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Article

Cognitive-behavioural therapy versus psychodynamic psychotherapy for the treatment of depression: a critical review of evidence and current issues

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Abstract

Two of the most popular psychotherapeutic approaches to treat depression are cognitive-behavioural therapy and psychodynamic psychotherapy, yet little consensus has been reached concerning which therapy is most beneficial for the treatment of depression. A review of the literature revealed that, while cognitive-behavioural therapy and psychodynamic psychotherapy are the most effective psychotherapeutic modalities for the treatment of depression, evidence suggests that neither of these modalities is superior to the other. Furthermore, multiple issues plague the studies investigating these treatments. Efficacy and effectiveness are often confounded, while rates of remission and response are often far less than might be expected from such highly regarded and widely used treatments. Severity of depression appears to moderate treatment outcomes, yet many studies overlook this, while the impact that the aetiology of a patient's depression has on treatment outcomes is largely ignored in the literature. Additionally, a majority of studies have focused on therapies of short duration, which often have poor follow-up results. Finally, mechanisms of change in the treatment of depression have been ignored to a large extent, but there is some evidence that non-specific therapeutic factors may be more important than specific therapeutic techniques in producing positive treatment outcomes. These issues need to be closely examined and resolved if researchers and clinicians are serious about optimising treatments, improving outcomes, and adequately addressing the serious problem of depression.

Keywords

CBT, cognitive-behavioural therapy, depression, psychodynamic psychotherapy, treatment

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Since 2006, depression has accounted for the fourth-highest burden of disease across the globe (Mathers & Loncar, 2006) and is expected to rank second by 2020 (World Health Organization, 2001) and first by 2030 (Mathers & Loncar, 2006). Studies assessing the prevalence rates of depression suggest that one in five people living in high-income countries experiences a depressive episode in his or her lifetime (Blazer, Kessler, McGonagle, & Swartz, 1994; Jacobi et al., 2004). In response to this, psychologists have been trying to deliver evidence-based best practice interventions, and over 350 randomised controlled trials (RCTs) have shown that psychotherapies are an efficacious form of treatment for depression (Cuijpers, van Straten, Andersson, & van Oppen, 2008).

While there is evidence that psychotherapeutic interventions can help treat depression, many issues surround the determination of which treatment modality is most effective. Much empirical support has been found for cognitive-behavioural therapy (CBT) (see Butler, Chapman, Forman, & Beck, 2006; Churchill et al., 2001) and psychodynamic psychotherapy (PP) (see Driessen et al., 2010; Shedler, 2010), and a comparison of these two therapies and the issues surrounding their research is of particular interest given their popularity in clinical practice (Cuijpers et al., 2008; O'Neal, Jackson, & McDermott, 2014).

This overview article will begin by summarising the evidence in support of CBT and PP and will then highlight findings from comparisons between these two therapeutic modalities. Thereafter, key issues surrounding the investigation of CBT and PP in the treatment of depression will be discussed. A summary of these issues and their implications for the future research and practice of psychotherapy in the treatment of depression will conclude the article. Out of necessity, this article has to operate at a very high level of abstraction, and as such, despite the various forms of CBT and PP, these terms have to be used in a general way.

The evidence base for CBT and PP in the treatment of depression

CBT and PP have both been tested empirically under a variety of conditions and have been found to be efficacious treatments for depression when compared to usual care, wait-list control, or placebo conditions (for a definitive guide to CBT, see Beck, Rush, Shaw, & Emery, 1979; for a description of PP, see Shedler, 2010). Butler et al. (2006) and Cuijpers et al. (2008) reviewed meta-analytic evidence from a collective 123 studies and found substantial support for the efficacy of CBT in the treatment of depression.

The most common form of PP investigated in the literature is short-term PP (STPP). The reason for this is that it is manualised (e.g., Luborsky, 1984) and time-limited (Lewis, Dennerstein, & Gibbs, 2008) and is thus comparable to manualised, time-limited CBT interventions. The reviews and meta-analyses by Barth et al. (2013), Cuijpers et al. (2014), Driessen et al. (2010), Leichsenring (2001), Leichsenring and Klein (2014), and Leichsenring and Schauenburg (2014) summarised the findings of a large majority of the literature investigating the efficacy of STPP and showed that STPP effectively led to significant reductions in depressive symptoms in 51 independent RCTs.

Comparing CBT and PP

While considerable evidence exists showing that CBT and PP are efficacious treatments for depression, what might be of greater interest is which of the two treatments is most effective when compared to one another. Due to the limited number of studies directly comparing CBT and PP, studies comparing a variety of therapeutic modalities to each other are included below, but only the results pertaining specifically to CBT and PP are reported.

Dobson (1989) and Gloaguen, Cottraux, Cucherat, and Blackburn (1998) found CBT to be more effective than non-CBT interventions, including PP, over 76 independent RCTs. In a review of meta-analyses comparing CBT to STPP in the treatment of depression, O'Neal et al. (2014) found that, overall, CBT appeared to be slightly more efficacious than STPP, but that the effectiveness of the two treatments seemed to be the same (the importance of distinguishing effectiveness from efficacy will be discussed later).

In contrast, Barth et al. (2013) and Cuijpers et al. (2008) conducted meta-analyses of a combined 236 RCTs comparing seven psychotherapeutic modalities in the treatment of depression, and found no significant differences between any of the modalities (including CBT and STPP), and moderate to large effect sizes for treatment groups compared to control groups. King (1998) compared the data pertaining specifically to CBT from the seminal National Institute of Mental Health (NIMH) study on depression (Elkin et al., 1989) to three other short-term psychotherapies (including STPP), and found that there was no evidence that CBT was superior in the short-term to other psychotherapies, or even to placebo. Leichsenring (2001) conducted a meta-analysis of six RCTs using stringent selection criteria and found both STPP and CBT to be highly effective treatments for depression, with no differences in outcome between the two modalities.

Overall, the evidence to date suggests that CBT and STPP are equally effective for treating depression. However, numerous issues surround the evidence for these therapies, meaning that results of clinical importance may be obscured.

Issues concerning the investigation of CBT and PP for depression

Multiple issues beset the literature concerning treatments for depression, including (but not limited to) researcher allegiance (see Gaffan, Tsaouis, & Kemp-Wheeler, 1995), outcome measures chosen (see Shapiro et al., 1994; Steuer et al., 1984), lack of consensus over what types of research provide acceptable evidence for the usefulness of a therapeutic modality (see Barth et al., 2013; Cuijpers et al., 2008; Cuijpers, van Straten, Bohlmeijer, Hollon, & Andersson, 2010; Wampold, Minami, Baskin, & Tierney, 2002), and complex statistical analyses that are difficult for clinicians to interpret (see Shedler, 2010). As these issues are discussed in the aforementioned papers, I will focus on other issues that seem to be most crucial when determining which therapeutic modality might be better for the treatment of depression.

Efficacy versus effectiveness

When assessing how well a treatment modality works, understanding the difference between efficacy and effectiveness is imperative. Efficacy refers to 'how well a particular therapeutic intervention works under scientific, experimental conditions' (O'Neal et al., 2014, p. 199). Most studies assessing CBT and PP assess the efficacy of these treatments in RCTs, which are said to be the very essence, or gold standard, of evidence-based practice (Bower, 2003). While RCTs have good internal validity, they often possess questionable external validity (O'Neal et al., 2014), meaning that results attained in a highly controlled RCT may not be found in real-world clinical settings where many variables are uncontrolled and may influence treatment outcomes.

This is where the concept of effectiveness becomes important. Effectiveness can be understood as the clinical utility of a particular treatment across a variety of treatment environments, where all variables cannot be controlled (O'Neal et al., 2014). Effectiveness assesses whether therapy provides any tangible or practical benefits for patients in their day-to-day lives outside of treatment, and while a psychological treatment may demonstrate excellent efficacy, it may have poor

effectiveness. As such, an increase in the number of studies investigating effectiveness will help supplement efficacy studies to link research and practice more closely (Westen & Morrison, 2001).

One of the only studies to take this into account was that of Cuijpers et al. (2014), who conducted a meta-analysis of 92 RCTs assessing the effects that various psychotherapies had on depression. They avoided the use of effect sizes, relative risks, or odds ratios to present their findings, noting that the use of these statistical methods often obscures actual therapeutic change (for a more thorough discussion of the pitfalls of using effect sizes to measure the clinical utility of a treatment, see Cummings, 2011). Instead, Cuijpers et al. measured therapeutic change by assessing (a) score reduction on standardised depression measures from pre- to post-treatment, (b) the number of patients who responded to treatment, and (c) the number of patients who achieved remission as a result of treatment. They found that the studies they had analysed had inflated the amount of clinically significant change that took place in patients' depressive symptoms, as results were most often reported in terms of effect sizes and not in terms of clinically significant reductions on a depression measure. This means that previous studies may have confounded the efficacy of a treatment with clinically significant, lasting change in a patient's life (i.e., effectiveness), giving the impression that the treatment was more useful than it may actually have been.

Rates of remission and response

A major issue in the treatment of depression using CBT or PP is determining just how effective the treatments are. In other words, does either treatment bring about clinically and statistically significant ($p < .05$) remission (i.e., no presence of depression post-treatment), and/or response rates (i.e., a 50% or greater reduction on a depression measure) (Cuijpers et al., 2014) after treatment?

Andersson et al. (2013) showed very low rates of remission for group-based CBT (19%), and Driessen et al. (2013) showed remission rates of 24.3% for CBT and 21.3% for STPP after 16 sessions of treatment over 22 weeks, whereas response rates were 38.7% and 36.9%, respectively. Gloaguen et al. (1998) found average remission rates of only 29% at one year follow-up over 48 studies investigating CBT, while the meta-analysis by Cuijpers et al. (2014) found results suggesting that psychotherapies only provide a disappointing 14% benefit over usual care. Shea et al. (1992) conducted a follow-up study of the participants in the NIMH study of depression (Elkin et al., 1989), and found remission rates of only 26% both eight weeks after therapy and at the 18 month follow-up for the sample who received CBT. Relapse rates were 36% for the CBT group at 18 month follow-up, and no differences were found between CBT and other therapeutic modalities for remission or relapse. Additionally, the studies by Barkham, Shapiro, Hardy, and Rees (1999), Shapiro et al. (1994), and Shapiro, Rees, Barkham, and Hardy (1995) found no difference in rates of remission or response between CBT and STPP at long-term follow-up (one year or greater).

Driessen et al. (2013) understand low remission and response rates as results of the time-limited duration of treatment. Across all studies, this seems to be a possible factor contributing to poor rates of remission and response and the resultant lack of benefit from therapy for many patients. Additionally, it should be noted that response to treatment does not mean that a patient returned to normal functioning or obtained maximum benefit from the treatment (Leichsenring, 2001), and it is likely that people respond differently to various therapeutic modalities for multiple reasons. As such, Parker, Roy, and Eyers (2003) suggest that researchers need to start focusing on determining when specific therapeutic modalities will be most effective, and for which patients. Which therapy suits which person? Under what conditions? Why is that so? How can this information be used to improve treatment? These questions have yet to be answered and may be the missing link in understanding why response and remission rates are, on average, so poor.

Factors influencing treatment outcomes

The severity of a patient's depression might be a fundamental factor determining which therapeutic modality would work best, as greater severity is correlated with poorer treatment response and poorer long-term outcomes (Elkin et al., 1995; Haby, Donnelly, Corry, & Vos, 2006; Shea et al., 1990; Thase, 1996). For patients with mild to moderate depression, CBT seems to be as efficacious as STPP (e.g., Barth et al., 2013; Cuijpers et al., 2008; Driessen et al., 2013; Leichsenring, 2001; Wampold et al., 2002) or more efficacious than STPP in some cases (e.g., Barkham et al., 1999; O'Neal et al., 2014), but CBT is unlikely to be effective for more severely depressed patients (DeRubeis, Galfand, Tang, & Simons, 1999; Hollon, Shelton, & Davis, 1993).

Thase, Bowler, and Harden (1991) found that 16-session CBT proved to be effective for more severely depressed patients immediately after treatment, but that 75% of their sample relapsed after being discharged from the hospital. Similar results found by Shea et al. (1992) suggest that more intensive or extended therapy might be required for more severely depressed patients.

A problem pervading the literature on treatment for depression is that, while multiple models of depression have been proposed – including biological (see Malhi, Parker, & Greenwood, 2005), social (see Brown & Harris, 1978), and biopsychosocial models (see Schotte, Van Den Bossche, De Doncker, Claes, & Cosyns, 2006) – a unitary view of depression as a disorder that can be simply differentiated according to severity is dominant. This obscures the fact that people with different types of depression (e.g., melancholic, non-melancholic, and psychotic; Malhi et al., 2005) are likely to respond to different kinds of therapy, which may be the reason why different treatments work for different people. Additionally, scant attention is paid in the treatment literature to the various socioeconomic conditions that have long been known to give rise to and perpetuate depression (e.g., low socioeconomic status, serious losses, major difficulties in life, chronic stress, and trauma; Brown, 1993; Brown, Harris, & Hepworth, 1994; McGonagle & Kessler, 1990).

In South Africa in particular, low socioeconomic status (along with the high rates of violence, crime, poverty, and trauma that go along with it) is associated with increased prevalence of mental illness (Myer, Stein, Grimsrud, Seedat, & Williams, 2008). None of the literature has addressed whether CBT or PP is effective in settings where socioeconomic problems abound and have such a strong relationship with mental illness. In such settings, contextualising treatment approaches is imperative, and the fact that these therapies are focused on individual capacities and growth means that they may arguably be less effective and less appropriate than other methods of psychological service provision (like community-focused preventative measures or support groups for depressed individuals).

Duration of treatment

There is a paucity of studies assessing the long-term effects of various therapeutic modalities (Dekker et al., 2008; Driessen et al., 2013; Parker et al., 2003), which might be particularly relevant as different types of therapy are intended to be effective over different time frames. For example, while an overwhelming majority of studies investigating PP focus on STPP, a basic principle of PP is that insight and change take time and are not necessarily easily produced in a predetermined number of sessions (Shedler, 2010).

Howard, Kopta, Krause, and Orlinsky (1986) showed that studies of less than 13 sessions of STPP may produce questionable results due to the insufficient time provided for treatment to bring about change. Hilsenroth, Ackerman, Blagys, Baity, and Mooney (2003) conducted a study of the effectiveness of open-ended PP (i.e., not time-limited) for depression, and 65% of their sample demonstrated clinically significant improvement (although a limitation was that the naturalistic

design of this study and lack of a control group made the statistical significance of this result indeterminable). Svartberg and Stiles (1991) found that therapies of more than 12 sessions of STPP produced significantly greater improvements than briefer therapies when compared to wait-list control groups. Additionally, Shapiro et al. (1995) showed that improvement was substantially better after 16-session therapy when compared to eight-session therapy (CBT or STPP), and that eight-session STPP might be insufficient to treat major depression. Collectively, these results provide support for the claim by Driessen et al. (2013) that longer therapies might be required to attain better rates of remission and response, especially for patients with more severe depression.

Mechanisms of change

While it has been shown that CBT and PP can result in favourable outcomes for depressed patients, 'no well-established mediators or mechanisms of change are known for psychotherapies for depression' (Cuijpers, 2013, p. 1057). This may seem trivial if psychotherapies are able to help all, or at least the majority of patients with depression. However, low remission and response rates mean that elucidating the therapeutic factors resulting in symptom reduction for patients with depression may be the determining factor that helps improve future treatment.

The central hypothesis in CBT is that depression is cognitively mediated (Beck et al., 1979). As such, changes to maladaptive cognitive schemas and attitudes should lead to recovery from depression. However, Parker, Gladstone, Mitchell, Wilhelm, and Roy (2000) and Quilty, McBride, and Bagby (2008) found evidence that depression may cause negative cognitions (rather than negative cognitions causing depression), while Burns and Spangler (2001) found no support for the cognitive mediation hypothesis, nor for the hypothesis that change in depression leads to changes in attitudes.

Studies showing that cognitive therapy is equal to behaviour therapy (Gloaguen et al., 1998) and CBT (Miller & Berman, 1983) provide further evidence suggesting that cognitive restructuring techniques have little to do with symptomatic improvement (Ilardi & Craighead, 1994), meaning that non-specific treatment factors might be responsible for improvement (Burns & Nolen-Hoeksema, 1992; Orlinsky, Ronnestad, & Willutzki, 2004; Wampold, 2001b). As such, there is minimal evidence with regard to a cognitive-mediational mechanism of depression, suggesting that 'cognitive components of CT may not be necessary to treat depression psychologically' (Wampold et al., 2002, p. 163).

Barber, Crits-Christoph, and Luborsky (1996), Hilsenroth et al. (2003), and Leichsenring and Schauenburg (2014) have shown that the effectiveness of psychodynamic treatment may be due to the techniques utilised. Blagys and Hilsenroth (2000) identified seven techniques and mechanisms that distinguish PP from other therapies and that are central to the change process in PP, namely (a) a focus on affect and expression of emotion, (b) exploring patient attempts to avoid distressing thoughts and feelings, (c) identifying recurrent themes and patterns, (d) discussing past experiences, (e) focusing on interpersonal relations, (f) focusing on the therapeutic relationship, and (g) exploring wishes and fantasies. Of importance, multiple studies (e.g., Ablon & Jones, 1998; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Hayes & Strauss, 1998; Jones & Pulos, 1993; Teasdale, 1999) have found that these techniques, traditionally understood to be psychodynamic, are significantly related to depressive symptom reduction in CBT when employed in this treatment.

Ablon and Jones (1998, 1999) have shown that, in practice, therapists often blend therapeutic techniques belonging to different theoretical frameworks, despite attempting to practise a particular brand of psychotherapy (e.g., CBT), and that a therapist's use of psychodynamic techniques predicts successful therapeutic outcomes regardless of whether the therapist is practising CBT or

PP (see also Jones & Pulos, 1993). This means that therapeutic processes are rarely strictly manual-based, and this calls into question whether it is the therapeutic modality that is really of importance, or whether non-specific factors are most important in determining whether therapies are effective.

Common therapeutic factors

Studies finding that all psychotherapies are equally effective for the treatment of depression (e.g., Barth et al., 2013; Cuijpers et al., 2014; Wampold et al., 2002) suggest that the non-specific and interpersonal aspects of psychotherapy, rather than specific therapeutic techniques, may be what are of true importance in bringing about therapeutic change (Orlinsky et al., 2004; Wampold, 2001b). For example, a positive therapeutic alliance/relationship (traditionally a psychodynamic concept, now accepted to be a key component of all successful psychotherapies; see Krupnick et al., 1996) has long been lauded as a possible common factor mediating recovery in a variety of disorders (see Grencavage & Norcross, 1990; Horvath & Bedi, 2002; Orlinsky et al., 2004). Therapist expressions of confidence in the process of therapy have been found to strongly predict maintenance of therapeutic gains (Shapiro et al., 1995), while factors such as a therapeutic explanation for a client's distress (Frank & Frank, 1991; Wampold, 2001a, 2001b); a patient's perception of the therapist as skilled, involved, and confident (Cuijpers, 2013; Shaw et al., 1999); and a patient's belief in or expectations of therapy may predict positive therapeutic outcomes better than other possible moderators like cognitive style (Greenberg, Constantino, & Bruce, 2006; Wampold, 2012).

Indeed, it is often assumed that the success of an effective therapy is due to the therapeutic techniques utilised (Ablon & Marci, 2004). However, research has shown that therapeutic success may depend as much on patient characteristics – such as commitment to therapy, being able to reformulate problems, and a willingness to challenge themselves (Ablon & Marci, 2004; Crowe et al., 2012; Krupnick et al., 1996) – as on the techniques employed in therapy. Incisively, Wampold (2012) asserts that the most important common factor linking all psychotherapies is their inherent humanism, the genuine interest in improving another person's quality of life by focusing on the 'personal, interpersonal and contextual dimensions of therapy and on clients' reflections on their relationship with self, others, and the larger psychosocial world' (Schneider & Längle, 2012, p. 427).

While this article focuses only on two types of psychotherapy for the treatment of depression, considering that these two treatments show little difference in outcomes (as is common with many psychotherapies), and that there is evidence that non-specific therapeutic factors may be responsible for therapeutic improvement, perhaps the question of 'Which therapy is better?' should be replaced by 'Why are these therapies producing the same outcomes and what are we missing?'. The answer to the latter question may lie in the mechanisms of change, and while much research has tried to uncover what these mechanisms are, there is little consensus about what actually produces change in psychotherapy for depression (Crowe et al., 2012; Cuijpers, 2013).

Future directions for research and practice

This overview article has raised several important issues in psychotherapy research concerning the treatment of depression with CBT and PP. First, it appears that CBT and PP are equally effective for the treatment of depression, yet rates of remission and response are too low to consider either of these treatments a panacea. Future research should include longitudinal designs to determine whether treatment results are maintained over time, and to determine which factors contribute to

poor remission and response. Second, once the efficacy of a treatment has been shown, further research should focus on determining the effectiveness of the treatment to see whether it is able to bring about lasting clinically significant positive change in a person's life outside of therapy. Finally, the treatment literature has almost completely ignored the factors that influence treatment outcomes as well as what therapeutic ingredients are actually responsible for positive outcomes. Both non-specific therapeutic factors and psychodynamic techniques in particular may be responsible for at least some degree of the positive change effected in both CBT and PP. Research aimed at uncovering the therapeutic processes responsible for change is sorely needed, and Kazdin (2009) provides instructive guidelines as to how this may be achieved.

By elucidating the therapeutic processes that produce change, researchers and clinicians will be able to combine the strengths of different therapeutic approaches in order to deliver optimally effective treatments for depression. This will help streamline treatment processes by enabling therapists to be trained with specific skills to treat depression, and will help provide the most effective care to people suffering from this serious and debilitating psychiatric disorder. In conclusion, we return to the question raised almost half a century ago by Gordon Paul (1967): '*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem and under which set of circumstances?' (p. 111). In the South African context, this question could not be more appropriate, and while the way forward may well be paved by combining the strengths of multiple treatment approaches, for the time being, clinicians will need to rely on their own training, instincts, and experience until more conclusive evidence can point towards a superior or more effective treatment modality.

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