Evidence Profile

Authors & year	Design	Intervention (I) and Comparison (C)	Country	Intervention Delivery methods, frequency, duration, (delivered to)	Depression Diagnosis	Primary Outcome domain (Measure(s))	Secondary Outcome domain (Measure(s))	Characteristics of Sample	Participants	
									I	C
COGNITIVE THERAPIES										
Cognitive Behavioural Therapy (CBT)										
Mohr, C.; Ho, Duffecy, Reifler, Sokol, Burns, Jin & Siddique, 2012	RCT	(I): Telephone-administered cognitive behavioural therapy (T-CBT) (C): Face-to-face cognitive behavioural therapy (CBT)	USA	18 weekly sessions. T-CBT patients attended significantly more sessions (mean 16) than those receiving CBT (mean 14) (Individual)	Met criteria for MDD and scored ≥16 on Ham-D	Discontinuation vs. non-discontinuation of treatment before week 18	Depression symptoms (HRSD; PHQ-9)	N = 325	N = 163 age (M=48, SD=14) 77% female	N = 162 age (M= 48, SD=13) 78% female
Significantly fewer participants discontinued T-CBT (20.9%) before session 18 compared with CBT (32.7%). Participants showed significant improvement in depression symptoms across both treatments, but there were no significant post-treatment differences between treatments. At six-months follow-up, participants who had received CBT were significantly less depressed than those who had received T-CBT. No harm or adverse effects were reported										
Serfaty, Haworth, Blanchard, Buszewicz, Murad & King, 2009	RCT	(I): Cognitive behavioural therapy (CBT) + TAU (GP contact) (C): Talking control group + TAU (GP contact) (C): TAU (GP contact)	UK	Up to 12 (average of seven) 50 minute sessions (Individual)	Geriatric Mental State Diagnosis of Depression	Depression symptoms (BDI-II)	Anxiety (BAI) Social functioning (SFQ) Quality of life (Euroqol)	N = 204 Aged ≥65	N = 70 age (M=74, SD=8) 84% female	N = 67 (Talking control group + TAU) age (M=75, SD=7) 75% female N = 67 (TAU) age (M=73, SD=6) 79% female

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Greater post-treatment improvements in BDI-II scores were found for the CBT group relative to both the talking control + TAU group and the TAU only group, and these findings were maintained at 10 months post-commencement. No harm or adverse effects were reported.										
GUIDELINES: CBT effective; ***CBT has the largest dataset and shows broad equivalence of effect across the range of severity of depression; however brief CBT not recommended*** **(NICE, 2010)**										
Rational Emotive Behavioural Therapy (REBT)										
Sava, Yates, Lupu, Szentagotai & David, 2009	RCT	(I): Rational emotive behavioural therapy (REBT) (I): Cognitive therapy (CT) (C): Fluoxetine and brief weekly psychiatrist appointments	Romania	An average of 18 (maximum of 20) 50-minute therapy sessions over 14 weeks (Individual)	Met criteria for MDD on DSM-IV and ≥20 on BDI and ≥14 on HRSD	Depression symptoms (BDI; HRSD)		N = 170 68% female	N = 57 (REBT) age (M=35, SD=13) N = 56 (CT) age (M=39, SD=10)	N = 57 (fluoxetine) age (M=37, SD=2)
Depression scores had improved for all three groups at post-treatment. All three treatments performed equally well, and effects were maintained at six months follow-up. No harm or adverse effects were reported.										
GUIDELINES: ***REBT no commentary towards recommendations stated ; one RCT on REBT (REBT vs. antidepressant) included in guidelines, no other information is provided regarding REBT; (NICE, 2010)***										
INTERPERSONAL PSYCHOTHERAPY										
Carter, Luty, McKenzie, Mulder, Frampton & Joyce, 2011	RCT	(I): Interpersonal psychotherapy (IPT) (I): Cognitive behavioural therapy (CBT)	New Zealand	Up to 19 weekly sessions, with a minimum of eight. (Individual)	Principal current diagnosis of MDD via DSM-IV	Patient predictors of response to CBT and IPT for depression (MADRS)	NA	N = 177	N = 91 (IPT) age (M=35, SD= 11) 76% female N = 86 (CBT) age (M=35, SD=10) 69% female	
There were no significant differences in the mean pre-treatment, post-treatment and percent improvement on the MADRS by therapy modality. No harm or adverse effects were reported.										

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Power & Freeman, 2012	RCT	(I): Cognitive-behavioural therapy (CBT) (I): Interpersonal psychotherapy (IPT) (C): TAU (GP contact)	UK	16 sessions (IPT) 12-16 sessions (CBT) (Individual)	DSM SCID Diagnosis of Depression	Depression symptoms (BDI-II; HRSD)		N = 125	N = 46 (CBT) N = 54 (IPT)	N = 25
Depression scores had improved for all three groups at post-treatment. IPT and CBT performed better than TAU. In some analyses IPT performed slightly better than CBT. There were no differences between groups in depression symptoms five months post-treatment. No harm or adverse effects were reported.										
Talbot, Chaudron, Ward, Duberstein, Conwell, O'Hara, Tu, Lu, He & Stuart, 2011	RCT	(I): Interpersonal psychotherapy (IPT) (C): TAU (biweekly individual sessions using a variety of interventions including supportive, cognitive–behavioural or dialectical–behavioural, integrated/eclectic and client-centred approaches)	USA	Up to 16 sessions (average of 13) over 36 weeks (Individual)	Structured clinical interview for Axis-I DSM-IV Disorders	Depression symptoms (HRSD; BDI-II)	PTSD symptoms (Modified PSS-SR) Mental health-related functioning (SF-36) Social functioning (SAS-SR) Shame (DES)	N = 70 Women with histories of childhood sexual abuse	N = 37 age (M=39, SD=11)	N = 33 age (M=34, SD=8)
Compared with women assigned to TAU, women who received IPT had greater reductions in depressive symptoms on both measures at post-treatment. No harm or adverse effects were reported.										
GUIDELINES: IPT effective; ***"for many patients with mild to moderate depression IPT is an appropriate alternative to CBT" (pp. 294); dataset not as large as that for CBT; recommendations not as broad in scope as for CBT (NICE, 2010)***										
BEHAVIOURAL ACTIVATION										
Ekers, Richards, McMillan, Bland & Gilbody, 2011	RCT	(I): Behavioural activation delivered by a non-specialist (C): TAU (GP or primary care mental health worker)	UK	Twelve 1-hour sessions over three months (48% received all 12 sessions)	Clinical Interview Revised (CISR) to confirm an ICD-10 Diagnosis of Depression	Depression symptoms ((BDI-II)	Functioning (WSAS); satisfaction (CSQ-8)	N = 47	N = 23 age (M=46, range 24-63) 65% female	N = 24 age (M=43, range 28-63) 58% female

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				(Individual)						
BDI-II scores for the BA group had decreased significantly compared to the control group at post-treatment. No harm or adverse effects were reported.										
GUIDELINES: ***"The GDG decided that although the evidence was not sufficiently robust to recommend behavioural activation as a direct alternative individual treatment option to CBT or IPT, it could be considered an option" (pp. 293; NICE, 2010)***										
SHORT-TERM PSYCHODYNAMIC PSYCHOTHERAPY										
Johansson, Ekbladh, Hebert, Lindström, Möller, Petitt, Poysti, Larsson, Rousseau, Carlbring, Cuijpers & Andersson, 2012	RCT	(I): Internet-based psychodynamic guided self-help treatment (C): Structured support intervention (psychoeducation and weekly online contact)	Sweden	Nine modules, including weekly contact with therapist, over ten weeks. 78% of participants completed all modules. (Individual)	15-35 on self-rated Montgomery-Asberg Depression Rating Scale (MADRS-S) and Diagnosis of MDD on DSM-IV with current acute episode of depression OR an episode in partial remission	Depression symptoms (BDI-II)	Depression symptoms (MADRS-S; PHQ-9). Anxiety (BAI; GAD-7). Quality of life (QOLI). Global improvement (CGI-I)	N = 92 (75% female)	N = 46 age (M=46, SD=15) 80% female	N= 46 age (M=46, SD=13) 70% female
The intervention group displayed continuous within-group improvements throughout the trial. The effect size between the groups at post-treatment was large .Mixed-effect model analyses showed a significant interaction effect of group and time. No harm or adverse effects were reported										
GUIDELINES: : ***"…short-term psychodynamic psychotherapy may be considered for people with mild to moderate depression who have declined an antidepressant, CBT, IPT, behavioural activation or behavioural couples therapy, that that the limited evidence should be drawn to the attention of the healthcare professional." (pp. 296; NICE, 2010)***										