Review: cognitive therapy has a beneficial effect equivalent to behaviour therapy and that of antidepressants in patients with mild to moderate depression


Question
In patients with mild to moderate depression, is cognitive therapy (CT) an effective treatment?

Data sources
Studies were identified by searching Medline and EMBASE/Excerpta Medica; scanning the bibliographies of identified papers and books; referring to previous reviews; reviewing the abstracts from congress presentations; and preprints sent by authors.

Study selection
Studies were selected if they were randomised controlled trials with ≥1 CT group and 1 comparison group (waiting list, placebo, antidepressants, behaviour therapy, or another psychotherapeutic treatment) in patients who had major depression or dysthymic disorder, with the exclusion of psychotic depression and bipolar affective disorder.

Data extraction
Data were extracted on patient characteristics, treatment conditions, and severity of depression after treatment measured using the Beck Depression Inventory (BDI).

Main results
78 trials were identified of which 48, including 2765 patients, met the selection criteria. In the 20 studies that compared CT with waiting list or placebo, the average patient in the CT group was 29% better than the average patient in the control group after treatment (effect size 0.82, p < 0.001). In the 17 trials that compared CT with antidepressants, the average patient in the CT group was 15% better than the average patient in the antidepressant group after treatment (effect size 0.38, p < 0.001). In the 22 trials that compared CT with a group of miscellaneous therapies (including psychodynamic therapies, interpersonal therapies, non-directive, supportive, relaxation, and alternative bibliotherapy), the average patient in the CT group was 10% better than the average patient in the other therapies group after treatment (effect size 0.24, p < 0.01). There was no significant heterogeneity* in the results of studies comparing CT v antidepressants, or CT v other therapies. In the 13 trials that compared CT with behaviour therapy, no difference existed between groups (effect size 0.07, p = 0.95), but there was evidence of significant heterogeneity* between studies (p < 0.001). In multiple regression analysis, after adjustment for type of treatment, no association was found between the effect size and BDI score, sex, and age. In the 8 trials that allowed a comparison of CT with antidepressants at 1 year follow up, 5 of the 8 studies suggested a preventive effect of CT on relapse rate.

Conclusion
In patients with mild to moderate depression, cognitive therapy has a beneficial effect equivalent to that of behaviour therapy and that of antidepressants and a group of other miscellaneous therapies.

*Heterogeneity means that there is greater variation in the results of the trials than would be expected by chance variation alone, and the pooled estimate must be interpreted with caution.

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Commentary
The conclusion about the efficacy of CT for depression is no longer tentative. For mild to moderate depression, it may even be the treatment of choice. Scientific evaluation of the effectiveness of different modes of treatment is welcome news for the clinician. This is especially meaningful when emerging conventional clinical wisdom is supported by research. Clinicians seem comfortable with the conclusion that for mild to moderate depression patients can be offered the choice of short term therapy (cognitive or behavioural) or medication. This review by Gloaguen et al supports those who believe that cognitive behavioural therapy should be the treatment of first choice for depression.

The comparison of CT with behaviour therapy and other psychotherapies leads the reader to the “specific, non-specific” factors debate of what is central to therapeutic change. This debate has recently been discussed by Oei and Shuttlewood in the area of CT for depression and remains a controversial issue. The suggestion that “cognitive modification” is the specific factor in the treatment of depression was not supported by the analysis by Gloaguen et al. This was attributed to the use of a number of similar strategies by both CT and behaviour therapy.

An additional point of interest in this review is the suggestion of a preventive effect of CT on relapse rate. The possibility that treating depression with CT or behaviour therapy may reduce the risk of relapse or perhaps the need for further treatment is considered by some to be one of the most exciting outcomes of research in this area because recurrence of depressive episodes is not uncommon after successful treatment.

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1 Antonuccio DO, Danton WG, De Nelksy GY. Psychotherapy versus medication for depression: challenging the conventional wisdom with data. Professional Psychology: Research and Practice 1995;26:574–85.
OTHER ARTICLES NOTED

The journals that are reviewed and the criteria for selecting articles from these journals for inclusion in *Evidence-Based Mental Health* are set out in the purpose and procedure in each issue. All articles that meet our criteria in the reviewed journals are cited in *Evidence-Based Mental Health*, but there is not enough space to abstract them all. The following articles passed all criteria but were not abstracted because, in the judgment of the editors, their findings were less widely applicable to clinical practice in the area of mental health.

**Therapeutics**


**Diagnosis**


**Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study.** Spitzer RL, Kroenke K, Williams JBW, and the Patient Health Questionnaire Primary Care Study Group. *JAMA* 1999 Nov 10;282:1737–44.

**Prognosis**

**Minor and major depression and the risk of death in older persons.** Penninx BWJH, Geerlings SW, Deeg DJH, et al. *Arch Gen Psychiatry* 1999 Oct;56:889–95.

**Aetiology**


**Charting the relationship trajectories of aggressive, withdrawn, and aggressive/withdrawn children during early grade school.** Ladd GW, Burgess KB. *Child Dev* 1999 Jul-Aug;70:910–29.


**Qualitative**


**Correction**

In the August 1998 issue of *Evidence-Based Mental Health*, 2 errors were detected in the abstract for the article by Gloaguen *et al* (p 76). In the main results section of the abstract, we indicate that there was no significant heterogeneity in the results of studies comparing cognitive therapy (CT) *v* other therapies when in fact there was. Furthermore, we indicate that there was significant heterogeneity in the results of studies comparing CT *v* behaviour therapy when in fact there was not.