British Association for Counselling & Psychotherapy

Psychological therapies for depression

A summary of the evidence

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Overview

The National Institute of Clinical Excellence (NICE) has recommended that some psychological therapies, namely CBT and some of its variations are provided for clients with mild to moderate depression (NICE, 2009). This recommendation is based on evidence from randomised controlled trials and systematic reviews, study designs which form the basis of all NICE guidelines. Organisations in the US and Canada have also recommended CBT and IPT for treating depression (Parikh et al, 2009; Wolf and Hopko, 2008). However there are a wide range of studies of depression which have been published, and not all are incorporated in the guidelines. This overview of the evidence for psychological therapies is based on a systematic search of a number of databases in relation to counselling and psychological therapies for depression. Due to the volume of evidence, its main focus is on systematic reviews (as these summarise the best available evidence) however individual studies for a range of therapeutic interventions are also presented, particularly if they were unlikely to have been included in the systematic reviews listed.

Overall these studies show that a wide range of psychological therapies are effective in treating depression. This includes in both primary and secondary care; and for mild, moderate, severe and sub threshold depression across a range of age groups. Modality or type of intervention appears to make little difference in terms of effectiveness, all have similar effects. Pharmacologic interventions, however are more effective than psychological interventions for severe depression. A great deal of work has been summarised by Cuijpers et al who have developed a database of studies and performed a range of meta-analyses which are outlined below and summarised in Cuijpers et al (2011).

However, a number of systematic reviews noted limitations in the evidence provided, namely short follow up times, small sample sizes, lack of randomized studies, lack of control groups and heterogeneity between studies making comparisons difficult. Furthermore one study also cautions that there has been a publication bias leading to an overestimation of the treatment effects obtained for psychotherapy for adult depression (Cuijpers et al, 2010).

The evidence from studies included in this overview has been summarised in the form of evidence tables, which give a brief overview of each study (based on the abstracts) and are arranged in a hierarchy of evidence (systematic reviews and randomised controlled trials then other empirical studies). More information can be found by locating and reading the full journal articles, those marked with * are available free and open access via the internet. The articles selected for inclusion in the overview are primarily those which are higher up the evidence hierarchy, have been published since 2005 and are applicable to the UK.

Notes

This bulletin is based on searches of PubMed, Psychinfo and NHS Evidence from 2000 onwards. Searches were conducted in April 2012 and updated in December 2012. Items have been selectively included with a main focus on systematic reviews of psychological therapies. Where abstracts have been amended from the Psychinfo database, they are marked AA. The overview has been written using the abstracts of the articles and no attempt has been made to critically appraise the full text.

This bulletin has been created by Brettle Innovations Ltd on behalf of the British Association of Counselling and Psychotherapy (BACP).

Guidelines

Details	Therapy	Overview	Findings/Conclusions
Quick Reference Guide - Depression, National Institute for Health and Clinical Excellence.*	CBT, group CBT, guided self help (based on CBT principles), computerised CBT	Quick reference guide that summarises NICE recommendations made to NHS in the following two clinical guidelines: _ Depression: the treatment and management of depression in adults (update) (NICE clinical guideline 90). _ Depression in adults with a chronic physical health problem: treatment and management (NICE clinical guideline 91).	For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person's preference: – individual guided self-help based on the principles of cognitive behavioural therapy (CBT) – computerised CBT (CCBT)1 – a structured group physical activity programme. For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, consider offering one or more of the following interventions, guided by the patient's preference: – a structured group physical activity programme – a group-based peer support (self-help) programme – individual guided self-help based on the principles of CBT – CCBT1. **Treatment for moderate depression** _ For patients with initial presentation of moderate depression and a chronic physical health problem, offer the following choice of high-intensity psychological interventions: – group-based CBT **or** – individual CBT for patients who decline group-based CBT or for whom it is not appropriate, or where a group is not available or behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where

			involving the partner is considered to be of potential therapeutic benefit
Clark, D. M. (2011). "Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience." Int Rev Psychiatry 23(4): 318-27.	Psychological therapies	Describes the background to the IAPT programme, the arguments on which it is based, the therapist training scheme, the clinical service model, and a summary of progress to date.	At mid-point in a national roll-out of the programme progress is generally in line with expectation, and a large number of people who would not otherwise have had the opportunity to receive evidence-based psychological treatment have accessed, and benefited from, the new IAPT services. Planned future developments and challenges for the programme are briefly described.
Parikh, S. V., Z. V. Segal, et al. (2009). "Canadian Network for Mood and Anxiety Treatments (CANMAT) clinical guidelines for the management of major depressive disorder in adults. II. Psychotherapy alone or in combination with antidepressant medication." Journal of Affective Disorders 117(Suppl 1): S15-S25.	Psychotherapy	Reviews new studies of psychotherapy in the acute and maintenance phase of MDD, including computer-based and telephone-delivered psychotherapy for inclusion in CANMAT guidelines.	CBT and IPT are the only first-line treatment recommendations for acute MDD and remain highly recommended for maintenance. Both computer-based and telephone-delivered psychotherapy primarily studied with CBT and IPT are useful second-line recommendations. Where feasible, combined antidepressant and CBT or IPT are recommended as first-line treatments for acute MDD.
Wolf, N. J. and D. R. Hopko (2008). "Psychosocial and pharmacological interventions for depressed adults in primary care: A critical review." Clinical Psychology Review 28(1): 131-161.	Psychosocial and pharmacological interventions	Contemporary review of outcome data for psychosocial and pharmacological interventions in primary care and extends beyond AHCPR guidelines (Agency for Health Care Policy and Research and American Psychiatric Association)	Problem-solving therapy (PST-PC), interpersonal psychotherapy, and pharmacotherapy would be considered efficacious interventions for major depression, with cognitive-behavioral and cognitive therapy considered possibly efficacious. Psychotherapy and pharmacotherapy generally are of comparable efficacy, and both modalities are superior to usual care in treating depression. Methodological limitations and directions for future research are discussed.

Systematic reviews of multiple therapies	**Therapy**	**Overview**	**Findings/Conclusions**
Bortolotti, B., M. Menchetti, et al. (2008). "Psychological interventions for **major depression** in primary care: A meta-analytic review of randomized controlled trials." General Hospital Psychiatry 30(4): 293-302.	Psychological interventions	Meta-analyses to compare psychological forms of intervention with either usual GP care or antidepressant medication for major depression	The main analyses between 10 trials showed greater effectiveness of psychological intervention over usual GP care in both the short and long term . The comparison between psychological forms of intervention and antidepressant medication yielded no effectiveness differences, for either the short term or the long term. The authors concluded that psychological forms of intervention are significantly linked to clinical improvement in depressive symptomatology.
Cape, J., C. Whittington, et al. (2010). "Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression." BMC Med 8: 38.*	Brief psychological therapies	Meta-analyses to compare the effectiveness of different types of brief psychological therapy administered within primary care across and between anxiety, depressive and mixed disorders.	Thirty-four studies, involving 3962 patients, were included. Most were of brief cognitive behaviour therapy (CBT; n = 13), counselling (n = 8) or problem solving therapy (PST; n = 12). There was differential effectiveness between studies of CBT, with studies of CBT for anxiety disorders more effective than studies of CBT for depression or studies of CBT for mixed anxiety and depression. Counselling for depression and mixed anxiety and depression and problem solving therapy (PST) for depression and mixed anxiety and depression were also effective. Controlling for diagnosis, meta-regression found no difference between CBT, counselling and PST.
Cuijpers, P., G. Andersson, et al. (2011). "Psychological treatment of depression: results of a series of meta-analyses." Nord J Psychiatry 65(6): 354-64.	Psychological therapies	Describes a series of meta-analyses examining the effects of psychotherapies for adult depression.	Different types of psychotherapy are efficacious in the treatment of adult depression, including cognitive behavior therapy, interpersonal psychotherapy, problem-solving therapy, non-directive supportive therapy and behavioral activation therapy. Differences between types of psychotherapy are small. The efficacy of psychotherapy for mild to moderate depression is about the same as the efficacy of pharmacotherapy, and that combined treatment is more effective than psychotherapy alone and pharmacotherapy alone. Psychotherapy is not only effective in depressed

			adults in general, but also in older adults, women with postpartum depression, patients with general medical disorders, in inpatients, in primary care patients, patients with chronic depression and in subthreshold depression. We also found that the effects of psychotherapy are probably overestimated because of publication bias and the relatively low quality of many studies in the field.
Cuijpers, P., A. van Straten, et al. (2008). "Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies." J Consult Clin Psychol 76(6): 909-22.	Psychological therapies	7 meta-analyses (with a total of 53 studies) in which 7 major types of psychological treatment for mild to moderate adult depression (cognitive-behavior therapy, nondirective supportive treatment, behavioral activation treatment, psychodynamic treatment, problem-solving therapy, interpersonal psychotherapy, and social skills training) were directly compared with other psychological treatments.	Each major type of treatment had been examined in at least 5 randomized comparative trials. There was no indication that 1 of the treatments was more or less efficacious, with the exception of interpersonal psychotherapy (which was somewhat more efficacious; d = 0.20) and nondirective supportive treatment (which was somewhat less efficacious than the other treatments; d = -0.13). The drop-out rate was significantly higher in cognitive-behavior therapy than in the other therapies, whereas it was significantly lower in problem-solving therapy. This study suggests that there are no large differences in efficacy between the major psychotherapies for mild to moderate depression.
Cuijpers, P., A. van Straten, et al. (2008). "Are psychological and pharmacologic interventions equally effective in the treatment of adult depressive disorders? A meta-analysis of comparative studies." J Clin Psychiatry 69(11):	Psychological therapies	Thirty randomized trials were included in a meta-analysis that compared the effects of a psychological treatment for 3178 adults with a diagnosed depressive disorder (major depressive disorder, dysthymia, minor depressive disorder) with	In studies of patients with dysthymia, pharmacotherapy was significantly more effective than psychotherapy (d = -0.28, 95% CI = -0.47 to -0.10). In patients with major depressive disorder, treatments with selective serotonin reuptake inhibitors (SSRIs) were significantly more effective than psychological treatments, while treatment with other antidepressants did not differ significantly. Subgroup and metaregression analyses did not show that pretest severity of depressive symptoms was associated with differential effects of psychological and pharmacologic treatments of major depressive disorder. Dropout rates were smaller in psychological

1675-85; quiz 1839-41.		the effects of a pharmacologic treatment.	interventions compared with pharmacologic treatments (odds ratio = 0.66, 95% CI = 0.47 to 0.92). CONCLUSIONS: Pharmacologic treatments may be more effective than psychological interventions in the treatment of dysthymia. Pharmacologic treatment with SSRIs may also be more effective in the treatment of major depressive
Cuijpers, P., A. van Straten, et al. (2010). "The effects of psychotherapy for adult depression are overestimated: A meta-analysis of study quality and effect size." Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences 40(2): 211-223.	Psychotherapy	To examine whether the quality of the studies examining psychotherapy for adult depression is associated with the effect sizes found.	Using a database of 115 randomized controlled trials in which 178 psychotherapies for adult depression were compared to a control condition we found strong evidence that the effects of psychotherapy for adult depression have been overestimated in meta-analytical studies. Although the effects of psychotherapy are significant, they are much smaller than was assumed until now, even after controlling for the type of control condition used.

Systematic reviews of psychological therapies in particular contexts			
Barkham, M., W. B. Stiles, et al. (2008). "Effects of psychological therapies in randomized trials and practice-based studies." British Journal of Clinical Psychology 47(4): 397-415.	Psychological therapies	Comparison of treatment effects between RCTs and practice based studies.	Scores from five randomized trials of depression = 477 clients) were transformed into Clinical Outcomes in Routine Evaluation-Outcome Measure (COREOM) scores and compared with CORE-OM data collected in four practice-based studies; 196 clients). Conversely, the practice-based studies CORE-OM scores were transformed into BDI scores and compared with randomized trial data. Outcomes of completed treatments for depression in randomized trials appeared to be modestly greater than those in routine care settings. The size of the difference may be distorted depending on the method for calculating degree of change. Transforming BDI scores into CORE-OM scores and vice versa may be a preferable alternative to effect sizes for comparisons of studies using these measures. (Amended PsycINFO Database Record)
Cuijpers, P., F. Clignet, et al. (2011). "Psychological treatment of depression in inpatients: a systematic review and meta-analysis." Clin Psychol Rev 31(3): 353-60.	Psychological treatments	Meta-analysis investigating how effective psychological treatment is for depressed inpatients	This set of studies had sufficient statistical power to detect small effect sizes. Psychological treatments had a small (g=0.29), but statistically significant additional effect on depression compared to usual care and structured pharmacological treatments only. Although the number of studies was small, and the quality of many studies was not optimal, it seems safe to conclude that psychological treatments have a small but robust effect on depression in depressed inpatients. More high-quality research is needed to verify these results.
Cuijpers, P., A. van Straten, et al. (2009). "Psychological treatment of depression in primary care: a meta-analysis." Br J Gen Pract 59(559): e51-60.	Psychological treatments	To integrate the results of RCTs of psychological treatment of depression in adults in primary care, and to compare these results to psychological treatments in other settings.	Although the number of studies was relatively low and the quality varied, psychological treatment of depression was found to be effective in primary care, especially when GPs refer patients with depression for treatment.

Specific Therapies			
Abbass Allan, A., T. Hancock Jeffrey, et al. (2006) Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD004687.pub3	Psychodynamic	Systematic review of the efficacy of STPP relative to minimal treatment and non-treatment controls for adults with common mental disorders.	23 studies of 1431 randomised patients with common mental disorders were included. These studies evaluated STPP for general, somatic, anxiety, and depressive symptom reduction, as well as social adjustment. Outcomes for most categories of disorder suggested significantly greater improvement in the treatment versus the control groups, which were generally maintained in medium and long term follow-up. However, only a small number of studies contributed data for each category of disorder, there was significant heterogeneity between studies, and results were not always maintained in sensitivity analyses. The authors concluded that STPP shows promise, with modest to moderate, often sustained gains for a variety of patients. However, given the limited data and heterogeneity between studies, these findings should be interpreted with caution. Furthermore, variability in treatment delivery and treatment quality may limit the reliability of estimates of effect for STPP.
Bell, A. C. and T. J. D'Zurilla (2009). "Problem-solving therapy for depression: a meta-analysis." Clin Psychol Rev 29(4): 348-53.	Problem solving	To conduct a meta-analysis of controlled outcome studies on efficacy of PST for reducing depressive symptomatology.	Based on results involving 21 independent samples, PST was found to be equally effective as other psychosocial therapies and medication treatments and significantly more effective than no treatment and support/attention control groups. Moreover, component analyses indicated that PST is more effective when the treatment program includes (a) training in a positive problem orientation (vs. problem-solving skills only), (b) training in all four major problem-solving skills (i.e., problem definition and formulation, generation of alternatives, decision making, and solution implementation and verification), and (c) training in the complete PST package (problem orientation plus the four problem-solving skills).
Chiesa, A. and A. Serretti (2010). "Mindfulness based cognitive therapy for psychiatric disorders: A	Mindfulness based cognitive therapy	To review and conduct a meta-analysis of the current findings about the efficacy of MBCT for	Main findings included the following: 1) MBCT in adjunct to usual care was significantly better than usual care alone for reducing major depression (MD) relapses in patients with three or more prior depressive episodes (4 studies),

systematic review and meta-analysis." Psychiatry Research 187(3): 441-453.		psychiatric patients	2) MBCT plus gradual discontinuation of maintenance ADs was associated to similar relapse rates at 1 year as compared with continuation of maintenance antidepressants (1 study), 3) the augmentation of MBCT could be useful for reducing residual depressive symptoms in patients with MD (2 studies) and for reducing anxiety symptoms in patients with bipolar disorder in remission (1 study) and in patients with some anxiety disorders (2 studies).
Coull, G. and P. G. Morris (2011). "The clinical effectiveness of CBT-based guided self-help interventions for anxiety and depressive disorders: A systematic review." Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences 41(11): 2239-2252.	CBT-based guided self-help interventions	To review the effectiveness of CBT-based GSH interventions for anxiety and depressive disorders	Thirteen studies were meta-analysed and indicated the effectiveness of GSH at post-treatment, but limited effectiveness at follow-up or among more clinically representative samples. Although there is support for the effectiveness of CBT-based GSH among media-recruited individuals, the finding that the reviewed RCTs had limited effectiveness within routine clinical practice demonstrates that the evidence is not conclusive.
Cuijpers, P., T. Donker, et al. (2010). "Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies." Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences 40(12): 1943-1957.	Guided self help, face to face psychotherapy	Meta-analysis of randomized controlled trials in which the effects of guided self-help on depression and anxiety were compared directly with face-to-face psychotherapies for depression and anxiety disorders	The overall effect size indicating the difference between guided self-help and face-to-face psychotherapy at post-test 0.02, in favour of guided self-help. At follow-up (up to 1 year) no significant difference was found either. No significant difference was found between the drop-out rates in the two treatments formats. The authors suggest that It seems safe to conclude that guided self-help and face-to-face treatments can have comparable effects
Cuijpers, P., A. S. Geraedts, et al. (2010). "Interpersonal	IPT	Meta-analysis to integrate	Thirty-eight studies including 4,356 patients met all inclusion criteria. The overall effect size (Cohen's d) of the 16 studies that compared IPT and a

psychotherapy for depression: a meta-analysis." Am J Psychiatry 168(6): 581-92.		research on the effects of IPT.	control group was 0.63. Ten studies comparing IPT and other psychological treatments showed a nonsignificant differential effect size favoring IPT. Pharmacotherapy was more effective than IPT and combination treatment was not more effective than IPT alone, although the paucity of studies precluded drawing definite conclusions. Combination maintenance treatment with pharmacotherapy and IPT was more effective in preventing relapse than pharmacotherapy alone. Authors conclude that IPT efficaciously treats depression, both as an independent treatment and in combination with pharmacotherapy.
Cuijpers, P., A. van Straten, et al. (2007). "Behavioral activation treatments of depression: a meta-analysis." Clin Psychol Rev 27(3): 318-26.	Behavioral activation treatments of depression	Meta-analysis of randomized effect studies of activity scheduling	Sixteen studies with 780 subjects were included. The pooled effect size indicating the difference between intervention and control conditions at post-test was 0.87 (95% CI: 0.60 - 1.15). This is a large effect. Heterogeneity was low in all analyses. The comparisons with other psychological treatments at post-test resulted in a non-significant pooled effect size of 0.13 in favor of activity scheduling. In ten studies activity scheduling was compared to cognitive therapy, and the pooled effect size indicating the difference between these two types of treatment was 0.02. The changes from post-test to follow-up for activity scheduling were non-significant, indicating that the benefits of the treatments were retained at follow-up. The differences between activity scheduling and cognitive therapy at follow-up were also non-significant. Activity scheduling is an attractive treatment for depression, not only because it is relatively uncomplicated, time-efficient and does not require complex skills from patients or therapist, but also because this meta-analysis found clear indications that it is effective.
Cuijpers, P., A. van Straten, et al. (2007). "Problem solving therapies for depression: a meta-analysis." Eur Psychiatry 22(1): 9-15.	Problem solving therapy	Meta-analysis of PST	13 randomized studies examining the effects of PST, with a total of 1133 subjects. The quality of studies varied and all were very different from each other. Concluded that although there is no doubt that PST can be an effective treatment for depression, more research is needed to ascertain the

			conditions and subjects in which these positive effects are realized.
de Mello, M. F., J. de Jesus Mari, et al. (2005). "A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders." European Archives of Psychiatry and Clinical Neuroscience 255(2): 75-82.	IPT	To summarize findings from controlled trials of the efficacy of IPT in the treatment of depressive spectrum disorders (DSD) using a meta-analytic approach.	Thirteen studies were included and four meta-analyses conducted. The efficacy of IPT proved to be superior to placebo, similar to medication and did not increase when combined with medication. Overall, IPT was more efficacious than CBT. Current evidence indicates that IPT is an efficacious psychotherapy for DSD and may be superior to some other manualized psychotherapies.
Donker, T., K. M. Griffiths, et al. (2009). "Psychoeducation for depression, anxiety and psychological distress: a meta-analysis." BMC Med 7: 79.	Psychoeducation	Meta-analyses of the effectiveness of passive psychoeducation in reducing symptoms of depression, anxiety or psychological distress	Four research studies targeting passive psychoeducation for depression and psychological distress met the inclusion criteria. The pooled standardized-effect size (four studies, four comparisons) for reduced symptoms of depression and psychological distress at post-intervention was d = 0.20 (95% confidence interval: 0.01-0.40; Z = 2.04; P = 0.04; the number needed to treat: 9). Heterogeneity was not significant among the studies (I2 = 32.77, Q:4.46; P = 0.22). This meta-analysis revealed that brief passive psychoeducational interventions for depression and psychological distress can reduce symptoms. Brief passive psychoeducation interventions are easy to implement, can be applied immediately and are not expensive. They may offer a first-step intervention for those experiencing psychological distress or depression and might serve as an initial intervention in primary care or community
Driessen, E., P. Cuijpers, et al. (2010). "The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis." Clin Psychol Rev 30(1): 25-36.	Psychodynamic	To assess the efficacy of STPP for depression and to identify treatment moderators.	23 studies totaling 1365 subjects were included in a meta-analysis. STPP was found to be significantly more effective than control conditions at post-treatment (d=0.69). STPP pre-treatment to post-treatment changes in depression level were large (d=1.34), and these changes were maintained until 1-year follow-up. Compared to other psychotherapies, a small but significant effect size (d=-0.30) was found, indicating the superiority of other treatments immediately post-treatment, but no significant differences were

			found at 3-month (d=-0.05) and 12-month (d=-0.29) follow-up. Studies employing STPP in groups (d=0.83) found significantly lower pre-treatment to post-treatment effect sizes than studies using an individual format (d=1.48). Supportive and expressive STPP modes were found to be equally efficacious (d=1.36 and d=1.30, respectively).
Ekers, D., D. Richards, et al. (2008). "A meta-analysis of randomized trials of behavioural treatment of depression." Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences 38(5): 611-623.	Behavioural therapies	Systematic review of behavioural therapy for depression	Seventeen randomized controlled trials including 1109 subjects were included in this meta-analysis. A random-effects meta-analysis of symptom-level post-treatment showed behavioural therapies were superior to controls, brief psychotherapy, supportive therapy and equal to cognitive behavioural therapy Concluded that this study indicates behavioural therapy is an effective treatment for depression with outcomes equal to that of the current recommended psychological intervention.
Jakobsen, J. C., J. L. Hansen, et al. (2011). "The effect of interpersonal psychotherapy and other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder." PLoS ONE 6(4): e19044.	IPT and Psychodynamic	Systematic review methodology with meta-analysis and trial sequential analysis of randomized trials comparing the effect of psychodynamic therapies versus 'treatment as usual' for major depressive disorder.	We included six trials randomizing a total of 648 participants. Five trials assessed 'interpersonal psychotherapy' and only one trial assessed 'psychodynamic psychotherapy'. All six trials had high risk of bias. Meta-analysis on all six trials showed that the psychodynamic interventions significantly reduced depressive symptoms compared with 'treatment as usual'. DISCUSSION: We did not find convincing evidence supporting or refuting the effect of interpersonal psychotherapy or psychodynamic therapy compared with 'treatment as usual' for patients with major depressive disorder. The potential beneficial effect seems small and effects on major outcomes are unknown. Randomized trials with low risk of systematic errors and low risk of random errors are needed.
Lau, M. A. (2008). "New developments in psychosocial interventions for adults with unipolar depression." Curr Opin	Psychosocial interventions	To summarize psychotherapy efficacy studies across the depression treatment continuum and the effectiveness of psychosocial	New psychotherapies in the acute treatment of mild-moderate depression include emotion-focused therapy, self-system therapy, cognitive control training and positive psychotherapy. Furthermore, emerging evidence supports the use of psychotherapy for moderate-severe and treatment-resistant depression and for recurrent depression with a seasonal pattern.

Psychiatry 21(1): 30-6.		interventions in community settings.	An important area of growth is the development and evaluation of continuation/maintenance treatments based on cognitive behavioral therapy and interpersonal therapy to reduce depressive relapse risk in recurrent and chronic depression. Finally, there is evidence supporting the effectiveness of stepped care, chronic disease management and collaborative care models in community settings.
Parker, G. and K. Fletcher (2007). "Treating depression with the evidence-based psychotherapies: A critique of the evidence." Acta Psychiatrica Scandinavica 115(5): 352-359. –	CBT/IPT	Systematic review of the limitations of studies of CBT and IPT	The specificity of CBT and IPT treatments for depression has yet to be demonstrated. The superiority of CBT and IPT may well be able to be demonstrated across defined rather than universal circumstances. To achieve this aim, outcome research should move away from testing treatments as if they have universal application for heterogeneous disorder categories.

Client groups/types of depression			
Cuijpers, P., A. van Straten, et al. (2009). "Is psychotherapy for depression equally effective in **younger and older adults**? A meta-regression analysis." Int Psychogeriatr 21(1): 16-24.	Psychological therapies	Meta-analysis comparing younger and older client groups	112 studies with 170 comparisons between a psychotherapy and a control group (with a total of 7,845 participants). Twenty studies with 26 comparisons were aimed at older adults. We found no indication that psychotherapies were more or less effective for older adults compared to younger adults. The effect sizes of both groups of comparisons did not differ significantly from each other (older adults: d = 0.74; 95% CI: 0.49-0.99; younger adults: d = 0.67; 95% CI: 0.58-0.76). There appears to be no significant difference between psychotherapy in younger and older adults, although it is not clear whether this is also true for clinical samples, patients with more severe depression, and the older old.
Cuijpers, P., F. Smit, et al. (2007). "Psychological treatments of subthreshold depression: a meta-analytic review." Acta Psychiatr Scand 115(6): 434-41.	Psychological treatments	Meta-analysis of randomized controlled studies examining the effects of psychological treatments for subthreshold depression, including the effects on depressive symptoms and the preventive effects on the incidence of major depression.	Seven high-quality studies with a total of 700 subjects were included. The mean effect size at post-test was 0.42, with very low heterogeneity. The relative risk of developing a major depressive disorder in subjects who received the intervention was 0.70 (95% CI: 0.47-1.03; P = 0.07). Authors concluded that psychological treatments have significant effects on subthreshold depression. Furthermore, these interventions may prevent the onset of major depression.

Evidence for individual therapies

IPT

Carreira, K., M. D. Miller, et al. (2008). "A controlled evaluation of monthly maintenance interpersonal psychotherapy in late-life depression with varying levels of cognitive function." Int J Geriatr Psychiatry 23(11): 1110-3.	IPT	To evaluate the effect of maintenance Interpersonal Psychotherapy (IPT) on recurrence rates and time to recurrence of major depression in elderly patients	Two-year maintenance study of monthly maintenance IPT vs supportive clinical management (CM) in remitted depressed elderly who were participants in a previously reported placebo-controlled study of maintenance paroxetine and IPT (Reynolds et al., 2006). The authors observed a significant interaction between cognitive status and treatment: lower cognitive performance was associated with longer time to recurrence in IPT than in CM (58 weeks vs 17 weeks) (HR = 1.41 [95% CI = 1.04, 1.91], p = 0.03). Subjects with average cognitive performance showed no effect of maintenance IPT vs CM on time to recurrence (38 vs 32 weeks, respectively). It was concluded that monthly maintenance IPT confers protection against recurrence of major depression in elders with lower cognitive functioning.
Frank, E., D. J. Kupfer, et al. (2007). "Randomized trial of weekly, twice-monthly, and monthly interpersonal psychotherapy as maintenance treatment for women with recurrent depression." Am J Psychiatry 164(5): 761-7.	IPT	To determine whether a greater frequency of interpersonal psychotherapy (IPT) sessions during maintenance treatment has a greater prophylactic effect than a previously validated once-a-month treatment.	233 women 20-60 years of age with recurrent unipolar depression were treated in an outpatient research clinic. After participants had achieved remission with weekly IPT or, if required, with weekly IPT plus antidepressant pharmacotherapy, they were randomly assigned to weekly, twice-monthly, or monthly maintenance IPT monotherapy for 2 years or until a recurrence of their depression occurred. RESULTS: Among participants who remitted with IPT alone and entered maintenance treatment (N=99), 19 (26%) of the 74 who remained in the study throughout the 2-year maintenance phase experienced a recurrence of depression. Among participants who required the addition of a selective serotonin reuptake inhibitor to achieve remission (N=90), 32 (36%) sustained that remission through continuation treatment and drug discontinuation and began maintenance treatment; of these, 13 (50%) of the 26 who remained in

			the study throughout the maintenance phase experienced a recurrence. These results suggest that maintenance IPT, even at a frequency of only one visit per month, is a good method of prophylaxis for women who can achieve remission with IPT alone. In contrast, among those who require the addition of pharmacotherapy, IPT monotherapy represents a significantly less efficacious approach to maintenance treatment.
Talbot, N. L., L. H. Chaudron, et al. (2011). "A randomized effectiveness trial of interpersonal psychotherapy for depressed women with sexual abuse histories." Psychiatr Serv 62(4): 374-80.	IPT	To compare interpersonal psychotherapy with usual care psychotherapy among women in a CMHC.	Seventy women with major depression and sexual abuse before age 18 were randomly assigned to interpersonal psychotherapy (N=37) or usual care psychotherapy (N=33). Compared with women assigned to usual care, women who received interpersonal psychotherapy had greater reductions in depressive symptoms, posttraumatic stress disorder symptms, and shame. Interpersonal psychotherapy and usual care yielded comparable improvements in social and mental health-related functioning.
van Calker, D., I. Zobel, et al. (2009). "Time course of response to antidepressants: predictive value of early improvement and effect of additional psychotherapy." J Affect Disord 114(1-3): 243-53.	IPT	We have analysed in more severely depressed inpatients treated with antidepressants i) the predictive value of early improvement for later response and ii) the impact of additional psychotherapy on the time course of response.	124 patients with a major depression referred for hospitalized care were randomized to 5 weeks of sertraline (or amitriptyline as a second choice) plus either additional Interpersonal Psychotherapy modified for inpatients (IPT) or Clinical Management (CM). Early improvement within two weeks was highly predictive of later stable response or stable remission irrespective of the type of medication or additional IPT or CM. Patients of the IPT group had a shorter time to "onset of response" than patients in the CM group however, there was no significant difference in the time to onset of response, when more stringent conditions were used. In combination therapy, the additional

			benefit of psychotherapy occurs at least as rapid as the response to antidepressants.
van Schaik, D. J., H. W. van Marwijk, et al. (2007). "Interpersonal psychotherapy (IPT) for late-life depression in general practice: uptake and satisfaction by patients, therapists and physicians." BMC Fam Pract 8: 52.	IPT	To evaluate IPT in general practice for older patients	Patients were motivated for the psychotherapy intervention: of the 205 eligible patients, 143 (70%) entered the study, and of the 69 patients who were offered IPT, 77% complied with the treatment. IPT proved to be an attractive therapy for patients as well as for therapists from mental health organizations. General practitioners evaluated the intervention positively afterwards, mainly because of the time-limited and structured approach. Organizational barriers: no IPT therapists were available; an IPT trainer and supervisor had to be trained and training materials had to be developed and translated. Additionally, there was a lack of office space in some general practices; for therapists from private practices it was not feasible to participate because of financial reasons. IPT was superior to usual care in patients with moderate to severe depression.
Zobel, I., S. Kech, et al. (2011). "Long-term effect of combined interpersonal psychotherapy and pharmacotherapy in a randomized trial of depressed patients." Acta Psychiatr Scand 123(4): 276-82.	IPT	An RCT of the long-term benefits of combined pharmacological and psychotherapeutic depression treatment and the differential impact of early childhood trauma.	Patients in both treatments reduced their depressive symptoms between baseline and 5-year follow-up significantly with a faster decrease early in the follow-up phase. The time rate of change and acceleration on the HRSD was higher for patients in the combination therapy group. The contrast between the conditions at year 5 was non-significant. However, 28% of the IPT patients showed a sustained remission compared with 11% of the CM patients (P = 0.032). Early adversity was found to be a moderator of the relationship between treatment and outcome.

ACT

Bhanji, S. (2011). "Is it time we turn towards 'third wave' therapies to treat depression in primary care? A review of the theory and evidence with implications for counselling psychologists." Counselling Psychology Review 26(2): 57-69.	Mindfulness-based Cognitive Therapy, Metacognitive Therapy, and Acceptance and Commitment Therapy	Theoretical models and empirical outcomes for Mindfulness-based Cognitive Therapy, Metacognitive Therapy, and Acceptance and Commitment Therapy as third wave treatments for depression are examined with implications for how mindfulness approaches can be integrated into the therapeutic work of counselling psychologists (CoPs).	Conclusion: Further theoretical and empirical considerations for the inclusion of third wave therapies into the IAPT agenda are discussed with suggestions for further research. (PsycINFO Database Record Amended)

Music Therapy

Erkkila, J., M. Punkanen, et al. (2011). "Individual music therapy for depression: randomised controlled trial." Br J Psychiatry 199(2): 132-9.	Music therapy	RCT to determine the efficacy of music therapy added to standard care compared with standard care only in the treatment of depression among working-age people.	Participants receiving music therapy plus standard care showed greater improvement than those receiving standard care only in depression symptoms, anxiety symptoms and general functioning at 3-month follow-up. The response rate was significantly higher for the music therapy plus standard care group than for the standard care only group.
Gold, C., H. P. Solli, et al. (2009). "Dose-response relationship in music therapy for people with serious mental disorders: systematic review and meta-analysis." Clin Psychol Rev 29(3): 193-207.	Music therapy	Review to examine the benefits of music therapy for people with serious mental disorders.	The findings suggest that music therapy is an effective treatment which helps people with psychotic and non-psychotic severe mental disorders to improve global state, symptoms, and functioning. Slight improvements can be seen with a few therapy sessions, but longer courses or more frequent sessions are needed to achieve more substantial benefits.
Maratos, A., C. Gold, et al. (2008) Music therapy for depression. Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD004517.pub2	Music therapy	Systematic review to examine the efficacy of music therapy with standard care compared to standard care alone among people with depression and to compare the effects of music therapy for people with depression against other psychological or pharmacological therapies.	Five studies met the inclusion criteria for the review. Marked variations in the interventions offered, the populations studied and the outcome measures used meant that quantitative data synthesis and meta-analysis were not appropriate. Four studies reported greater reductions in symptoms of depression among those randomised to music therapy. The fifth study reported no change in mental state among those receiving music therapy compared to those randomised to standard care alone. Findings from individual studies suggest that music therapy for people with depression is feasible and indicate a need for further research.