Assessing the Effectiveness of Therapies for Depression

Many clinical outcome studies have shown that depression can be successfully treated and that although therapies for depression are effective, no one treatment is any more effective than others are. There is debate about the nature of *effectiveness*, however, and this handout looks at factors that influence our assessment of effectiveness (such as defining *effectiveness* and who decides whether the therapy has been effective). We also consider empirical evidence that has been used to evaluate the effectiveness of therapies for depression. Finally, we consider the ethical issues associated with therapies and treatments.

Defining *effectiveness*

Before we can say that a therapy is effective, we have to know what counts as effective. Psychologists from different background disagree radically about this. As you may remember form your work on Substance Abuse, there are several problems in assessing the effectiveness of treatment programmes:

1. *Different conditions pose different treatment problems (Kleber and Gawin 1987), so one treatment might work for one condition but not for another.*
2. *Some people recover spontaneously from their problems without any intervention at all (known as* spontaneous remission*) so to claim that it is a particular treatment that has caused the recovery is problematic.*
3. *Some people appear to have recovered, but then will relapse some time later (Comer 1995), so it is extremely difficult to determine whether the treatment is succeeding or failing.*
4. *Different criteria for success used by different clinical researchers make it difficult to draw conclusions about a therapy's effectiveness (Woody et al 1988). It is not easy to determine which criterion of success (Crooks and Stein 1991) is most appropriate. For example, if time is the criterion, for how long must a person show a relief of symptoms in order to be categorised as a treatment success? Is a total absence of symptoms the only criterion that should be used? Some therapists, notably behavioural therapists, argue that the most obvious, straightforward and objective measure is observable behaviour change. If a person has a phobia before the therapy and does not have it afterwards, then the therapy has been successful, arguably (Guscott and Taylor 1994). For psychoanalysts, however, unconscious conflicts that have caused the phobia must be removed. This removal cannot be directly measured so direct measurement (for example, of observable behaviour change) can not be the only criterion.*

These issues should be borne in mind when considering the effectiveness of any therapy.

Who decides?

Who decides whether a therapy has been successful or not? To rely on the therapist would seem dubious as they are unlikely to say that their treatment has been ineffective, especially as they may have been seeing the client over a long period of time and may have been receiving money from them. A

therapist's belief that the therapy works will mean that they cannot without contradiction believe the therapy is useless.

Psychoanalysts might want to rely on the client's own decisions. This assumes that clients are insightful, good judges of their own state of being and behaviour and can communicate this effectively to those who are assessing the effectiveness of the therapy. This seems unrealistic.

Using family and friends of the client to decide may seem plausible, given that they have no stake in the therapy as such and would want the best for the client. However, in some cases family and/or friends may be at the root of the problems and so their judgement is unlikely to be reliable or valid. For example, if a person's anxiety disorder arises from distorted communication in the family and low self-esteem, then the family may find it difficult to approve of the client re-shaping the family relationships and so would be reluctant to say the therapy was successful.

Finally, other therapists might be in the best position to determine effectiveness, as they would have the expertise to recognise improvement and would be less likely to be biased in their judgements.

Empirical Studies on Effectiveness

The National Institute of Mental Health (NMIH) sponsored a study in USA by Elin et al (1989) with the aim of comparing the effectiveness of cognitive therapy, interpersonal therapy and antidepressants for overcoming unipolar depression. At three research centres, a total of 250 moderately to severely depressed people, 70% of whom were female, were assigned to one of four groups: Beck's cognitive-behaviour therapy (CBT), interpersonal therapy (IPT), antidepressant medication (the tricyclic drug *imipramine*) and a control group who were given a placebo (an inactive substance). The focus of CBT was to detect and change negative thoughts and assumptions. IPT originated in psychoanalysis but rather than looking at childhood and defences, it looks at current disputes, anxieties and frustrations (such as grief, fights, role transitions and social deficits). Therapy lasted for 16 weeks, used 28 therapists, and recovery from depression was assessed by interviews and tests such as the Hamilton Rating Scale for Depression.

The **results** showed that just over 50% of patients recovered in each of the CBT and IPT groups as well as in the drug group. Only 29% recovered in the placebo group. The drug treatment produced faster results, but it seems **the NIMH study shows that there is no difference in the effectiveness of CBT, IPT and drug treatment.** In other words, it doesn't matter which treatment you get; they all have the same result.

In general terms, a lack of difference in the effectiveness of a range of therapies could be because certain therapies are effective only for certain disorders. When they are used to treat a range of disorders, a given therapy's effectiveness with some disorders is cancelled out by its ineffectiveness with other disorders. The net result is that there appears to be no difference between the therapies, so we need to know which therapies are effective for which disorders. This does not apply to the NIMH study of course, as it considered treatments for one disorder only. Alternatively, it could be that there is no difference in the effectiveness of therapies because the therapies have certain factors in common. For example, all therapies involve a warm interpersonal relationship, reassurance and support, therapists reinforcing behaviours that are deemed to be on the road to recovery, the

opportunity to gain insight or a gradual process of the person becoming less bothered about the threatening quality of their experience (desensitization).

Rush et al (1977) suggest the higher relapse rate for those treated with the drug arises because patients in a cognitive therapy programme learn skills to cope with depression that the patients given drugs do not. Most other comparative outcome studies (e.g. Stravynski and Greenberg 1992, Hollon et al 1992) show that there is little difference in effectiveness of these three kinds of treatment. However, more and more studies are showing that cognitive therapies are more effective than drug treatment alone at preventing relapse/recurrence except when drug treatment is continued long-term (Hollon and Beck 1994). Furthermore, a combination of psychotherapy (cognitive or interpersonal) and drugs appears to be moderately more successful than either psychotherapy or drugs alone (Klerman et al 1994).

Behavioural therapy is less affective than cognitive, interpersonal or biological therapy, although it is more effective than no attention or a placebo (Emmelkamp 1994). It is of less help in relieving severe depression than mild or moderate depression.

Psychodynamic therapies are less effective than other therapies in treating all levels of unipolar depression (Svartberg & Stiles 1991). Berk and Efran (1983) found that psychodynamic therapies were no more effective than a placebo (30% of cases improved) although clinicians argue that the approach does not lend itself to empirical research. In contrast, a study by Smith et al (1980) looked at 475 other studies (this is known as a meta-analysis) and found that psychodynamic therapies were beneficial according to many different criteria for success. They concluded that the average person is better off after psychodynamic therapy than 80% of those who receive no therapy.

Ethical Issues associated with Therapies and Treatments

Once we have considered all of the above, if a treatment is deemed to be effective, should it be used regardless of the ethical implications? Does the end justify the means? You will need to decide this for yourself but some of the ethical issues surrounding therapies and treatments are outlined here: -

- **ECT** (electroconvulsive therapy) – As we do not know precisely how ECT works and its effectiveness could be due to the staff-patient relationship, critics have argued that administering ECT is unnecessary. Furthermore, patients should not have to suffer the memory loss that is associated with ECT which can cover the 6 months prior to the treatment as well as up to two months afterwards for some patients.

- **Drugs** – Although many drugs do relieve symptoms, they do not provide a cure (i.e. they do not remove the cause). Several studies have shown a dependency can arise with antidepressants and side-effects may be undesirable, so their use can be questioned.

- **Behaviour therapies** – These involve a loss of freedom to choose how to behave and may involve punishments that by their very nature are undesirable (such as electric shocks, emetics, social isolation or withholding of food). The decision about whether to reward is often in the hands of the therapist and could be open to abuse. Some believe electric shock is acceptable as a last resort

after other treatments have failed (Martin 1975). The distress a person may undergo during flooding could be argued to be both unnecessary as well as exploitative.

- **Psychoanalysis** – This brings out feelings and experiences that the person has buried in their unconscious precisely because they are painful. An equally effective but less traumatic therapy could be seen to be more ethical.