CRD summary
The authors concluded that there is currently a lack of evidence from randomised controlled trials to demonstrate the effectiveness of massage therapy in the treatment of depression in populations with depression or subsyndromal symptoms of depression. In light of the methodological weaknesses of the included studies, the authors’ conclusions are appropriate.

Authors' objectives
To evaluate the effectiveness of massage therapy (MT) in the treatment of depression.

Searching
PubMed, EMBASE, Scopus, ISI Web of Science, the Cochrane CENTRAL Register, PsycINFO, CINAHL and AMED were searched from inception until June 2006; the search terms were reported and no language restrictions were applied. The references of retrieved articles were also checked.

Study selection
Randomised controlled trials (RCTs) of classical European (Swedish) MT delivered over more than one session were eligible for inclusion. Trials of self-massage or using mechanical devices were excluded. Trials of MT as part of a multi-component therapy were excluded unless the study design enabled evaluation of MT alone. The included studies were of MT delivered by a trained therapist, psychology students, or participants' significant others following training by a therapist. Sessions lasted 20 to 30 minutes and the number delivered ranged from 5 to 32. Control conditions in the included studies were relaxation therapy, watching a relaxing videotape, depression-specific acupuncture (DSPEC), non-specific acupuncture (NSPEC), or prenatal care as usual. Studies of people with a depressive disorder or subsyndromal depressive symptoms (SSD) were eligible for inclusion. Studies were excluded if they included participants with bipolar disorder or cyclothymic disorder. The included trials were of adolescents with depression or dysthymia, adolescent mothers with dysthymia, and pregnant mothers with depression. Studies of depression or SSD measured pre- and post-treatment were eligible for inclusion. Physiological measures were excluded. The outcome measures evaluated in the included studies were Profile of Mood States, Behaviour Observation Scales, Centre for Epidemiological Studies Depression Scale, the Beck Depression Inventory (BDI) and the Hamilton Rating Scale for Depression (HRSD).

Two reviewers independently selected the studies. Studies were only included if both reviewers reached agreement.

Assessment of study quality
Methodological quality was assessed using a modified version of the Jadad scale. One item was adapted such that 1 point was allocated for blinding of the outcome assessor rather than for double-blinding; this resulted in a maximum achievable score of 4 rather than 5. Additional information was collected on allocation concealment, baseline comparability, number of withdrawals, intention-to-treat analysis and power calculations.

Two reviewers independently assessed validity.

Data extraction
Where possible, data were extracted to calculate the odds ratios (ORs). Two reviewers independently extracted the data, with any disagreements resolved through discussion.

Methods of synthesis
A narrative synthesis was provided.

Results of the review
Four RCTs (n=185) were included.

Two trials scored 1 point on the Jadad scale, one scored 2 and one scored 3. Allocation concealment, intention-to-treat analysis and power calculations were either not clear or not used for all trials. Three studies used groups that were similar at baseline on prognostic indicators.

One study compared MT with acupuncture. MT was less effective than DSPEC in reducing symptoms of depression, as measured by the BDI in the 8-week acute phase (number-needed-to-treat effect size 2.7, 95% confidence interval, CI: 1.5, 16, p=0.03). DSPEC showed a greater rate of improvement in symptoms compared with MT in the first month of treatment (t=1.72, p=0.047 and d=0.70), but there was no difference between the two treatments in the second month. There was no difference between MT and NSPEC in numbers of participants responding to treatment (OR 0.51, 95% CI: 0.14, 1.92). MT was as effective as DSPEC and NSPEC in achieving full remission, as defined by a score on the HRSD of 8 or less (OR 0.33, 95% CI: 0.05, 2.10 and OR 2.00, 95% CI: 0.49, 8.24, respectively).

Three studies of MT versus relaxation provided insufficient data to enable a comparison of MT and watching a relaxing video or combined yoga and progressive muscular relaxation (PMR) therapy. One study reported a significant benefit of MT administered by significant others compared with PMR in pregnant women with depression (p<0.001).

**Authors’ conclusions**

There is currently a lack of evidence from RCTs to demonstrate the effectiveness of MT in the treatment of depression in participants with depression or SSD.

**CRD commentary**

The inclusion criteria for the participants, intervention, outcomes and study design were clearly defined and several relevant databases were searched. No language restrictions were applied, thereby minimising the risk of language bias. There were no specific attempts to identify unpublished material, although some databases did cover grey literature, therefore it is not possible to rule out publication bias. Appropriate steps were taken in the study selection, validity assessment and data extraction processes to rule out reviewer error and bias. In light of the methodological weaknesses of the included studies, the authors’ cautious conclusions are appropriate.

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

**Practice:** The authors stated that patients using or considering using MT as a treatment for depression should be informed about the current evidence for effectiveness. Whilst MT is generally safe, the therapist should be aware of the potential indirect risks, such as hindering access to mainstream services.

**Research:** The authors stated that further trials of MT as a treatment for depression should improve upon the current methodological and reporting limitations.

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**Bibliographic details**


**Other publications of related interest**


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Record Status
This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.