

6. Psychotherapy

- Is any type of psychotherapy effective for patients with major depression?

There are different types of psychological treatments for a wide variety of health problems, including depression. These treatments vary according to the theoretical foundation on which they are based, the level of formal development of their techniques, the available studies that allow endorsing their efficacy and their use by health professionals of the health system.

The randomised clinical trials that are used assessing drugs have also become a key piece for psychotherapy, although with a series of specific difficulties¹¹⁵:

- ~ There are a series of common factors that are well-recognised in all psychological treatments, which are related to the therapeutic relationship (such as unconditional acceptance, the expectation of change, etc.) and are potentially important to the treatment outcome, as well as a series of active ingredients that are not easy to specify. Moreover, psychotherapies are constantly evolving, and new techniques are developed within the same approach or through approximations between different orientations. This can mean a source of innovation and flexibility in routine clinical practice in the interest of each patient, but in a clinical trial, treatment manuals that clarify exactly what has been done in the trial are essential.
- ~ It is necessary to control the dependent variables of the therapist, especially their psychotherapeutic training and clinical experience, as well as their adherence to the treatment manual through independent evaluations.
- ~ It is impossible to blind the treatment for whoever is administering it (psychotherapist), and it is relatively problematic to mask the active treatment condition for the independent external evaluator.
- ~ The same psychological treatment can be provided in different formats (for example, individual or group), and the duration can also be variable, which should probably be evaluated separately, given that it could affect the outcome and efficiency.
- ~ Several variables have been proposed for the patient (personality, biographical history, education level, etc.) or for the depressive disorder (type and severity, previous recurrence, etc.), which could have a greater likelihood of affecting the outcome of psychotherapy than the outcome of biological therapies.
- ~ In recent years, clinical practice guidelines are consistent in recognising the efficacy of psychological therapies in the treatment of depression, especially those that have been specifically designed, such as cognitive behavioural therapy and interpersonal psychotherapy^{21, 29, 97}.

6.1 Cognitive Behavioural Therapy (CBT)

Cognitive therapy was originally developed by Beck and formalised at the end of the 70s in order to be applied to depression¹⁶, and it has become the most-frequently studied mode of psychological therapy in depression¹⁷. Intervention focuses on the modification of dysfunctional behaviours, distorted negative thoughts associated with specific situations and disadaptive attitudes related to depression. The therapist adopts an educational style and seeks the patient's cooperation so that he can learn to recognise his patterns of negative thinking and re-evaluate this thinking. This approach requires that the patient practice his new skills between sessions through tasks at home and that he try new behaviours. It is commonly acknowledged that all cognitive therapy interventions include more or less behavioural techniques, which is where it gets the name of cognitive behavioural therapy.

Moreover, the CBT includes a range of different interventions that share the basic theoretical assumption that most human behaviour is learned. Thus, these interventions seek to implement certain skills in depressed persons, such as problem-solving therapy, assertive training or behavioural couples therapy. Behavioural activation is one of the ingredients of Beck's cognitive therapy, which emphasises the relationship between activity and mood and which has been the object of renewed attention¹⁸. Nevertheless, these other interventions have been evaluated with less intensity than Beck's cognitive therapy, and they are summarised briefly below.

CBT adopts a structured format, it is limited in time, and it is based on the cognitive-behavioural model of affective disorders. It has been evaluated in a diversity of contexts (primary care, specialised care, hospitalised patients), compared mainly with pharmacological treatment and with different patient samples¹⁹. The most frequent duration varies between 15-20 sessions of 50 minutes each and at a weekly frequency, although there are also studies that adopt briefer formats for less serious cases (from 6 to 8 sessions), and it is assumed that the duration of therapy can be extended in the event of greater severity or associated comorbidity.

NICE²¹ synthesises the available evidence based on 30 trials referring to patients whose depression varies from moderate to very severe, with the following conclusions:

- ~ CBT is as effective as antidepressant drugs in reducing the symptoms at the end of treatment. While the effect is maintained for one year after ending CBT, the same thing does not always occur with antidepressants. This therapy seems to be better tolerated than antidepressants, especially in patients with severe or very severe depression, and its benefits are maintained to a greater extent than antidepressant medication.
- ~ Adding cognitive behavioural therapy to antidepressant medication is more effective than treatment with antidepressants alone, especially in those patients with severe symptoms. In general, there is no indication that adding antidepressants to cognitive behavioural therapy is useful, although effects on specific symptoms, such as sleep, have not been explored. There is insufficient information to assess the effects of combined treatment on relapse rates.

- ~ There is evidence coming from a wide study on chronic depression¹²⁰ that a combination of CBT and antidepressant medication is more beneficial in terms of response and remission than either of those treatments separately.
- ~ In patients with residual symptoms who take antidepressants, adding CBT seems to be useful, given that it reduces the relapse rates during follow-up, although this advantage is not always evident at the end of treatment.
- ~ With respect to the mode of providing treatment, there are data that suggest that group cognitive behavioural therapy is more effective than other group therapies, but there are few studies that compare the group mode and the individual mode of cognitive behavioural therapy to each other. A group mode of cognitive behavioural therapy based on mindfulness seems to be effective at maintaining the response in people who have recovered from depression, especially in those who have had more than two previous episodes¹²¹.

An important study subsequently published endorses CBT as a therapeutic strategy in resistant depression. In the STAR*D¹²² project, after an unsatisfactory response to citalopram, patients who accepted being randomly assigned to an alternative drug strategy or to CBT generally had a comparable outcome. Adding another drug produced a faster outcome than adding CBT to citalopram, although the switch to CBT was better tolerated than the switch to another antidepressant. The degree of acceptance of CBT (less than a third of patients) has been considered relatively low, although there are aspects of the experimental design that could have skewed the choice, as the authors themselves acknowledge, in addition to the fact that the cost of the therapy had to be paid for in the event that it was not covered by the patients' health insurance, which would not occur in the case of pharmacological options.

Regarding recurrent depression, it has been seen that increasing the duration of CBT can reduce relapse and recurrence, especially in high-risk patients¹²³. This protector effect seems to be robust, regardless of whether or not CBT is provided alone or in combination with medication or if the combination is applied simultaneously or sequentially. Furthermore, another clinical trial reports a reduction of the relapse/recurrence rate from 72% to 46% (in a period of 2 years) in patients with multiple previous episodes by adding 16 hours of CBT to the usual treatment after remission¹²⁴.

In samples of patients with greater severity and comorbidity (more than 80% of the cases showed an additional diagnosis on Axis I or II of the DSM, 30% with melancholic depression), a controlled clinical trial with placebo showed that CBT reaches efficacy that is comparable to pharmacological treatment (which included dispensing suitably increased doses or augmentation, if necessary), although this degree of effectiveness seems to be linked to a high level of experience of the cognitive behavioural therapist¹¹⁹.

This recommendation of CBT as first-line treatment in severe depression expands prior recommendations referring to mild and moderate depression¹²⁵. It has been included in the decision algorithm of the clinical practice guidelines of Australia and New Zealand⁹², although they suggest drug therapy in advance, but not in the ICSI⁹¹ or NICE²¹, which preferably recommend combined therapy in depression that is initially shown to be severe.

Summary of the evidence

1++	In general, CBT is as effective as treatment with antidepressants in dealing with major depression (21).
1+	In mild depression, the brief CBT formats (from 6 to 8 sessions) are as effective as the more extended ones (21).
1+	The combination of antidepressant treatment and CBT offers outcomes that are superior to either of these treatments alone in chronic or severe depression (21, 118).
1+	CBT seems to be tolerated better than antidepressants, especially in the most severe cases (120).
1+	CBT has an independent protector effect that is cumulative to maintenance medication against relapses/recurrence, and the cases with multiple previous episodes or with residual symptoms are those that benefit the most due to their high risk of relapse (121, 122).

6.2 Interpersonal Therapy (IPT)

IPT was originally developed by Klerman¹²⁶ to be applied as maintenance treatment for depression, although it was subsequently used as independent treatment, and it currently has been expanded to a variety of different disorders. IPT mainly deals with current interpersonal relationships, and it focuses on the immediate social context of the patient. The original format of the therapy has 3 phases over 12-16 weeks, with weekly sessions during treatment of the acute phase. The symptoms and distress are related to the patient's situation in a formulation that includes one or more of the following areas of life: grief, interpersonal disputes, role transition and interpersonal deficits. The therapy sessions are structured, and they focus on facilitating an understanding of the most recent events in interpersonal terms and on exploring alternative ways of managing these situations.

The number of rigorous randomised clinical trials in which IPT has been evaluated is scarce. For NICE, there are data that suggest that IPT is more effective than the placebo and the usual care by the primary care physician. Moreover, the effectiveness of IPT can be increased when combined with an antidepressant, and it can also be effective as a maintenance strategy for patients whose depression has remitted previously with drug treatment²¹.

A meta-analysis compared the efficacy of IPT with CBT¹²⁷, and it observed that the former obtains a certain clinical advantage regarding the likelihood of a response, although two of the three considered studies showed considerable methodological limitations, wherefore a prudent assessment must be made. The study also compares combined therapy (IPT and medication) to medication alone, without obtaining efficacy differences either in acute treatment or in maintenance treatment.

In two previous studies, Hollon *et al*¹²³ emphasise the potential importance of improvement in social adjustment attributed specifically to IPT in comparison with medication and in the event of similar symptomatological remission, a variable that has, unfortunately, not been subsequently examined.

Finally, a recent trial¹²⁸ concludes that a weekly session of IPT can be sufficient to prevent recurrence in major depression for two years, but only in the cases in which remission has been achieved with this psychological intervention. Conversely, it would be ineffective if drug therapy had been needed during the course of follow-up in order to reach remission. Wherefore, the outcomes are difficult to interpret due to the design and the characteristics of the sample (women who initially did not want to treat their depression with drugs).

Summary of the evidence

1-	IPT has been shown to be effective in the treatment of major depression with respect to placebo, although reaching improvement can be slower than with antidepressants (21).
2+	Treatment with IPT could be associated with additional improvements in social functioning at the end of the therapy (121).
1-	Combined IPT and medication treatment offers better results than IPT alone at reducing relapse rates (126).

6.3 Other psychological therapies

There are no data that allow recommending *dynamic psychotherapy* as treatment for depression, which is a relatively non-directive form of therapy derived from psychoanalysis. Quality studies are infrequent, and those that exist offer unsatisfactory or inconclusive outcomes. Nevertheless, in these studies, dynamic psychotherapy tends to be used as an element of comparison with another, more valued form of treatment, wherefore there continue to be doubts about whether or not they have been suitably implemented¹²³.

In *behaviour therapy*, depression is conceived as the result of a low rate of reinforced behaviour or behaviour that can be reinforced. Here, the therapy is structured, and it focuses on behavioural activation, the objective of which is to get the patient to develop more gratifying behaviours through tasks of gradual exposure and the planning of pleasing activities that are congruent with the patient's objectives, role-playing for dealing with behavioural deficits, etc. Some of these purely behavioural techniques constitute a part of the aforementioned CBTs. NICE²¹ acknowledges growing interest in behavioural activation as a therapy in its own right, but it concludes that the information is insufficient for establishing conclusions due to the fact that the published studies have been scarce and without a placebo control group. A recent, randomised and controlled clinical trial compared CBT, paroxetine and behavioural activation (with augmented techniques for decreasing avoidance behaviours and cognitive rumination). The outcomes suggested the utility of behavioural activation techniques, and in the sub-group of the most severe patients, it obtained outcomes that were similar to antidepressant medication and superior to CBT¹¹⁸.

Problem-solving therapy is a structured and brief form of intervention that is centred on learning to face specific problems frequently associated with depression, and it is considered to be within the scope of behavioural therapies¹²⁹. It has demonstrated its efficacy over placebo in mild depression and within the context of primary care²¹, although there are no reliable, long-term outcomes. It also seems that professionals who are not specialists in mental health could be satisfactorily trained on these techniques²¹. A recent

meta-analysis based on 13 randomised clinical trials affirms that intervention is effective despite the high heterogeneity of the effects, which reflects a possible variability in the outcomes or highly diverse samples¹³⁰.

Counselling is a generic term used to describe a wide range of psychological interventions with different theoretical orientations (psychodynamic, systemic or cognitive-behavioural). The majority focus on the therapeutic relationship itself, in a process that attempts to offer the patient the opportunity to explore and discover more satisfactory ways of life. Counsellors usually receive training on listening with respect, empathy and authenticity, on reflecting on the patients' feelings and on helping to comprehend the meanings of those feelings. There is certain evidence of its efficacy in primary care and for patients with a recent onset of mild to moderate depression²¹.

Couples therapy is a psychological intervention format in which the depressed patient and his or her partner usually participate. It is based on a transactional model of the relationship in which the behaviours of both partners have mutual influence and interact with the depressive symptomatology, which in turn generates changes in the behaviours of those involved. The style of the therapy varies according to the theoretical approach followed by the therapist (for example, cognitive-behavioural or systematic), and it attempts to successfully change the communication between them both and to provide them with new skills for the interpersonal relationship. In the summary provided by NICE²¹, it highlights that there are certain data to the effect that couples therapy is effective treatment against depression when compared with a wait-list condition, and it seems to be better tolerated than antidepressants, although no comparisons with the latter have been established regarding efficacy. Some reviews point out that certain formats of couples therapy have reached efficacy that is similar to individual CBT in dissatisfied couples with one of the partners depressed, but only couples therapy seems to improve the dyadic adjustment. Thus, marital stress could provide an indication for prescribing this type of therapy^{123,131}.

Summary of the evidence

1-	In mild depression, no treatment has been shown to be more effective than problem-solving therapy or different forms of counselling (support, advice, orientation) (21, 128).
2	In mild or mild-moderate depression in which couple difficulties simultaneously exist, couples therapy seems to offer additional advantages over other forms of treatment by improving the marital adjustment (121, 129).

Recommendations

✓	Psychological interventions should be provided by professionals who have experience at managing depression and who are experts in the applied therapy. This is especially important in the most severe cases.
B	In mild and moderate depression, specific and brief psychological treatment (such as problem-solving therapy, cognitive behavioural therapy or counselling) in 6 to 8 sessions during 10-12 weeks should be considered.
B	The preferred psychological treatment for moderate, severe or resistant depression is cognitive behavioural therapy. Interpersonal therapy can be considered as a reasonable alternative.

B	For moderate and severe depression, suitable psychological treatment should include 16 to 20 sessions during at least five months.
B	For moderate depression, either antidepressant drug treatment or suitable psychological intervention can be recommended.
B	Cognitive behavioural therapy should be offered to patients with moderate or severe depression who reject drug treatment or for whom avoiding the secondary effects of antidepressants is a clinical priority or who express that personal preference.
B	Couples therapy should be considered, if applicable, in the event that a suitable response is not obtained with previous individual intervention.
B	Cognitive behavioural therapy should be considered for patients who have not had a suitable response to other interventions or who may have a prior history of relapses or residual symptoms, despite treatment.
B	Cognitive behavioural therapy should be considered for patients who have recurrent depression and who have relapsed despite antidepressant treatment or who express a preference for psychological treatment.
A	For patients whose depression is resistant to pharmacological treatment and/or who have multiple episodes of recurrence, a combination of antidepressants and cognitive behavioural therapy should be offered.
A	A combination of cognitive behavioural therapy and antidepressant medication should be offered to patients with chronic depression.
C	Whenever cognitive behavioural therapy is applied to more severe patients, the techniques based on behavioural activation should be given priority.
C	Psychological interventions other than the aforementioned could be useful for dealing with comorbidity or the complexity of the family relationships frequently associated with the depressive disorder.