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Evidence-based practice guideline for the treatment of adult patients with depressive disorders. Part II: Psychotherapy

Oparte na dowodach wytyczne leczenia dorosłych pacjentów z zaburzeniami depresyjnymi. Część II: psychoterapia

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Abstract

This document is the second instalment in a two-part series outlining evidence-based recommendations for the treatment of adult patients with depressive disorders. Part II focuses on psychotherapy as an important treatment option – as a standalone treatment or in combination with pharmacotherapy. This guideline adapts the definition of evidence-based practice in psychology, as proposed by the American Psychological Association, to the practice of psychotherapy. As such, evidence-based practice in psychotherapy is anchored in best available research evidence, the psychotherapist's clinical expertise, and the patient's characteristics, culture and preferences. The article reviews the best available research evidence for psychological treatments for depression and describes in some detail each of the current empirically-supported treatments with strong and modest research support. Further, it discusses the key components of clinical expertise, as it relates to both the person of the therapist and the process of psychotherapy. In particular, the discussion covers the following key areas of clinical expertise: 1) assessment, diagnosis, and case formulation; 2) treatment planning and implementation and ongoing monitoring of patients' progress; 3) interpersonal expertise; 4) self-reflection, utilising available resources and ongoing professional growth; 5) scientific expertise; and 6) diversity expertise. Finally, the guideline addresses important patient-related variables and how they should inform treatment in order to maximise its effectiveness.

Keywords: guideline, depression, psychotherapy, clinical expertise, patient characteristics

Streszczenie

Niniejsza praca jest drugą i ostatnią częścią serii omawiającej oparte na dowodach zalecenia *(evidence-based recommendations)* w zakresie leczenia dorosłych pacjentów z zaburzeniami depresyjnymi. Część II skupia się na psychoterapii jako na istotnej opcji leczenia – czy to stosowanej jako jedyna, samodzielna forma terapii, czy też w połączeniu z leczeniem farmakologicznym. W pracy zaadaptowano definicję praktyk opartych na dowodach w zakresie psychologii w kształcie zaproponowanym przez Amerykańskie Towarzystwo Psychologiczne (American Psychological Association) do praktyki psychoterapii. Tym samym oparte na dowodach praktyki w zakresie psychoterapii zakotwiczone są w najlepszych dostępnych dowodach naukowych i doświadczeniu klinicznym psychoterapeutów oraz umieszczone w odpowiednim kontekście kulturowym, jak również uwzględniają indywidualne uwarunkowania i preferencje pacjentów. Praca omawia najlepsze dostępne dowody na skuteczność leczenia depresji na drodze psychoterapii i opisuje na pewnym poziomie szczegółowości każdą ze stosowanych obecnie terapii o empirycznie dowiedzionej wysokiej lub umiarkowanej skuteczności. W dalszej części poruszono kluczowe elementy praktyki klinicznej w odniesieniu zarówno do osoby terapeuty, jak i samego procesu psychoterapii. W omówieniu tym uwzględniono następujące kluczowe aspekty praktyki klinicznej: 1) ocena, ustalanie rozpoznania, formułowanie diagnozy wyjaśniającej; 2) planowanie i wdrażanie leczenia oraz ciągłe monitorowanie jego postępów; 3) aspekt interpersonalny; 4) autorefleksja, wykorzystywanie istniejących zasobów i ciągły rozwój zawodowy; 5) źródła wiedzy naukowej oraz 6) umiejętność doboru sposobu postępowania w zależności od indywidualnych i kulturowych uwarunkowań pacjenta. Ponadto omówiono indywidualne zmienne mające wpływ na leczenie danego pacjenta i sposób, w jaki powinny one warunkować dobór leczenia, tak aby pozwolić na osiągnięcie optymalnych efektów.

Słowa kluczowe: wytyczne, depresja, psychoterapia, doświadczenie kliniczne, charakterystyka pacjenta

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INTRODUCTION

The present English-language version of this two-part guideline is published in parallel with a Ukrainian-language version appearing in the official peer-reviewed journal of the Ukrainian Psychiatric Association (Voytenko et al. 2018b, 2018a). As briefly discussed in Part I (Psychiatric management) of this guideline, psychotherapy is an important option in the treatment of depressive disorders at every level of severity, either in combination with medication (in moderate to severe depression) or as a monotherapy (in mild to moderate depression). Research on the effects of psychological interventions indicates that psychotherapy is generally safe and effective in various patient populations, including children, adolescents, adults, and older adults. The effects of psychotherapy are often more enduring than the effects of psychopharmacological treatment. Literature also demonstrates that psychotherapy may decrease the overall medical costs and increase patient productivity and life satisfaction.

Part II of this guideline is adapted from the American Psychological Association's Report of the 2005 Presidential Task Force on Evidence-Based Practice (APA PTFEBP) (American Psychological Association, 2005) and applied to the practice of psychotherapy. Borrowing from APA PTFEBP, evidence-based practice in psychotherapy (EBPP) could be broadly defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (p. 5) (American Psychological Association, 2005). EBPP, therefore, could be conceptualised as a "three-legged stool," where the "legs" are 1) best available research evidence, 2) clinical expertise, and 3) patient characteristics, culture and preferences. Rather than focusing solely on *psychotherapies* that have shown to be effective for the treatment of adult patients with depression in clinical trials (i.e. best available research evidence), we have chosen to include relevant considerations around *the person of the therapist* (i.e. clinical expertise), and *the person of the patient* (i.e. patient's characteristics and preferences) in this guideline for a more comprehensive overview.

BEST AVAILABLE RESEARCH EVIDENCE

A number of different research designs can be used to provide evidence for the effectiveness of a psychotherapeutic intervention, including, but not limited to, clinical observation, qualitative research, systematic case studies, randomised controlled trials and meta-analysis. Randomised controlled trials (RCTs) have become the standard for assessing efficacy of psychotherapeutic interventions, paralleling the example of pharmacological research, and are the most widely-used type of evidence. The advantages of this approach include minimising potential biases, reducing the impact of confounding variables, and allowing for causal inferences to be drawn between treatments and outcomes. However, this approach presents limitations in the context of *psychotherapy* research because the application of a specific psychotherapeutic framework cannot be equated to the administration of a "pure" pharmacological agent, even with manualised psychotherapies. Evidence-based practice requires that the clinician consider the strengths and limitations of varied types of research. Psychotherapeutic interventions that have not been tested systematically should not be assumed to be either effective or ineffective.

Division 12 (Society of Clinical Psychology) of the American Psychological Association has created a website (www.psychologicaltreatments.org) that provides a periodically-updated list of psychological treatments that have been shown to be effective to treat specific mental disorders. The treatments included are separated into two categories by the robustness of available research evidence: *strong research support* and *modest research support*. The current list of empirically-supported treatments (ESTs) with corresponding levels of research support is shown in Tab. 1. A brief description of each of the treatments is provided below.

Behavioural activation (BA) (Hopko et al., 2003) is considered an EST for depression with strong research support. BA assumes depression persists because a person with depression withdraws from his or her environment, which

Empirically supported treatments for adults with depression	
Behaviour therapy/behavioural activation	Strong research support
Cognitive therapy	Strong research support
Cognitive behavioural analysis system of psychotherapy	Strong research support
Interpersonal therapy	Strong research support
Problem-solving therapy	Strong research support
Self-management/self-control therapy	Strong research support
Acceptance and commitment therapy	Modest research support
Behavioural couples therapy	Modest research support
Emotion-focused therapy (process-experiential)	Modest research support
Rational emotive behavioural therapy	Modest research support
Reminiscence/life review therapy	Modest research support
Self-system therapy	Modest research support
Short-term psychodynamic therapy	Modest research support

Tab. 1. Empirically supported treatment for adults with depression

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decreases the reinforcement available for non-depressed behaviour. The goal of treatment is to increase exposure to positive reinforcement of non-depressed behaviour (e.g., pleasant and/or productive experiences and social activities). Treatment can range from eight to 24 sessions and requires the patient to complete homework between each session.

Cognitive therapy (CT) (Beck, 1995) is another EST with strong research support. Aaron Beck is credited for developing CT in the 1960s. In his theory it is assumed that depression develops and persists because a person has a negative view of himself/herself, the world, and his or her future. According to CT, people with depression often believe they are unlovable, helpless, and worthless. The goal of CT is to teach the patient to identify, evaluate, and change maladaptive thoughts and beliefs so that their cognitions are more accurate and adaptive. Treatment often lasts from eight to 16 sessions and can include "booster sessions" for up to a year for relapse prevention.

Cognitive behavioural analysis system of psychotherapy (CBASP) (Arnow, 2005) is a treatment that was developed specifically for chronic depression. This treatment model draws from the work of developmental psychologist Jean Piaget and assumes that people with chronic depression have deficits in the areas of social problem solving, affect regulation, and communication. A main component of CBASP is conducting a situational analysis (SA) which assists a person in modifying maladaptive thoughts and behaviours, increasing awareness of the consequences of one's thoughts and behaviours, and to change patterns that maintain depression. CBASP can last up to 32 sessions.

Interpersonal therapy (IPT) (Weissman, 2006) is based on the premise that a change in the social environment of a person is often what causes depression to start and persist. The aim of treatment is to address interpersonal deficits, resolve grief, process through life transitions successfully, and to resolve interpersonal disputes. IPT assumes that improved relationship patterns will decrease depressive symptoms over time. Treatment is typically 12 to 16 sessions (Weissman, 2006).

Problem-solving therapy (PST) (Bell and D'Zurilla, 2009) is a therapy approach that attempts to reduce symptoms of depression by increasing a person's ability to solve current problems in his or her life. The therapy involves teaching a person to identify a problem, identify possible solutions, select the most promising solution, develop and implement an action plan, and then assess how effective the problem-solving attempt was. Treatment is typically eight to 16 sessions.

Self-management/self-control therapy (Rehm, 1977) for depression was developed in the 1970s by Lynn Rehm and was modelled after Frederick Kanfer's model of self-control. This approach to treatment assumes depression is caused by deficits in the areas of self-monitoring, self-evaluation, and self-reinforcement. Treatment involves didactic presentations and other instructional exercises to teach the skills needed to improve these areas. The person is expected to complete homework assignments that involve practicing the skills they have learned between sessions. Treatment typically lasts around ten sessions.

Acceptance and commitment therapy (ACT) (Hayes et al., 2004) is a treatment modality that emerged from the tradition of behavioural analysis that uses acceptance and mindfulness techniques to move to a posture of openness to and restructuring of psychological experience. It is theorised that psychopathology comes from psychological inflexibility and as such, movements toward flexibility have the potential for rapid symptom improvement. Commitment and behaviour change strategies offer the individual the opportunity to change or persist in behaviours in a more congruent way with their values. Treatment typically lasts around 12 sessions.

Behavioural couples therapy (BCT) (Fischer and Fink, 2014) is a treatment theoretically rooted in the social learning theory, behaviour analysis, and uses operant conditioning principles. It is designed for couples with relationship distress and one depressed partner. It uses behavioural interventions that focus on negative exchanges between partners, communication, conflict reduction, and problem solving. It is broadly designed to decrease depression in the impacted individual and also improve relationship functioning. BCT typically includes 12–20 sessions.

Emotion-focused therapy (EFT) (Greenberg and Watson, 2006) builds on Leslie Greenberg's general process-experiential approach that was designed to help patients identify, utilise, and process emotions. Depression is thought to stem from poor processing of emotion and as such relief is gained through healthier experience and response to emotions. EFT typically includes three specific phases of treatment, i.e. emotion awareness, emotion regulation, and emotion utilisation. Through this, individuals become more in touch with and open to their emotional experience and learn to regulate them better or generate more adaptive alternatives. Treatment typically lasts 16–20 sessions.

Rational emotive behavioural therapy (REBT) (DiGiuseppe et al., 2002) is a form of cognitive behavioural therapy developed by Albert Ellis. It is a present-focused, directive, short-term therapy modality. In REBT the therapist works with his or her clients to help them make changes in their maladaptive cognitions and core beliefs that contribute directly to emotional and behavioural difficulties.

Life review/reminiscence therapy (Korte et al., 2012; Serrano et al., 2004). This therapy modality is designed for older adults with depression and is based theoretically on Eric Erikson's life stage theory and seeks to establish ego integrity. The therapist acts as a coach and guide as the individual reconstructs the story of their life examining both positive and negative memories while gaining perspective, acceptance of self, and conflict resolution. Goals include decreasing depression, increasing self-care, and coping with transition, loss and crisis, and ultimately finding meaning in this stage of life. This treatment typically lasts 4–12 sessions.

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Self-system therapy (SST) (Vieth et al., 2003) is a brief, structured psychotherapy for the treatment of depression in individuals who struggle primarily with self-regulation. Depression is conceptualised as a failure of motivation and goal pursuit due to chronic failures. SST combines techniques from other empirically validated therapeutic interventions, such as behavioural activation, cognitive and interpersonal therapies. The ultimate goal is to shift to more realistic goals and effective means of pursuing and attaining them. This treatment generally lasts 20–25 sessions.

Short-term psychodynamic therapy – this short-term modality broadly focuses on increasing the individual's awareness of dysfunctional patterns and relational themes related to depression. While there are numerous psychodynamic approaches that have been studied, many involve increasing the awareness of the how past experiences influence the present, affect and emotional expression, avoidance, facilitation of insight, the therapeutic relationship, and identification of core relational themes. This time-limited therapy typically lasts 16–20 sessions.

CLINICAL EXPERTISE

The APA PTFEBP defines "clinical expertise" as "competence attained by [clinicians] through education, training, and experience resulting in effective practice [and] is not meant to refer to extraordinary performance that might characterise an elite group (e.g., the top two percent) of clinicians" (p. 9) (American Psychological Association, 2005). Clinical expertise guides the integration of best available research evidence with specific patient characteristics and preferences to produce a personalised treatment that would lead to the best possible outcomes.

There is strong evidence to support a positive correlation between the level of expertise of the individual clinician and patient outcomes. Therefore, clinical expertise (above and beyond the EST of choice) should be viewed as a way of improving patient outcomes. The widely-agreed-upon areas of competence that comprise clinical expertise are as follows:

1. assessment, diagnosis, and case formulation;
2. treatment planning and implementation, ongoing monitoring of patients' progress;
3. interpersonal expertise;
4. self-reflection and utilising available resources, ongoing professional growth;
5. scientific expertise;
6. diversity expertise.

Assessment, diagnosis, and case formulation

The psychotherapist should conduct a thorough assessment of patient pathology and relevant strengths, which will inform an accurate diagnostic judgment. The clinician should develop a clear case formulation that is informed by an established psychological theory. For more detail on assessment and diagnosis, see Patient management section in Part I: Psychiatric management or this guideline.

Treatment planning and implementation, ongoing monitoring of the patient's progress

Treatment planning should be informed by the patient's case formulation. In other words, the clinician should always have a coherent rationale for the treatment strategy utilised. The choice of treatment strategy should also be informed by research evidence on the effectiveness of the particular approach. Treatment planning includes identifying the patient's specific problem areas and setting measurable and achievable goals and objectives for treatment that are in line with the patient's preferences and available resources. In order to achieve this, the clinician should develop the treatment plan in collaboration with the patient. Treatment implementation involves a process of ongoing fine-tuning of the treatment strategy based on the patient's feedback (communicated overtly or covertly).

Patient progress should be monitored on an ongoing basis (which may include the use of outcome measures, such as the 9-item Patient Health Questionnaire – PHQ-9) (Kroenke et al., 2001) or 7-item Generalized Anxiety Disorder scale (GAD-7) (Spitzer et al., 2006). If there is not sufficient progress, the clinician should evaluate possible obstacles to the implementation of the treatment plan and assess for possible rupture in the therapeutic alliance. The treatment strategy may need to be adjusted accordingly. In cases where insufficient progress persists, the diagnosis and case formulation may need to be revised.

Interpersonal expertise

At its core, psychotherapy is an interpersonal relationship between the therapist and the patient. Both the interpersonal skill of the therapist and the quality of fit between the therapist and the patient impact treatment outcomes. Interpersonal expertise encompasses establishing therapeutic alliance, instilling hope, and responding empathically to the patient's concerns. One critical element of interpersonal expertise is the ability to create a safe and supporting therapeutic environment, where the patient's maladaptive behaviours or cognitions can be effectively disclosed and challenged. The expert therapist is able to be flexible in how he or she relates to patients from a variety of backgrounds and interpersonal styles so that openness, exploration and change are fostered.

Self-reflection and utilising available resources, ongoing professional growth

Continued self-reflection on the person and practices of the therapist (e.g., one's affective experience, case formulation and hypotheses, ethics framework, knowledge base and skill set) is essential to clinical expertise. This self-reflection should prompt the therapist to reformulate case conceptualisations when deemed inaccurate/incomplete and enhance treatment strategies accordingly. The expert therapist is also

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mindful of personal biases which could impact his or her clinical judgment/intuition. In addition, the therapist effectively maintains professional boundaries in the therapeutic relationship and, when appropriate, seeks out consultation or supervision in situations involving boundary crossing. The therapist should actively seek out new knowledge and skills from a variety of sources, such as feedback from supervisors, colleagues and patients, continuing education and professional literature.

In cases when an adjunctive empirically-supported and/or culturally-sensitive treatment could be of benefit to the patient, the therapist should consider making such a referral; patients who show insufficient response with psychotherapy alone often benefit from concurrent pharmacotherapy. If the patient is not making progress as expected, the therapist should seek consultation or supervision. When insufficient progress persists, the therapist should consider referring the patient to another provider.

Scientific expertise

An expert psychotherapist's work is informed by psychological theory and research data. This means that the expert therapist is an active consumer of psychological research, prioritising trusted peer-reviewed journals and presentations sponsored by national-level professional associations.

Diversity expertise

In assessment, diagnosis, treatment planning and implementation the therapist should take into account the unique characteristics of the patient and their environment. The individual, cultural, and contextual differences that may influence treatment include age and developmental stage, sex and gender identity, socioeconomic status, race and ethnicity, culture, sexual orientation, religion/spirituality, ability/disability, and other factors. The expert psychotherapist adapts treatment strategies and creates an environment that both validates and accommodates these diversity characteristics. It is recommended that the therapist consult published discipline-specific guidelines for multicultural practice.

PATIENT CHARACTERISTICS, CULTURE, AND PREFERENCES

There is considerable evidence to suggest that treatment outcomes are impacted by a number of patient-related variables, including the patient's level of functioning, motivation for change, and the amount of available social supports. Other essential patient characteristics are the aetiology of the disorder and present comorbidities, developmental/life stage factors, socioeconomic, cultural, and familial aspects, recent or current life stressors, and treatment-related preferences, to name a few. Evidence-based practice in psychotherapy requires that the therapist be mindful of such patient characteristics and allow for these characteristics to shape their approach to fostering a treatment relationship, developing a case formulation, and implementing treatment of the individual patient. In other words, "it is important to know the person who has the disorder in addition to knowing the disorder the person has" (p. 16) (American Psychological Association, 2005).

Psychotherapy is a collaborative process in which the patient and the therapist work together in agreed-upon ways that are most likely to lead to positive outcomes. EBPP requires that therapists carefully assess patient values and preferences (e.g., beliefs, goals/objectives, and preferred treatment options/modalities) and balance these factors with their own clinical judgment (which, in turn, is informed by available evidence and clinical expertise) in selecting the most appropriate treatment. Therefore, clinical decisions regarding a particular intervention or treatment plan should be made in collaboration with the patient and with consideration of the likely costs, benefits, and available resources.

CONCLUSIONS

The above guideline represents the state-of-the-science of psychological treatment of depressive disorders in adult patients, based on the research evidence published in western professional literature. It should be noted that not all of the empirically-supported treatments mentioned in this article are equally available in different geographic areas and some may be unavailable in the reader's region at the present time. However, as was suggested above, evidence-based psychotherapy for the treatment of depression is not only about picking the "right" treatment modality. The psychotherapist's clinical expertise and ability to evaluate and incorporate patient characteristics and preferences into treatment can be equally important for the treatment's outcome.

Conflict of interest

The authors do not report any financial or personal links to other persons or organizations that might negatively affect the content of this publication and/or claim rights thereto.

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