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Is cognitive behaviour therapy of benefit for melancholic depression?

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Abstract

Objective: This paper seeks to determine the relevance and likely salience of cognitive behaviour therapy (CBT) as a treatment for melancholic depression.
Methods: The findings of a randomised trial comparing 12-week outcome of 18 patients with melancholic depression receiving antidepressant medication and 11 receiving CBT were evaluated, and qualitative explanations for the outcomes were provided principally by the treating CBT practitioners.
Results: In the trial, CBT showed no improvement in depression severity in the first four weeks and then some level of improvement over the subsequent eight weeks. Outcome was superior for those receiving antidepressant medication at 12 weeks and was first demonstrated at four weeks. The benefits of CBT appeared to be in settling anxiety, dealing with cognitive processing of having a melancholic depression and addressing any personality vulnerabilities.
Conclusion: While a pilot study, our qualitative reports indicate that CBT may provide a useful role in managing melancholia as an adjunct to antidepressant medication. Future studies examining such a combination treatment model should seek to determine if indicative data provided here argue for a sequencing model of CBT being introduced after medication has addressed core biological underpinnings.

Cognitive behavioural therapy (CBT) has become the psychological treatment of choice for patients suffering from depression, with a variety of studies attesting to its benefits [1]. CBT assumes that dysfunctional cognitive attitudes both predispose to and maintain depression, and employs specific treatment strategies designed to identify and modify dysfunctional and automatic thoughts. It has also been positioned as superior to antidepressant medication by some writers, with support coming from a meta-analysis undertaken by Gloaguen et al. [2] – although findings from that meta-analysis have been challenged [3].

Most studies examining the efficacy of CBT in treating depression have assumed a unitary model (i.e. there is only one type of depression varying in severity). If depression is a unitary entity, then CBT should be an applicable strategy across depressions of differing severity – and thus have 'universal' application as a therapeutic modality. If not a universal therapy, we would anticipate CBT having differing relevance across differing depressive sub-types or for those with differing levels of depression. For example, the British government-supported NICE organization recommends CBT as the principal therapy for mild to moderate depression and an adjunctive therapy in severe depression [4]. The binary model of depression posits two principal 'types' of depression – melancholia and a contrasting residual set of non-melancholic conditions. Long-held ascriptions about melancholia include it being a more 'biological' condition in being genetically predisposed with primary biological underpinnings, having a set of relatively specific symptoms and signs, showing a minimal placebo response and being distinctly more likely to respond to physical treatments (i.e. antidepressant drugs and electroconvulsant therapy) than to psychotherapy. As reviewed elsewhere [5] the last ascription largely reflects clinical opinion rather than empirical evidence. There is, in fact, little research evaluating psychological treatments for melancholia, and with one of only a few meta-analyses reporting mixed findings [6]. The

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status of CBT as a salient and evidence-based treatment for melancholia therefore remains to be clarified.

We undertook a trial effectively comparing antidepressant medication against CBT for those with a well-characterised melancholic depressive episode [5] and who had not received medication or CBT for a significant period (if ever). We operationalized melancholia in this study as the patient a) having met DSM-IV criteria for a current major depressive episode with melancholic features; b) a diagnosis of current melancholia according to clinical interview with a specialised psychiatrist, which weighted for example, symptoms of anhedonia, psychomotor disturbance, anergia, a disproportionately severe response (i.e., [7]) and with no evidence of bipolar disorder; c) a depression severity score ≥11 on the16-item Quick Inventory of Depressive Symptomatology – self-report (QIDS; [8]). Further details of the trial are specified in the original research article [5]. Despite the small number of trial completors (n = 29), analyses comparing the 18 receiving medication with 11 receiving CBT demonstrated a significant advantage to antidepressant medication on our principal outcome measure (the Hamilton Depression Rating Scale [9] or HDS) – at four weeks as well as at trial completion at 12 weeks – and also at trial end on two secondary measures. Thus, superiority of antidepressant medication was evident across the trial, and with differentiation occurring early. Intriguingly, there was no suggested improvement in the overall CBT group over the first four weeks. Subsequently, however, the participants in the CBT group began to improve. This paper explores why there was delayed improvement, principally by drawing on qualitative information provided by the study psychologists, and considers the potential relevance of CBT to managing melancholia.

1. Methods

Recruitment was initially sought from the Black Dog Institute out-patient Depression Clinic, before being progressively extended to a wide group of Sydney psychiatrists and, later, to a large number of Sydney primary practitioners by mail contact and later by newspaper advertisements. Details on patient recruitment and selection criteria are described more fully elsewhere [5] with the most pertinent criteria being no CBT for the previous 12 months, and no antidepressant medication for the previous three months. Depression severity was measured by two principal measures – the Hamilton Depression Rating Scale or HDS [9] and the Hamilton Endogenous Scale (HES) [10] at baseline, as well as at 4, 8 and 12 weeks, while depression severity was also assessed by the self-report Daily Rating Scale or DRS [11] daily. The Hamilton Endogenous Scale measures several common features of endogenous depression or melancholia including diurnal variation, weight loss and retardation. The HDS and HES were completed by a PhD qualified blind interviewer. Participants were instructed and reminded prior to assessment not to provide details of their clinical treatment. Anecdotal evidence suggests blinding was approximately 97% effective with one patient deliberately breaking the blind.

Participants in the CBT group were assigned to one of three clinical psychologists who had training and extensive experience in treating patients with CBT. Treatment comprised 10 individual sessions of CBT delivered on a weekly basis for eight sessions followed by two fortnightly sessions. The program included teaching participants to identify links between thoughts, feeling and behaviours, to identify cognitive distortions, to challenge negative thoughts and to use specific strategies such as 'behavioural experiments' to address worry and avoidance behaviours. Participants were required to complete weekly homework tasks throughout the program. Details on medications received by those assigned to receive an antidepressant drug are provided in the principal study report [5]. In this report, results from the selective serotonin reuptake inhibitor (SSRI) and broad-spectrum anti-depressant subgroups are pooled for comparison with the effectiveness of CBT.

2. Results

2.1. Overview of progress

Eleven participants completed 10 weeks of CBT. As noted earlier, the CBT group (see Fig. 1) showed no improvement in HDS scores over the first four weeks compared to those receiving antidepressant medication (with the CBT group having a 3.4% increase in HDS scores and the medication group decreasing by 34.2%). At the final 12-week assessment the percentage improvement (from baseline) was 59.5% for those assigned to the medication arm and 32.5% for those assigned to the CBT arm. While this difference (as for the four-week analysis) was formally significant, Fig. 1 does show a 'trend break' for those receiving CBT to demonstrate some level of improvement after the first four weeks.

When we plotted HDS scores for individual CBT recipients, nine of the eleven showed no clear improvement over the first four weeks, while two participants had a

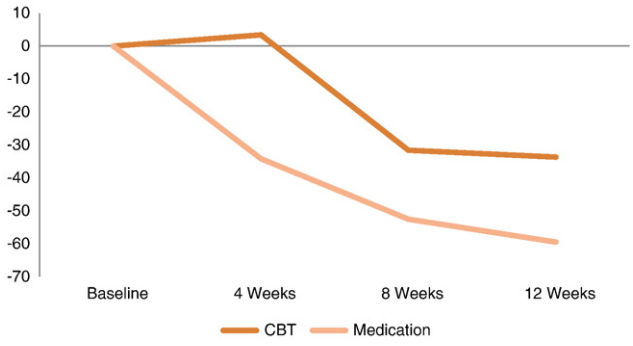

Fig. 1. Percentage Decrease in Hamilton Rated Depression Severity score from baseline every 4 weeks.