Psychotherapy for depression – a review and practical guide

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Psychological therapies can be effective in the treatment of depression and are valued by patients. Here, the authors provide an overview of the main psychological therapies available, their evidence base and their use in practice.

In a busy clinical setting the issue of psychotherapy for depression can sometimes seem like considering the inaccessible for the indefinable. In this article we will briefly describe the nature and evidence base for psychological therapies used in the treatment of depression, their place in relation to antidepressants, and their indications and use in practice. It is beyond the scope of this article to discuss the diagnosis and overall treatment of depression, which has previously been reviewed recently in Prescriber.1

In clinical practice, depression raises both conceptual and therapeutic difficulties, these include identifying the threshold between depression and unhappiness, the overlap and co-existence with anxiety disorders and physical illness, and the social context, especially chronic adversity. These factors mean that psychological therapies are an important treatment option in the management of depressive disorders, offering as they do a more personal and less-medicalised approach than medication.

Patients value psychotherapy, with a recent meta-analysis reporting that 75 per cent of patients, especially younger patients and women, would prefer psychological rather than pharmacological treatment for psychiatric disorders,2 although only a quarter of those referred complete treatment.3

What is psychotherapy?
Psychotherapy is usually defined as ‘talking therapy’ (although other modalities such as drama or painting can be used) involving seeing a trained therapist, individually, as a couple or in a group. While the content and processes of different psychological therapies vary, there are shared common features that include instillation of hope, a therapeutic alliance, an explanation of distress and a process to promote healing, with an expectation that between-session changes in behaviour, thinking and/or attitudes occur.

The variety of psychological therapies available potentially allows for matching of therapy to patient; however, therapists tend to become eclectic in their practice, and there is evidence that outcome depends more on the therapist than their therapeutic orientation. Table 1 describes the psychological therapies commonly used to treat depression.

Efficacy of psychological therapies
A recent large network meta-analysis of 198 randomised controlled trials (RCTs) used direct and indirect comparisons to evaluate the relative efficacy of seven...
psychological treatments for depression (CBT, IPT, BAT, PST, BDT, SUP, social skills training; see Table 1). Studies involving CBT were the most numerous and comparisons with waiting list (WL) the most common followed by treatment as usual (TAU). All therapies were more effective than WL with large effect sizes ranging from 0.62 to 0.92. The most robust findings were for CBT, IPT and PST, with differences between therapies small (the only significant difference was IPT being superior to SUP).

In a series of meta-analyses psychological therapies were reported to be effective in a wide range of situations including in older adults, women with postpartum depression, patients with general medical disorders, inpatients, primary-care patients, and in those with chronic or sub-threshold depression. However, the size of effect is almost certainly overestimated. Effect sizes are smaller in larger better-quality studies, and in those with blind assessment of

<table>
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<tr>
<th>Therapeutic Intervention</th>
<th>Description</th>
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<tr>
<td>Low-intensity</td>
<td>Interventions based on self-help materials that are facilitated by paraprofessionals. NICE guidelines also include physical activity programmes under this category</td>
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<tr>
<td>Computerised CBT (cCBT)</td>
<td>A computerised/internet version of CBT using key ideas from the CBT model, encouraging homework tasks between sessions, and active behaviour monitoring. It is facilitated (guided) by a professional introducing, monitoring and reviewing the outcome.</td>
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<tr>
<td>Guided self-help</td>
<td>Self-administered intervention, often based on CBT or behavioural approaches, making use of specially designed books or self-help manuals. It is facilitated by a professional introducing, monitoring and reviewing the outcome.</td>
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<td>High Intensity</td>
<td>Interventions that are delivered by a trained therapist based on a specific theoretical approach.</td>
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<td>Cognitive Behavioural Therapy (CBT)</td>
<td>A structured therapy involving a collaboration between the therapist and patient to identify and challenge dysfunctional beliefs underlying negative mood, and to modify them and the associated behaviour patterns. It involves homework and between-session activities. CBT can also be delivered in group settings and modified for relapse prevention.</td>
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<td>Behavioural Activation Therapy (BAT)</td>
<td>This emphasises maladaptive behaviours in relation to stress rather than cognitions. It involves activity scheduling in order to increase positive, rewarding interactions and to overcome avoidance and negative reinforcement.</td>
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<tr>
<td>Interpersonal Psychotherapy (IPT)</td>
<td>A structured treatment based on identifying the interpersonal context of the person’s depression, and then using specific strategies to address them, including encouragement, problem solving, rehearsal and review.</td>
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<tr>
<td>Behavioural Couples Therapy (BCT)</td>
<td>Involvement of both partners with a therapist to identify negative interactions and to encourage more supportive ways of relating through improved communication and changing interaction patterns.</td>
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<tr>
<td>Problem Solving Therapy (PST)</td>
<td>A collaboration between therapist and patient identifying key problem areas, breaking them down into more manageable problems and identifying coping strategies.</td>
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<td>Brief Psychodynamic Therapy (BDT)</td>
<td>Based on psychodynamic approaches where the therapist and patient explore recurrent internal and relationship conflicts, including experiences from childhood and historical patterns. The aim is to enhance understanding of these, and their impact on the present, in order to help resolve the conflicts and bring about change.</td>
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<tr>
<td>Supportive counselling (SUP)</td>
<td>Nondirective therapy involving allowing ventilation of emotions and experiences, nonjudgemental listening and empathy. The patient is not taught specific skills.</td>
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<tr>
<td>Mindfulness-based Cognitive Therapy (MBCT)</td>
<td>Combination of mindfulness-based meditation approaches with CBT and psychoeducation to provide patients with new ways of dealing with their symptoms to help reduce relapse risk. It is a group therapy requiring daily meditation practice between sessions that continues afterwards.</td>
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Table 1. Main psychological therapies for depression
Assessment

- Recent onset subthreshold depressive symptoms or mild depression
  - Explore, monitor
  - Low intensity psychotherapy
  - Antidepressant

- Moderate to severe depression, chronic depression including persistent subthreshold symptoms
  - PP nonresolution
  - High-intensity psychotherapy
  - Antidepressant

- Remission after initial treatment in recurrent illness or if at risk of relapse
  - PP
  - CBT or MCBT

Treatment

- First episode
  - Recurrent mild episodes

- Non-resolution

Figure 1. Place of psychotherapy in the management of depression; PP = consider patient preference bearing in mind evidence for superior efficacy of antidepressants in dysthymia and for combined antidepressants + psychotherapy in moderate to severe depression; a timely availability/access with influence choice; b change in drug treatment is also a strategy for nonresolution of depression following antidepressants; c antidepressants need to be continued after acute remission (see NICE guidelines).

Meta-analyses of self-administered therapies against TAU (cCBT and guided self-help based on CBT) report moderate short-term benefit not sustained at three to six month follow-up, however, studies are poor quality with high risk of bias. The evidence for the efficacy of psychological therapy for relapse prevention is largely limited to CBT and MBCT. Both have been shown to be effective in patients with highly recurrent depression and for those with residual symptoms after acute treatment.

Psychological therapies compared, and combined, with antidepressants

Methodological differences, and the inescapable fact that patients cannot be blinded to their psychological treatment, mean that caution is required when comparing psychological and drug treatment studies. CBT has been the most-studied psychotherapy that has been directly compared with antidepressants in RCTs with very limited evidence comparing other psychotherapies and antidepressants. A meta-analysis of 20 studies found equal efficacy for CBT and antidepressants in the acute treatment of depression, and the naturalistic nonblinded randomised STAR*D study also found equal efficacy following failure to respond to an initial antidepressant; response to CBT was slower but it was better tolerated than switching antidepressants. Combined treatment with CBT and medication is moderately more effective than medication alone and probably than CBT alone. A recent UK primary-care study has shown that CBT added to TAU (including pharmacotherapy) in patients who failed to respond to an antidepressant doubled the response rate from 22 to 46 per cent at six months.

We have limited knowledge about predictors of response to psychological or drug therapy. A meta-analysis of six studies found that dysthymia (chronic or persistent subthreshold depressive symptoms) responded better to antidepressants than to psychotherapy. In contrast a recent large primary-care depression study found a higher response rate to brief IPT than an SSRI antidepressant; however, moderator analysis showed that...

Outcome. Controlling for publication bias, or restricting analysis to those against a drug or psychological placebo control condition, reduces the effect size by a quarter and by a half respectively. In addition longer-term outcomes are poorly studied and inconsistent. A recent UK primary care RCT found CBT and SUP more effective than TAU at four-month but not 12-month follow-up. Therefore, evidence is strong for the short-term efficacy of high-intensity individual psychological therapies, but less so for longer-term benefit; in addition the largest part of the effect appears to be due to nonspecific factors, with only small therapy-specific effects.

There is less evidence for group and couple therapy, with studies of poor quality and a high risk of bias. A meta-analysis of 14 RCTs found that group CBT was more effective than TAU and this was probably maintained at three-month follow-up; however, it appeared less effective than individual CBT in the short term. A meta-analysis of six RCTs of couple, compared with individual, therapy (mostly CBT or BAT) found no significant difference in efficacy.
**Table 2.** Summary of NICE recommendations for the delivery and choice of psychotherapy for depression

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<tr>
<th>Delivery</th>
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<td>Stepped care</td>
<td>Intended to enhance efficiency by providing low-intensity interventions first to a proportion of depressed patients before ‘stepping up’ to high-intensity interventions for those who do not improve. It requires identifying those who might benefit from low-intensity interventions initially, and ‘scheduled review’ so that more intensive interventions can be offered if needed.</td>
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<td>Training and process</td>
<td>Interventions should be delivered by competent practitioners receiving regular supervision, based on treatment manuals, using routine outcome measures and engaging the patient in reviewing efficacy.</td>
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<td>Duration of treatments</td>
<td>Low-intensity treatments: up to 6–8 sessions over 9–12 weeks. Recommended high-intensity individual psychotherapies and BDT: 16–20 sessions over 3–4 months; SUP: 6–10 sessions over 2–3 months. Group CBT: 10–12 sessions over 3–4 months; MCBT: 8 sessions over 8 weeks.</td>
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<tr>
<th>Clinical situation</th>
<th>Recommended evidence-based psychological treatments*</th>
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<tr>
<td>Subthreshold depression and mild to moderate depression</td>
<td>Low-intensity interventions</td>
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<tr>
<td>Subthreshold depression and mild to moderate depression that persist despite treatment</td>
<td>CBT, BAT, IPT or BCT</td>
</tr>
<tr>
<td>Moderate to severe depression</td>
<td>Combination of CBT or IPT and an antidepressant</td>
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<tr>
<td>Failure to respond to drug or psychotherapy alone</td>
<td>Combination of CBT and an antidepressant</td>
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<tr>
<td>Relapse prevention</td>
<td>CBT, MBCT</td>
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**Second-line psychological treatments***

| When recommended psychological interventions are declined | Group CBT, BDT or SUP |

*see Table 1 for explanation of treatments*
KEY POINTS

- Psychological therapies offer a personal and nonmedicalised option for the acute treatment of depression and for relapse prevention, but availability is limited.
- More patients express a preference for psychotherapy than drug therapy.
- Take into account patient preference in choice of therapy, as this influences take-up and adherence to therapy, and probably outcome.
- NICE recommends a ‘stepped-care’ approach, matching patient needs to therapy, and offering low- to high-intensity therapies, in order to increase the efficiency of treatment provision.
- Low-intensity interventions include cCBT and guided self-help, and can be effective for milder depressions.
- A range of effective high-intensity psychotherapies exist, with most evidence for CBT.
- Evidence is stronger for the acute efficacy of psychotherapies, than for their longer-term benefit.
- High-intensity psychotherapies and antidepressants are equally effective; their combination is more effective than either alone.

patients in a second episode, and those with moderate to severe depression, poorer functioning and co-morbid anxiety, responded better to an SSRI than IPT. Sequel psychotherapy added following acute response to antidepressants has been found to reduce relapse both when antidepressants are discontinued or continued. Applying the evidence to practice

Although the different psychological therapies and antidepressants appear to be broadly of comparable efficacy in the treatment of depression, there are a number of factors that guide choice. First, timely access to treatment is important, and some therapies may simply be less accessible or unavailable in some areas. The Improving Access to Psychological Therapies (IAPT) programme in England is an ambitious attempt to increase access, reduce waiting times, and improve outcomes; it follows the NICE stepped-care model (see Table 2), and offers a range of low- and high-intensity interventions.

However, availability alone does not ensure uptake and the latest evaluation shows that only 49 per cent of those referred enter treatment, with about half of these completing treatment. This is likely to be related to a second factor, whether the person wants, and can attend, the treatment offered; for example strength of patient preference for drug or psychological treatment predicts whether treatment is started and adhered to, although its relationship to outcome when treatment is undertaken is equivocal. Third, there are clinical considerations suggested by the evidence discussed above (see Table 2 and Figure 1).

Given the evidence cited above there is no general clear ‘first choice’ of psychological therapy, although CBT has the best evidence base. For many patients brief therapies may be sufficient, but for those with insufficient improvement the option of longer treatment courses and more frequent sessions are needed. Table 2 gives NICE recommendations related to psychological treatments for depression. Figure 1 provides a simplified flowchart for the use of psychological therapies and antidepressants in the treatment of depression.

Conclusions

Psychological therapies can be effective in the treatment of depression but need to be considered in the context of availability, patient preference, illness characteristics and pharmacological treatment. The challenge is to be able to personalise treatment for individual patients to optimise outcome, and as yet we only have limited knowledge about how best to do this.

References


Declaration of interests

Katie Williams has none to declare. Professor Anderson chaired the Guideline Development Group for the 2009 NICE clinical guideline for the treatment of depression (CG90).

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