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## MISCONCEPTIONS ABOUT DEPRESSION AND ITS TREATMENT (II)

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*Este trabajo y su primera parte (Sanz y García-Vera, 2017) analizan la veracidad de diez ideas sobre la depresión y su tratamiento que se defienden en medios de comunicación de amplia difusión en Internet o en algunas guías de práctica clínica y manuales de psicopatología o psiquiatría de prestigio. Estas ideas obstaculizan que los pacientes accedan a un tratamiento adecuado para su depresión y favorecen la medicalización del mismo en detrimento de los tratamientos psicológicos. En este segundo trabajo se contrastan seis ideas sobre el tratamiento de la depresión con los resultados de la literatura científica. Una revisión de esta literatura indica que, contrariamente a esas ideas, la psicoterapia cura la depresión y, al menos en el caso de la terapia cognitivo-conductual, es eficaz tanto en la depresión leve o moderada como en la grave, es igual de eficaz que la medicación antidepressiva, previene mejor que esta las recaídas y recurrencias, y suele ser un tratamiento de corta duración. Los resultados de esta revisión se discuten en el contexto de la necesidad y de las dificultades para transmitir información sobre la salud basada en los conocimientos científicos vigentes.*

**Palabras clave:** Depresión, Psicoterapia, Medicación antidepressiva, Eficacia, Conocimientos sobre salud.

*This paper and its first part (Sanz & García-Vera, 2017) analyze the veracity of ten ideas about depression and its treatment that are defended in media widely available on the Internet or in some prestigious clinical practice guidelines and manuals of psychopathology or psychiatry. These ideas hinder patients' access to appropriate treatment for their depression and favor the medicalization of this treatment over the use of psychological therapies. In this second paper, six ideas about the treatment of depression are contrasted with the results of the scientific literature. A review of this literature indicates that, contrary to these ideas, psychotherapy cures depression and, at least in the case of cognitive-behavioral therapy, is efficacious in both mild-to-moderate and severe depression, is equally as efficacious as antidepressant medication, prevents relapse and recurrences better than antidepressant medication, and is usually a short-term treatment. The results of this review are discussed in the context of the need for –and difficulties of– transmitting health information based on existing scientific knowledge.*

**Key words:** Depression, Psychotherapy, Antidepressant medication, Efficacy, Health literacy.

**T**he objective of this paper and its first part (Sanz & García-Vera, 2017) is to contrast with current scientific knowledge some misconceptions about depression and its treatment that hinder patients from accessing appropriate treatment for their depression, favoring medicalization to the detriment of psychological treatments and defended by widely disseminated media on the Internet such as, for example, the Internet portal *DMedicina* associated with the newspaper *El Mundo*, or by some clinical practice guidelines or manuals of psychopathology or psychiatry of prestige and wide dissemination (e.g., American Psychiatric Association, 2010; González Pinto, López Peña, & Zorrilla Martínez, 2009; Grupo de trabajo de la guía de práctica clínica sobre el manejo de la

depresión en el adulto (Grupo de trabajo) [Clinical Practice Guide Working Group on Adult Depression Management (Working group)], 2014, Vallejo Ruiloba, 2005, Vallejo & Urretavizcaya, 2015). In order to do this, in the first part of this work, four of these ideas related to the nature of depression were reviewed, in light of the data currently available in the scientific literature. In this second part, the same is done with six of these ideas that deal with the treatment of depression. The latter are shown in Table 1, as well as the answers to these, which, as will be demonstrated below, correspond to the current scientific literature.

### MISCONCEPTIONS ON THE TREATMENT OF DEPRESSION

#### *Psychotherapy does not cure depression*

For *DMedicina* psychotherapy does not cure depression and its arguments to justify this claim are that:

There is no study that demonstrates that psychological techniques eradicate major depression. However, they are very useful in people who suffer from certain depressive symptoms, such as adjustment disorders (the effects of some adverse personal circumstance). In cases of major

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depression the only thing that has been proven effective is pharmacological treatment. (Editorial team of *DMedicina*, 2015, para.13)

However, contrary to the arguments in *DMedicina*, it is false that there are no studies that demonstrate that psychological therapies are effective for major depression. For example, in the meta-analysis by Cuijpers, Berking et al. (2013) on the efficacy of cognitive-behavioral therapy (CBT) in adult depression, the results of 115 studies were analyzed, of which 50 were carried out on patients diagnosed with a major depressive disorder and 29 on patients diagnosed with a mood disorder. The results of this meta-analysis clearly showed that CBT was significantly more effective than the waiting list condition (Hedges'  $g = 0.83$ ), placebo ( $g = 0.51$ ) or the usual treatment ( $g = 0.59$ ). The latter included very diverse interventions ranging from antidepressants or other psychotropic drugs prescribed by family physicians to single sessions of psychoeducation or brochures with information on therapeutic resources. The results also showed that CBT was equally effective in patients with high levels of depressive symptomatology measured by a questionnaire ( $g = 0.71$ ) and in patients with a diagnosed disorder ( $g = 0.70$ ). The Hedges  $g$  statistic is a variant of the Cohen  $d$  effect size statistic that takes into account the sample size in order to correct bias due to the use of small samples. Both statistics represent the standardized difference between two means, such that a value of  $g$  or  $d$  equal to 1 would indicate, for example, that, in posttreatment, the mean score in a depression measure of the waiting list group is one standard deviation greater than the mean score of the patient group receiving CBT. Usually, a value of  $g$  or  $d$  equal to 0.20

represents a small effect size, a value of 0.50 represents a mean or moderate size and a value of 0.80 a large size (Cohen, 1988). Thus the differences in therapeutic benefits mentioned above between CBT and the waiting list condition, treatment as usual or placebo (between  $g = 0.51$  and  $g = 0.83$ ) may be considered moderate to large according to the effect size standards.

In the same vein as the study by Cuijpers, Berking et al. (2013), a recent meta-analysis by Johnsen and Friborg (2015) demonstrated, from the results of 43 studies, that upon finishing CBT, 57% of patients could be considered as having recovered from their depression, defined as a post-treatment score on the Beck Depression Inventory (BDI) of less than 10 or even less than 7.

Although CBT is the psychological therapy with the most studies demonstrating its efficacy for depression, it is not the only one that has such studies. In the meta-analytic reviews conducted by the UK National Institute of Health and Clinical Excellence (NICE) to develop its clinical practice guideline for adult depression, a total of 64 clinical trials were analyzed on the efficacy of three types of therapies: 46 on CBT, 4 on behavioral activation therapy and 14 on interpersonal therapy, of which 41, 4 and 12 trials, respectively, were performed exclusively with patients diagnosed with major depressive disorder (National Collaborating Centre for Mental Health, 2010). The results of the NICE reviews confirmed the efficacy of the three therapies, so they were recommended in its guideline as treatments for depression in adults.

Moreover, at the present time, the list of psychological therapies that cure depression is even longer. The American Psychological Association (APA) Division 12 (Society of Clinical Psychology) has proposed a set of criteria to determine the "well-established" psychological treatments with regards to their efficacy for a psychological disorder (now called treatments with "strong research support"). The first of these criteria is that there must be at least two well-conducted intergroup experimental studies (studies with a control group and random allocation of patients to the groups, also known as controlled clinical trials) that demonstrate the efficacy of the psychological treatment showing its superiority (statistically significant) in comparison with a pharmacological treatment, a psychological placebo or another psychological treatment, or showing, in experiments with samples of adequate size, its equivalence in comparison with a treatment that has already been established. In view of these criteria, Division 12 believes that the following psychological therapies have currently shown empirically their efficacy for adult depression (Division 12 of the APA, 2016):

- ✓ Behavioral activation therapy (or behavioral therapy)
- ✓ Cognitive-behavioral therapy (or cognitive therapy)
- ✓ Interpersonal therapy
- ✓ Problem-solving therapy
- ✓ McCollough's cognitive behavioral analysis system of psychotherapy
- ✓ Rehm's self-control therapy

**TABLE 1**  
**MISCONCEPTIONS ABOUT THE TREATMENT OF DEPRESSION**

Idea	Supposedly correct answer	Answer according to scientific literature
1. Psychotherapy does not cure depression.	True	False
2. Psychotherapy is less efficacious than antidepressant medication.	True	False
3. Psychotherapy is not efficacious for severe depression, but only for mild or moderate depression.	True	False
4. Psychotherapy is worse at preventing relapses and recurrences than antidepressant medication.	True	False
5. The treatment for depression is long.	True	Partially false
6. The psychologist is not the practitioner who treats depression.	Partially true	False

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Barth et al. (2013) conducted a classic meta-analysis and a network meta-analysis on the efficacy of psychotherapy for adult patients with depression. In network meta-analyses, novel analysis techniques are used which, based on a network of studies that examine the effects of various treatments, allow the incorporation of information from direct comparisons (e.g., the comparison between treatments A and B analyzed in the same study) and indirect comparisons (e.g., the comparison of treatments A and B derived from studies that compare either of these two treatments with a common condition C, e.g., with a control condition or with another treatment). Barth et al. (2013) identified 198 clinical trials, with a total of 15,118 patients, comparing a psychotherapeutic intervention with a condition of waiting list control, treatment as usual or placebo, or another psychological treatment. As in the meta-analysis by Cuijpers, Berking et al. (2013), treatment as usual was a very heterogeneous category ranging from interventions with antidepressants or other psychotropic drugs prescribed by family physicians to single sessions of psychoeducation or brochures with information on therapeutic resources. The results of the network meta-analysis revealed that seven psychotherapies showed significantly superior therapeutic benefits to the waiting list condition with a difference between moderate and large (between  $d = -0.62$  and  $d = -0.92$ , since in these comparisons an effect size less than 0 indicated that psychotherapy was more effective than the waiting list). Of these seven psychotherapies, four were those mentioned previously: CBT, behavioral activation, interpersonal therapy and problem-solving therapy, to which must be added psychodynamic therapy, social skills training and psychological counseling. Moreover, the efficacy of psychotherapy was similar in studies with patients with high levels of depressive symptomatology and studies with patients with a diagnosis of depressive disorder, so that in the latter, with the exception of social skills training, all of the psychotherapies showed superior therapeutic benefits to the control conditions as a whole, and with moderate to large differences (between  $d = -0.69$  and  $d = -1.14$ ). However, of the seven psychotherapies, CBT was the one that showed the most robust efficacy results. Thus, CBT was the only psychotherapy in both types of meta-analysis (classic and network) that was significantly superior to the three types of control condition: waiting list, treatment as usual and placebo (Table 3 by Barth et al., 2013). In addition, CBT was one of the three psychotherapies that proved to be efficacious (along with interpersonal therapy and problem solving therapy) when analyses were restricted to studies that included treatment groups of at least 50 patients in order to control the bias found due to the use of small samples.

In summary, with the data currently available, it can be concluded that psychotherapy does cure depression, or at least the therapies that have had their efficacy empirically demonstrated do. Therefore, the idea that psychotherapy does not cure depression is FALSE.

### ***Psychotherapy is less efficacious than antidepressant medication***

Contrary to the suggestions of certain clinical practice guidelines and certain psychiatry and psychopathology manuals (American Psychiatric Association, 2010; González Pinto et al., 2009; Vallejo & Urretavizcaya, 2015), the current scientific literature demonstrates that some of the psychological therapies that have solidly demonstrated their efficacy for major depression are equally as effective as antidepressants. The meta-analysis by Cuijpers, Berking et al. (2013) identified 20 studies that compared the efficacy of CBT with antidepressants and the difference between the two therapies was not significant and of almost null effect size ( $g = 0.03$ ). This absence of significant differences was independent of the type of measurement instrument ( $g = 0.06$  and  $0.13$  for HRSD and BDI, respectively), of the type of antidepressant medication of comparison ( $g = 0.15$  and  $0.05$  for tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs)), of the type of CBT ( $g = 0.0$  and  $0.07$  for Beck's cognitive therapy and other types of CBT, respectively), or of the patient recruitment procedure ( $g = -0.08$  and  $0.04$  for community and clinical samples, respectively). In all of these comparisons, an effect size ( $g$ ) greater than 0 indicated that CBT was more effective than antidepressant medication, but it was not statistically significant.

It is true that in the case of interpersonal therapy the results are less clear. In their meta-analysis of its efficacy for depression, Cuijpers et al. (2011) found only 10 studies that compared the therapy with antidepressant medication and the difference between the two was found to be non-significant ( $p > .05$ ) and well below the criterion for a small effect size ( $g = -0.12$ ), even when only patients with major depressive disorder were taken into consideration and patients with dysthymic disorder were excluded ( $p > .05$ ;  $g = -0.12$ ) or when only the results obtained with the HRSD ( $p > .05$ ;  $g = -0.16$ ) were taken into consideration. However, in all three cases the trend favored antidepressants, a trend that in the overall comparison became significant when a study with atypical results was eliminated ( $p < .05$ ;  $g = -0.19$ ). In all of these comparisons, an effect size ( $g$ ) of less than 0 indicated that antidepressant medication was more effective than interpersonal therapy, although statistical significance was not necessarily reached. This only happened when the study with atypical results was eliminated.

In any case, the results for CBT clearly indicate that this psychological therapy is equally as effective for depression as antidepressants and, therefore, the idea that psychotherapy is less effective than antidepressant medication is FALSE, since at least it is false in relation to CBT.

### ***Psychotherapy is not efficacious for severe depression, but only for mild or moderate depression***

The misconception that psychological treatments are only effective for mild or moderate depressive disorders but not for severe ones, has been perpetuated in some prestigious clinical

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practice guidelines (American Psychiatric Association, 2010; Grupo de Trabajo [Working Group], 2014; Vallejo Ruiloba, 2005) and in some widely disseminated psychopathology and psychiatry manuals (González Pinto et al., 2009, Vallejo & Urretavizcaya, 2015). However, this idea does not correspond to what the available scientific literature indicates. For example, Driessen, Cuijpers, Hollon and Dekker (2010) analyzed the results of 132 randomized studies comparing psychological treatment (mostly CBT) with a control condition and totaling 10,134 patients. In their meta-analysis, they found no data to indicate that the initial level of depressive symptomatology predicted the size of the posttreatment difference between the therapeutic benefits of psychological treatment and those of the control condition, even after controlling for the most relevant characteristics of those studies and finding that the initial levels of depression in these studies ranged from mild to very severe levels of depressive symptomatology according to the criteria of different instruments (the mean pretreatment scores in the different studies ranged from 14 to 36 on the BDI, between 18 and 36 on the BDI-II, and between 8 and 31 on the Hamilton Rating Scale for Depression or HRSD, with cut-off scores indicating severe depression, according to various criteria, of 24 or 30 for the BDI, 29 for the BDI-II and 18, 19, 23 or 25 for the HRSD, Sanz, 2013).

In fact, among the studies that directly compared the difference between psychological treatment and the control condition in patients with more and less severe levels of depression, Driessen et al. (2010) did not find that the treatment-control difference was significantly different for patients with more severe depression than for patients with less severe depression ( $d = 0.39$  versus  $0.23$ , respectively,  $p = .31$ ). In addition, both treatment-control differences were statistically significant ( $p = .01$  and  $p = .03$ , respectively). Furthermore, contrary to the misconception that psychological treatment is not effective for severe depression, among the studies which specifically found that psychological treatment was significantly superior to the control condition and which directly compared this difference in patients with more and less severe levels of depression, Driessen et al. (2010) found that the treatment-control difference was significantly higher for patients with more severe depression than for patients with less severe depression ( $d = 0.63$  versus  $0.22$ , respectively,  $p = .05$ ).

However, the origin of the misconception that psychological treatments are not effective for severe depressive disorders does not appear to be based on studies that compare the efficacy of psychological treatments for patients with varying degrees of severity in their depression. Instead, it likely goes back to some of the results of the classic National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (Elkin et al., 1995) that compared the differential efficacy of psychological treatments versus antidepressant medication in patients with severe depression. In this study, antidepressant medication (imipramine, a tricyclic

antidepressant) was found to be more effective than CBT ( $p < .03$ ) among patients with severe depression according to the HRSD (with a pretreatment score 20). In posttreatment, the mean HRSD score, adjusted for pre-treatment scores, was significantly lower with imipramine than with CBT (14 vs 10.7, DeRubeis, Gelfand, Taung, & Simons, 1999). However, these results have been much questioned since, firstly, in the study it was not clear that such differences were found when depression was measured with the BDI (Elkin et al., 1995, however see DeRubeis et al. 1999). Indeed, according to DeRubeis et al. (1999), among patients with severe depression on the BDI (with a pretreatment score 30), imipramine was no more effective than CBT, with similar average post-treatment BDI scores, adjusted for pre-treatment scores, being obtained for imipramine and CBT (17.5 vs 18). Secondly, in a follow-up performed at 18 months (Shea et al., 1992), no differences were found between imipramine and CBT in the therapeutic benefits obtained, regardless of whether the benefits were measured with the HRSD or the BDI or in patients with less severe or more severe depression.

But beyond the different analyses performed in the NIMH study, the important thing is that further studies have confirmed that there are no differences between antidepressant medication and CBT in terms of efficacy in patients with severe major depressive disorder. For example, DeRubeis et al. (1999) performed a mega-analysis of four studies conducted in this regard, including the NIMH study, i.e., an analysis of the original data of patients with severe depression in those four studies. The results of their mega-analysis indicated that among patients with severe depression, according to both the HRSD (pretreatment score 20) and the BDI (pretreatment score 30), antidepressant medication was no more effective than CBT, resulting in similar posttreatment mean scores, adjusted for pretreatment scores, with the HRSD (12.7 vs 12.1), and even with a tendency to a greater efficacy of CBT with the BDI (18 vs 14.5), although in both cases the differences were statistically non-significant ( $p = .67$  for the HRSD and  $p = .21$  for the BDI).

More recently, in a meta-analysis by Weitz et al. (2015) on individual patient data from 16 clinical trials comparing the efficacy of CBT and antidepressant medication in a total of 1,700 outpatients with a diagnosed depressive disorder, it was found that the severity of the depression did not moderate the differences between the two treatments in the reduction of depressive symptoms or in the probability of response or remission after such treatments. Therefore, these data demonstrate, as the authors concluded, that "the data are insufficient to recommend ADM [antidepressant medication] over CBT in outpatients based on baseline severity alone" (Weitz et al., 2015, p.1108).

In short, according to the current scientific literature: (a) psychological treatments are equally as effective for less severe and more severe depression, and (b) antidepressant medication and CBT do not differ in their efficacy in the acute treatment of

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patients with severe major depressive disorder. Therefore, the idea that psychotherapy is not effective for severe depression, but only for mild or moderate depression, is FALSE, since it is effective for all severity levels of depression and, in the case of CBT, is equally as effective for severe depression as antidepressant medication.

### ***Psychotherapy prevents worse relapses and recurrences than antidepressant medication***

In some manuals of psychiatry and psychopathology it is stated that long-term pharmacological therapy is the only treatment that has proven to be effective for the prevention of relapses and recurrences of depression. In others, the role of psychotherapy in continuation and maintenance treatments aimed at the prevention of relapses/recurrences of depression is questioned. Finally, in yet others, psychotherapy is simply not mentioned when alternatives to these treatments are presented (González Pinto et al., 2009; Vallejo Ruiloba, 2005; Vallejo & Urretavizcaya, 2015). For this reason, it is likely that many clinicians would be surprised to know that the idea that psychotherapy is worse at preventing relapses and recurrences than antidepressant medication is really a misconception. However, although there is much less research on the preventive effects of treatments than on their acute effects, the current scientific literature clearly suggests that CBT is more effective in preventing relapses and recurrences of depression than acute antidepressant medication and that its efficacy in this regard is equal to or even greater than the continued administration of antidepressant medication for an additional 6 or 12 months after the completion of the acute treatment. Thus, a meta-analysis by Cuijpers, Hollon et al. (2013) showed that among patients with a diagnosed depressive disorder, a year after completing the treatment and significantly, those treated with CBT were almost three times as likely (OR = 2.6) not to suffer a relapse or to have recovered from the depression than patients treated with antidepressants, and almost twice as likely (OR = 1.62) not to have relapsed or to have recovered than patients treated with antidepressants on a continuous basis for 6 months to one year, although this latter difference did not reach the conventional level of statistical significance ( $p = .07$ ).

Given the scarcity of research into the preventive effects of treatments, it is not currently possible to know whether this superiority shown by CBT is also generalizable to other psychological therapies that have empirically demonstrated their efficacy in the acute treatment of depression (e.g., interpersonal therapy). However, this is likely to be the case, as in a recent meta-analysis of the efficacy of psychological interventions to prevent relapse in adults who had recovered from depression, CBT, interpersonal therapy and mindfulness-based cognitive therapy all achieved, after 12 months, a significant 22% reduction in relapse compared to control conditions, including treatment as usual, nonspecific support and continuous assessment, but also antidepressant drugs (Clarke, Mayo-

Wilson, Kenny & Pilling, 2015). In any case, the fact that CBT has indeed demonstrated such superiority leads to the conclusion that the idea that psychotherapy is worse at preventing relapses and recurrences than antidepressant medication is FALSE, since at least CBT is more effective in preventing relapses and recurrences of depression than acute treatment with medication and, at the very least, it is equally as effective as continued treatment with medication.

### ***The treatment of depression is long***

The idea that the treatment of depression is long is defended by *DMedicina* based on the following arguments:

Therapy for major (severe) depression should be carried out for at least one year. This duration is because it is a recurrent disease (one which reappears). This is why, when it first appears, therapy is prolonged for a year and in successive recurrences (reappearances of the disease) it will be longer. (Editorial team of *DMedicina*, 2015, para. 5).

It is true that major depressive disorder shows a very high rate of relapse and recurrence. Between 40% and 60% of patients who have suffered a first major depressive episode will in the future have at least one other episode, and after the second and third episodes, the risk of relapse or recurrence rises to 60% and 90%, respectively (Eaton et al., 2008, Solomon et al., 2000). It is also true that in order to combat these high relapse/recurrence rates, the continuation of antidepressant medication for at least 6 months after remission of a depressive episode has proven effective, and is even continued for at least 2 years if there is a very high risk of relapse/recurrence (e.g., if two or more depressive episodes have been experienced in the recent past and in these the patient experienced significant functional impairment) (National Collaborating Center for Mental Health, 2010).

However, the psychological therapies that are currently considered effective for depression (which were mentioned earlier) are short therapies that are usually applied in 16-20 sessions, in weekly sessions, performed over 3-4 months. For example, in the meta-analysis of Johnsen and Friborg (2015), the mean duration of CBT was approximately 15 sessions; in that of Cuijpers, Berking et al. (2013), almost two-thirds of the studies applied CBT over 8 to 16 sessions, and in Cuijpers et al. (2011), more than 70% of the studies applied interpersonal therapy between 8 and 16 sessions.

Moreover, as discussed in a previous point, CBT has in this short duration or, at most, the inclusion of 3 or 4 additional booster sessions, preventive effects that significantly reduce the risk of relapses or recurrences, so its efficacy in this regard is equal to, or even greater than, the continued administration of antidepressants for an additional 6-12 months. For example, Hollon et al. (2005; DeRubeis et al., 2005) found that in a sample of patients with moderate or severe major depressive disorder, with 16 sessions of CBT, 58% of patients improved

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and, with only three booster sessions of CBT over the next year, 69.2% of the patients who had improved had not suffered a relapse two years after the initial treatment, a percentage significantly higher than that found among patients who had initially received antidepressant medication (23.8%), and also higher, although not significantly, than that found among patients who had also received antidepressant medication continuously during the following year (52.8%).

In summary, although the psychological treatment of depression may be prolonged depending on the characteristics of the case (e.g., with high comorbidity and a very significant functional impairment), it is usually a short treatment and, therefore, the idea that the treatment of depression is long is PARTIALLY FALSE, at least as far as psychotherapy is concerned.

### ***The psychologist is not the practitioner who treats depression***

The arguments of *DMedicina* to defend the idea that the psychologist is not the practitioner who treats depression are the following:

The psychologist can take care of depressive disorders, a condition of alterations that is less severe than depression. The latter is the subject of psychiatrists, although family physicians are the ones who most frequently detect the disease (*DMedicina*, 2015, para. 11)

Beyond the confusion regarding the differences between the concepts of depression, depressive disorder and major depressive disorder (García-Vera & Sanz, 2016), underlying this argument and others mentioned above are two misconceptions. Firstly, that psychological treatments are only effective for mild or moderate depressive disorders, but not for severe depressive disorders (an idea already disproved in section 3). Secondly, that severe depression is a disease and, therefore, can only be treated with drugs and, thus, can only be treated by physicians. However, as we saw in more detail in the first part of this paper (Sanz & García-Vera, 2017), this second idea is a hypothesis that has not yet been demonstrated.

Even in some forensic psychological environments and in the context of the discussion of the famous case known as "Osheroff vs. Chestnut Lodge Hospital" (Klerman, 1990), the authors of this article have had the experience of having heard statements such as "A psychologist or psychiatrist can be sued for treating a major depressive disorder only with psychotherapy." In 1982, a US nephrologist named Raphael Osheroff who suffered from major depression, sued the hospital where he had been receiving intensive psychoanalytic psychotherapy (4 sessions a week) for seven months, because this therapy had not improved his depression and, on the contrary, his condition did improve when he was later transferred to another hospital and received antidepressant medication. Furthermore, Osheroff's lawsuit was also focused on the fact that the hospital had not given him information about other therapeutic alternatives for his disorder and in particular on antidepressant medication, even when after

seven months the psychoanalytic psychotherapy was not working (Klerman, 1990). Leaving aside this last aspect of the lawsuit related to the lack of information, the current state of scientific knowledge allows us to affirm that, today, it would not be possible to sue a psychologist or psychiatrist for treating a major depressive disorder only with psychological therapy, specifically with one of the therapies mentioned above that have strong empirical support regarding their efficacy for depression. These therapies, alone, are a first-line treatment for major depressive disorder. This does not imply that a professional cannot be sued for not offering the patient information about other therapeutic alternatives, especially if the treatment is not working, but this possibility must be considered for both psychotherapy and for antidepressant medication. Of course, this does not also imply that, after a reasonable time without obtaining the expected results, the treatment should not be modified and other effective therapeutic alternatives used, such as the combination of psychotherapy and antidepressant medication. However, this modification and this combination must also be considered both when psychotherapy fails and when the medication does.

In summary, returning to the idea that the psychologist is not the practitioner who treats depression, this idea is FALSE, since, contrary to the arguments of *DMedicina*, depression is currently considered a mental disorder, not a mental illness and, therefore, it is also the object of attention of psychologists, who can alone treat the less severe depressive disorders and the more severe ones. Of course, the fact that this idea is false does not imply that there are no other mental health professionals besides the psychologist that can treat depression, specifically those mentioned by *DMedicina*: psychiatrists and family physicians.

### **CONCLUSIONS**

In the same vein as its first part (Sanz & García-Vera, 2017), the present work sought to analyze, in light of the most current scientific literature, the veracity of six ideas on the treatment of depression that are defended in media communications widely available on the Internet or in some prestigious clinical practice guidelines and manuals of psychopathology/psychiatry. Of these six ideas, according to the current scientific literature, five were false, and the last one was partially false (see Table 1). Furthermore, the arguments underlying these misconceptions about the treatment of depression were fraught with errors, inaccuracies, and outdated data.

The problem with these discrepancies in ideas and arguments between what the current scientific literature says about the treatment of depression and what some media, clinical guidelines or manuals say, is that the latter underestimate, and even discredit, the effectiveness of psychotherapy in the treatment of depression and, therefore, collaborate in preventing patients from accessing an appropriate treatment for their depression, since they encourage the patients themselves

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not to demand psychological treatment or they dissuade the doctors and psychiatrists from offering it or referring them to the appropriate professionals to apply it. Moreover, these ideas and their arguments promote, without scientific basis, the medicalization of the treatment of depressive disorders to the detriment of the application of psychological treatments, even when the latter, or at least CBT, have a better efficacy profile than that of antidepressant medication: equal efficacy in acute treatment, lower relapse rates, lower risk of early treatment withdrawal, shorter duration and practically no adverse effects.

As discussed in more detail in the first part of this paper (Sanz & García-Vera, 2017), the finding that there are misconceptions on the Internet on the treatment of depression, including in portals and media specialized in health information, should not be surprising, but it is nevertheless worrying. However, the finding that some of these misconceptions about the treatment of depression appear in clinical practice guidelines and reference manuals of psychopathology and psychiatry should be more surprising and even more worrying, since these guidelines and manuals are usually the primary sources that support the information provided by the Internet portals and media that aim to follow codes of conduct to protect citizens from misinformation concerning health.

It is therefore important that the authors of the clinical guidelines and manuals on depression and its treatment are aware of the latest advances in this area, since in recent years the scientific literature on this subject has grown considerably. Moreover, it is important that the authors of these guidelines and manuals are willing to change their previous ideas about depression and its treatment based on current knowledge and that they are aware that this change is sometimes difficult when the knowledge is not favorable or does not coincide with current professional practice. In fact, there is sometimes great inertia and great resistance to change among specialists, even when they are aware of the data that support such a change. For example, regarding the misconception that psychotherapy is not effective for severe depression, it is curious that the clinical practice guideline on the management of depression among adults in the Spanish National Health System (Working Group, 2014), whilst acknowledging in its arguments that CBT is efficacious for severe depression, finally insists on the misconception and does not recommend CBT as a sole treatment for severe depression. Specifically, this guideline (Working Group, 2014, pp. 83-84, 88, 171) recognizes that "CBT scored similarly to antidepressant drug therapy (primarily SSRIs and ADTs) on the HRSD and BDI scales, both upon finishing treatment and in follow-up after a month, whereas at 12 months after treatment, a certain superiority of CBT was observed", that "CBT presented a lower risk of discontinuation, in terms of early cessation of treatment, than drug antidepressant treatment, and lower relapse rates at one year follow-up" and that "no benefit was observed in adding antidepressant treatment to CBT at the end of treatment or after a month". In addition, this guideline

recommends that "the psychological treatment of choice in moderate-to-severe depression is cognitive-behavioral therapy or interpersonal therapy" and that "cognitive-behavioral therapy should be considered for patients with an inadequate response to other interventions or with a previous history of relapses and/or presence of residual symptoms". However, in proposing its therapeutic algorithm, the guideline finally discards the use of CBT (or other type of psychotherapy) as a single treatment for severe depression and only recommends the use of antidepressant medication or medication combined with CBT or interpersonal therapy for this type of depression. In other words, the guide ultimately persists in the misconception that psychotherapy is not efficacious for severe depression, when, according to the data that the guideline itself reviews and based on data from the current scientific literature, CBT should also be recommended as a single treatment for severe depression.

**CONFLICT OF INTERESTS**

There is no conflict of interest.

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