Debate about outpatient treatment of unipolar depression is characterized by tensions between science and the marketplace and by ideological differences between and within the major mental health professions. Billions of dollars are spent annually on sales and marketing of antidepressant medications; the pharmaceutical industry also funds research, but it controls whether to submit results of funded clinical trials for publication. Funding for psychotherapy research and marketing is scant in comparison.

Ideologically, psychiatrists overall are commonly viewed as major proponents of medication for depression, whereas psychologists are viewed as stronger advocates of psychotherapy. Even within psychiatry, however, the biological and psychoanalytic factions disagree as to the best treatment for depression; and within psychology, debate is under way about pursuing prescription privileges.

In the competition to treat this illness, the stakes are high, not only in direct financial ways but also indirectly: when untreated, depression costs billions of dollars in lost productivity, and the cost in human suffering is immeasurably high. Because of these high stakes and the potential of marketing and ideological forces to control the debate, it is essential that clinicians be aware of the latest research findings comparing psychotherapy and medication treatment for depression, as well as combined treatments.

The purpose of this column—the first in a series—is to provide an update on the latest research and thinking on this topic. I will summarize and comment on all the major review articles I could find that were published in this decade.
The review of research on the treatment of major depression reaches these conclusions: 1) most studies find equivalence or superiority of psychotherapy compared with tricyclic antidepressant medication; 2) the data on possible additive or synergistic effects of combined medication and psychotherapy treatments are inconsistent; 3) the apparent equivalent efficacy of different psychotherapy models may be due to their shared characteristics, including a time-limited contract, an active therapist, and the focused nature of the psychotherapy; 4) antidepressants, as compared with placebo or psychotherapy, were most efficacious in symptom reduction and relapse prevention, but psychotherapy was more effective in resolving problems in living, social functioning, and interpersonal relationships; and 5) medication does not decrease a patient’s interest in psychotherapy and does not lead to early termination or poor response; nor is there a negative effect of psychotherapy on medication treatment.

Comment: An excellent starting point for readers not familiar with core contextual issues relevant to studies comparing psychotherapy versus medication versus combined treatments. The review of results does not include the studies summarized below, except for Manning et al.

Combined Treatment Is Not Superior to Psychotherapy or Medication Alone


The authors analyze multiple independent studies of unipolar depression, emphasizing the clinical application of the results. The focus is on three studies in which three treatment groups were compared: pharmacotherapy alone, psychotherapy alone, and combined pharmacotherapy and psychotherapy. In addition, four other studies that compared only two of the above treatment conditions are analyzed.

The seven studies were relatively homogeneous in the following ways: each reported the number of patients with either a robust positive response to treatment or a poor response; the same rating scale was used in each (Beck Depression Inventory); and similar cutoff scores were used to determine treatment outcome. In addition, each treatment lasted 12 to 16 weeks. The pharmacotherapy treatments included either amitriptyline or imipramine, with daily doses between 200 and 300 mg. These patients were seen weekly for 15 to 30 minutes and provided with support, encouragement and advice. Symptoms and clinical state were also monitored. The psychotherapy groups were primarily cognitive or interpersonal, although one study included a dynamic treatment. Therapy was conducted weekly in one-hour sessions. Analyses focused on treatment success, failure, and dropout rates.

The most noteworthy finding is that combined treatment was no more successful than psychotherapy alone, but did offer a modest advantage over pharmacotherapy alone. In other analyses, pharmacotherapy was associated with significantly more treatment failures and higher dropout rates than psychotherapy alone or combined therapy. On the basis of cost-effectiveness and side-effect considerations, the authors conclude that psychotherapy alone should usually be the initial treatment.

Comment: Strengths of this analysis are the homogeneity of the studies compared; the statistical sophistication; the use of objective criteria to determine treatment success or failure; and, most important, the direct application of the results to clinical practice. Weaknesses are the relatively small number of studies compared; the lack of adjustment for researcher allegiance to a particular treatment; and the sole reliance on patient ratings of treatment outcome. The latter measure has consistently been associated with a conservative bias in estimating treatment success.1 None of the outcome studies investigated the newer selective serotonin reuptake inhibitors. These agents may be associated with less dropout and a smaller failure rate. In addition, the results may not extend to severe or chronic depression. In general, however, the study disconfirms clinical lore that combined treatment is more efficacious than pharmacotherapy or psychotherapy alone.

Combined Treatment Is No Less Effective Than Psychotherapy or Medication Alone

Seventeen studies of randomly assigned treatment for nonpsychotic major depression are analyzed. Each study compared the combination of therapy and medication with one or both of these treatments delivered alone. Treatment lengths varied between 6 and 20 weeks. Medication treatment was primarily tricyclic antidepressant medication; psychotherapy treatments varied widely, from individual to group, marital, dynamic, interpersonal, and cognitive-behavioral. The authors used a box score method for comparing the studies. Each study was categorized according to whether the effect of combined therapy was more effective than, less effective than, or equally effective to comparison treatments.

The most striking result is that no study found combined treatment less effective than psychotherapy or medication alone. The authors report that combined therapy outperformed medication alone 40% of the time and psychotherapy alone 39% of the time. They interpret these results as suggesting that combined therapy is superior to either treatment delivered alone. A further conclusion is that their results provide hints that medication works faster, but that psychotherapy endures longer than acute psychopharmacologic treatment.

The authors recommend initial psychotherapy alone for mild depression, initial medication only for severe depression, and combined therapy for cases lying between the extremes. Combined treatment is also recommended when it has worked previously, when the depression is chronic, and when the patient prefers it.

Comment: A strength as well as a weakness of this analysis is that many studies are included in the review. The sample size of 17 studies potentially adds statistical power to the results. However, no inferential statistical analyses are carried out. The box score method was not used as a basis for estimating the statistical significance of the counts—a key difference from the Wexler and Cicchetti study discussed above. Even though 40% of the comparisons showed combined therapy to outperform either psychotherapy or medication alone, no statistical test of the significance of this finding is offered. The heterogeneity of the 17 studies gravely complicates the comparisons. For example, six studies appear to have employed psychotherapy primarily as a placebo condition. The quality of the therapy delivered was not discussed. Manning et al. acknowledge that their recommendations are based on their clinical experience and are largely unsupported by research. Notwithstanding the authors’ acknowledged preference for combined treatment in some cases, the strongest finding is consistent with other reviews: research has not demonstrated with inferential statistics that combining psychotherapy with medication has an advantage over either treatment alone.

Cognitive Therapy and Pharmacotherapy Are Equally Effective, Singly and in Combination


One hundred seven depressed patients were randomly assigned to 12 weeks of imipramine treatment, cognitive-behavioral therapy, or a combination of the two. Those undergoing imipramine treatment received dosages averaging 200–300 mg per day; they averaged 8.8 sessions across 11.4 weeks of treatment. Those completing cognitive-behavioral therapy averaged 14.9 sessions in 11.5 weeks (maximum of 20 sessions). No differences in the delivery of each treatment received were observed for those in the combined condition. For the 64 who completed treatment, no differences were observed in outcome; all three treatments were comparably effective. There was a nonsignificant trend for those in the combined treatment to end treatment with somewhat lower scores on depression measures. Severely depressed patients responded equally well, regardless of treatment condition. Three patients made suicide attempts using study medications; two of these patients died.

Comment: A rigorous, well-controlled study that again demonstrates the equivalence of medication, psychotherapy, and combined treatment for acute unipolar depression, regardless of severity. The authors believe their study lacked sufficient power to detect a modest advantage of combined treatment. Unlike those reviewed by Wexler and Cicchetti, this study found no differential dropout rate based on treatment condition. The study reports mean group differences only; it does not indicate the proportion of responders and nonresponders in each condition.
Psychotherapy:
There Is No Stronger Medicine
for Depression


The article reviews a wide range of well-controlled studies comparing psychological and pharmacological treatments for depression. Findings suggest that with the possible exception of dynamic therapy, which has not been compared extensively with medication, there is at least equivalence between medication and psychotherapy for treating depression, even if severe. The authors summarize six meta-analyses published between 1983 and 1992, and representing results from thousands of treated patients. The results again confirm equivalence, with the possible additional finding that cognitive therapy may reduce risk of relapse. Their conclusions extend to both vegetative and social symptoms, especially when patient-rated measures are used and long-term follow-up is considered. The authors recommend that psychotherapy, particularly cognitive-behavioral therapy or interpersonal therapy, be considered the treatment of first choice for depression. This conclusion is based on equivalence of treatment outcome, coupled with greater risks associated with medication.

Comment: Findings are similar to those presented in earlier studies. Among the studies discussed above, this one provides the most comprehensive review of the outcome literature.

SUMMARY

Most studies found that psychotherapy is equivalent or superior to tricyclic antidepressant medication. Research has not shown that combining psychotherapy and medication is more effective in treating unipolar depression than is either treatment alone. Further, medication does not negatively affect psychotherapy, nor does psychotherapy negatively affect medication. These conclusions apply primarily to acute episodes of depression, regardless of severity. Most of the studies reviewed did not systematically examine severity or chronicity, but those that did investigate severity showed no differences between combined treatment and either medication or psychotherapy alone, or between medication and psychotherapy. The reason combined treatment has not been shown to be more effective than individual treatment may be that psychotherapy and medication are each highly effective, leaving little room for additional improvement when one is added to the other.

When treating unipolar depression, clinicians should recognize that combined treatment is neither indicated nor contraindicated by the empirical literature. The treatment decision should take into account patient preference, relative side effects, relative treatment costs, and the relatively little empirical information available regarding chronic depression.

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REFERENCE