



Best Practice

Evidence Based Practice Information Sheets for Health Professionals

Group and Individual Therapy in the Treatment of Depression

Introduction

It has been estimated that one in every eight individuals may require treatment for depression at one point in their lifetime. Depression if untreated can lead to reduced social functioning, illness and even death. However, with the correct interventions depression can be successfully treated in most individuals. In recent guidelines psychotherapy is not seen as a frontline measure in the treatment of major depression. It has been recommended that pharmacotherapy or combined psychotherapy and pharmacotherapy be the treatments of choice in these people. However, although nurses are generally part of a multi-disciplinary team and have some input into pharmacotherapeutic treatment, drug prescribing is not generally an option for nurses. Furthermore, the initial goal of any treatment of depression is to reduce the severity of the depression as quickly as possible in order for the patient to respond to further treatment.

This Practice Information Sheet Covers The Following Concepts

- Introduction
- Quality of Research
- Treatment of Depression in Adults
- Treatment of Depression in Adolescents

Glossary

Beck Depression Inventory (BDI) - A 21 item self report of depressive symptoms (score 0-63). The larger the score the greater the severity of depression.

Hamilton Rating Scale for Depression (HRSD) - A 17 item psychiatric rating scale widely used to assess severity of depression (score 0-50).

Levels of Evidence

All studies were categorised according to the strength of the evidence based on the following classification system.

- **Level I** Evidence obtained from a systematic review of all relevant randomised controlled trials.
- **Level II** Evidence obtained from at least one properly designed randomised controlled trial.
- **Level III.1** Evidence obtained from well designed controlled trials without randomisation.
- **Level III.2** Evidence obtained from well designed cohort or case control analytic studies preferably from more than one centre or research group.
- **Level III.3** Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments.
- **Level IV** Opinion of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Cognitive behavioural therapy (CBT), a form of psychotherapy, can be regarded as a non-pharmacologic intervention that can provide depressed subjects with the skills with which to manage their own illness. However, the usefulness of CBT as an intervention in moderate to

severely depressed patients has not been adequately evaluated. Therefore, the aim of this best practice information sheet is to summarise the best available evidence for the use of individual or group CBT in people suffering from moderate to major depression.

Quality of Research

The randomised control trial (RCT) is considered the clearest scientific method for judging efficacy of a treatment when compared to an established treatment or control. Due to the large volume of RCT available on this topic, this panel considered only published peer reviewed RCT in the preparation of this practice information sheet and in the development of practice guidelines.

The purpose of this report was to examine the effectiveness of group or individual cognitive behavioural therapy on subjects presenting with moderate to major depression. Therefore, only studies that evaluated subjects with Beck Depression Inventory (BDI) scores of ≥ 14 were included.

In searching for studies on group and individual therapy for the treatment of depression the psychotherapeutic treatment most often utilised was cognitive behavioural therapy (CBT). The number and types of treatment protocols that have been evaluated were numerous, and a summary of them is presented in Table 1. Finally, due to subtle differences between cognitive therapies with and without explicitly stated behavioural components the panel of experts decided that all individual and group therapies of a cognitive type would be classed as forms of CBT.

Table 1: Description of Interventions

A summary of approaches as described by the systematic review of the research

Cognitive Group Therapy (CGT)

- Involved distancing, cognitive restructuring, and behavioural hypothesis-testing procedures.
- Consists of three modules: (1) progressive relaxation, (2) cognitive restructuring and (3) assertion training.
- Techniques to improve the cohesiveness of the group by dealing with negative thoughts about group treatment and anticipating negative responses from group members.
- Consists of emotional support, relaxation training, assertion training, cognitive restructuring, thought stopping, behavioural homework assignments, bibliotherapy, and didactics.

Individual Cognitive Therapy (ICT)

- Involved distancing, cognitive restructuring, and behavioural hypothesis-testing procedures.
- Consists of three modules: (1) progressive relaxation, (2) cognitive restructuring and (3) assertion training.
- Consisting of verbal and behavioural techniques to aid subjects in (a) recognising relationships between cognitions, affects, and behaviours; (b) monitoring negative thoughts; (c) examining evidence for and against each distorted thought; and (d) substituting reality-oriented interpretations for maladaptive, distorted thinking.
- The use of strategies and techniques to help identify and correct, negative and distorted views of themselves.
- An active, directive, time-limited, structured approach used to treat depression. The therapeutic techniques are designed to identify, reality-test, and correct distorted conceptualisations and the dysfunctional beliefs underlying these cognitions.
- Five cognitive processes relating to adaptive depression management, 1) positive self-evaluation, 2) precise self-reporting of affect, 3) adaptive reaction to stress, 4) effective choice making and 5) assuming non-punitive responsibility for behaviour.

Pharmacotherapy

- Imipramine at a dosage of at least 150 mg per day.
- 50 then 75mg of nortriptyline (a tricyclic antidepressant) per day.
- Not less than 150 mg/day of amitriptyline or doxepin.
- Amitriptyline or clomipramine at 150 mg/day.

Coping with Depression Course

- An eight week course of 12 sessions of 2 per week for the first 4 weeks and then once a week for the remaining 4 weeks. The first two sessions of the course addressed the social learning approach to depression and provided instruction on self-change skills. The next eight sessions included instruction on how to: relax, increase pleasant activities, change aspects of thinking and improve social skills and group interactions. The final 2 sessions involved getting the patient to use the skills they had learned, and found to be most useful, to develop a life plan. Used for both group and individual therapies.

Individual Psychotherapy (IP)

- Techniques to help the patient to identify and better understand their interpersonal problems and conflicts and to develop more adaptive ways of relating to others.

Computer Assisted Therapy (Therapeutic Learning Program or TLP)

- Computer assisted interactive program that enables the subject to identify and describe inter and intra-personal conflicts and behaviours which block their problem solving ability and personal growth. The patient is required to pose an action step to reduce personal stress and then to report their progress to the therapist and the group. The first 30-40 minutes of the session was devoted to the computer work with a summary of the segment at the end for the therapist to review. The remainder of the session was used to process, as a group, those issues associated with the segment.

Waiting List With Medication Support (MS)

- Group continued to see their psychiatrist weekly to receive medication and support. They were given no structured therapy related to depression management.

Waiting List With No Other Treatment

- Waiting list control subjects were told they could begin treatment after 14 weeks and could call for an appointment for therapy in the interval if needed.

Waiting List With Support (Treatment as Usual)

- Continued to receive treatment from their referring physician and were not appraised of treatment allocation.
- Treated by their personal physician, some patients were taking antidepressant medication.

Treatment of Depression in Adults

Numerous non-pharmacologic therapies have been evaluated for the treatment of chronic depression of adults. The following discussion examines:

- the effectiveness of therapies to reduce depression (as measured by the Beck Depression Inventory (BDI), a self report measure, and the Hamilton Rating Scale for Depression (HRSD), an independent assessor score) and
- comparisons of the effectiveness of treatment modalities to reduce depression scores.

Cognitive Behavioural Therapy versus Pharmacotherapy

Pharmacotherapy is an accepted and often frontline treatment for depression. Recent guidelines have stated that psychotherapy alone should not be attempted with chronic, severely depressed subjects. Recommendations to clinicians suggest the use of combined therapy (psychotherapy and pharmacotherapy) or pharmacotherapy alone. However, with this form of treatment comes the possibility of unwanted side effects. Therefore, several studies sought to determine how individual cognitive therapy (ICT) would compare to pharmacotherapy or combined therapy in the treatment of chronic depression.

Individual Cognitive Therapy versus Pharmacotherapy

When individual cognitive therapy is compared to the treatment of moderate to major depression (mean BDI of 27-30) with medication alone both treatment modalities were found to be effective in reducing depression scores after treatment and at follow-up. Neither therapy was found to be significantly more effective than the other and an examination of the number of patients that obtained normal depression scores at the end of treatment also showed no significant differences between the two treatments.

However, caution must be used in the interpretation of these studies. The pharmaceuticals used in these studies predate popular use of a new generation of drugs such as selective serotonin reuptake inhibitors (SSRI), which are considered to have fewer side effects but are equally as effective at reducing the symptoms of depression. Therefore, it is imperative that studies evaluating the effectiveness of cognitive behaviour therapy and this new class of drugs be performed.

Individual Cognitive Therapy versus Individual Cognitive Therapy Combined with Pharmacotherapy

Several studies have assessed the effectiveness of psychotherapy alone when compared to combined therapy. Results suggest that both treatments were effective in reducing depression scores and that there was no significant differences in effectiveness between the two treatments.

Cognitive Behavioural Therapy versus Waiting List

Several studies evaluated the effectiveness of group or individual therapy, compared to waiting list control subjects with or without their usual medical support structure.

Individual Cognitive Therapy versus Waiting List with Medication Support

Waiting list controls were provided with pharmaceutical support while waiting to be treated for depression. One study revealed that ICT significantly reduced BDI scores over the period of treatment while the control did not. The effect of treatment continued through to follow-up. Also, ICT was significantly more effective at reducing BDI scores than was Medication Support from pre to post-treatment and follow-up. However, because of the small number of subjects in this study the results should be regarded with caution.

Cognitive Individual and Group Therapy versus Waiting List with Support (treatment as usual)

“Treatment as usual” subjects continued to receive treatment from their referring physician while waiting for psychotherapy and some continued to receive medications over the period of the study.

Several studies were examined and results were found to be contradictory. Results of one study reported that both ICT and waiting list groups showed significant improvement in depression scores. At follow-up, while wait

ing list scores continued to drop significantly, compared to both pre and post-treatment: the ICT group showed a significant increase in depression scores compared to post-treatment. However, follow-up values remained significantly lower than pre-treatment scores.

In another study ICT and CGT significantly improved depression scores at post-treatment compared to pre-treatment that continued through to follow-up. Control subjects however showed no significant improvement in depression scores at any measured time point.

A measure of the effectiveness of a treatment can also involve the ability of subjects to adhere to the treatment regimen. In an analysis including patients who did not complete treatment, results indicated that only CGT was effective at reducing depression significantly over the period of the study.

Because of the contradictory nature of study results no conclusions can be made as to the effect of CGT and ICT compared to treatment as usual.

Researchers caution that they were unable to determine whether the

improvement in depression scores compared to control was an effect of cognitive therapy or rather simply by the implementation of some therapeutic regimen that was not presented to the control group.

Cognitive Group Therapy or Individual Cognitive Therapy versus Waiting List (no other treatment)

To determine the absolute effectiveness of cognitive therapy in the treatment of depression, both group and individual cognitive therapy have been compared to doing nothing at all for depressed patients. Both CGT and ICT were found to significantly reduce depression scores after treatment, with the effects of ICT continuing through to follow-up (CGT follow-up was not measured). Waiting list subjects showed no significant reductions in depression scores over the period of the study.

Cognitive Behavioural Therapy versus Cognitive Behavioural Therapy

Presented here are numerous comparisons between different forms of cognitive behavioural therapy. The benchmark standard therapy that is used as the comparison in most studies is indi-

Individual cognitive therapy. Cognitive Group Therapy versus Individual Cognitive Therapy

Since the introduction of group therapy earlier in the century there has been debate regarding the effectiveness of this treatment compared to the individual attention given by one on one therapy. Does group therapy really work to treat depression and how effective is it compared to individual therapy?

Studies showed that both CGT and ICT were effective in reducing depression scores at post-treatment and follow-up when compared with pre-treatment scores. In a comparison of the effectiveness of the two treatments to reduce depression scores, studies found no significant differences between the two treatments. When examining the number of patients that obtained normal depression scores after treatment, both treatments were equally effective.

It has been suggested that in an era of cost-cutting measures the apparent usefulness of group therapy and its substantial cost saving could be used with confidence for depressed patients.

***Individual
Psychotherapy
versus
Individual
Cognitive Therapy.***

Psychotherapy is also an established treatment method for depression. However its effectiveness in comparison with cognitive therapy is limited. One study determined that both treatment methods were effective in reducing depression scores and that neither treatment was more effective than the other for treating depressed subjects. This study used a large number of subjects per group and examined the effectiveness of treatment including patients who dropped out before completion.

***Cognitive Group
Therapy versus
Computer Assisted
Therapy
(Therapeutic
Learning Program).***

A recent development in the treatment of depression is the use of computers instead of therapists to initially lead the subject through an examination and reflection of their perception of their environment and then to direct the subject through new coping skills. However, this

treatment still involves a group therapy component as the subjects return to the group to share their insights and thoughts that may have been provoked during the computer session.

Results showed that both treatments were able to reduce depression scores significantly over the time of treatment and that no significant differences in the effectiveness of either treatment in reducing depression scores was found.

***Coping with
Depression: A
Course,
Comparison of
Group or Class
Therapy and
Individual Therapy.***

The use of a structured course on coping with depression has been examined in both individual and group therapy formats. Moderate to severely depressed patients at the beginning of treatment had reduced depression scores at the end of treatment for both individual and group (or class) formats. While individual treatment was shown to be more effective than class therapy

for reducing depression scores at end of treatment, neither treatment format was shown to be significantly more effective than the other at follow-up.

***Treatment of
Depression in
Adolescents***

The treatment of adolescents has been espoused to be different than that for adults. However, most research makes little differentiation in treatment methods between adults and adolescents other than to impose age limit criteria on treatment subjects. Subjects undergoing either individual or group cognitive therapy were compared to waiting list subjects. Therapy subjects were found to have significantly improved depression scores and significantly larger numbers in remission from depressive disorder than waiting list subjects. Authors of one report did caution that ICT could not yet be recommended, based on study results, for adolescents with severe depression.

Recommendations

Individual and cognitive behavioural therapies for moderately or severely depressed adults (BDI 14) are comparable with each other in effectiveness and both are superior to providing no treatment at all. Individual cognitive therapy is equal to or better than tricyclic antidepressant drugs given at recommended therapeutic dosages for depressed people with a mean BDI of 30. This information is based on Level II Evidence (RCT).

For Adults:

- Either group (CGT) or individual cognitive behavioural therapy (ICT) can be used to treat moderate to severely depressed patients with the choice of therapy dependent upon the clinicians perceived receptiveness of the individual patient to group versus individual treatment.
- The use of the computer-assisted therapy can be useful as an aid to CGT in moderate to severely depressed patients.
- ICT can be effective in place of pharmacotherapy in moderate to severely depressed patients if the patient is opposed to being treated with drug therapy.
- CGT has not been compared to pharmacotherapy so no direct recommendation can be given as to its effectiveness as a replacement therapy.

For Adolescents:

- Either group or individual cognitive behavioural therapy can be used to treat moderately depressed adolescents (BDI 14).
- More research is needed to determine the effectiveness of individual or group cognitive behavioural therapy in severely depressed adolescents (BDI 20)

This Best Practice Information Sheet has been based on a systematic review undertaken by the Joanna Briggs Institute for Evidence Based Nursing and Midwifery (JBIEB/M) under the guidance of a review panel of clinical experts. It has been subject to peer review by experts nominated by the Joanna Briggs Institute centres throughout Australia, New Zealand and Hong Kong and was led by Mr Brent Hodgkinson (JBIEB/M), Ms Ann O'Donnell (Adelaide City Continuing Care), Mr David Evans (JBIEB/M) and Dr Ken Walsh (JBIEB/M).

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