Gelenberg AJ, Markowitz JC, Nemeroff CB, Russell JM, Thase ME, Trivedi MH, Zajecka J. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy and their combination for the treatment of chronic depression. *New Engl J Med.* 2000; 342:1462–1470. [PubMed: 10816183]
- Kessler RC, Merikangas KR, Wang PS. Prevalence, comorbidity, and service utilization for mood disorders in the United States at the beginning of the twenty-first century. *Annu Rev Clin Psychol.* 2007; 3:137–158. [PubMed: 17716051]
- Kessler RC, Stün TB. The World Mental Health survey initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI) in the U.S. National Comorbidity Survey. *Int J Met Psych Res.* 2004; 13:93–121.
- Kovess V, Sapinho D, Briffault X, Villamaux M. Psychotherapeutic practices in France: Results of a professional-based health insurance participant survey. *Encephale.* 2007; 33:65–74. [PubMed: 17457296]
- Lei Orgânica de Saúde–1990 (Organic Health Law). Available at: <http://www.soleis.adv.br/leiorganicasaude.htm>.

- Leichsenring F, Rabung S. Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. *Br J Psychiatry*. 2011; 199(1):15–22. [PubMed: 21719877]
- Lewis G, Pelosi A, Araya RC, Dunne G. Measuring psychiatric disorder in the community: a standardized assessment for use by lay interviewers. *Psychol Med*. 1992; 22:465–486. [PubMed: 1615114]
- Mari JJ, Williams P. Minor psychiatric disorder in primary care in Brazil: a pilot study. *Psychol Med*. 1984; 14(1):223–227. [PubMed: 6709789]
- Mari JJ, Williams P. A comparison of the validity of two psychiatric screening questionnaires (GHQ-12 and SRQ-20) in Brazil, using relative operating characteristic (ROC) analysis. *Psychol Med*. 1985; 15:651–659. [PubMed: 4048323]
- McManus, S.; Meltzer, H.; Brugha, T.; Bebbington, P.; Jenkins, R. Adult psychiatric morbidity in England, 2007: Results of a household survey. 35 Northampton Square, London EC1V 0AX, UK: NHS Information Centre for Health and Social Care; 2009. www.hscic.gov.uk
- Mitte K. Meta-analysis of cognitive-behavioral treatments for generalized anxiety disorder: A comparison with pharmacotherapy. *Psychol Bull*. 2005; 131:785–795. [PubMed: 16187860]
- Mojtabai R. Americans' attitudes toward mental health treatment seeking 1990–2003. *Psychiatr Serv*. 2007; 58:642–651. [PubMed: 17463345]
- Mojtabai R, Olfson M. National trends in psychotherapy by office-based psychiatrists. *Arch Gen Psych*. 2008; 65:962–970.
- National Institute for Health and Clinical Excellence. CG123. London: NICE; 2011. Common mental health disorders: identification and pathways to care. <http://guidance.nice.org.uk/CG123>
- Olfson M, Marcus SC. National trends in outpatient psychotherapy. *Am J Psychiatr*. 2010; 167:1456–1463. [PubMed: 20686187]
- Olfson M, Marcus SC, Druss B, Pincus HA. National trends in the use of outpatient psychotherapy. *Am J Psychiatr*. 2002; 159:1914–1920. [PubMed: 12411228]
- Paim J, Travassos C, Almeida C, Bahia L, Macinko J. The Brazilian health system: history, advances, and challenges. *Lancet*. 2011; 377:1778–1797. [PubMed: 21561655]
- Parikh SV, Segal ZV, Grigoriadis S, Ravindran, Kennedy SH, Lam RW, et al. and Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorder in adults: psychotherapy alone or in combination with antidepressant medication. *J Affect Dis*. 2009; 117:S15–S25. [PubMed: 19682749]
- Patten SB. Accumulation of major depressive episodes over time in a prospective study indicates that retrospectively assessed lifetime prevalence rates are too low. *BMC Psychiatry*. 2009; 9:19. [PubMed: 19422724]
- Roth, AD.; Fonagy, P. What Works for Whom? A Critical Review of Psychotherapy Research. Second Edition. New York: Guilford; 2006.
- Singleton, N.; Bumpstead, R.; O'Brien, M.; Lee, A.; Meltzer, H. Psychiatric morbidity among adults living in private households, 2000: summary report. London, UK: Office for National Statistics; 2001.
- Streiner DL, Patten SB, Anthony JC, Cairney J. Has 'lifetime prevalence' reached the end of its life? An examination of the concept. *Int J Meth Psychiatr Res*. 2009; 18:221–228.
- van Hees ML, Rotter T, Ellermann T, Evers SM. The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review. *BMC Psychiatry*. 2013; 11:13–22.
- van't Hof E, Cuijpers P, Waheed W, Stein DJ. Psychological treatments for depression and anxiety disorders in low- and middle- income countries: a meta-analysis. *Afr J Psychiatry*. 2011; 14(3): 200–207. (Johannesburg).
- Vos T, Flaxman AD, Naghavi M, et al. Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. 2012; 380(9859):2163–2196. [PubMed: 23245607]
- Wampold BE, Mondin GW, Moody M, Stich F, Benson K, et al. A meta-analysis of outcome studies comparing bona fide psychotherapies: empirically, “All must have prizes”. *Psychol Bull*. 1997; 122:203–215.

Westen D, Novotny CM, Thompson-Brenner H. The empirical status of empirically supported psychotherapies: assumptions, findings and reporting in controlled clinical trials. *Psychol Bull.* 2004; 30:631–663. [PubMed: 15250817]

Table 1

Percentage of individuals reporting lifetime, previous 12 months, and current use of psychotherapy by sociodemographic characteristics and presence of common mental disorders

		Lifetime use of psychotherapy			Past 12-month use of psychotherapy			Current use of psychotherapy		
	Total sample (N=2000) N (%)	No (N=1708) N (%)	Yes (N=292) N (%)	p value ^a	No (N=1909) N (%)	Yes (N=91) N (%)	p value ^a	No (N=1955) N (%)	Yes (N=45) N (%)	p value ^a
Sex: Female	1035 (51.7)	853 (82.4)	182 (17.6)	<.001	977 (94.4)	58 (5.6)	<.019	1010 (97.6)	25 (2.4)	.605
Male	965 (48.3)	855 (86.6)	110 (11.4)		932 (96.6)	33 (3.4)		945 (97.9)	20 (2.1)	
Age: 18–34y	861 (43.1)	744 (86.4)	117 (13.6)	.538	825 (95.8)	36 (4.2)	<.008	844 (98.0)	17 (2.0)	.151
35–49y	631 (31.6)	534 (84.6)	97 (15.4)		590 (93.5)	41 (6.5)		611 (96.8)	20 (3.2)	
50–65y	508 (25.3)	430 (84.6)	78 (15.4)		494 (97.2)	14 (2.8)		500 (98.4)	8 (1.6)	
Education 7 years	781 (39.1)	690 (88.3)	97 (11.7)	.003	756 (96.8)	25 (3.2)	<.020	771 (98.7)	10 (1.3)	.019
8 years	1219 (61.0)	1118 (83.5)	201 (16.5)		1153 (94.6)	66 (5.4)		1184 (97.1)	35 (2.9)	
Income										
High	587 (29.3)	458 (78.0)	129 (22.0)	<.001	547 (93.2)	40 (6.8)	.002	567 (96.6)	20 (3.4)	.025
Low	1413 (70.7)	1250 (88.5)	163 (11.5)		1362 (96.4)	51 (3.6)		1388 (98.2)	25 (1.8)	
Marital status										
Married	1169 (58.5)	1041 (89.1)	128 (10.9)	<.001	1135 (97.1)	34 (2.9)	<.001	1151 (98.5)	18 (1.5)	.009
Never married	606 (30.3)	491 (81.0)	115 (19.0)		560 (92.4)	46 (7.6)		583 (96.2)	23 (3.8)	
Previously married	225 (11.3)	176 (78.2)	49 (21.8)		214 (95.1)	11 (4.9)		221 (98.2)	4 (1.8)	
Employed: Yes	635 (31.7)	1185 (86.8)	180 (13.2)	.009	1311 (96.0)	54 (4.0)	.062	1344 (98.5)	21 (1.5)	.002
No	1365 (68.3)	523 (82.4)	112 (17.6)		598 (94.2)	37 (6.8)		611 (96.2)	24 (3.8)	
Common mental disorders										
Yes	455 (22.7)	362 (79.6)	93 (20.4)	<.001	416 (91.4)	39 (8.6)	<.001	433 (95.2)	22 (4.8)	<.001
No	1545 (77.3)	1346 (87.1)	199 (12.9)		1493 (96.6)	52 (3.4)		1522 (98.5)	23 (1.5)	

^a p-value based on chi square test; there are missing data for some variables

Table 2

Concomitants of (A) lifetime, (B) 12-month, (C) current use of psychotherapy. Adjusted logistic regression analyses.¹

Variables	A. Lifetime users (N=292)		B. 12-month users (N=91)		C. Current users (N=45)	
	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p
Gender: Female	1.73 (1.35–2.30)	.001	1.82 (1.16–2.86)	.010	1.12 (0.61–2.04)	.719
Age: 18–34 years (ref)					Continuous 0.99 (0.97–1.02)	.577
35–49 years	1.54 (1.11–2.15)	.010	2.76 (1.63–4.69)	.001	-	
50–65 years	1.65 (1.12–2.42)	.011	1.28 (0.62–2.66)	.506	-	
Education: 8+ y	1.41 (1.03–1.93)	.031	1.42 (0.82–2.44)	.207	-	
Income: High	1.42 (1.02–1.97)	.035	1.36 (0.77–2.39)	.286	1.98 (0.91–4.30)	.085
Marital status: married	Reference		Reference		--	-
Never married	2.17 (1.57–3.00)	.001	3.24 (1.91–5.51)	.001	-	-
Previously married	1.84 (1.26–2.70)	.002	1.36 (0.66–2.80)	.401	-	-
Employed: yes	0.79 (0.60–1.05)	.101	0.72 (0.45–1.15)	.165	-	-
Common mental disorders	1.69 (1.28–2.34)	.001	2.63 (1.70–4.10)	.001	3.36 (1.85–6.11)	.001

¹ Because of the small sample of current users, only four variables could be included in analysis. Age was included as a continuous variable.

Table 3

Socioeconomic determinants of payer for psychotherapy, (a) income, (b) education

	Source of payer for psychotherapy			
	Public pay (N=48)		Private pay (N=43)	
	OR ² (95% CI ³)	P	OR (95% CI)	P
(a) Income ¹				
High income (ref)	1		1	
Low	4.42 (1.31–14.9)	.017	0.23 (0.07–0.76)	.017
(b) Education ¹				
High education (ref)	1		1	
Low	3.37 (1.14–9.97)	.028	0.30 (0.10–0.88)	.028

¹ Income and education analyses adjusted for gender, age, and marital status² OR = Odds ratios³ CI = confidence interval