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A Study Comparing Medication Treatment Versus Medication and Psychotherapy for Adults with Major Depression

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A STUDY COMPARING MEDICATION TREATMENT VERSUS MEDICATION AND PSYCHOTHERAPY FOR ADULTS WITH MAJOR DEPRESSION

By

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Abstract

Treatment outcome has become increasingly the subject of focus in the area of psychological research. Often contested has been the ever widening debate over the efficacy of medication treatment versus psychotherapy. Using a sample of 62 adults diagnosed with Major Depression, this study compared the treatment outcome of those receiving just medication versus those receiving medication and psychotherapy. The data were collected for subjects receiving treatment over a six month period. The study examined whether those receiving medication and therapy experienced a higher degree of improvement as measured by the Basis-32 symptom identification scale which was completed by all participants both pre-treatment and after six months of treatment. Results suggested that overall the subjects receiving both medication and psychotherapy compared with those receiving medication only scored significantly lower on the Basis-32 indicating a significantly higher degree of improvement, including, a significantly higher degree of improvement with depressive symptoms.

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CHAPTER ONE

INTRODUCTION

PURPOSE OF THE STUDY

The purpose of this research was to measure the outcome that therapy offers when combined with medication in the treatment of depression. Improvement was assessed using the BASIS-32 symptom identification scale (Basis-32) which is completed at the onset of treatment and at the end of six months. This research is an attempt to support the notion that the inclusion of both medication and therapy will provide the best treatment option for Major Depression.

Availability of Information:

There is a significant amount of research supporting therapy as an effective intervention for the treatment of depression (Paykel, et al., 1999). There is also a significant amount of research supporting that anti-depressant medication is an effective treatment intervention (Elkin, et al., 1989). There have been numerous studies comparing the effectiveness of different types of therapy, as well as, different types of medication (Shea, et al., 1992). Recently, there has been an increase in the study of combining psychotherapy and medication in the treatment of depression (Moyer, 2004). Research has shown that compliance issue arise during the treatment process, such as, during the initial six weeks which is approximately how long it takes for medication to reach a therapeutic response. Also, during remission when patients feel well enough to attempt to discontinue medication. It is here where therapy can be both supporting and beneficial (DeRubeis, et al, 2002).

Need for the Study:

The primary focus of this research is to determine if therapy positively influences treatment outcome. There are critical phases during the treatment process for depression that are connected to treatment outcome and are vital during the course of treatment in order for patients to be least distressed and most comfortable throughout the process (Spigset & Bjorn, 1999). This research will determine if therapy combined with medication versus just medication will improve treatment outcome. This being established, perhaps a closer look at the critical phases of treatment will show that some modes of psychotherapy may be more effective than others. The initial six weeks of treatment is a critical phase in the treatment process. It is here where patients are initially assessed and often prescribed medication. Most Seratonin Specific Reuptake Inhibitors (SSRIs) take six to eight weeks before patients notice improvement with their symptoms. Some research indicates that therapy is important during this phase of treatment (Paykel, et al., 1999). Without support during this period, many patients are likely to drop out of treatment or to suffer unnecessarily. Also, toward the end of treatment may be considered another critical phase when patients may want to titrate off of their medications and try to move on with their lives without medication. Often during this period cognitive therapy can be beneficial (Paykel, et al., 1999). Helping patients rebuild positive thought processes in this stage is critical. Educating patients about certain thought processes which encourage depressive responses versus thought process that are recovery centered can be taught during this stage (Paykel et al., 1999).

Definition of Terms:

Psychotherapy cannot be defined with any precision. Psychotherapy could be defined as a formal process of interaction between two parties, each party usually consisting of one person but with the possibility that there may be two or more people in each party. The interaction is for the purpose of ameliorating distress in one of the two parties (i.e., client) relative to any of the following areas of disability or malfunction: cognitive functions (disorders of thinking), affective functions (suffering or emotional discomforts), or behavioral functions (inadequacy of behavior). The interaction would require that the therapist have some theory of personality origins and development. The therapist would need to posses a high level of self-understanding, and experience with change along with some method of treatment logically related to the theory the therapist has taken into practice. Also, the therapist should possess the professional and legal approval to act as a therapist (Corsini, 1989). It is important to note that some modes of psychotherapy may fit the definition better than others. This definition would be more suited for the more non-directive psychotherapies, such as, person centered. Whereas, more directive therapy, such as, behavior modification would rely less on the interaction and more on the actions created in treatment.

OMM: Out-patient Medication Maintenance (OMM) is a community based not-for-profit program that provides outpatient treatment for adults who are assessed to have a need for medication and counseling services yet do not fulfill the criteria for case management services which would include home visits, medication monitoring, and access to entitlements. The criteria for admission into the OMM program are as follows: A) You must be 18 years old or older.

B) You must carry an Axis I diagnosis which fulfills the criteria indicated in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV).

C) You must be able to independently attend appointments which are prescheduled.

D) Your treatment requires that you are in need of medication intervention.

E) You do not fulfill the criteria for case management or more intensive services.

Once an individual is admitted into the OMM program, the option of therapy is offered to all participants. The therapy offered is supportive in nature but also provides coping strategies for patients to manage problem areas. During therapy the client is encouraged to discuss experiences as related to affect, thought processes and day to day stressors. In this study the therapy would be classified as "supportive therapy" initially in treatment with more focus on goals and objectives as treatment progresses. Perhaps a more detailed review of the thought processes which may be reinforcing the depression and the introduction of techniques which can intervene to break patterns that may have developed prior to treatment can be explored once a positive and trusting relationship develops between the patient and therapist. The patient's initial assessment begins with seeing the psychiatrist for a comprehensive initial psychiatric evaluation which incorporates a history of the client's treatment, a mental status exam and the client's social history. Past substance use related difficulties, vocational history and medical concerns are also part of the assessment. Subsequent medication evaluations which are shorter in duration are scheduled every three months if the patient needs to be medicated. Patients who do not meet the criteria are referred to non-medication outpatient programs. All candidates complete the Basis-32 during their initial interview and at the six-month treatment interval.

CHAPTER II

REVIEW OF RELATED RESEARCH

There is a significant amount of current research that indicates the potential benefits of medication and psychotherapy in the treatment of depression. Some studies indicate that medication alone will provide the best outcome. In 1989, the National Institute of Mental Health (NIMH) instituted the Treatment of Depression Collaborative Research Program. This was the first multi-site coordinated study in the field of psychotherapy. The study was designed to determine what works effectively in the treatment of depression. During the late 1980's there was a growing onset of the diagnosis of depression and the need to determine the most viable and effective treatment. Initially, the study wanted to clarify the effectiveness of each possible mode of treatment. The study contained four modes of treatment: Imipramine-CM, Placebo-CM, cognitive behavioral therapy, and interpersonal therapy. This study was also the first study to directly compare two different forms of psychotherapy (Elkin, et al., 1989).

The study's results indicated that all of the treatments were effective. The Imipramine-CM was most effective, the least effective being the placebo, and the psychotherapies in the middle. The two therapies were equally effective. In follow up studies (Shea, 1992), results showed that there were no significant differences in relapse between each group, and there were no significant differences in those achieving a full recovery in each group.

In a more recent study funded by the National Institute of Mental Health, researchers from the University of Pennsylvania and Vanderbilt University indicate that cognitive therapy is at least as effective as medication for long term treatment of severe depression,

and it is less expensive. DeRubeis et al., (2002) agreed that there was a need to look at depression from a different angle than in prior studies. From their perspectives, prior studies centered on what gets people better faster. The researchers felt that a more important question to ask is what will keep depression away for the long term (DeRubeis, et al., 2002).

This study involved a four-month period of acute treatment followed by an additional year of treatment for those who showed improvement in the initial phase. Among those who continued into the second phase of the study, 75% of patients who underwent cognitive therapy avoided a relapse, compared to 60% of patients on medication and 19% of those receiving a placebo pill. Results also showed that a brief course of cognitive therapy was better than a similarly brief course of medication in the year long continuation phase. These results suggest that even after termination, a brief course of cognitive therapy may offer enduring protection (DeRubeis, et al., 2002).

Paykel et al., (1999) studied the effects of cognitive therapy on relapse prevention of residual depression. The study indicated that depressed patients in partial remission with residual symptoms following anti-depressant treatment are at high risk for a complete relapse. There is evidence that cognitive therapy may reduce relapse rates in depression. Results of the study indicated that cognitive therapy significantly reduced relapse rates for acute major depression and persistent and severe residual symptoms (Paykel, et al., 1999).

In another study examining the economic aspects of managed care plans and psychotherapy treatment alternatives, a discovery was made that a new trend had been developing regarding the allocation of funds toward treatment research (Stoil, 1999). In

his study, Stoil revealed that practitioners have long complained that managed care threatens the viability of psychotherapy as a treatment for mental health problems. Stoil also discovered that reimbursement policies favor medication over talk therapies (Stoil, 1999.). Mental health clinicians argue that practice guidelines and reimbursement policies enforced by managed care could result in the elimination of long-term psychotherapy. While conducting this research Stoil's attention had turned to the federal government's role in fostering this situation (Stoil, 1999). Stoil suggested that Medicare and Medicaid policies created a model favoring drugs that offer a quick reduction of symptoms. Critics had suggested that the federal government's mental health research priorities might contribute to the declining support for therapy. Very little federal money is offered to researchers investigating the specific psychotherapies that are effective for helping various types of patients. If this trend continues the efficacy of the treatment for depression may be held in question. The declining support for the continued research of psychotherapy when there is evidence that psychotherapy enhances treatment outcome supports this notion.

A recent study presented at the 157th annual meeting of the American Psychiatric Association (APA) supported that psychotherapy combined with antidepressant medication is more effective than pharmaceutical monotherapy in treating depression (Moyer, 2004). In this study 167 patients were randomized to receive either combination psychotherapy and antidepressant pharmacology or pharmacology alone. Of the combination therapy group 72% experienced a remission of their depression symptoms compared with 57% of patients in the pharmacotherapy alone (Moyer, 2004).

Other psychiatrists who presented research at the 157th meeting of the (APA) were

representatives of an evolving project by the APA to restore psychotherapy as a cornerstone of psychiatric treatment.

Psychiatrists noted that the research Moyer presented validates psychiatrists' assumption regarding the value of combined treatment. In particular, Dr. Barton Binder noted that researchers are looking at the neurobiological basis of mental conflict and psychotherapeutic change. He stated that brain imaging studies are helping to show the ways that psychotherapy improves functioning. Binder stated that researchers want to integrate these findings and develop a rational understanding of the brain and the individual which will help clinicians deliver combined treatment more effectively (Moyer, 2004).

CHAPTER III

RESEARCH METHODS AND PROCEDURES

Intent of the Study:

The intent of this study was to examine whether psychotherapy combined with medication compared to medication treatment alone improves treatment outcome in Major Depression. This study also measured whether the groups would differ across the various domains of functioning within the Basis-32. Measuring these domains would provide a more specific measure of symptom improvement across various areas of the patient's functioning.

Sample and Population:

The sample consisted of 62 adults between the ages of 27 and 56 who completed at least 6 months of treatment at a community mental health center in Rhode Island. All of the subjects carried a diagnosis of Major Depression and were treated with medication. Individual therapy was available to all subjects. The therapy involved the patient developing a positive supportive relationship with the therapist. The therapy included the monitoring of symptoms, as well as, intervening with techniques that will interrupt unproductive thought patterns that may reinforce depression. Assisting and educating patients to identify their own negative thought processes was of major importance for the development of their own personal insight. Identifying strengths that were beneficial to treatment was also explored.

The group receiving medication and therapy will be referred to as the MT group. The group receiving just medication will be referred to as the JM group. Each group will be

measured for change in Basis-32 scores during the six months of treatment. The degree of symptoms that were present after 6 months of treatment to the JM group will be referred to as JMA6M. The degree of symptoms that were present after six months of treatment to the medication and therapy group will be referred to as MTA6M group.

Seventeen of the subjects chose to receive therapy as well as medication. The remaining 45 chose just medication. Of the seventeen who chose MT, eleven successfully completed the Basis-32 both during the initial phase and at the six month interval of treatment. Of the remaining 45 subjects who received just medication, 26 patients completed the Basis-32 both at the initial phase of treatment and at the six month interval. Of these 26 subjects in the JM group, eleven were chosen who matched the eleven subjects in the MT group who had completed the Basis-32. The groups were matched for age, gender and history of treatment. No subjects within each group were ever hospitalized. Each group contained eight females and three males, all between the ages of 34 and 47.

Data Collection:

Data were gathered by acquiring the completed Basis-32 scores for subjects who successfully completed the scale both during the initial phase of treatment and then at the six month interval of treatment.

Hypothesis Tested:

Patients treated with medications and therapy compared with patients treated just with medication would show a significantly better treatment outcome as measured by the Basis-32.

Basis-32:

The Basis-32 was developed and introduced in 1994 by McLean Hospital. The Basis-32 is one of the most widely used outcomes measurement scales used in the United States. The Basis-32 is completed at the onset of treatment and at the end of six months. The Basis-32 measures the change in self-reported symptoms and problem difficulty over the course of treatment. The Basis-32 identifies a wide range of symptoms and problems that occur across the diagnostic spectrum. The 32 refers to the first 32 questions included in the instrument. These 32 questions are directly related to symptoms. The remaining questions on the tool are more demographically related and non-clinical. The Basis-32 measures symptoms by degree of difficulty. A score of 0 indicates no difficulty with a specific symptom. A score of 4 indicates extreme difficulty with a specific symptom. Therefore, a lower score on the Basis-32 indicates less difficulty with symptoms. As it pertains to this study, a lower score would indicate more improvement with symptoms.

Research indicates that the Basis-32 is an effective tool across race and culture and was found to be reliable. Chun-Chung, Snowden and McConnell (2001) performed confirmatory factor analysis across major racial and ethnic groups of the Basis-32. The results suggested acceptable levels of agreement within groups between racial and ethnic minority groups and whites. The study revealed little reason to believe that the Basis-32 varied in underlying structure across racial and ethnic boundaries (Chun-Chung, et al, 2001).

In another study concerning reliability and validity, Klinkenberg, Cho, and Vieweg, (1998) found that the Basis-32 had good internal consistency and test-retest reliability on most subscales. Subjects were randomly assigned to either a self-report or an interview

condition. The study indicated that subjects rated themselves higher in the self report condition than in the interview condition. Results of this study indicated that the group assigned to the self report condition was more internally consistent than the group assigned to the interview condition (Klinkenberg, et al., 1998).

The Basis-32 is divided into five functional domains which include:

1) Activities of Daily Living (Questions 1-6)
2) Interpersonal (Questions 7-13)
3) Depression (Questions 14-20)
4) Psychosis (Questions 21-25)
5) Compulsivity (Questions 26-32)

The focus of this study emphasized the use of the Basis-32 as a whole. The five domains were tested individually as well with increased focus on the depression domain to assess how the two groups compared with depressive symptoms.

Methods used in Data Analysis:

The research was classified as Ex Post Facto. The primary analysis was to determine if the two groups would differ on the mean number of improved psychiatric symptoms after receiving treatment at a mental health center for six months. The clinical records for all subjects were reviewed to classify them into the MT or JM group. T-tests were calculated to measure any differences between means for the two groups. The t-test level of significance was set at .05. A baseline analysis was completed between groups initially to determine if the MT and JM groups differed on their initial level of distress, a t-test was also run on the initial Basis-32 scores for the two groups. An analysis within groups was conducted first within the JM group between initial treatment and after six

months. The same analysis was conducted for the MT group. Analysis between groups was conducted during the initial phase, after six months phase and then the CA6M was analyzed between groups. To measure treatment outcome for each group separately a t-test was calculated within each group comparing initial vs. after six months Basis-32 scores. In order to measure differences between the two groups, a between groups t-test was calculated to determine if one group improved more than the other. Also, between groups and within group t-tests were run to determine each group's change across the Basis-32 domains and then to compare changes in these domains between the JM and MT groups.

CHAPTER IV

FINDINGS RELEVENT TO THE HYPOTHESIS

Findings supported the hypothesis. The hypothesis predicted that patients treated with medication and therapy compared with patients treated just with medication would show a significantly better treatment outcome (see figure). Results show a significant overall degree of improvement for both the JM and MT groups. The study also showed a significant amount of improvement in three of the five domains included in the Basis-32 for both the JM and MT groups. It is important to note that the three domains mentioned are directly related to the indicators of depression while the other two domains (Compulsivity and Psychosis are less relevant). The three domains include Activities of Daily Living Skills (ADLs), Interpersonal Related Difficulties and Depression. All three showed significant improvement.

Findings indicated that when both groups were compared initially, the groups were not significantly different on level of distress during the initial phase of treatment $t(20)=.49$, $p>.05$ (see table 1).

Within groups:

When comparing the JM group's Basis-32 pre- treatment scores with JMA6M there was a significant amount of improvement with symptoms $t(10) = 9.83$, $p<.05$. When comparing the MT group's pre-treatment scores with MTA6M there was also a significant amount of improvement with symptoms $t(10) = 7.89$, $p<.05$.

Between groups:

Although both groups showed significant improvement in symptoms after treatment, the results reveal significantly greater improvement of symptoms or a significant

reduction in difficulty with symptoms for the MT group compared to the JM group after six months of treatment $t(20) = .84$, $p<.05$ (see table 2).

Basis-32 Domains:

Results also yielded a significant degree of improvement in Activities of Daily Living skills, Interpersonally Related Difficulties and Depression for both groups. When the domain of Activities of Daily Living Skills was compared between the JM and MT groups during the initial phase of treatment the t-score yielded a score of $t(20) = .39$, $p>.05$ indicating that these groups were not significantly different. The t-score for the Interpersonal Related Difficulties between the JM and MT groups at the initial phase of treatment also yielded a score revealing that the groups were not significantly different $t(20) = .34$, $p>.05$. The t-score for the Depression domain between the JM and MT groups at the initial phase of treatment revealed that both groups were not significantly different $t(20) = .42$, $p>.05$.

Although both groups showed significant improvement the MT group compared to the JM group showed greater improvement in all three domains. The t-score in the domain of Depression for JM after 6 months of treatment compared with the initial assessment indicated a score of $t(10) = 1.18$, $p<.05$. This suggested a significant decline in depression for the JM group after 6 months of treatment. The t-score in the Depression domain for the MT group after 6 months of treatment compared with the initial assessment indicated a score of $t(10)=.67$, $p<.05$. This indicated a significant reduction in depression symptoms than the JM group. The t-score between groups in the depression domain after 6 months of treatment yielded a score of $t(20)= 2.10$, $p<.05$, which indicated that the MT group compared to the JM group showed significantly greater improvement

in the Depression domain.

The t-score in the domain of ADLs for the JM group after 6 months of treatment compared with the initial assessment yielded a score of $t(10)=1.36$, $p<.05$. This suggested a significant decline of difficulty with ADLs in the JM group after 6 months of treatment. The t-score in the ADLs domain for the MT group compared with the initial assessment yielded a result of $t(10)=.89$, $p<.05$. This indicated a significant reduction of symptoms with ADLs in the MT after 6 months of treatment. The t-score between groups in the ADLs domain yielded a result of $t(20)= 1.98$, $p<.05$, which indicated that the MT group compared to the JM group showed significantly greater improvement in the ADLs domain after 6 months of treatment.

Finally, the t-score in the domain of Interpersonal Related Difficulties for the JM group after 6 months of treatment compared to the initial assessment yielded a score of $t(10)=1.78$, $p<.05$. This suggested a significant decline in difficulty with the domain of interpersonal related difficulties for the JM group. The t-score in the domain of Interpersonal Related Difficulties for the MT group after 6 months of treatment compared to the initial assessment yielded a score of $t(10)=.95$, $p<.05$. This indicated a significant reduction of symptoms in the MT group after 6 months of treatment. The t-score between groups in the Interpersonal Related Difficulties domain yielded a result of $t(20)= 2.22$, $p<.05$, which indicated that the MT group compared to the JM group showed significantly greater improvement in the Interpersonal Related Difficulties domain after 6 months of treatment.

Table 1

Table one presents mean Basis-32 scores at the initial phase of treatment for adults receiving treatment for Major Depression who have been treated with Just Medication (JM) and who have been treated with Medication and Therapy (MT).

Just Medication	Medication and Psychotherapy
X=67.45	X= 69.18
N=11	N=11
T= .49	
P>.05	

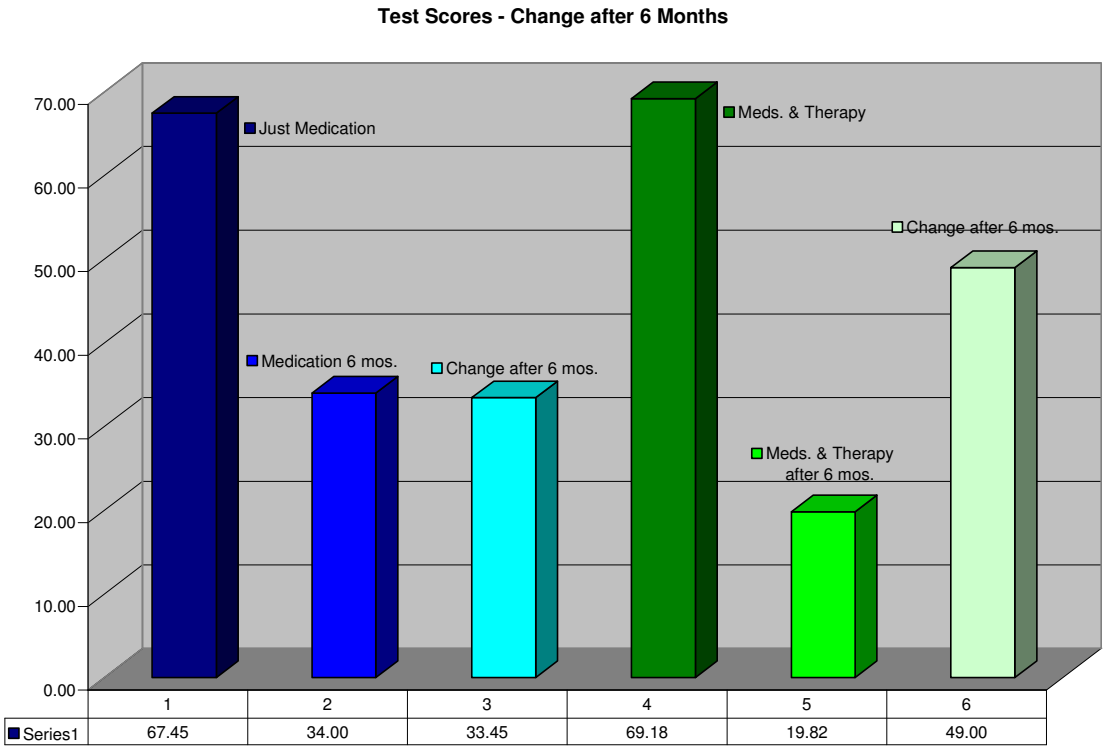
Table 2

Table two represents mean Basis-32 scores after 6 months of treatment for adults treated for Major Depression with Just Medication (JM) or with Medication and Therapy (MT).

Just Medication	Medication and Therapy
X= 34	X= 19.82
N= 11	N= 11
T= .84	
P<.05	

Figure

Levels of Symptom Difficulty



1) Basis-32 score JM Pre-treatment : 67.45
2) Basis-32 score JM after 6 months of treatment (A6M) : 34:00
3) Change within group after 6 months JM (CA6M) : 33.45
4) Basis-32 score MT Pre-treatment : 69.18
5) Basis-32 score MT after 6 months of treatment (A6M) :19.82
6) Change within group after 6 months (CA6M) : 49.00

NOTE: Higher scores reflect greater degree of symptoms.

CHAPTER V

SUMMARY OF THE STUDY

Discussion

The hypothesis was supported. It was hypothesized that adults receiving treatment for Major Depression with medication and therapy (MT) would show significantly greater improvement with their symptoms after six months of treatment than those receiving treatment solely with medication (JM). By comparing the change that occurred within each group after 6 months of treatment (CA6M) it was clearly evident that the MT group showed significantly more improvement than the JM group. As hypothesized having the support, direction and encouragement from psychotherapy seemed to significantly improve symptoms for patients receiving this added service.

During critical phases of treatment, the addition of therapy may be critical. Perhaps the most critical phase of treatment would be during the initial six weeks where most anti-depressant medication trials take to reach a therapeutic level. It is here where the highest distress levels are likely to be found. Throughout treatment there are likely times when the added support of psychotherapy could be beneficial. Mood swings and personal crisis are examples of typical struggles that occur during treatment. Also, at the end of treatment patients often want to titrate off their medication as they feel strong enough to handle stressors without medication. Spigset and Bjorn, (1999) summarized that in general no anti-depressant drug is clearly more effective than another. If successful and the medications are deemed no longer necessary, a therapist can be a support as medications are no longer necessary. The dose should be gradually lowered over several weeks before withdrawal and the therapist can provide support until the

patient feels prepared to disengage from treatment (Spigset & Bjorn, 1999).

Therapy may be helpful as a support to avoid relapse during the transition. These critical phases were not taken into consideration during the analysis of this study and perhaps could be implications for further research. Also, the social, family and environmental supports of each patient were not taken into consideration during the analysis of this study. If support is sufficient in these areas, then therapy may not be necessary.

The findings of this study indicated that both groups benefited from the use of medication. The MT group improved to a greater degree that the JM group and also improved significantly more in three of the five domains expressed in the Basis-32. Of special significance would be the domain of Depression which improved most significantly in this study. The depression domain symptoms are most relevant to the subjects studied. A significant improvement here indicates that the subjects not only have benefited from the addition of therapy but have improved the circumstances of their diagnosis.

Limitation of the Study:

Due to the small size of this group results should be cautiously interpreted. The extent to which this group is generalizeable is very questionable. In this study the sample included adults of a lower socioeconomic scale who were already receiving treatment. Due to the study being ex post facto and not having within the sample a group treated with therapy only limits the results we will receive. Also, this study can be difficult to generalize it to the CMHC due to the small sample size and lack of control.

Implications for Further Research:

There has been a fair amount of research available on the effectiveness or necessity of psychotherapy in the treatment of depression. This is an important area to continue to research. Focusing on the initial six weeks of treatment may be important. It is during this time that patients are most distressed and more likely to be less compliant with their medication regimen. It would be interesting to compare drop out rates for those receiving just medication versus those receiving combined treatment.

When patients have been successfully treated and are in remission, less intensive residual symptoms may continue and need to be addressed without medication. Specific types of therapy could be analyzed here to rule out what may or may not be effective at the beginning of treatment, and also when clients are in remission. There is much research studying the independent effects of medication and psychotherapy treatment for depression. There is less research available that looks at combined treatment as the preferred treatment.

Research in this area could lead to more comprehensive treatment alternatives which include both medication and therapy in a more inclusive and strategic manner to treat each individual. Perhaps it makes sense to incorporate therapy into the initial phase of treatment and explain the benefits it can present. Also, to possibly educate patients with information about thought processes that may be counter-productive versus beneficial for patients while in treatment and in remission. As indicated in studies mentioned earlier, the pharmacological approach appeared to be becoming the dominant mode of treatment research in the late 1990s. Designs used specifically to study medications consistently revealed positive results which reinforced this trend. Some changes have begun to occur within the American Psychiatric Association (APA) that may be leading to a more

balanced approach to treatment. It is clear that both psychotherapy and medication are effective modes of treatment. Which is most effective has yet to be proven. It is likely or it appears that if depression is treated by both medication and therapy together, the best outcome may be reached.

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