Relative efficacy of psychotherapy and combined therapy in the treatment of depression: a meta-analysis

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CRD summary
This well-conducted review found that combined therapy (psychotherapy with pharmacotherapy) yielded better results than psychotherapy alone in the acute treatment of adult psychiatric patients with major depression. Severity and chronicity appeared to be important modifiers in the efficacy of both treatments. The authors' conclusions appear to be reliable.

Authors' objectives
To investigate the relative efficacy of psychotherapy and combined therapy (psychotherapy with pharmacotherapy) for the acute treatment of depression. The aim was to have a high level of clinical homogeneity across the studies.

Searching
The databases MEDLINE, EMBASE, Cochrane Central Register of Controlled Trials, Cochrane Database of Reviews and Protocols and PsycINFO were searched from 1980 to 2005. Search terms were reported. References of the articles retrieved and consulted book chapters (unspecified) about the treatment of depression were also checked. No extra efforts were made to find unpublished data.

Study selection
The authors sought randomised controlled trials (RCTs) comparing psychotherapy with a combination of psychotherapy and pharmacotherapy. Included trials had to focus on the efficacy of acute treatment rather than maintenance or sequential treatment. The trial sample had to consist of psychiatric outpatients aged between 19 and 65 years of age, diagnosed with unipolar depression according to the Diagnostic and Statistical Manual of Mental Disorders (DSM III or DSM IV) or the Research Diagnostic Criteria. Trial treatment protocols were required to involve formal, time-limited (maximum six months) individual psychotherapy and adequate treatment with regular antidepressants (defined in the review). Trials also had to report remission rates and drop-out rates. The main outcome was remission rates at the end of treatment based on a sample consisting of all randomised patients. Methodological quality was also used for trial selection (see below).

Most of the included trials focused on non-chronic depression. No trials of severe depression were located. The duration of interventions ranged from eight to 20 weeks and involved from 16 to 24 sessions.

Two reviewers were involved in the selection of studies for the review with disagreements to be resolved by discussion.

Assessment of study quality
Trials were only included if they were randomised, groups were treated equally apart from the intervention under consideration, intention-to-treat analysis was performed, or differences in drop-outs were specified and outcomes were assessed blind.

Two reviewers were involved in the assessment of quality with disagreements to be resolved by discussion.

Data extraction
Remission and drop-out rates were presented for each trial.

The authors did not state how the papers were extracted, or how many reviewers were involved in the data extraction.

Methods of synthesis
Relative risks and odds ratios were calculated for pooled remission rates. Drop-out rates were pooled by calculating the relative risk. Meta-analysis was conducted with data pooled in a fixed-effect model. Formal tests of statistical heterogeneity were conducted ($\chi^2$ and $I^2$ tests). Analyses were performed for sub-samples according to chronicity and severity of the depression.

**Results of the review**

Seven randomised controlled trials (RCTs) were included in the meta-analysis (n=903 participants). Six trials focused on non-chronic depression, whilst one trial investigated chronic depression. Three trials were of mild depression. Four trials were of moderate depression.

Whilst drop-out rates across the trials ranged from 18 to 36%, pooled drop-out rates for combined therapy (psychotherapy with pharmacotherapy) and psychotherapy alone did not differ statistically. There was no evidence of statistical heterogeneity for this outcome.

The pooled remission rate for combined therapy (46%) was statistically significantly higher than for psychotherapy (34%) (relative risk 1.32, 95% confidence interval: 1.12 to 1.56). There was no evidence of statistical heterogeneity. Based on one trial of patients with chronic depression, remission rates of combined therapy were statistically significantly better than with psychotherapy (48% versus 32%, p<001). In moderate depression, the pooled remission rates were also better with combined therapy (47% versus 34%, p=0.001). In non-chronic depression and in mild depression the pooled remission rates of psychotherapy and combined therapy did not differ significantly.

Further subgroup analyses were presented in the paper.

**Authors' conclusions**

Combined therapy yielded better results than psychotherapy alone in the acute treatment of adult psychiatric patients with major depression. Severity and chronicity appeared to be important modifiers in the efficacy of both treatments.

**CRD commentary**

This review had defined inclusion criteria for participants, intervention, study design and outcomes. A range of databases were searched, but unpublished data were not actively sought, which could leave the review open to publication bias. It was not clear if attempts were made to minimise language bias. Study quality was assessed and used as inclusion criteria. The meta-analysis appeared to be appropriate, given the attempts to ensure homogeneity across the review and subsequent tests of statistical heterogeneity. Two reviewers were involved in the review process, which helped to minimise errors and bias. The review appears to be well conducted and conclusions reliable.

**Implications of the review for practice and research**

The authors did not state any implications for practice or further research.

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