



Psychotherapy and Counselling
Federation of Australia

A Resource for Counsellors and Psychotherapists Working with Clients Suffering from Depression

**Christine Knauss
Margot J. Schofield**

School of Public Health, La Trobe University, Melbourne, Australia

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Foreword

This document is a literature review of research prior to 2009 into the effectiveness of therapeutic approaches for depression, intended as a resource for counsellors and psychotherapists. It was written on behalf of the PACFA Research Committee. However, this does not imply that PACFA or its Member Associations endorses any of the particular treatment approaches described.

The PACFA Research Committee recognises that it is important to counsellors and psychotherapists that they have access to recent research evidence that demonstrates the effectiveness of different therapeutic approaches, to assist them in their practice. This document is one of a series of reviews that was commissioned by the PACFA Research Committee to support its Member Associations in their work.

The PACFA Research Committee endorses the American Psychological Association's definition of evidence-based practice as 'the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences', although we would prefer to use the word client or consumer rather than 'patient'.

The PACFA Research Committee recognises that there is overwhelming research evidence to indicate that, in general, counselling and psychotherapy are effective and that, furthermore, different methods and approaches show broadly equivalent effectiveness. The strength of evidence for effectiveness of any specific counselling and psychotherapy intervention or approach is a function of the number, independence and quality of available effectiveness studies, and the quality of these studies is a function of study design, measurements used and the ecological validity (i.e. its approximation to real life conditions) of the research.

The PACFA Research Committee acknowledges that an absence of evidence for a particular counselling or psychotherapy intervention does not mean that it is ineffective or inappropriate. Rather, the scientific evidence showing equivalence of effect for different counselling and psychotherapy interventions justifies a starting point assumption of effectiveness.

We recognise the need to improve the evidence-base for the effectiveness of various therapeutic approaches. The PACFA Research Committee is committed to supporting our Member Associations and Registrants to develop research protocols that will help the profession to build the evidence-base to support the known effectiveness of counselling and psychotherapy.

We hope that you will find this document useful and would welcome your feedback.

Dr Sally Hunter
Chair of the PACFA Research Committee, 2011

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1. Introduction

A literature review of studies and meta-analyses of the efficacy and effectiveness of psychotherapeutic treatments for depression has been conducted to provide an overview of evidence-based treatment of depression. Where available, meta-analyses and review articles including studies with controlled trials as well as existing guidelines on treatment of depression (APA, 2000b; Ellis & Smith, 2002; Montgomery, 2006; NICE, 2004; RANZCP, 2004; Segal et al., 2001a; Segal et al., 2001b) were reviewed. Table 1 gives an overview of the meta-analyses and Table 2 of the guidelines currently available. This document focuses on therapy for major depressive disorders as classified in the DSM-IV-TR (APA, 2000a) and does not address the treatment of other mood disorders such as bipolar disorder or dysthymia.

There is a volume of literature about the nature, definition, epidemiology and risk factors of depression. This literature review reports selectively about the most important aspects of these areas and gives short summaries from recent literature.

2. Symptoms and diagnosis of depression

Depression is highly variable in terms of presentation of symptoms and the duration of these symptoms. It is characterised by a loss of positive affect and interest in activities and can be differentiated from depressed or sad mood by being more persistent and intense and by being accompanied with cognitive, behavioural and physiological changes, as well as functional and social impairment (NICE, 2004). Some of the symptoms a client with depression may experience are lack of joy (anhedonia), loss of feelings (apathy), a feeling of hopelessness, social withdrawal, lowered or heightened appetite, sleeping difficulties, pessimistic or negative thoughts and lowered self-esteem (Law, 2007; Megna & Simionescu, 2006). Psychotic symptoms such as delusions or hallucinations may occur in severely depressed clients.

According to the DSM-IV-TR (APA, 2000a), a major depressive episode is diagnosed if five out of the following nine symptoms are present for at least two weeks:

1. Depressed mood
2. Diminished interest or pleasure in activities
3. Weight loss or gain
4. Sleep difficulties (insomnia or hypersomnia)
5. Psychomotor agitation or slowing down
6. Loss of energy
7. Feelings of worthlessness or guilt
8. Poor concentration and difficulty thinking and
9. Recurrent thoughts of death or self-harm.

Core symptoms that are necessary for the diagnosis are depressed mood and loss of interest. A major depressive disorder can be diagnosed as either a single episode (first major depressive episode) or recurrent (if one or several major depressive episodes have been experienced previously) and as mild, moderate or severe.

Further mood disorder subtypes such as dysthymic disorder, bipolar or cyclothymic disorder, can be differentiated from a major depressive disorder by the severity of symptoms, patterns of recurrence, and the presence or absence of manic or hypomanic episodes. Counsellors and psychotherapists could also consider whether the depression is due to a medical condition, substance abuse or a specific stressor as in adjustment disorder. It would be useful to consider whether or not other psychiatric conditions are also present, such as anxiety.

3. Prevalence

Depression is a common mental disorder and one of the leading causes of disability worldwide (WHO, 2008). Lifetime prevalence rates of 16% and 12-month prevalence rates of 7% have been reported for adults (Kessler et al., 2003). Data from the Australian Bureau of Statistics have shown that in the prior 12 months, about 6% of the adult Australian population had one or more depressive disorders (Andrews, Henderson, & Hall, 2001; Henderson, Andrews, & Hall, 2000). Women have higher prevalence rates (7.4%) than men (4.2%) (Henderson, Andrews, & Hall, 2000). A study of depression in Australian adolescents has found a prevalence rate of 14%, with significantly higher rates of depression in girls than boys (18.8% versus 9.3%) (Boyd, Kostanski, Gullone, Ollendick, & Shek, 2000). Women are more likely to develop a major depressive disorder. These gender differences seem to emerge in adolescence and persist throughout adulthood (Pettit & Joiner, 2006).

3.1 Onset

Adolescence and young adulthood seem to be higher risk periods for the first onset of depression (Hankin & Abramson, 2001). However, the first episode can occur at any age in life (NICE, 2004; WHO, 2008).

3.2 Duration

Duration of episodes can vary as well as the type of episode and, for some individuals, depression can last for months or years with several relapses (Law, 2007). Kessler and colleagues (2003) found that the average episode duration was 16 weeks in their large-scale community study. In a meta-analysis (Posternak & Miller, 2001) with 19 studies ($N = 221$) it has been found that 20% of clients improved in the short-term without treatment. Longitudinal follow-up data shows that the majority of clients who recovered after treatment will experience a recurrence (Brodaty, Luscombe, Peisah, Anstey, & Andrews, 2001; Mueller et al., 1999). In an Australian 25-year longitudinal

study of the outcome of major depression after inpatient treatment (Brodaty et al., 2001), it has been shown that 12% of the 49 clients fully recovered and 84% experienced at least one relapse. Clients experienced on average three depressive episodes over the 25 years and 58% (25/43) received at least one more inpatient treatment in the 25 years. In a 15-year observational follow-up study (Mueller et al., 1999), 85% of the 380 clients who had recovered after an episode of major depression experienced a recurrence. Of 105 clients who stayed well for at least 5 years, 58% had a relapse (Mueller et al., 1999).

Depression mostly presents together with other disorders. Comorbid mental disorders have been found in 64% to 79% of individuals suffering from a depressive disorder (Kessler et al., 2003). More than half of individuals with a depressive disorder reported severe or very severe role impairment (Kessler et al., 2003).

4. Causes and risk factors

Knowledge about risk factors and aetiology of depression is important for the development of more effective prevention and treatment programs. Numerous studies have investigated risk factors for depression and focused on the biological (e.g., genetics, structural dysfunction), psychological (e.g., cognitive schemata, problem-solving) and social factors (e.g., early trauma and loss, life events, social support) that contribute to the development of depression (Dobson & Dozois, 2008). Factors which describe stable individual differences such as gender, socio-economic status, race, culture or age have also been shown to be related to depression. A common finding is that the development of depression is determined by multiple, correlating risk factors which probably change over the lifespan (Dobson & Dozois, 2008). Depression also appears to include self-sustaining processes (Pettit & Joiner, 2006). During major depressive episodes, depressed mood and patterns of negative thinking can lead to changes in the patterns of thinking which can stay present even after recovery from the episode. Therefore, it may be that risk factors for onset of depression differ from risk factors for relapses (Dobson & Dozois, 2008).

As mentioned earlier, it has been shown that depression is more prevalent in women than in men (Boyd et al., 2000; Andrews et al., 2001; Henderson et al., 2000). Although these gender differences in depression are well documented, there is little evidence about their development and the underlying mechanisms (Hankin & Abramson, 2001; Pettit & Joiner, 2006). Different theories have been reported such as undetected higher depression rates in men (masked by alcohol and substance use), higher exposure to stressors in women due to lower social status and difficulties with relationships and dependence due to the social role of women (Pettit & Joiner, 2006).

5. Therapeutic interventions

5.1 Psychotherapy

Psychotherapy and psychological interventions are important and effective in relation to depression (APA, 2000b; Ekers, Richards, & Gilbody, 2008). They have been shown to be more effective than usual GP care (Bortolotti, Menchetti, Bellini, Montaguti, & Berardi, 2008). The WHO (2008) has reported that, world-wide, fewer than 25% of people suffering from depression have access to effective treatments. Although depression is a serious and disabling condition, it is often unrecognised and untreated (Hawthorne, Cheek, Goldney, & Fisher, 2003). Kessler et al. (2003) found that of 514 participants with major depression, 57% received some kind of treatment for their depression in the last 12 months of which only 22% were classified as adequate treatment. Henderson et al. (2000) found similar results in their Australian study, with 40% of the people with depression having sought help from their GP, 29% from other health professionals, 8% from a psychiatrist and 6% from a psychologist.

A large number of studies, meta-analyses and review articles report convincingly on the effectiveness of psychotherapy as an intervention for depression. Clinical guidelines have been produced by many professional bodies and research groups to support clinicians and researchers in making choices about interventions (APA, 2000b; Ellis & Smith, 2002; NICE, 2004; RANZCP, 2004; Segal et al., 2001a; Segal et al., 2002b).

Although clinicians often use a combination of approaches, and although there are common factors which are effective across different therapeutic approaches such as the therapeutic relationship, it is important to know about the effectiveness of specific therapeutic approaches. The following section gives an overview of existing research about effectiveness of specific therapeutic approaches.

Table 1: Overview of meta-analysis, and review studies

Study	Title	Approaches	No. of Studies	No. of Clients	Outcome
Abbass, Hancock, Henderson & Kisely (2006)	Short-term psychodynamic psychotherapies for common mental disorders.	STPP vs. control	2	-	STPP was more effective than control.
Barbato & D'Avanzo (2008)	Efficacy of couple therapy as a treatment for depression: A meta-analysis.	Couple vs. individual therapy	8	567	Relationship distress was significantly reduced in the couple therapy group. Not enough data available for comparison with drug treatment or no treatment. Evidence on efficacy of couple therapy is inconclusive.
Barbato & D'Avanzo (2006)	Marital therapy for depression.	Marital therapy vs. other psychosocial and pharmacological treatments	8	232 couples	Large effect of marital therapy compared to no treatment. No significant differences between marital therapy and individual therapy/drug treatment. Lower drop-out rate for marital therapy compared to drug therapy.
Bortolotti et al. (2008)	Psychological interventions for major depression in primary care: A meta-analytic review of randomized controlled trials.	Psychological vs. GP, antidepressant medication	10	-	Greater effectiveness of psychological interventions over usual GP care in short and long term. The comparison between psychological intervention and antidepressant medication yielded no effectiveness difference.
Butler et al. (2006)	The empirical status of cognitive-behavioural therapy: A review of meta-analyses.	CBT	-	-	Large effect sizes were found for CBT.
Cuijpers, van Straten, Andersson & van Oppen (2008)	Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies.	CBT, nondirective supportive, BT, psychodynamic, problem-solving, IP social skills training	53	2757	All the treatments were equally efficacious; except IP was somewhat more efficacious and nondirective supportive treatment was somewhat less efficacious than other treatments. Drop-out rate was significantly higher in CBT than in other therapies.
Cuijpers, van Straten & Warmerdam (2008)	Are individual and group treatments equally effective in the treatment of depression in adults? A meta-analysis	Group vs. individual therapy	15	673	Individual therapy seemed slightly more effective than group therapy at the end of therapy. No significant differences at follow-up.
Cuijpers, van Straten & Warmerdam (2007).	Behavioural activation treatments of depression: A meta-analysis.	Behaviour activation vs. control condition, CBT	16	780	A large effect-size (.87) between behaviour activation and control condition has been found. Behaviour activation and CBT were equally effective, directly after the intervention, but also at follow-up. The benefits of the treatments were retained at follow-up.

Study	Title	Approaches	No. of Studies	No. of Clients	Outcome
De Maat et al. (2008)	SPSP, antidepressants, and their combination in the treatment of major depression: A meta-analysis based on three randomized clinical trials.	SPSP vs. pharmacotherapy, combined therapy	3	313	Combined therapy was more efficacious than pharmacotherapy. SPSP and pharmacotherapy were equally efficacious. Combined therapy and SPSP also seem equally efficacious, except that patients thought that the first is better in symptom reduction.
De Maat et al. (2006).	Relative efficacy of psychotherapy and pharmacotherapy in the treatment of depression: A meta-analysis.	Psychotherapy (CT, CBT or IPT) vs. pharmacotherapy	10	1233	Remission did not differ between psychotherapy (38%) and pharmacotherapy (35%). Dropout was larger in pharmacotherapy (28%) than in psychotherapy (24%). At follow-up relapse in pharmacotherapy (57%) was higher than in psychotherapy (27%).
De Mello et al. (2005)	A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders.	IPT vs. placebo, CBT And IPT plus medication vs. medication only	13	2199	The efficacy of IPT proved to be superior to placebo, similar to medication and did not increase when combined with medication. IPT was more efficacious than CBT.
DeRubeis et al. (1999).	Medications versus cognitive behaviour therapy for severely depressed outpatients: meta-analysis of four randomized comparisons.	CBT vs. antidepressant medication	4	-	The overall effect-size favoured CBT (compared to antidepressant medication), but tests comparing the two approaches did not reveal a significant difference.
Dobson (1989)	A meta-analysis of the efficacy of cognitive therapy for depression.	CT vs. waiting list, no-treatment, pharmacotherapy, BT, other psychotherapies	28	-	Greater degree of change for CT in comparison to waiting list or no-treatment control, pharmacotherapy, behaviour therapy, and other psychotherapies. The degree of changes was not significantly related to the length of therapy.
Ekers, Richards, & Gilbody (2008)	A meta-analysis of randomized trials of behavioural treatment of depression.	BT vs. controls, brief psychotherapy, CBT	17	1109	Behavioural therapies were superior to controls, brief psychotherapy and equal to CBT.
Gloaguen et al. (1998)	A meta-analysis of the effects of cognitive therapy in depressed patients.	CT vs. waiting list, antidepressant, other therapies	48	2765	At post-test, CT appeared significantly better than waiting-list, antidepressants and some other therapies (however, between-trial homogeneity was not met for waiting-list, placebo and other therapies). CT was equal to BT. Results also suggest that CT may prevent relapses in the long-term, while relapse rate is high with antidepressants in naturalistic studies.
Gregory et al. (2004)	Cognitive bibliotherapy for depression: A meta-analysis.	Cognitive bibliotherapy	17	-	Cognitive bibliotherapy yielded a medium effect size of 0.77.

Study	Title	Approaches	No. of Studies	No. of Clients	Outcome
Henken et al. (2007)	Family therapy for depression.	Family therapy vs. no treatment, waiting list	6	519	Family therapy was more effective than no treatment or waiting list on decreasing depression and family functioning. However, evidence-base is too heterogeneous and sparse.
Jorm, Morgan & Hetrick (2008)	Relaxation for depression.	Relaxation vs. no treatment, psychological treatment	11	-	Relaxation was more effective than no treatment, but not as effective as psychological treatment.
Leichsenring (2001)	Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioural therapy in depression: A meta-analytic approach.	STPP vs. CBT, BT	6	-	There were no significant differences between STPP and CBT or BT.
Lewis, Dennerstein, & Gibbs (2008)	Short-term psychodynamic psychotherapy: Review of recent process and outcome studies.	STPP vs. other psychotherapies or no treatment	18	-	STPP can be equal in effects than other psychotherapies and was significant better than no treatment in the short term.
McDermut, Miller, & Brown (2001)	The efficacy of group psychotherapy for depression: A meta-analysis and review of the empirical research.	Group therapy vs. untreated controls, individual therapy / Group CBT vs. group psychodynamic	48	-	Group psychotherapy is an efficacious treatment for depression compared to no treatment. Individual therapy was not superior to group therapy. CBT group therapy was slightly more efficacious than psychodynamic group psychotherapy.
Mead et al. (2008)	Exercise for depression.	Exercise vs. control	3	-	Exercise no significant effect. However, number of studies was small.
Moncrieff, Wessely & Hardy (2004)	Active placebos versus antidepressants for depression.	Antidepressant medication vs. active placebos	9	751	The difference between antidepressants and active placebos was small.
Pampallona et al. (2004)	Combined pharmacotherapy and psychological treatment for depression. A systematic review.	Psychological treatment vs. pharmacotherapy	16	1842	Psychological treatment in combination with pharmacotherapy was superior to pharmacotherapy alone.
Pinquart, Duberstein, & Lyness (2006)	Treatments for late-life depressive conditions: A meta-analytic comparison of pharmacotherapy and psychotherapy.	drug treatments vs. psychotherapeutic treatments	37	-	Pharmacotherapy and psychotherapy were similarly effective.
Posternak, M. A. & Miller, I. (2001)	Untreated short-term course of major depression: a meta-analysis of outcomes from studies using wait-list control groups.	Untreated depression	19	221	20% of clients showed a decrease in depressive symptoms.

Study	Title	Approaches	No. of Studies	No. of Clients	Outcome
Spek et al. (2007)	Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: A meta-analysis.	Internet-based CBT vs. control	5	337	Internet-based CBT with therapist support yielded to a large effect size (1.00).
Vittengl et al. (2007)	Reducing relapse and recurrence in unipolar depression: A comparative meta-analysis of cognitive-behavioural therapy's effects.	CBT vs. pharmacotherapy	28	1880	CBT reduced relapse-recurrence significantly compared with acute-phase pharmacotherapy discontinued. Continuation CBT reduces relapse-recurrence significantly compared with nonactive comparison condition.
Wilson, Mottram & Vassilas (2008)	Psychotherapeutic treatments for older depressed people.	CBT vs. PD, waiting list controls	9	-	CBT was more effective than waiting list, PD was equally effective than CBT

CBT = Cognitive behavioural therapy, BT = Behavioural therapy, PD = Psychodynamic, STPP = Short-term psychodynamic psychotherapy, SPSP = Short Psychodynamic Supportive Psychotherapy, IPT = Interpersonal therapy

Table 2: Overview of guidelines

Authors/Organisation	Title
American Psychiatric Association (2000)	Practice guidelines for the treatment of patients with major depressive disorder (2 nd ed.)
Anderson et al. (2008)	Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2000 British Association of Psychopharmacology guidelines.
Anderson, Nutt & Deakin (2000)	Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 1993 British Association for Psychopharmacology guidelines.
Beutler, Clarkin & Bongar (2000)	Guidelines for the systematic treatment of the depressed patient.
Ellis & Smith (2000)	Treating depression: The Beyond Blue guidelines for treating depression in primary care. 'Not so much what you do but that you keep doing it'
National Institute for Clinical Excellence (2004)	Depression: Management of depression in primary and secondary care. National Practice Guideline Number 23
Montgomery (2006)	Guidelines in major depressive disorder, and their limitations.
Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression (2004)	Australian and New Zealand clinical practice guidelines for the treatment of depression.
Segal et al. (2001a)	Clinical guidelines for the treatment of depressive disorders. III. Psychotherapy.
Segal et al. (2001b)	Clinical guidelines for the treatment of depressive disorders. V. Combining psychotherapy and pharmacotherapy.

Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) aims to use behavioural and cognitive techniques to try to challenge and change negative beliefs and attitudes toward the self, the environment and the future. These negative beliefs and attitudes are assumed to maintain depressive symptoms (Beck, Rush, Shaw, & Emery, 1979).

CBT has been described as an effective, short (Dobson, 1989) and cost-effective (Antonuccio, Thomas, & Danton, 1997) therapy for major depression. In a review of meta-analyses on treatment outcome of CBT, this intervention yielded large effect sizes for the treatment of depression (Butler, Chapman, Forman, & Beck, 2006). The effectiveness of CBT has been studied in numerous controlled trials (APA, 2000b). It has been shown in several meta-analyses that CBT was significantly more effective than waiting list, untreated controls or no treatment (Dobson, 1989; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Wilson, Mottram, & Vassilas, 2008). The level of the therapist's experience was shown to influence the outcome of CBT (DeRubeis et al., 2005).

Results of meta-analyses comparing CBT with other treatments have been inconsistent (APA, 2000b), yielding support for the argument that common factors may be more influential than specific therapeutic approaches. Some argue that further meta-analyses are needed to provide data about the efficacy of different psychotherapeutic approaches (Butler et al., 2006). In one study (Luty et al., 2007), CBT and interpersonal therapy were found to be equally effective in general, although CBT was more effective than interpersonal therapy in severely depressed clients.

The comparison of CBT with pharmacotherapy has also led to inconsistent results. Some meta-analyses have found better outcomes in CBT than in pharmacotherapy (Dobson, 1989; Gloaguen et al., 1998), whilst other studies have not found a significant difference between these two treatments or found them to be equally effective (DeRubeis et al., 2005; DeRubeis et al., 1999; Elkin et al., 1989; Hollon et al., 1992). In one study (Bhar et al., 2008) it was shown that cognitive therapy and pharmacotherapy resulted in the same patterns of change for cognitive and vegetative symptoms. Elkin and colleagues (1995) have found that pharmacotherapy was more effective than CBT for more severely depressed clients. However, DeRubeis and colleagues (1999) found that the two treatments were equally effective in their meta-analysis that included four studies comparing CBT and medication as treatments for severely depressed clients. They concluded that antidepressant medication should not be seen as superior to CBT.

Relapse prevention is a further important part of the treatment. One meta-analysis of eight studies that compared relapse rates for CBT and medication reported that the relapse rate for CBT was, on average, 29.5% versus 60% for medication only (Gloaguen et al., 1998). Average relapse rates in the first year of follow-up across

three large-scale clinical trials were about 26% of clients who received cognitive therapy and 64% of clients who received pharmacotherapy (DeRubeis & Crits-Cristoph, 1998). Vittengl, Clark, Dunn, and Jarrett (2007) included seven studies ($N = 335$) in their meta-analysis. They found comparable results, with clients who received cognitive therapy having a 22% lower chance to relapse compared to clients who received pharmacotherapy.

There is a vast amount of evidence showing that CBT is an effective treatment for depression. However, it is not clear how CBT compares with other psychotherapeutic approaches in terms of effectiveness. In a meta-analysis (Cuijpers, van Straten, Andersson, & van Oppen, 2008) in which seven different treatments were compared, no significant differences were found between CBT and other psychotherapies. However, drop-out rates were significantly higher in CBT than in other psychotherapies.

Behavioural therapy

Behavioural therapy uses operant learning by enhancing behavioural activation, relaxation-skills, problem-solving and engagement in pleasant activities to increase rewarding and task-focused behaviour. A recent meta-analysis (Ekers et al., 2008) including 17 randomized controlled trials of behavioural therapy ($N = 1109$) has investigated the effectiveness of this therapeutic approach. The results showed that behavioural therapy was superior to the control groups, and to brief psychotherapy or supportive therapy groups. Furthermore, it has shown to be equally effective as CBT. This has also been shown in the extensive meta-analysis by Gloaguen and colleagues (1998) and in a more recent meta-analysis by Cuijpers, van Straten, & Warmerdam (2007). Dimidjian and colleagues (2006) indicated in their randomized trial ($N = 241$) that behavioural activation was as effective as antidepressants and more effective than CBT for severely depressed clients. Therefore, behavioural therapy seems to be an effective treatment for depression.

Mindfulness-based cognitive therapy

Mindfulness-based cognitive therapy (MBCT) is a relatively new approach which integrates CBT techniques and mindfulness meditation techniques (Segal, Williams, & Teasdale, 2002). The aim of MBCT is to become more aware of thoughts and feelings and to change the relationship to these in order to establish metacognitive insight. The eight session MBCT group program has been described in the book 'Mindfulness-based cognitive therapy for depression' (Segal et al., 2002). Williams, Teasdale, Segal and Kabat-Zinn (2007) have also described MBCT in their book 'the mindful way through depression' which is accompanied by a CD with guided meditations.

MBCT has found to be an effective treatment for clients who had not responded to treatment and had suffered from recurrent depression (Eisendrath et al., 2008;

Kenny & Williams, 2007 (pre-post Effect Size = 1.04); Kingston, Dooley, Bates, Lawlor, & Malone, 2007). Furthermore, MBCT has also been shown to reduce the risk of relapse (Kuyken et al., 2008; Ma & Teasdale, 2004; Michalak, Heidenreich, Meibert, & Schulte, 2008; Teasdale et al., 2000; Teasdale et al., 2002). Most empirical evidence about the effectiveness of MBCT has been reported in the area of relapse prevention.

A manualised group skills MBCT training program ($N = 145$) has been shown to result in significantly lower risk of relapse when offered additionally to treatment as usual (40% of clients relapsed) than if the treatment as usual was offered by itself (66% of clients relapsed) over a 60-week period for clients with three or more previous depressive episodes. MBCT has therefore been described as an effective way to prevent relapse during recovery (Teasdale et al., 2000). Ma and Teasdale (2004) have replicated this study with similar outcomes (36% of the MBCT and 78% of the treatment as usual group relapsed). This decrease in risk to relapse has been explained by an increase in metacognitive awareness (Teasdale et al., 2002). A qualitative study (Smith, Graham, & Senthinathan, 2007) has indicated that clients aged over 65 who suffered from depression reported MBCT to be a helpful intervention.

Current MBCT research has been reviewed and it was concluded that MBCT has an additive benefit for clients with three or more previous depressive episodes and reduces the risk of relapse (Coelho, Canter & Ernst, 2007; Williams, Russell, & Russell, 2008). MBCT has been recommended (NICE, 2004) as treatment for clients with recurrent depression.

Psychodynamic psychotherapy

In psychodynamic psychotherapy, feelings, conscious and unconscious conflicts and their current depressive manifestations are explored. There are different variations of psychodynamic therapy with some approaches focusing on drives and some on relationships, attachment or object relations.

A clinically significant improvement in depressed clients has been found in a naturalistic study after short-term psychodynamic psychotherapy (STPP) ($N = 21$) (Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003). Short psychodynamic supportive psychotherapy ($n = 97$) was found to be equally effective as pharmacotherapy ($n = 45$) for the treatment of major depressive disorder in a randomised controlled trial (De Maat et al., 2008).

In a Cochrane review (Abbass, Hancock, Henderson, & Kisely, 2006) STPP has found to be more effective than controls, with moderate effects. Lewis, Dennerstein, & Gibbs (2008) concluded that outcome of STPP was comparable to outcome of other psychological approaches. Shapiro and colleagues (1994) showed that psychodynamic-interpersonal therapy had comparable outcomes

with CBT (8 and 16 sessions; $N = 117$). However at a one-year follow-up, the eight sessions of psychodynamic-interpersonal therapy were less effective than the other three treatments (8 sessions CBT, 16 sessions psychodynamic-interpersonal and 16 sessions CBT). This study has been replicated (Barkham et al., 1996). The results of the second study ($N = 36$) indicated that outcomes of psychodynamic-interpersonal and CBT were equivalent.

In a study comparing CBT and brief psychodynamic therapy there were no significant differences between these two treatment approaches in depressed family caregivers ($N = 66$) (Gallagher-Thompson & Steffen, 1994). In a meta-analysis of six studies (Leichsenring, 2001), no significant difference between CBT and STPP was found.

Further empirical evidence about the effectiveness of psychodynamic psychotherapy was found in a meta-analysis that included heterogeneous samples of clients with anxiety and depression. Leichsenring & Rabung (2008) included five studies ($N = 274$) with demonstrated large effects in all outcome areas.

Psychodynamic psychotherapy is a common treatment in clinical practice. However, there is only limited empirical evidence about the effectiveness of this therapeutic approach for the treatment of depression and evidence is mostly available in form of naturalistic studies (Bond, 2006). The efficacy of psychodynamic therapy has not yet been fully demonstrated for major depressive disorders (Connolly Gibbons, Crits-Christoph, & Hearon, 2008). This lack of empirical evidence has been criticised (Law, 2007), although it should not be viewed as evidence of ineffectiveness.

Interpersonal therapy

Interpersonal therapy (IPT) for depression focuses on current interpersonal relationships by analysing social dysfunctions related to the depression (Weissmann & Markowitz, 1998). The client learns to recognise the associations between their mood and their interpersonal contacts and to improve interpersonal processes and their depressive state, by focusing on four different interpersonal problem areas: interpersonal role disputes, interpersonal role transitions, unresolved grief, and interpersonal deficits or sensitivity (Law, 2007).

One meta-analysis suggested that IPT has significantly higher efficacy to a placebo in nine studies (De Mello, Mari, Bacaltchuk, Verdelli, & Neugebauer, 2005). It has also been found to be more efficacious than usual GP care (NICE, 2004) and more effective than CBT (De Mello et al., 2005). Furthermore, no difference has been found between IPT and medication and the combination of IPT and medication did not show a superior effect to medication alone (De Mello et al., 2005). In a meta-analysis (Cuijpers, van Straten, Andersson, & van Oppen, 2008) in which seven major types of psychological treatment were compared (53 studies, $N = 2757$), IPT

was found to be somewhat more efficacious than other psychotherapeutic treatments. Current empirical evidence suggests that IPT is an effective psychotherapeutic approach for depression. However, De Mello et al. (2005) concluded that these results will need replication due to the small number of studies.

Emotion-focused therapy

Emotion-focused therapy is situated within the humanistic, client-centred and experiential therapy traditions. Greenberg and Watson (2006) have described the main therapeutic emotion-focused methods in their book about emotion-focused therapy for depression. Process-experiential treatment of depression uses process-directive interventions to restructure depression-related emotion schemas (Greenberg, Rice, & Elliott, 1993). Specific tasks such as evocative unfolding, focusing, two-chair work, and empty-chair dialogue are used within a client-centred approach.

Process-experiential emotion-focused therapy (PEEFT) has been compared to CBT (Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003) and client-centred therapy for the treatment of depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998). No significant differences were found between clients who completed 16 weeks of CBT or PEEFT after end of treatment ($N = 66$) (Watson et al., 2003). However, clients who received PEEFT had a significantly better outcome on interpersonal problems than clients who received CBT. PEEFT has also shown to result in significantly better outcomes than client-centred therapy on its own ($N = 34$) (Greenberg & Watson, 1998). The outcome was predicted by a strong early working alliance perceived by the client. Goldman and colleagues' (2006) results suggest that outcomes may be improved if emotion-focused interventions are added to a client-centred approach.

The available research suggests that process-experiential emotion-focused therapy may be an effective therapeutic approach for the treatment of depression. However, only a limited number of outcome studies with small sample sizes are currently available. Therefore, more empirical evidence is needed to further investigate the effectiveness of this therapeutic approach.

Couple and family therapy

There are different therapeutic couple therapy models with backgrounds in cognitive-behavioural, systemic or insight-oriented approaches (Barbato & D'Avanzo, 2008). However, couple therapy approaches all aim to increase interpersonal and communication skills, to enhance relationship satisfaction, and to change interpersonal context linked to depression.

In a Cochrane review (Barbato & D'Avanzo, 2006), the results show a large effect for couple therapy in comparison to no treatment for depressive symptoms (based on two studies) and no significant differences between couple therapy and individual therapy (based on six studies). Barbato and D'Avanzo (2008), in their meta-analysis of eight controlled trials ($N = 567$) examining the efficacy of couple therapy as a treatment for depression, found that relationship distress was significantly reduced in the couple therapy group compared with individual psychotherapy group. However, there was no significant difference between the two groups on depressive symptoms. Barbato & D'Avanzo (2008) concluded that there is currently insufficient data available and that it is not possible to make conclusions about couple therapy in comparison to no treatment or pharmacotherapy. Therefore, further empirical evidence about the efficacy of couple therapy is necessary.

In a Cochrane Review (Henken, Huibers, Churchill, Restifo & Roelofs, 2007) the effectiveness of family therapy for the treatment of depression was investigated. Six studies ($N = 519$) were included and results showed that family therapy was more effective than no treatment or waiting list condition in improving depression and family functioning. The authors concluded that further outcome studies were needed.

Group therapy

It has been found that group psychotherapy was more effective than no treatment (McDermut, Miller, & Brown, 2001). Cuijpers, van Straten and Warmerdam (2008) conducted a meta-analysis to compare the effectiveness of individual therapy and group therapy for the treatment of depression. They included 15 studies ($N = 673$) and found that individual therapy was slightly more effective at the end of therapy, but no significant differences were found at follow-up. They concluded that there is insufficient empirical evidence about the effectiveness of group therapy in comparison to individual therapy for depression.

Guided self-help

Guided self-help can be delivered through books, videos or the internet. It has been shown that guided-self help leads to better outcome than no intervention in mild to moderate depression and it has therefore been recommended as part of the treatment of mild depression (NICE, 2004). In a meta-analysis with 17 studies (Gregory, Schwer Canning, Lee, & Wise, 2004), cognitive bibliotherapy yielded a medium effect size (0.77). This effect size is comparable to effect sizes from individual therapies. In a further meta-analysis (Spek, Cuijpers, Nyklíček, Riper, Keyzer, & Pop, 2007) in which five guided-self help studies ($N = 337$) with clients with anxiety or depression were included, a large effect size was found. In a randomized controlled trial (Mead et al., 2005) conducted to test the effectiveness

of guided self-help for clients with depression or anxiety ($N = 114$), no significant differences were found between guided self-help treatment and waiting-list control. In a further study (Salkovskis, Rimes, Stephenson, Sacks, & Scott, 2006), treatment with an antidepressant plus self-help did not have additional effects on outcome for clients treated in primary care standard treatment alone. Further empirical evidence about the efficacy of guided-self help for the treatment of depression is needed.

Exercise

In a Cochrane Review (Mead et al., 2008) the role of exercise for the improvement of symptoms of depression was investigated. Results of the meta-analysis of three studies, showed a moderate, but non-significant effect. However, the number of studies included in this review was small. There is currently only limited data about the effectiveness of exercise for the improvement of depressive symptoms.

Relaxation

In a further Cochrane Review (Jorm, Morgan, & Hetrick, 2008) the effect of relaxation on depressive symptoms has been investigated. Relaxation techniques were found to be more effective than no or minimal treatment, but not as effective as psychological treatments. It has been suggested, that relaxation could be used as a first-line treatment in a stepped care approach.

5.2 Pharmacological treatment

Antidepressant medications can be classified according to their chemical structure and the way they work. There are four different groups of antidepressant medication: heterocyclics; monoamine oxidase inhibitors; serotonin reuptake inhibitors; and atypical drugs (Pettit & Joiner, 2006).

The mean difference between outcome after antidepressant medication and a placebo has shown to be very small and clinically insignificant (Kirsch, Scoboria, & Moore, 2002; Moncrieff, Wessely, & Hardy, 2004), particularly in mild depression and it has therefore been concluded that psychotherapy should be offered instead of pharmacological treatment (Kirsch et al., 2002). It has been recommended in the NICE guidelines (2004) that antidepressants should not be chosen as an initial treatment for mild depression. However, there is strong evidence for the use of antidepressants in treatment of depression of at least moderate severity (Anderson et al., 2008; Anderson, Nutt, & Deakin, 2000; NICE, 2004), but with 55-65% of clients remaining symptomatic after antidepressant treatment. The response to antidepressant treatment seems not to be highly dependent on depression type or earlier life events (Anderson et al., 2008).

It has been found in a meta-analysis comparing the efficacy of psychotherapy and pharmacotherapy (De Maat, Dekker, Schoevers, & De Jonghe, 2006) in which ten

randomised controlled trials were included, that both treatments were equally effective. Bortolotti et al. (2008) have also shown in their meta-analysis in which they included 10 studies that psychological treatment and antidepressant medication were equally effective. In a meta-analysis about treatments for later-life depression (Pinquart, Duberstein, & Lyness, 2006), in which 37 studies were included, pharmacotherapy and psychotherapy were found to be similarly effective in decreasing depression. However, acceptability of psychotherapy was shown to be higher than of pharmacotherapy (Dekker et al., 2008) and dropout rates were higher in pharmacotherapy (28%) than in psychotherapy (24%), particularly at follow-up (57% pharmacotherapy; 27% psychotherapy) (De Maat et al., 2006).

The evidence-based guidelines for the treatment of depressive disorders by the British Association for Pharmacology (Anderson et al., 2008; 2000) give a good review of pharmacological treatment for depression. For clients with severe depression or treatment resistant depression a combination of antidepressant medication and psychotherapy has been recommended (APA, 2000b; NICE, 2004). Symptoms, side effects and suicidal risk should be monitored. It has been recommended (NICE, 2004) to continue antidepressant drug treatment for six months after remission to prevent relapse. Further recommendations about treatment with antidepressants can be found in the NICE guidelines (2004), the APA guidelines (2000b) and the guidelines by Anderson et al. (2000; 2008).

5.3 Psychotherapy combined with pharmacotherapy

There is limited empirical evidence about the superiority of combined treatments over one treatment (Segal et al., 2001b). In a meta-analysis (Thase et al., 1997) the remission rate for the combined treatment (IPT plus pharmacotherapy) was 48% in comparison to 37% for IPT alone. The combination of CBT and antidepressants is common in practice (Butler et al., 2006). Shasmaei, Rahimi, Zarabian & Sedehi (2008) demonstrated in their controlled clinical trial (N = 120) that the combination treatment of cognitive therapy and pharmacotherapy was significantly more effective than the two treatments alone. In a further study (Hollon et al., 1992), combined treatment of CBT and pharmacotherapy did not show a better outcome than the two treatments alone.

Combined treatment was also significantly better in severely depressed clients (Thase et al., 1997). In a study (N = 74) comparing the combination of psychodynamic psychotherapy and medication with medication alone, the combined treatment was more effective (better treatment success, work adjustment, global functioning, and lower hospitalization rates) than medication alone (Burnand, Andreoli, Kolatte, Venturini, & Rosset, 2002). In a further study (De Jonghe, Kool, van Aalst, Dekker, & Peen, 2001) a combination of short psychodynamic supportive psychotherapy with pharmacotherapy was more

accepted by clients, resulted in a lower drop out rate, and achieved a better outcome than pharmacotherapy by itself. De Maat et al. (2008) found that combined therapy (short psychodynamic supportive psychotherapy (SPSP) and pharmacotherapy) was more efficacious than pharmacotherapy alone. However, combined treatment was not believed to be superior to SPSP alone by therapists and independent observers. De Jonghe et al. (2004) did not find combined treatment to be superior to psychotherapy alone.

It has been shown in a meta-analysis (Pampallona, Bollini, Tibaldi, Kupelnick & Munizza, 2004) including 16 trials that the combination of psychological treatment and antidepressants was superior to drug treatment alone.

The Clinical Guidelines for the Treatment of Depressive Disorders by the Canadian Psychiatric Association and the Canadian Network for Mood and Anxiety Treatments (Segal et al., 2001b) that included 13 studies, concluded that there is a lack of evidence for greater efficacy of combined treatment in comparison to pharmacotherapy or psychotherapy alone. More studies are needed to investigate whether or not the combination of CBT and antidepressant medication for severely depressed clients is more effective than just one of these treatments.

5.4 Good practice recommendations for therapy for depression

Besides knowing about the effectiveness of specific therapeutic approaches, increasing interest has been devoted to understanding key treatment principles which have been developed from empirical research (Beutler, Clarkin, & Bongar, 2000; NICE, 2004). The following recommendations have been drawn from current guidelines for depression (Beutler, Clarkin, & Bongar, 2000; NICE, 2004) and focus on some important aspects in the treatment of depression to help to improve treatment efficiency.

- If the client suffers from both depression and anxiety symptoms, therapy for depression should be seen as the main priority.
- The initial assessment should include assessment of symptoms and comorbid conditions, severity of the depressive disorder, history of symptoms, history of treatment, psychosocial stressors and social support systems of the client.
- Important components of therapy include assessment of symptoms, level of safety and risk, level of impairment, establishment and maintenance of a sound therapeutic relationship, education of client and family, monitoring of the treatment process, and relapse prevention.
- For clients with mild depression, exercise, guided-self help, or brief psychotherapy or counselling can be considered. It might also be helpful to provide advice on sleep hygiene and anxiety management.

- CBT has been recommended as the most widely validated psychotherapeutic treatment approach for moderate, severe and treatment-resistant depression.
- Positive outcomes are related to a good therapeutic relationship, proficiency of the therapist and exposure of the client to contents of behavioural or emotional avoidance.
- Higher impairment may be an indication for longer and more intensive therapy.
- The psychological, social and physical characteristics and the relationships of the client should be considered during therapy.
- Suicidal ideas or intent should be assessed. Inpatient treatment could be considered for clients with increased suicide risk or risk of self-harm.
- The psychotherapist or counsellor should be competent to assess and manage the risks, or refer the client to another health professional when necessary.
- For clients with severe or chronic depression a combination of psychotherapy and antidepressant medication may be helpful and therapists should work in collaboration with the client's medical practitioner, where possible.

5.5 Maintenance for recurrent depression

Relapse prevention is a significant part of therapy and it is important to help clients to sustain recovery. There is some evidence that supports psychotherapy, mostly CBT or IPT, for recovery treatment (Segal et al., 2001a). As mentioned earlier, MBCT has been developed and investigated as an approach to prevent relapse in clients with depression (Kuyken et al., 2008; Ma & Teasdale, 2004; Michalak, Heidenreich, Meibert, & Schulte, 2008; Teasdale et al., 2000; Teasdale et al., 2002). Several studies showed that MBCT was an effective approach to reduce the risk of relapse in clients who had experienced several depressive episodes.

With over 20 trials of pharmacotherapy, antidepressant medication has received most empirical evidence for maintenance treatment (APA, 2000b) and is currently the best validated approach for maintenance treatment (Lau, 2008). It has been recommended that antidepressant medication should be continued for at least 4-6 months after full remission (Montgomery, 2006).

Current results suggest that both antidepressants and psychotherapy are effective for relapse prevention (APA, 2000b).

6. Summary and conclusion

It can be concluded, based on current empirical evidence, that no therapeutic approach seems to be superior to others for the treatment of mild to moderate depression. Currently, the psychotherapeutic approach with most empirical validation is CBT, and therefore CBT has been recommended as the preferred modality in some guidelines (APA, 2000b; NICE, 2004). Interpersonal psychotherapy and behavioural therapy have also received substantial empirical support and can therefore also be recommended for depression. Several authors (Cuijpers et al., 2008; Wilson et al., 2008) have shown that there was not much difference in the efficacy between different therapeutic approaches for depression. Nondirective supportive treatment seems slightly less efficacious than other treatments (Cuijpers et al., 2008). Antidepressants may be used for moderately to severely depressed clients but have not been recommended for the treatment of mild depression. Although empirical results of efficacy studies comparing psychotherapy and drug treatment are inconsistent, results suggest lower relapse rates after psychotherapeutic treatment than antidepressant treatment alone. The literature suggests that a good therapeutic relationship, a therapeutic approach according to the client's choice and adequate length of treatment with continuation of treatment to full remission and relapse prevention, are important for a successful treatment of depression.

Table 3: Internet Resources

The Centre for Mental Health Research, The Australian National University:
Information about depression: <http://bluepages.anu.edu.au/home/>

National Institute for Health and Clinical Excellence (NICE): Clinical guidelines
for depression: <http://www.nice.org.uk/CG023>

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