BEST in Mental Health
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Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* MH *clinical question-answering service*

Question

"In adults with depression, how effective is adding psychiatric medication to psychotherapy compared with psychotherapy alone for improving patient outcomes?"

Clarification of question using PICO structure

Patients:	Adults with depression-related diagnoses
Intervention:	Combination of psychiatric medication and psychotherapy
Comparator:	Psychotherapy alone
Outcome:	Improving patient outcomes

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Clinical and research implications

No definite clinical implications can be made from the current evidence. The studies included in this BEST summary included patients with different severities of depression, and also evaluated different medications and types of psychotherapy, so that generalisations are difficult to make. One well conducted systematic review (which included studies evaluating any type of pharmacotherapy and any type of psychotherapy) reported that combined treatment was more effective than psychological treatment alone in the short-term. The authors also reported, however, that these results should be treated with caution.

None of the included studies made clear research recommendations. The authors of the systematic review stated that more long-term studies needed to evaluate the relative efficacy of psychological and combined treatments, and that more basic research is required to explore the mechanisms through which both treatments work.

What does the evidence say?

Number of included studies/reviews (number of participants)

Two systematic reviews (SRs) (Cuijpers et al. 2009; 2012), one 'mega-analysis' (de Maat et al. 2008), and two randomised controlled trials (RCTs) (Blom et al. 2007; Zu et al. 2014) met the inclusion criteria for this BEST summary.

Main Findings

A meta-analysis by Cuijpers et al. (2009) demonstrated that patients who received psychotherapy and pharmacotherapy had lower levels of depression in the short-term than patients who received psychotherapy alone (SMD 0.35 [95%CI: 0.24 to 0.45), p<0.001, but the authors suggested that these results should be treated with caution as no difference was found in the longer term, and because a number of the included studies had methodological limitations. A later review by Cuijpers et al. (2012), which included a number of the same papers as in the 2009 publication, reported meta-analyses by specific population groups/characteristics, with a view towards developing personalised treatments. Six patient 'characteristics' were defined in studies that compared combined treatment versus psychotherapy alone in depressed patients: patients with dysthymia, patients with chronic depression, older adults, stroke patients, primary care patients, and outpatients. Meta-analysis demonstrated significant results in favour of combined treatment for only two of these groups: patients with chronic depression (SMD 0.41 [95% CI: 0.35 to 0.73], p<0.001), and outpatients (SMD 0.40 [95% CI: 0.13 to 0.67], p<0.01).

One study pooled original data from three RCTs conducted in patients with mild-to-moderate major depression (de Maat et al. 2008). In their 'mega-analysis', the authors reported that independent observers and therapists did not observe a difference in symptom reduction in patients who were treated with combined therapy (pharmacotherapy and short psychodynamic supportive psychotherapy) vs. short psychodynamic supportive psychotherapy alone. For patient reported outcomes (i.e. SCL-depression and QLDS), however, combined therapy was found to be significantly more effective in treating symptoms of depression than psychotherapy alone.

An RCT by Blom et al. (2007) aimed to assess the efficacy of the combination of interpersonal psychotherapy and medication (nefazodone) with both treatment forms alone in the acute

treatment of 193 depressed outpatients. After 12-16 weeks of treatment, the authors found that all treatments were effective, but there were no significant differences between treatments on the HAMD. In contrast, the combination of medication with psychotherapy was found to be more effective in reducing depressive symptoms (as measured using MADRS) compared to medication alone, but not to psychotherapy alone.

A recent RCT examined the effects of cognitive behavioural therapy (CBT) in 180 Chinese patients with moderate to severe major depressive disorder (Zu et al. 2014). Similar to other studies, this trial included several intervention groups including antidepressants alone (citalopram, escitalopram, paroxetine or sertraline), CBT alone, combined CBT and antidepressants, or standard treatment. They authors found no significant difference between any of these treatment groups for depressive symptomology.

Authors Conclusions
Cuijpers et al. (2009) concluded that combined treatment is more effective than psychological treatment alone, although it is not clear whether this difference is relevant from a clinical perspective.

Cuijpers et al. (2012) concluded that although a considerable number of studies have compared medication, psychotherapy, and combined treatments, some preliminary results are useful for deciding which treatment is best for which patient.

de Maat et al. (2008) concluded that no difference in efficacy was found between short psychodynamic supportive psychotherapy and combined therapy, except that patients thought that combined therapy was more efficacious in terms of symptom reduction.

Blom et al. (2007) concluded that their study supports the use of combining medication with psychotherapy, over medication alone for the treatment of depressed outpatients. They also stated that, in their study, combination treatment did not have an advantage over psychotherapy alone.

Zu et al. (2014) concluded that CBT appears to be a feasible and equally effective method (compared to medication alone, or combined, or standard treatment) for treating moderate to severe depression in Chinese patients.

Reliability of conclusions/Strength of evidence
Both SRs were considered to have a low risk of bias, so that the authors' (cautious) conclusions are likely to be reliable. The meta-analysis by de Maat et al. (2008) and the RCT by Blom et al. (2007) had an unclear risk of bias so that the reliability of their results is uncertain. The Zu et al. (2014) trial was considered to have a high risk of bias. The authors appropriately noted the limitations of their trial, and also stated that their results should be viewed with caution.

What do guidelines say?

NICE guidelines (NICE, 2009) makes the following comments regarding the use of psychotherapy compared with combined psychotherapy and pharmacotherapy:

"For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT)." (pp.22)

"For a person whose depression has not responded to either pharmacological or psychological interventions, consider combining antidepressant medication with CBT." (pp.32)

"For a person whose depression has failed to respond to various strategies for augmentation and combination treatments, consider referral to a practitioner with a specialist interest in treating depression, or to a specialist service." (pp.32)

Date question received: 18/09/2006
Date searches conducted: 18/08/2014, updated from 09/2006
Date answer completed: 08/09/2014

References

SRs

Cuijpers, P., van Straten, A., Warmerdam, L., & Andersson, G. (2009). Psychotherapy versus the combination of psychotherapy and pharmacotherapy in the treatment of depression: a meta-analysis. *Depression and anxiety*, *26*(3), 279-288.

Cuijpers, P., Reynolds, C. F., Donker, T., Li, J., Andersson, G., & Beekman, A. (2012). Personalized treatment of adult depression: medication, psychotherapy, or both? A systematic review. *Depression and anxiety*, *29*(10), 855-864.

Mega-Analyses

de Maat, S., Dekker, J., Schoevers, R., van Aalst, G., Gijsbers-van Wijk, C., Hendriksen, M., ... & de Jonghe, F. (2008). Short Psychodynamic Supportive Psychotherapy, antidepressants, and their combination in the treatment of major depression: a mega-analysis based on three Randomized Clinical Trials. *Depression and anxiety*, *25*(7), 565-574.

RCTs

Blom, M. B., Jonker, K., Dusseldorp, E., Spinhoven, P., Hoencamp, E., Haffmans, J., & van Dyck, R. (2007). Combination treatment for acute depression is superior only when psychotherapy is added to medication. *Psychotherapy and Psychosomatics*, *76*(5), 289-297.

Zu, S., Xiang, Y. T., Liu, J., Zhang, L., Wang, G., Ma, X., ... & Li, Z. J. (2014). A comparison of cognitive-behavioral therapy, antidepressants, their combination and standard treatment for Chinese patients with moderate–severe major depressive disorders. *Journal of affective disorders*, *152*, 262-267.

Guidelines

National Institute of Health and Care Excellence. (2009). *Depression in Adults: The Treatment and Management of depression in Adults. CG90*. London: National Institute of Health and Care Excellence.

Results

Systematic Reviews

Author (year)	Search Date	Inclusion criteria	Number of included studies	Summary of results	Risk of bias
Cuijpers et al. (2009)	12/2007	*Participants*: Studies were included when all randomized participants had a diagnosed depressive disorder, or scored above a cut-off point on a self-report instrument. Comorbid general medical or psychiatric disorders were not used as an exclusion criterion. *Intervention*: Any psychotherapy (e.g., Cognitive Behavioural Therapy, Interpersonal Psychotherapy). *Comparator*: Any combination of psychotherapy and pharmacotherapy (e.g., antidepressants). Studies were excluded if they involved maintenance treatments or if a psychological treatment plus placebo were compared to a psychological treatment plus active antidepressant, in case the placebo has an effect. *Outcome*: Depressive symptomatology.	19 (n=1,838 participants)	There was a significant effect in favour of combined treatment, such that patients who received psychotherapy and pharmacotherapy had lower levels of depression than patients who received psychotherapy alone (SMD 0.35 [95%CI: 0.24 to 0.45), p<0.00l, I squared = 0. None of the analyses indicated a significant difference between psychological and combined treatments at 3-6 months follow-up, and at 12 months follow-up.	Low
Cuijpers et al. (2012)	01/2011	*Participants*: Patients from outpatient and primary care settings with a diagnosed depressive disorder, aged 18 years and over. Studies were selected in which one of the comparisons (pharmacotherapy versus	52 (n=4,734 participants)	The authors conducted analyses for three types of comparisons (pharmacotherapy vs, psychotherapy, pharmacotherapy vs. combined, and psychotherapy vs. combined) – we have only extracted data on the last	Low

		psychotherapy, pharmacotherapy versus combined, psychotherapy versus combined) was examined in a specific target group with (a) a predefined sociodemographic characteristic (e.g., older adults or minority groups), (b) with a specific type of depression (e.g., dysthymia, chronic depression, or postnatal depression), (c) depression and a comorbid (mental or somatic) disorder, or (d) a target group from a specific setting (outpatients, primary care). Studies in which patients were recruited from the community were excluded because this does not represent a specific or definable patient group which could be included in the analysis. *Intervention*: Any psychotherapy (e.g., Cognitive Behavioural Therapy, Interpersonal Psychotherapy). *Comparator*: pharmacotherapy (e.g., antidepressants); any combination of psychotherapy and pharmacotherapy. *Outcome*: Depressive symptomatology (Beck Depression Inventory; HRSD).		comparison as it is relevant to this BEST summary. In this review, meta-analyses were conducted within specific target populations. Combined treatment was found to have a significantly better impact than psychotherapy alone for patients with chronic depression (SMD 0.41 [95% CI: 0.35 to 0.73], p<0.001), but not for patients with dysthymia. Results were also significant for outpatients (SMD 0.40 [95% CI: 0.31 to 0.67], p<0.01), but not for patients in primary care settings. Results were non-significant between treatments in studies conducted in older adults, and in studies of stroke patients. No other target populations were evaluated for this comparison.	

Mega-Analyses

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
De Maat (2008)	*Participants*: Patients aged 18-65 years with a DSM-III-R or DSM-IV diagnosis of major depression with or without	*N* = 313 (pharmacotherapy = 45,	The authors compared pharmacotherapy alone vs. psychotherapy alone, pharmacotherapy alone vs. combined treatment, and psychotherapy alone vs. combined	Unclear

	dysthymia, with HDRS baseline scores of 14–24. Exclusion criteria: any psycho-organic disorder, drug abuse, a psychotic disorder, a dissociative disorder, serious communication problem, physical restrictions, being ''too ill'' and/or ''too suicidal'', pregnancy or a wish to become pregnant. Exclusion criteria associated with medication were: a contra-indication for one of the antidepressants prescribed by the pharmacotherapy protocol, a history of adequate treatment with antidepressants during the present depressive episode, and use of psychotropic medication not prescribed by the pharmacotherapy protocol. *Intervention*: Short psychodynamic supportive psychotherapy (SPSP). SPSP consists of up to 16 sessions delivered within a 6-month period. *Comparators*: Pharmacotherapy (Pharmacotherapy was provided in accordance with an antidepressant medication protocol, allowing for changes in medication in response to inefficacy or intolerance) and SPSP and pharmacotherapy combined. Treatment was intended to last for 6 months. *Outcome*: depressive symptoms (Hamilton Rating Scale for Depression; Clinical Global Impression of Severity and Improvement; the depression subscale of the 90-	psychotherapy = 97, combined = 171)	treatment. We have only extracted results for the last comparison as it is relevant to this BEST summary. At 24 weeks, no significant differences in remission and response rates were found between combined therapy and short psychodynamic supportive psychotherapy, except for one outcome – the Symptom Checkist depression subscale (which favoured combined therapy, p=0.016). Regarding mean scores, two of five outcomes were found to significantly differ between psychotherapy alone vs. combined treatment – the Symptom Checkist depression subscale (which favoured combined therapy, p=0.001), and the QLDS (which favoured combined therapy, p=0.031).	

	Symptom Checklist; Quality of Life Depression Scale).			

RCTs

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Blom et al. (2007)	*Participants*: Aged 18 years and over with a DSM-IV diagnosis of major depressive disorder and a score of 14 or above on the HRSD). Exclusion criteria: substance abuse, a serious medical condition, organic psychiatric disorder, severe suicidality, history of psychotic disorder or schizophrenia, bipolar disorder, current use of psychotropic medication and ongoing psychotherapy. *Intervention*: 12 sessions of Interpersonal Psychotherapy over a 16 week period, delivered by trained IPT therapists. *Comparator*: either (1) Nefazodone (100 mg per day initially and gradually increased to 400 mg a day. If insufficient improvement after 4 weeks, dose was increased to 600 mg); or (2) IPT and Nefazodone combined. *Outcome*: Primary outcome: depressive symptoms (HAMD). Secondary outcomes:	N=193	After 12-16 weeks of treatment, all treatments were found to be effective, but there were no significant differences between treatment groups using the HAMD. In contrast, the combination of medication with psychotherapy was found to be more effective in reducing depressive symptoms (as measured using MADRS) compared to medication alone, but not to psychotherapy alone.	Unclear

	depressive symptoms (Montgomery-Asberg Depression rating Scale) general mental health symptomatology (Clinical Global Impression Scale).			
Zu et al. (2014)	*Participants*: Aged between 17 and 60 with a diagnosis of non- psychotic DSM-IV major depressive disorder (length of illness less than 1 year); a total score of the HRSD or 17 or above; ability to communicate; have at least one family member cohabiting with them. Exclusion criteria: current or past history of any other psychiatric disorders including drug and alcoholic dependence; ongoing acute medical and neurological conditions; lack of response to citalopram, sertraline, or paroxetine; having had CBT previously; taking an antipsychotic medication or mood stabilizer; suicidal ideation, suicide plan or attempt in the current depressive episode. *Intervention*: 24- week individual CBT, comprising 20 sessions each lasting 1 hour. Session content included establishing a therapeutic goal and plan, understanding patterns of automatic thoughts and behaviours, and identifying warning signs of relapse. *Comparator*: either (1) antidepressant	N=180	After 6 months, there was no significant difference between any of the treatment groups for HAMD, QIDS-R, or WSAS (statistical results for the various group comparisons are not clearly reported).	High

	medication (Citalopram (20–60 mg/day), escitalopram (10–20 mg/day), paroxetine (20–60 mg/day), orsertraline (25–100mg/day) within the therapeutic dose ranges recommended by the Guidelines for the Prevention and Treatment of Major Depression in China); or (2) a combination of CBT and antidepressant medication. *Outcome*: depressive symptoms (HRSD; Quick Inventory of Depressive Symptomatology-Self Report); social functioning (Work and Social Adjustment Scale).			

Risk of Bias:

SRs

Author (year)	Risk of Bias				
	Inclusion criteria	Searches	Review Process	Quality assessment	Synthesis
Cuijpers et al. (2009)	☺	☺	?	☺	☺
Cuijpers et al. (2012)	☺	☺	☺	☺	☺

Mega-Analyses

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
De Maat (2008)	?	?	?	?	☺	☺

RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Blom et al. (2007)	?	?	Open label	☺	☺	☺
Zu et al. (2014)	☺	?	Open label	☺	☹	☹

☺ Low Risk ☹ High Risk ? Unclear Risk

Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
SRs and Guidelines			
NICE	cbt combined antidepressant depression	36	1
DARE	(depress*) IN DARE FROM 2006 TO 2014 1412 Delete 2 MeSH DESCRIPTOR Depression EXPLODE ALL TREES 513 Delete 3 MeSH DESCRIPTOR Depressive Disorder EXPLODE ALL TREES 922 Delete 4 MeSH DESCRIPTOR Depressive Disorder, Major EXPLODE ALL TREES 292 Delete 5 #1 OR #2 OR #3 OR #4 2069 Delete 6 (psychotherap*) IN DARE FROM 2006 TO 2014 526 Delete 7 MeSH DESCRIPTOR Psychotherapy EXPLODE ALL TREES 1837 Delete 8 (therap*) IN DARE FROM 2006 TO 2014 13771 Delete 9 ((combined adj2 modalit*) OR combination*) IN DARE FROM 2006 TO 2014 3224 Delete 10 #6 OR #7 OR #8 14742 Delete 11 #9 AND #10 2408 Delete 12 #5 AND #11	196	2
Primary studies			
CENTRAL	#1 depression or depressive:ti 14397 #2 mood or affective or adjustment:ti 3431 #3 MeSH descriptor: exp[Depression] 5420 #4 MeSH descriptor: exp[Depressive Disorder] 7497 #5 MeSH descriptor: [Mood Disorders] 442 #6 {or #1-#5}{or #1-#5} 23288 #7 psychotherapy or psychodynamic or psychoanal*psychotherapy or psychodynamic or psychoanal* 8576 #8 MeSH descriptor: [Psychotherapy] 15658	490	2

	#9 DDBT or CBT or psychoeducation or formulation 16506 #10 (behavio* or cognitive or group) near/3 therap* 26929 #11 {or #7-#10}{or #7-#10} 48747 #12 MeSH descriptor: [Antidepressive Agents] 4896 #13 antidepressant* or tricyclic* or SSRI* or "mood stabli?er"9226 #14 "drug therapy" or pharmacotherapy218155 #15 Serotonin-Reuptake-Inhibitor*1897 #16 Serotonin-Re-uptake-Inhibitor*352 #17 Monoamine-oxidase-inhibitor*732 #18 {or #12-#17}222541 #19 #6 and #11 and #181647 #20 2006 or 2007 or 2008 or 2009 or 2010 or 2011 or 2012 or 2013 or 2014371482 #21 #19 and #201043 #22 child* or adolesc*152288 #23 #21 not #22 705 (490 in Central)		
PsycINFO	1. PsycINFO; (Depression OR Depressive).ti,ab; 200066 results. 2. PsycINFO; exp MAJOR DEPRESSION/; 93891 results. 3. PsycINFO; Mood-Disorder*.ti,ab; 10785 results. 4. PsycINFO; exp AFFECTIVE DISORDERS/; 120583 results. 5. PsycINFO; Affective-Disorder*.ti,ab; 14057 results. 6. PsycINFO; 1 OR 2 OR 3 OR 4 OR 5; 230438 results. 7. PsycINFO; Antidepressants.ti,ab; 15757 results. 8. PsycINFO; SSRI*.ti,ab; 4879 results. 9. PsycINFO; Tricyclic*.ti,ab; 5069 results. 10. PsycINFO; Mood-Stabili?er*.ti,ab; 2477 results. 11. PsycINFO; Serotonin-Reuptake-Inhibitor*.ti,ab; 6566 results. 12. PsycINFO; Serotonin-Re-uptake-Inhibitor*.ti,ab; 300 results. 13. PsycINFO; drug-therapy.ti,ab; 2854 results. 14. PsycINFO; DRUG THERAPY/; 108330 results. 15. PsycINFO; exp ANTIDEPRESSANT DRUGS/; 32062 results.	241	

	16. PsycINFO; exp SEROTONIN REUPTAKE INHIBITORS/; 10567 results. 17. PsycINFO; exp MONOAMINE OXIDASE INHIBITORS/; 2118 results. 18. PsycINFO; Monoamine-oxidase-inhibitor*.ti,ab; 946 results. 19. PsycINFO; exp SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITORS/; 1314 results. 20. PsycINFO; 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19; 125961 results. 21. PsycINFO; Psychotherapy.ti,ab; 72333 results. 22. PsycINFO; exp PSYCHOTHERAPY/; 177009 results. 23. PsycINFO; exp COGNITIVE THERAPY/; 11683 results. 24. PsycINFO; exp GROUP PSYCHOTHERAPY/; 19771 results. 25. PsycINFO; (psychotherap* OR psychodynam* OR psychoanaly*).ti,ab; 154877 results. 26. PsycINFO; ((behavio* OR cognitive OR group) adj2 therap*).ti,ab; 41798 results. 27. PsycINFO; "transactional analy*".ti,ab; 1376 results. 28. PsycINFO; (solution* adj2 focus*).ti,ab; 1522 results. 29. PsycINFO; (DBT OR CBT).ti,ab; 8577 results. 30. PsycINFO; "schema therapy".ti,ab; 212 results. 31. PsycINFO; psychoeducation*.ti,ab; 6191 results. 32. PsycINFO; formulation.ti,ab; 13504 results. 33. PsycINFO; 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32; 275404 results. 34. PsycINFO; 6 AND 20 AND 33; 4207 results. 35. PsycINFO; CLINICAL TRIALS/; 7801 results. 36. PsycINFO; random*.ti,ab; 132312 results. 37. PsycINFO; groups*.ti,ab; 371690 results. 38. PsycINFO; (doubl* adj3 blind*).ti,ab; 18455 results. 39. PsycINFO; (singl* adj3 blind*).ti,ab; 1669 results. 40. PsycINFO; EXPERIMENTAL DESIGN/; 9233 results. 41. PsycINFO; controlled.ti,ab; 82103 results. 42. PsycINFO; (clinical adj3 study).ti,ab; 8049 results.		

	43. PsycINFO; trial.ti,ab; 69577 results. 44. PsycINFO; "treatment outcome clinical trial".md; 27525 results. 45. PsycINFO; 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44; 575950 results. 46. PsycINFO; 34 AND 45; 1613 results. 47. PsycINFO; 46 [Limit to: Publication Year 2006-2014]; 829 results. 48. PsycINFO; 47 [Limit to: (Methodology 2000 Treatment Outcome/Clinical Trial) and Publication Year 2006-2014]; 241 results.		
Embase	49. EMBASE; (Depression OR Depressive).ti,ab; 310929 results. 50. EMBASE; Mood-Disorder*.ti,ab; 15495 results. 51. EMBASE; Affective-Disorder*.ti,ab; 16547 results. 52. EMBASE; MOOD DISORDER/ OR MAJOR AFFECTIVE DISORDER/ OR exp DEPRESSION [+NT]/; 323307 results. 53. EMBASE; 49 OR 50 OR 51 OR 52; 450738 results. 54. EMBASE; Antidepressants.ti,ab; 33823 results. 55. EMBASE; SSRI*.ti,ab; 11146 results. 56. EMBASE; Tricyclic*.ti,ab; 17275 results. 57. EMBASE; Mood-Stabili?er*.ti,ab; 4154 results. 58. EMBASE; Serotonin-Reuptake-Inhibitor*.ti,ab; 12628 results. 59. EMBASE; Serotonin-Re-uptake-Inhibitor*.ti,ab; 954 results. 60. EMBASE; drug-therapy.ti,ab; 36197 results. 61. EMBASE; Monoamine-oxidase-inhibitor*.ti,ab; 3525 results. 62. EMBASE; exp TRICYCLIC ANTIDEPRESSANT/; 91257 results. 63. EMBASE; exp ANTIDEPRESSANT AGENT/; 302406 results. 64. EMBASE; exp MOOD STABILIZER/; 5403 results. 65. EMBASE; 54 OR 55 OR 56 OR 57 OR 58 OR 59 OR 60 OR 61 OR 62 OR 63 OR 64; 347078 results. 66. EMBASE; Psychotherapy.ti,ab; 34339 results. 67. EMBASE; (psychotherap* OR psychodynam* OR psychoanaly*).ti,ab; 61721 results.	739	

	68. EMBASE; ((behavio* OR cognitive OR group) adj2 therap*).ti,ab; 41973 results. 69. EMBASE; "transactional analy*".ti,ab; 235 results. 70. EMBASE; (solution* adj2 focus*).ti,ab; 623 results. 71. EMBASE; (DBT OR CBT).ti,ab; 9368 results. 72. EMBASE; "schema therapy".ti,ab; 108 results. 73. EMBASE; psychoeducation*.ti,ab; 3862 results. 74. EMBASE; formulation.ti,ab; 87102 results. 75. EMBASE; exp PSYCHOTHERAPY/; 181125 results. 76. EMBASE; 66 OR 67 OR 68 OR 69 OR 70 OR 71 OR 72 OR 73 OR 74 OR 75; 313050 results. 77. EMBASE; 53 AND 65 AND 76; 14646 results. 78. EMBASE; 77 [Limit to: (Clinical Queries Therapy maximizes specificity) and Publication Year 2006-2014]; 727 results. 79. EMBASE; 77 [Limit to: (Clinical Trials Randomized Controlled Trial) and Publication Year 2006-2014]; 739 results.		
Medline	30. MEDLINE; (Depression OR Depressive).ti,ab; 252608 results. 31. MEDLINE; Mood-Disorder*.ti,ab; 11035 results. 32. MEDLINE; Affective-Disorder*.ti,ab; 13534 results. 33. MEDLINE; MOOD DISORDER/ OR MAJOR AFFECTIVE DISORDER/ OR exp DEPRESSION [+NT]/; 88105 results. 34. MEDLINE; 30 OR 31 OR 32 OR 33; 292141 results. 35. MEDLINE; Antidepressants.ti,ab; 25238 results. 36. MEDLINE; SSRI*.ti,ab; 7147 results. 37. MEDLINE; Tricyclic*.ti,ab; 13649 results. 38. MEDLINE; Mood-Stabili?er*.ti,ab; 2648 results. 39. MEDLINE; Serotonin-Reuptake-Inhibitor*.ti,ab; 9798 results. 40. MEDLINE; Serotonin-Re-uptake-Inhibitor*.ti,ab; 748 results. 41. MEDLINE; drug-therapy.ti,ab; 28981 results. 42. MEDLINE; Monoamine-oxidase-inhibitor*.ti,ab; 3583 results. 46. MEDLINE; 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45; 72718	463	

	results. 47. MEDLINE; Psychotherapy.ti,ab; 25477 results. 48. MEDLINE; (psychotherap* OR psychodynam* OR psychoanaly*).ti,ab; 45563 results. 49. MEDLINE; ((behavio* OR cognitive OR group) adj2 therap*).ti,ab; 30699 results. 50. MEDLINE; "transactional analy*".ti,ab; 166 results. 51. MEDLINE; (solution* adj2 focus*).ti,ab; 462 results. 52. MEDLINE; (DBT OR CBT).ti,ab; 6555 results. 53. MEDLINE; "schema therapy".ti,ab; 66 results. 54. MEDLINE; psychoeducation*.ti,ab; 2667 results. 55. MEDLINE; formulation.ti,ab; 66209 results. 56. MEDLINE; exp PSYCHOTHERAPY/; 152488 results. 57. MEDLINE; 47 OR 48 OR 49 OR 50 OR 51 OR 52 OR 53 OR 54 OR 55 OR 56; 253527 results. 58. MEDLINE; exp ANTIDEPRESSIVE AGENTS/; 122615 results. 59. MEDLINE; 46 OR 58; 169269 results. 60. MEDLINE; 34 AND 57 AND 59; 4793 results. 61. MEDLINE; "randomized controlled trial".pt; 385578 results. 62. MEDLINE; "controlled clinical trial".pt; 89643 results. 63. MEDLINE; 61 OR 62; 470295 results. 64. MEDLINE; 60 AND 63; 867 results. 65. MEDLINE; 64 [Limit to: Publication Year 2006-2014]; 463 results.		
Summary	**NA**	**NA**	

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