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Number 62

Treatment for Depression After Unsatisfactory Response to SSRIs



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Treatment for Depression After Unsatisfactory Response to SSRIs

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Preface

The Agency for Healthcare Research and Quality (AHRQ) conducts the Effective Health Care Program as part of its mission to organize knowledge and make it available to inform decisions about health care. As part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress directed AHRQ to conduct and support research on the comparative outcomes, clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services to meet the needs of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

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Systematic reviews are the building blocks underlying evidence-based practice; they focus attention on the strength and limits of evidence from research studies about the effectiveness and safety of a clinical intervention. In the context of developing recommendations for practice, systematic reviews are useful because they define the strengths and limits of the evidence, clarifying whether assertions about the value of the intervention are based on strong evidence from clinical studies. For more information about systematic reviews, see

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We welcome comments on this CER. They may be sent by mail to the Task Order Officer named below at: Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, MD 20850, or by e-mail to epc@ahrq.hhs.gov.

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Treatment for Depression After Unsatisfactory Response to SSRIs

Structured Abstract

Objectives. A comparative effectiveness review was undertaken to evaluate treatment strategies in patients who failed to respond to selective serotonin reuptake inhibitors (SSRIs) as first-line treatment. The efficacy (benefits and harms) of monotherapy approaches (dose escalation, increased duration, or switch) or combined therapies were evaluated. Efficacy in the context of subgroups was also evaluated. Recommendations in Clinical Practice Guidelines (CPGs) from 2004 to April 2011 were compared.

Data Sources. MEDLINE[®], Embase[®], CINAHL[®], PsychINFO[®], AMED (Allied and Complementary Medicine), Cochrane Database of Systematic Reviews, and Cochrane Central[®] were searched from 1980 to April 13, 2011. An extensive grey literature search was also undertaken, including publications of drug regulatory agencies.

Review Methods. Systematic review methodology was employed. Eligibility criteria included English studies of adults (aged ≥ 18 years) or adolescents and children (8–18 years) with major depressive disorder, dysthymia, or subsyndromal depression, who had an inadequate response to an SSRI at entry into the study. Comparative study designs were eligible. Publications focusing only on treatment algorithms were not considered to be CPGs.

Results. From 46,884 citations, there were 44 studies and 27 guidelines that were eligible. Key Questions 1 and 2 (KQ1-a and KQ2): Forty-one studies included adults and three studies included adolescents; all included subjects with major depressive disorder except for one with adult dysthymia and subsyndromal patients alone. A limited number of studies ($n=11$) evaluated monotherapy strategies and these showed no differences among approaches. Although there were more studies evaluating monotherapy relative to combined therapies ($n=33$), the types of add-on agents were numerous and showed no relative differences; the exception was the addition of risperidone to an SSRI. KQ 3: Seven studies evaluated the impact of disease type, disease severity, previous comorbidities, age, gender, and race on treatment outcomes and showed no clear trend. KQ4: From 18 CPGs for adults, the majority did not provide specific recommendations for monotherapy strategies; for combination therapies, although specific agents were specified, there was variability across CPGs when recommending agents and strategies. Recommendations were more consistent for the CPGs for adolescents ($n=7$).

Conclusions. There is low strength of evidence evaluating relative differences for any monotherapy or combination therapy approach. All but 2 of 44 studies showed no relative differences in response and remission rates. Two studies with limited sample sizes and using risperidone as an augmenting agent showed benefit with combined therapy. The majority of studies were not designed to assess superiority of the strategies. Inconsistency and lack of clarity for clinical actions were noted when comparing CPGs.

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Executive Summary

Background

Depression is a complex mental illness associated with disability and reduced quality of life for the person with depression, as well as substantial societal burden. Major depressive disorder (MDD) is the second leading medical cause of long-term disability, the fourth leading cause of global burden of disease, and is predicted to become the second highest cause of disability by 2020.^{1,2} Depression exerts a negative impact on physical health; it reduces adherence to medical treatment,³ reduces participation in preventive activities,⁴ and increases the likelihood of risk factors such as obesity,⁵ smoking,⁶ and sedentary lifestyles.⁷ MDD may be associated with immune dysfunction⁸⁻¹¹ and cardiovascular disease,¹²⁻¹⁵ endocrine and neurological diseases, and a general increase in chronic disease incidence.¹⁶ Mortality rates are high: approximately 4 percent of adults with a mood disorder die by their own hand, and about two-thirds of suicides are preceded by depression.¹⁷ In adolescents, untreated depression results in significant impairment in school performance, interpersonal relationships, risk of suicidal behavior and completion of suicide, risk of early pregnancy, occupational maladjustment, and impaired social and family functioning.¹⁸

Pharmacological agents are one of several treatment modalities used for depression, and one of the most frequently utilized classes of antidepressant medications are the selective serotonin reuptake inhibitors (SSRIs). The rate of treatment response following first-line treatment with SSRIs is moderate, varying from 40 to 60 percent; remission rates vary from 30 to 45 percent.¹⁹ Up to one-third of persons taking antidepressant medications will develop recurrent symptoms of depression while on therapy.²⁰ The target goal for acute treatment should be remission, which is defined as a resolution of depressive symptoms (a score within the normal range of the symptom scale). Response to treatment (usually defined as at least a 50 percent reduction in symptom levels²¹) may not be sufficient as a target outcome because residual depressive symptoms are risk factors for relapse and negative predictors of long-term outcome.²² Clinicians are faced with a number of treatment options following an inadequate response to an SSRI, and these include monotherapy or combined therapy. Monotherapy options include: (1) an optimization strategy (increasing the dose or extending the duration of the SSRI), (2) switching to another SSRI, (3) switching to another class of antidepressants, or, (4) switching to a nonpharmacological intervention. Combination or add-on therapy options include: (1) combining the SSRI with an augmenting agent, (2) combining antidepressants, or (3) combining the SSRI with a nonpharmacological therapy (such as psychological therapies, exercise, etc.). It is also an option to switch to a new antidepressant and simultaneously combine that antidepressant with a second pharmacological or nonpharmacological treatment. This is sometimes referred to as an acceleration strategy.

Scope and Purpose of This Review

The primary goal of this comparative effectiveness review is to examine the evidence guiding clinical treatment decisions and ultimately to aid clinicians in their care of patients when SSRI therapy for an index episode does not result in an adequate treatment response. The Key Questions are as follows:

Key Question 1. Among adults and adolescents with major depressive disorder, dysthymia, and subsyndromal depression who are started on an SSRI and who are compliant with treatment but fail to improve either fully, partially, or have no response, what is the benefit (efficacy or effectiveness) of monotherapy and combined therapy?

Key Question 1a. How does efficacy/effectiveness vary among the different monotherapies and combined therapies?

Key Question 2. What are the harms of each of the monotherapies or combined therapies among these adults and adolescents? How do the harms compare across different interventions?

Key Question 3. How do these therapies compare in different populations (e.g., different depressive diagnoses, disease severity, age, gender, racial and socioeconomic group, and medical or psychiatric comorbidities)? These subgroups will be considered with respect to the different interventions.

Key Question 4. What is the range of recommended clinical actions following the failure of one adequate course of an SSRI based on current clinical practice guidelines published between 2004 and April 2011?

Methods

Search Strategy

The search strategy was limited to studies published from 1980 to April 13, 2011, as SSRIs first became available for the treatment of depression in the early 1980s. The databases searched were: MEDLINE®, Cochrane Central®, PsychINFO®, Cochrane Database of Systematic Reviews, Embase®, CINAHL®, and AMED (Allied and Complementary Medicine). The grey literature search included systematic searches of relevant citations of Web sites: health technology assessment agencies (Hayes Inc. Health Technology Assessment), regulatory information (U.S. Food and Drug Administration, Health Canada, Authorized Medicines for European Community), clinical trial registries (ClinicalTrials.gov, Current Controlled Clinical Trials, Clinical Study Results, WHO Clinical Trials), grants and federally funded research (including National Institute of Health, Health Services Research Projects in Progress [HSRProj]), abstracts and conference proceedings (Conference Papers Index, Scopus), and the New York Academy of Medicine's Grey Literature Index. Additionally, the sites of specialty organizations were searched for clinical practice guidelines (CPGs), and members of the Technical Expert Panel were queried for any additional guidelines of relevance. CPGs were limited to those published between 2004 and April 2011. Reference lists of eligible citations and systematic reviews were also searched for potentially relevant citations.

Study Selection

The study populations were eligible if they included adults (age ≥ 18 years of age) or adolescents (12 to 18 years of age) with MDD, dysthymia, or subsyndromal depression, who met the following criteria: (1) they were on SSRI treatment for the index episode at the time of entry into the study; (2) they have been judged to have had an "inadequate response" to an SSRI (fluoxetine, citalopram, fluvoxamine, sertraline, escitalopram, or paroxetine) at the time of entry into the study; or, (3) when recruited for entry into the study, they were to be placed on an SSRI for purposes of monitoring prospectively the adequacy of their response. Studies with subjects who failed to respond to a non-SSRI antidepressant or a nonpharmacological therapy or

combination treatment were excluded. Subjects not receiving an SSRI at the time of entry into the study, and not recruited to evaluate adequacy of response to an SSRI, were excluded. Studies where the entire sample included subjects with postpartum depression, bipolar depression, depressive psychosis, dysphoria, mourning syndrome, postoperative depression, premenstrual dysphoric disorder, pseudodementia, puerperal depression, or seasonal affective disorder were excluded. Similarly, studies where the entire sample were subjects with a cerebrovascular accident, dementias (including Alzheimer's disease, vascular dementia, mild cognitive impairment), Parkinson's disease, hypothyroidism, or Cushings' syndrome were also excluded.

Experimental studies and observational studies with comparator groups were included in this review. Study designs with no comparison group (e.g., case series, qualitative studies) were excluded. There were no exclusions based on the types of pharmacological and nonpharmacological interventions, with the exception of electroconvulsive therapy, vagal nerve stimulation, and repetitive transcranial nerve stimulation.

The primary outcomes included remission (freedom or near freedom from symptoms; 100 percent change relative to baseline) and response (either partial, from 0 to 49 percent change relative to baseline, or complete, from 50 to 99 percent change relative to baseline). Secondary outcomes of interest included speed of response, relapse, quality of life, adherence, return to work, global change as measured by global assessment scales, and external service utilization.

Data Extraction

Relevant fields of information were extracted from individual studies by trained data extractors using standardized forms and a reference guide; a second reviewer verified the accuracy of the data fields reported. Discrepancies were resolved by consensus or consultation. Extracted data included study and population characteristics, eligibility criteria, types of interventions and treatment specifications, and outcomes.

Assessment of Methodological Quality of Individual Studies

We selected the Risk of Bias Tool by the Cochrane Collaboration²³ to assess randomized controlled and controlled clinical trials. Studies were evaluated for adequacy of collecting and reporting harms using the McHarm scale.^{24,25} The AGREE II instrument was used to assess the methodological quality of the CPG.²⁶

Applicability

Applicability was assessed by establishing a priori the key attributes of the population (wide spectrum of age [8 to 80 years], both genders, range of disease severity, range of the number of previous failures), intervention (using antidepressants with established efficacy in standardized doses), comparator, and outcome (standardized measures) in the context of a wider spectrum of patients in primary care settings; that is, in the context of patients who would likely benefit from these interventions in "real world" conditions. The findings of this review would not apply to subjects who have a primary diagnosis of bipolar disorders, schizophrenia, or major anxiety disorder.

Rating the Body of Evidence

The overall strength of the body of the evidence was assessed using four domains: (1) risk of bias criteria; (2) consistency of results (degree to which study results for an outcome are similar

[variability is easily explained, range of results is narrow]); (3) directness of the evidence (assesses whether interventions can be linked directly to the health outcomes); and, (4) precision (degree of certainty surrounding an effect estimate for a specific outcome).²⁷ The strength of the evidence is classified in one of four grades: high, moderate, low, or insufficient. Grading of the strength of evidence is applied to individual primary outcomes of benefit (response and remission and also harms [suicidality, weight gain, and sexual dysfunction]).

Data Synthesis

Qualitative synthesis was undertaken separately for adults and adolescents, and for MDD, dysthymia, and subsyndromal depression. Studies were grouped into three categories of treatment strategies that reflected clinical decisionmaking and these included: (1) monotherapy versus monotherapy, (2) monotherapy versus combined therapy, and (3) combined therapy versus combined therapy.

We evaluated the clinical diversity of the study interventions, populations, and outcomes when considering meta-analyzing studies; given the diversity of interventions and populations, summary estimates were not undertaken. Graphs presenting relative risk of individual studies within the various clinical groupings of interventions were prepared to examine differences of effect size.

Results

Description of Eligible Studies and CPGs

From an initial 46,884 citations, 3,147 were screened at full text, and a final set of 44 primary studies (74 publications) and 27 CPGs were eligible for this review. Publications that presented subgroup analyses, secondary analyses, reanalyses, results of different outcomes (not primary outcome measures), or results for different time points on the same study cohort were considered to be secondary records (or companion publications) to the original studies; as such, all STAR*D study publications are counted as a single study (with multiple publications).

Key Question 1. Among adults and adolescents with major depressive disorder, dysthymia, and subsyndromal depression, who are started on an SSRI and who are compliant with treatment but fail to improve either fully, partially, or have no response, what is the benefit (efficacy or effectiveness) of monotherapy and combined therapy?

Key Question 1a. How does the efficacy/effectiveness vary among the different monotherapies and combined therapies?

Forty-one studies (61 publications)²⁸⁻⁸⁸ included adults, and three studies (13 publications)⁸⁹⁻¹⁰¹ included adolescents. One study evaluated subjects with subsyndromal depression⁷⁹ and another with dysthymia;⁶⁷ both of these studies showed no differences between groups when comparing monotherapy or combined therapy treatments. The findings for subjects with MDD are summarized below.

Monotherapy Versus Monotherapies in Adults

Twelve studies (18 publications)^{30,34,37,39,48,49,51-53,55,59-61,63,65,69,71,72} compared monotherapy interventions relative to other monotherapies. All participants (n=2,611) had MDD and were recruited almost exclusively from outpatient settings. The majority of subjects were white, female, and middle-aged (40 to 49 years). The interventions were a minimum of 4 weeks duration and three of the studies involved dose escalation of sertraline,⁶⁹ venlafaxine,³⁹ or paroxetine.⁵³ The remaining eight studies (nine publications) evaluated head-to-head comparison following switching from: (1) citalopram to venlafaxine, bupropion, sertraline, or cognitive behavior therapy (CBT);^{34,59,63} (2) paroxetine to venlafaxine;⁶¹ (3) fluoxetine to olanzapine or mianserin;^{37,71,72} or, (4) from an SSRI to duloxetine (tapering methods).^{52,55} As a group, these 11 studies are at moderate risk of bias across studies, with particular problems in randomization and the role of the funding agency. The findings suggest that there is no certainty of any advantage between different monotherapies (pharmacological or nonpharmacological) for either response to treatment or remission. The exception was a single study that showed that lower-dose sertraline had some small improvement in response, and that the frequency of adverse events decreased at the higher dose; this particular study also suggests that the differences may have been related to the longer trial duration as subjects were randomized after failure to respond to the lower dose.⁶⁹ There is limited evidence to establish with certainty that a dose escalation or a switch to another antidepressant (SSRI or non-SSRI) is equivalent or superior to any comparator treatment in patients with inadequate response to an initial SSRI; our limited pool of studies would suggest that these monotherapies are equivalent in their treatment effects.

Strength of the Evidence for Monotherapies

When considering any monotherapy versus other monotherapy treatments in adults with MDD, the differing pharmacological and nonpharmacological interventions were considered as a single group, given that so few studies were eligible in this category. The studies generally showed no difference between groups. However, taking into consideration the moderate risk of bias, the imprecision, and the applicability of the populations, the evidence was graded as insufficient for both outcomes of benefit (response and remission); harms (suicidality, weight gain, and sexual dysfunction) were not measured or not reported in most studies, and as such were rated as having insufficient strength of evidence (SOE).

Monotherapies Versus Combined Therapies in Adults

A total of 33 studies (49 publications)^{28-33,35-38,40-51,54,57-64,68-74,76-78,80-87} evaluated the efficacy and effectiveness of monotherapy relative to combined therapies. Participants in the studies (n=4,537) were all diagnosed with MDD and recruited predominately from outpatient settings. The majority of subjects in these studies were middle-aged females of the white race (when ethnicity was reported). Fifteen studies (18 publications)^{28,29,35-37,44,54,57,58,61-63,68,69,72,74,76,78} determined failure of response to the SSRI prospectively and 16 retrospectively (18 publications).^{31-33,38,40-43,45-47,64,70,71,73,77,80,84} No studies evaluated subjects specifically for failed response to fluvoxamine alone.

All but one study^{59,62,63} employed a randomized controlled trial (RCT) design, and all studies included a pharmacological intervention for at least one treatment arm. The majority of studies employed a study design that had the comparator arm receive ongoing treatment with an SSRI to which the subjects had not had an adequate response by the start of the study; fewer studies employed a design in which patients were switched to a new treatment in at least one study arm.

Four studies^{31,32,47,62,68} had one treatment arm that evaluated a combination therapy that included the non-SSRI antidepressants clomipramine, bupropion, or desipramine. Twenty-six of 33 studies evaluated combination therapies that included augmenting agents. From these, only five augmenting agents were evaluated in two or more studies; these included atypical antipsychotics (olanzapine and risperidone),^{37,44,57,72} lithium,^{47,61,68,74} buspirone,^{41,46,59,62,63,70,80} mianserin,^{69,72} and pindolol.^{42,45} Five studies evaluated the use of nonpharmacological interventions including CBT,^{43,59} dialectical behavior therapy,⁷⁸ interpersonal therapy,^{83,85,87} and exercise.⁷⁷ Method of randomization, compliance with treatment, and the role of the funder were at high risk of bias for over 75 percent of these studies. Eighteen studies (22 publications) were funded solely by industry,^{28,29,35-37,41,44,46,50,54,57,58,61,64,69-72,80-82,84} ten (13 publications) by non-industry sources,^{38,43,47,59,62,63,68,74,77,78,83,85,87} and one by both.³³ Overall, these studies were rated as having moderate risk of bias. Inadequate sample size was a factor in many studies.

The majority of studies showed no certainty of any difference for any monotherapy treatment, relative to the comparator combined therapy, for the outcomes of response and remission. The exception was with the atypical antipsychotics (olanzapine, risperidone, aripiprazole, quetiapine) used as augmenting agents, which showed small differences favoring the combination therapy. Overall, there is limited supportive evidence for any single augmenting drug or for switching to a different antidepressant (monotherapy) relative to adding another treatment (pharmacological or nonpharmacological).

SOE for Monotherapies Versus Combined Treatment

The SOE for the studies evaluating monotherapies relative to combined therapies had more eligible studies that were categorized into distinct intervention groups. When considering augmenting agents as a single group, the studies were at moderate risk of bias, inconsistent, and imprecise, and as such both the outcomes of benefit and harm were rated as of insufficient SOE. We also partitioned the studies into relevant subgroups based on the type of augmenting agent (atypical antipsychotics, buspirone, lithium, or mianserin). With the exception of atypical antipsychotics (low SOE) and switching to buspirone (low SOE), all other groupings for the different augmenting agents were given a rating of insufficient for evaluating both the outcomes of benefit and harm. When considering the grouping of interventions into those where switching to a new agent (monotherapy) was compared with switching and adding another treatment (such as a new SSRI, non-SSRI, or nonpharmacological treatment), the SOE was graded as low. The STAR*D trial contributed to many of the comparisons and affected the final grade in this treatment category.

Combined Therapies Versus Combined Therapies in Adults

There were six studies (n=832)^{35,47,59,62,68,75} for which there were treatment arms that compared combination therapies with each other. All but one study⁷⁵ were RCTs. Women were the majority in all studies, and age ranges varied from 37 to 59 years. Only two studies reported racial composition,^{59,62} and these subjects were predominately white. Two studies^{35,75} compared different doses of the same combination drug therapies (ziprasidone and lithium). In addition to SSRIs, added therapies included lithium, desipramine, buspirone, bupropion, citalopram, clomipramine, or CBT. Overall, these studies were rated as having a moderate risk of bias, with problems in randomization, reporting compliance, and balancing prognostic indicators between groups. Adequate sample size was an issue in these studies. There was no certainty of a

difference between any combination therapy, including a dose escalation, for the added augmenting agent.

SOE for Combined Therapies

All interventions within the combined therapies relative to other combined therapies were grouped as one category for grading SOE; the overall grade was assigned as insufficient for both the outcomes of benefit and harm due to serious risk of bias, inconsistency, and imprecision.

Treatment in Adolescents

Two studies (trials) evaluated therapies in children and adolescents who had failed to respond to a previous SSRI; one trial of patients ages 12 to 18,^{89,92,93,96-101} and a second trial of ages 8 to 18.⁹⁰ In the Treatment for Resistant Depression in Adolescents (TORDIA) trial, the majority of the sample (68 to 72 percent) were girls, with an average age of 16 years.^{89,92,93,96-101} Study subjects were randomized to four treatment arms that included venlafaxine alone or combined with CBT, or a switch to an SSRI (citalopram, fluoxetine, or paroxetine) alone, or with CBT. This study was at low risk of bias. The trial stated that it aimed to demonstrate the superiority of venlafaxine, but the findings failed to reject the null hypothesis showing no differences between the medication groups. There was a statistically significant difference in favor of including CBT for all outcomes, however. The second trial evaluated a dose escalation of fluoxetine in a small sample, and was suggestive of some benefit to the higher dose, but the study was underpowered to detect a difference.⁹⁰

SOE for Adolescent Studies

SOE was evaluated for the findings from the TORDIA trial alone. This trial had low risk of bias, and harms were well monitored and reported. The SOE was rated as low due to the potential imprecision of this study.

Key Question 2. What are the harms of each of the monotherapies or combined therapies among these adults and adolescents? How do the harms compare across different interventions?

Harms for interventions used for both adults and adolescents with MDD who had failed to respond to an SSRI were predominately derived from RCTs that evaluated treatment strategies in this population. No observational studies met the eligibility criteria. A clear trend for harms was difficult to specify across the differing interventions in adults. In general, the majority of harms reported were consistent with those associated with antidepressant use and were likely mild to moderate in nature.

With the exception of the studies evaluating children and adolescents, the reporting and collecting of harms was problematic, particularly for predefining harms (e.g., nausea for >1 day), including serious and severe events, and for reporting the total number of events per group in studies with adults. The two studies evaluating adolescents provide good evidence for harms within this population as they were generally at low risk of bias. In studies with adult MDD populations, severe events and serious events such as suicidality were reported inconsistently. A limited number of studies undertook statistical evaluation comparing harms between groups.

Key Question 3. How do these therapies compare in different populations (e.g., different depressive diagnoses, disease severity, age, gender, racial and socioeconomic group, and medical or psychiatric comorbidities)? These subgroups will be considered with respect to the different interventions.

Seven studies undertook stratified or subgroup analyses evaluating factors that may impact treatment outcomes in adults,^{30,37,41,46,51,64,66,68-70,80} and one for adolescents.^{89,92,93} The effects of baseline severity, previous treatment failure, age, gender, and race were not sufficiently evaluated and were inconsistent in their impact on outcomes in adults. There is some evidence from the STAR*D level 2 cohort that would suggest that persons with concurrent anxiety symptoms have less likelihood of achieving remission. There is some evidence from the TORDIA trial that milder depression, less family conflict, and the absence of suicidal behavior are associated with greater likelihood of a positive treatment response to combined therapy at 12 weeks in adolescents. A history of physical and sexual abuse may predict response to combined therapy in adolescents.

Key Question 4. What is the range of recommended clinical actions following the failure of one adequate course of SSRI based on current clinical practice guidelines published between 2004 and April 2011?

There were a total of 27 CPGs sponsored by unique organizations and described in 33 publications.^{18,102-133} Seven CPGs were specific only to adolescents,^{18,126-131} 18 CPGs were for adults alone,^{102,103,105,107-111,113-117,119,121,123-125} and 2 CPGs were applicable to both.^{132,133} Four CPGs for adults^{107,109,116,119} and three for adolescents^{18,127,130} did not provide any recommendations for patients with previous inadequate responses. Five of the 27 guidelines included patients with dysthymia and subsyndromal depression^{103,123,126,132,133} but none of the recommendations were for patients with this diagnosis who had failed to respond to previous treatment (pharmacological or nonpharmacological). The majority of CPGs did not specify a definition for inadequate response. All CPGs were applicable to patients from primary care and outpatient settings. The domains within the AGREE II showed great variability in the scores, suggesting significant differences amongst the CPGs. Domains with the greatest variability included domain 3 (rigor of development), domain 5 (applicability), and domain 6 (editorial independence). For adults, increasing the dose or duration was frequently recommended (often a first approach), but the interval or change in dose was not specified. The majority of CPGs did not recommend any specific type of antidepressant when recommending switching to monotherapy strategies. When combination therapy was recommended, there was a greater tendency to specify the drug for adding to the antidepressants. However, there was great variability in the augmenting agents recommended. For adolescents, there was an approximately equal number of CPGs that specified the agents to consider for monotherapy and for combined therapies. Many CPGs expressed a preference to commence treatment using nonpharmacological approaches prior to pharmacological treatment in this population. Some adolescent guidelines cited adult evidence as the evidentiary basis for suggesting treatment strategies.

Recommendations for Future Research

1. Future trials should specify a priori the intent of the trial as establishing either equivalence, noninferiority, or superiority of the head-to-head comparisons. Justification for the margin of inferiority or superiority should be specified. Ideally, designing trials to establish superiority is preferred, as this may assist clinicians in selecting amongst competing treatment strategies. Similarly, in studies designed to involve a population of patients who have failed to respond to treatment, determining this failure in a prospective manner as the first part of a two-part study, rather than simply asking patients about failure, confers methodological advantages with regard to minimizing bias and allowing disentanglement of the reasons for failure (adverse events, compliance, or physiological response). Sample sizes in future research studies should be sufficient to establish important margins of difference between groups and to evaluate potentially important confounders, such as age, gender, and baseline severity.
2. Future research should include a broader representation of adult patients with respect to age (>50 and <40 years), gender (equal proportion of men), and ethnicity (increased proportion of nonwhite or non-Caucasian, or broader representation of all ethnic groups). Similarly, a broader representation of participants with the medical or psychiatric comorbidities typically found in the primary care setting should be included.
3. Studies should be more consistent in reporting the manner for determining previous history of failed treatment trials and past episodes of depression.
4. There is a need to increase the number of studies including subjects with dysthymia and subsyndromal depression who have failed to respond to previous SSRI treatments.
5. There is also a need to increase research in children (ages 8 to 12 years) and adolescents (ages 12 to 18 years).
6. Trials of new add-on treatments for patients not responding to an antidepressant medication have not examined whether the add-on agent is equally effective when added to a range of antidepressant classes. There appears to be an assumption among investigators in this field that response and remission will be comparable regardless of the class of background medication; the clinical or neurobiological data to support this assumption should be confirmed or revisited.
7. Future clinical trials should conform to CONSORT¹³⁴ (Consolidated Standards of Reporting Trials) reporting standards for harms. Severe and serious events (including suicidality) were inconsistently reported and improvement is necessary in this area.
8. Development of future CPGs for adolescents or adults should provide a clear definition of inadequate response for both pharmacological and nonpharmacological treatments, and should include standardized methods for establishing this in “real world” settings. Future CPG recommendations should provide greater clarity with regards to recommended treatment actions and should make clear the link between the recommendation and the evidence.

Conclusions

Studies in adults with MDD who have had an inadequate response to an SSRI included a preponderance of subjects with multiple past depressive episodes and multiple past unsuccessful treatment trials. The generalizability of these data to people with few past episodes of depression and few past unsuccessful treatments for depression may be limited. In addition, these studies

included a high proportion of caucasians and women, and tended to have an average patient age in the early forties. Studies are needed with a sufficient sample size to explore whether there are differences in race, gender, or across the age spectrum.

The number of studies comparing single medications against each other (monotherapy compared with monotherapy) following an inadequate response to an SSRI are few and evaluate different agents. Extant studies are limited in type of agents utilized, sample sizes, and population characteristics. There is insufficient evidence to determine whether there is a difference between various single-agent therapies in the outcomes of response and remission following an inadequate response to an SSRI.

There is insufficient evidence to evaluate the benefits of ongoing monotherapy with an SSRI compared with combination treatment involving the addition of another antidepressant medication to the initial SSRI. There is low-grade evidence that comparable results are achieved following the switch to an alternate antidepressant medication (monotherapy with a new antidepressant) when compared with adding a nonantidepressant treatment to the initial SSRI (traditional augmentation approach). There is low-grade evidence that adding an atypical antipsychotic medication to ongoing SSRI treatment is associated with higher response and remission rates compared with adding a placebo to ongoing SSRI treatment (following inadequate response to the SSRI). There is insufficient evidence to confirm that there is an improvement in response and remission rates following the addition of any other augmentation agents. There is insufficient evidence to evaluate the benefits or harms of specific combinations of treatments relative to alternative combinations. There is a single study evaluating patients with subsyndromal symptoms and dysthymia who had had an inadequate response to SSRI medications; the evidence base is limited in these populations.

There are three studies evaluating children and adolescents. Only one study provided evidence to support the use of CBT in combination with an antidepressant following inadequate response to an SSRI for adolescents ages 12 to 18 years with MDD. A second study, a pilot with small sample size evaluating dose escalation, showed no effect.

A clear trend for harms was difficult to specify across the differing interventions in adults, although there were some studies (particularly for children and adolescents) where harms were well evaluated and clinically important differences between treatment groups were not apparent. The reporting and collecting of harms was problematic, particularly for predefining harms, including serious and severe events and reporting the total number of events per group in studies with adults.

The majority of CPGs for adults were applicable to patients with MDD in outpatient and primary care settings. Most CPGs did not specify definitions of “inadequate response” but did provide suggestions for treatment approaches. Recommendations for monotherapy (including dose or interval changes, switching to a different SSRI, or to a non-SSRI) were nonspecific as to the drug, interval, or dose change. Recommendations for combination therapy tended to endorse switching or adding different classes of antidepressants and augmenting agents. However, there was inconsistency across CPGs with regard to the types of augmenting agents to use. The variation amongst CPGs reflects the limitations of the evidentiary base.

References

1. Canal M, Legangneux E, van Lier JJ, et al. Lack of effect of amisulpride on the pharmacokinetics and safety of lithium. *Int J Neuropsychopharmacol*. 2003;6(2):103-9. PMID:12890302
2. World Health Organization. The World Health Report 2001: Mental health: New understanding, new hope. 2001 Oct 4. <http://www.who.int/whr/2001/en/>. Accessed November 13, 2011.
3. Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: Impact of depressive symptoms on adherence, function, and costs. *Arch Intern Med*. 2000;160(21):3278-85. PMID:11088090
4. Aro AR, de Koning HJ, Absetz P, et al. Psychosocial predictors of first attendance for organised mammography screening. *J Med Screen*. 1999;6(2):82-8. PMID:10444726
5. McIntyre RS, Soczynska JK, Konarski JZ, et al. The effect of antidepressants on glucose homeostasis and insulin sensitivity: Synthesis and mechanisms. *Expert Opin Drug Saf*. 2006;5(1):157-68. PMID:16370964
6. Murphy JM, Horton NJ, Monson RR, et al. Cigarette smoking in relation to depression: Historical trends from the Stirling County Study. *Am J Psychiatry*. 2003;160(9):1663-9. PMID:12944343
7. Van Gool CH, Kempen GI, Penninx BW, et al. Relationship between changes in depressive symptoms and unhealthy lifestyles in late middle aged and older persons: Results from the Longitudinal Aging Study Amsterdam. *Age Ageing*. 2003;32(1):81-7. PMID:12540353
8. Corcos M, Guilbaud O, Hjalmarsson L, et al. Cytokines and depression: An analogic approach. *Biomed Pharmacother*. 2002;56(2):105-10. PMID:12000135
9. Kop WJ, Gottdiener JS, Tangen CM, et al. Inflammation and coagulation factors in persons > 65 years of age with symptoms of depression but without evidence of myocardial ischemia. *Am J Cardiol*. 2002;89(4):419-24. PMID:11835923
10. Musselman DL, Miller AH, Porter MR, et al. Higher than normal plasma interleukin-6 concentrations in cancer patients with depression: preliminary findings. *Am J Psychiatry*. 2001;158(8):1252-7. PMID:11481159
11. Penninx BW, Kritchewsky SB, Yaffe K, et al. Inflammatory markers and depressed mood in older persons: Results from the Health, Aging and Body Composition study. *Biol Psychiatry*. 2003;54(5):566-72. PMID:12946885
12. Kop WJ. The integration of cardiovascular behavioral medicine and psychoneuroimmunology: New developments based on converging research fields. *Brain Behav Immun*. 2003;17(4):233-7. PMID:12831824
13. Taylor CB, Youngblood ME, Catellier D, et al. Effects of antidepressant medication on morbidity and mortality in depressed patients after myocardial infarction. *Arch Gen Psychiatry*. 2005;62(7):792-8. PMID:15997021
14. Wassertheil-Smoller S, Shumaker S, Ockene J, et al. Depression and cardiovascular sequelae in postmenopausal women. The Women's Health Initiative (WHI). *Arch Intern Med*. 2004;164(3):289-98. PMID:14769624
15. Gilmour H. Depression and risk of heart disease. *Health Reports Vol.19, no.3, 82-003-XPE*. Statistics Canada; 2008. http://dsp-psd.pwgsc.gc.ca/collection_2008/statcan/82-003-X/82-003-XIE2008003.pdf. Accessed November 13, 2011.
16. Patten SB, Williams JV, Lavorato DH, et al. Major depression as a risk factor for chronic disease incidence: Longitudinal analyses in a general population cohort. *Gen Hosp Psychiatry*. 2008;30(5):407-13. PMID:18774423
17. Seguin M, Lesage A, Chawky N, et al. Suicide cases in New Brunswick from April 2002 to May 2003: The importance of better recognizing substance and mood disorder comorbidity. *Can J Psychiatry*. 2006;51(9):581-6. PMID:17007225

18. U.S. Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force Recommendation Statement. *J Am Acad Pediatr.* 2009;123(4):1223-8. PMID:19336383
19. Carvalho AF, Cavalcante JL, Castelo MS, et al. Augmentation strategies for treatment-resistant depression: A literature review. *J Clin Pharm Ther.* 2007;32(5):415-28. ISI:000249450400001
20. Souery D, Papakostas GI, Trivedi MH. Treatment-resistant depression. *J Clin Psychiatry.* 2006;67(Suppl. 6):16-22.
21. McIntyre RS, Fallu A, Konarski JZ. Measurable outcomes in psychiatric disorders: Remission as a marker of wellness. *Clin Ther.* 2006;28(11):1882-91. PMID:17213009
22. Paykel ES, Ramana R, Cooper Z, et al. Residual symptoms after partial remission: An important outcome in depression. *Psychol Med.* 1995;25(6):1171-80. PMID:8637947
23. Higgins JPT. Cochrane Handbook for Systematic Reviews of Interventions Version 5.0.2. 2008. www.cochrane-handbook.org/. Accessed on November 13, 2011.
24. Santaguida P and Raina P. Development of a quality assessment scale specific to harms in studies evaluating the efficacy of health technologies: Manual for using the McHarm. 2010. <http://hiru.mcmaster.ca/epc/mcharm.pdf> Accessed November 13, 2011.
25. Chou R, Aronson N, Atkins D, et al. AHRQ series paper 4: Assessing harms when comparing medical interventions: AHRQ and the effective health-care program. *J Clin Epidemiol.* 2010;63(5):502-12. PMID:18823754
26. The AGREE Next Steps Consortium. Appraisal of guidelines for research and evaluation II (AGREE II). The AGREE Research Trust; 2009. www.agreetrust.org/?o=1397
27. Owens DK, Lohr KN, Atkins D, et al. AHRQ series paper 5: Grading the strength of a body of evidence when comparing medical interventions--Agency for Healthcare Research and Quality and the Effective Health Care Program. *J Clin Epidemiol.* 2010;63(5):513-23. PMID:19595577
28. Berman RM, Fava M, Thase ME, et al. Aripiprazole augmentation in major depressive disorder: A double-blind, placebo-controlled study in patients with inadequate response to antidepressants. *CNS Spect.* 2009;14(4):197-206. PMID:19407731
29. Preskorn SH, Baker B, Kolluri S, et al. An innovative design to establish proof of concept of the antidepressant effects of the NR2B subunit selective N-methyl-D-aspartate antagonist, CP-101,606, in patients with treatment-refractory major depressive disorder. *J Clin Psychopharmacol.* 2008;28(6):631-7. PMID:19011431
30. Rush AJ, Wisniewski SR, Warden D, et al. Selecting among second-step antidepressant medication monotherapies: Predictive value of clinical, demographic, or first-step treatment features. *Arch Gen Psychiatry.* 2008;65(8):870-80. PMID:18678792
31. Altamura AC, Dell'Osso B, Buoli M, et al. Intravenous augmentative citalopram versus clomipramine in partial/nonresponder depressed patients: A short-term, low dose, randomized, placebo-controlled study. *J Clin Psychopharmacol.* 2008;28(4):406-10. PMID:18626267
32. Altamura AC, Dell'Osso B, Buoli M, et al. Short-term intravenous citalopram augmentation in partial/nonresponders with major depression: A randomized placebo-controlled study. *Int Clin Psychopharmacol.* 2008;23(4):198-202. PMID:18545057
33. George TP, Sacco KA, Vessicchio JC, et al. Nicotinic antagonist augmentation of selective serotonin reuptake inhibitor-refractory major depressive disorder: A preliminary study. *J Clin Psychopharmacol.* 2008;28(3):340-4. PMID:18480694

34. Lenox-Smith AJ, Jiang Q. Venlafaxine extended release versus citalopram in patients with depression unresponsive to a selective serotonin reuptake inhibitor. *Int Clin Psychopharmacol.* 2008;23(3):113-9. PMID:18408525
35. Dunner DL, Amsterdam JD, Shelton RC, et al. Efficacy and tolerability of adjunctive ziprasidone in treatment-resistant depression: A randomized, open-label, pilot study. *J Clin Psychiatry.* 2007;68(7):1071-7. PMID:17685744
36. Michelson D, Adler LA, Amsterdam JD, et al. Addition of atomoxetine for depression incompletely responsive to sertraline: A randomized, double-blind, placebo-controlled study. *J Clin Psychiatry.* 2007;68(4):582-7. PMID:17474814
37. Thase ME, Corya SA, Osuntokun O, et al. A randomized, double-blind comparison of olanzapine/fluoxetine combination, olanzapine, and fluoxetine in treatment-resistant major depressive disorder. *J Clin Psychiatry.* 2007;68(2):224-36. PMID:17335320
38. Shapira B, Nemets B, Trachtenberg A, et al. Phenytoin as an augmentation for SSRI failures: A small controlled study. *J Affect Disord.* 2006;96(1-2):123-6. PMID:16814397
39. Thase ME, Shelton RC, Khan A. Treatment with venlafaxine extended release after SSRI nonresponse or intolerance: A randomized comparison of standard- and higher-dosing strategies. *J Clin Psychopharmacol.* 2006;26(3):250-8. PMID:16702889
40. Seidman SN, Miyazaki M, Roose SP. Intramuscular testosterone supplementation to selective serotonin reuptake inhibitor in treatment-resistant depressed men: Randomized placebo-controlled clinical trial. *J Clin Psychopharmacol.* 2005;25(6):584-8. PMID:16282843
41. Landen M, Hogberg P, Thase ME. Incidence of sexual side effects in refractory depression during treatment with citalopram or paroxetine. *J Clin Psychiatry.* 2005;66(1):100-6. PMID:15669895
42. Perry EB, Berman RM, Sanacora G, et al. Pindolol augmentation in depressed patients resistant to selective serotonin reuptake inhibitors: A double-blind, randomized, controlled trial. *J Clin Psychiatry.* 2004;65(2):238-43. PMID:15003079
43. Wiles NJ, Hollinghurst S, Mason V, et al. A randomized controlled trial of cognitive behavioural therapy as an adjunct to pharmacotherapy in primary care based patients with treatment resistant depression: A pilot study. *Behav Cognit Psychother.* 2008;36(1):21-33.
44. Keitner GI, Garlow SJ, Ryan CE, et al. A randomized, placebo-controlled trial of risperidone augmentation for patients with difficult-to-treat unipolar, non-psychotic major depression. *J Psychiatr Res.* 2009;43(3):205-14.
45. Sokolski KN, Conney JC, Brown BJ, et al. Once-daily high-dose pindolol for SSRI-refractory depression. *Psychiatry Res.* 2004;125(2):81-6.
46. Landén M, Björling G, Agren H, et al. A randomized, double-blind, placebo-controlled trial of buspirone in combination with an SSRI in patients with treatment-refractory depression. *J Clin Psychiatry.* 1998;59(12):664-8.
47. Fava M, Rosenbaum JF, McGrath PJ, et al. Lithium and tricyclic augmentation of fluoxetine treatment for resistant major depression: A double-blind, controlled study. *Am J Psychiatry.* 1994;151(9):1372-4.
48. Fava M, Rush AJ, Alpert JE, et al. Difference in treatment outcome in outpatients with anxious versus nonanxious depression: A STAR*D report. *Am J Psychiatry.* 2008;165(3):342-51. ISI:000253779400014
49. Rush AJ, Warden D, Wisniewski SR, et al. STAR*D: Revising conventional wisdom. *CNS Drugs.* 2009;23(8):627-47. PMID:19594193
50. Amsterdam JD, Williams D, Michelson D, et al. Tachyphylaxis after repeated antidepressant drug exposure in patients with recurrent major depressive disorder. *Neuropsychobiol.* 2009;59(4):227-33. PMID:19571597

51. Warden D, Rush AJ, Wisniewski SR, et al. What predicts attrition in second step medication treatments for depression?: A STAR*D Report. *Int J Neuropsychopharmacol*. 2009;12(4):459-73. PMID:18611293
52. Perahia DG, Quail D, Desai D, et al. Switching to duloxetine in selective serotonin reuptake inhibitor non- and partial-responders: Effects on painful physical symptoms of depression. *J Psychiatr Res*. 2009;43(5):512-8. PMID:18707693
53. Ruhe HG, Booij J, Weert HC, et al. Evidence why paroxetine dose escalation is not effective in major depressive disorder: A randomized controlled trial with assessment of serotonin transporter occupancy. *Neuropsychopharmacol*. 2009;34(4):999-1010. PMID:18830236
54. Marcus RN, McQuade RD, Carson WH, et al. The efficacy and safety of aripiprazole as adjunctive therapy in major depressive disorder: A second multicenter, randomized, double-blind, placebo-controlled study. *J Clin Psychopharmacol*. 2008;28(2):156-65. PMID:18344725
55. Perahia DG, Quail D, Desai D, et al. Switching to duloxetine from selective serotonin reuptake inhibitor antidepressants: A multicenter trial comparing 2 switching techniques. *J Clin Psychiatry*. 2008;69(1):95-105. PMID:18312043
56. Alexopoulos GS, Canuso CM, Gharabawi GM, et al. Placebo-controlled study of relapse prevention with risperidone augmentation in older patients with resistant depression. *Am J Geriatr Psychiatry*. 2008;16(1):21-30. PMID:17928573
57. Mahmoud RA, Pandina GJ, Turkoz I, et al. Risperidone for treatment-refractory major depressive disorder: A randomized trial. *Ann Intern Med*. 2007;147(9):593-602. PMID:17975181
58. Berman RM, Marcus RN, Swanink R, et al. The efficacy and safety of aripiprazole as adjunctive therapy in major depressive disorder: A multicenter, randomized, double-blind, placebo-controlled study. *J Clin Psychiatry*. 2007;68(6):843-53. PMID:17592907
59. Thase ME, Friedman ES, Biggs MM, et al. Cognitive therapy versus medication in augmentation and switch strategies as second-step treatments: A STAR*D report. *Am J Psychiatry*. 2007;164(5):739-52. PMID:17475733
60. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: A STAR*D report. *Am J Psychiatry*. 2006;163(11):1905-17. PMID:17074942
61. Bondolfi G, Aubry JM, Golaz J, et al. A stepwise drug treatment algorithm to obtain complete remission in depression: A Geneva study. *Swiss Med Week*. 2006;136(5-6):78-85. PMID:16633950
62. Trivedi MH, Fava M, Wisniewski SR, et al. Medication augmentation after the failure of SSRIs for depression. *N Engl J Med*. 2006;354(12):1243-52. PMID:16554526
63. Rush AJ, Trivedi MH, Wisniewski SR, et al. Bupropion-SR, sertraline, or venlafaxine-XR after failure of SSRIs for depression. *N Engl J Med*. 2006;354(12):1231-42. PMID:16554525
64. Fava M, Thase ME, DeBattista C. A multicenter, placebo-controlled study of modafinil augmentation in partial responders to selective serotonin reuptake inhibitors with persistent fatigue and sleepiness. *J Clin Psychiatry*. 2005;66(1):85-93. PMID:15669893
65. Birkenhager TK, van den Broek WW, Mulder PG, et al. Efficacy and tolerability of tranylcypromine versus phenelzine: A double-blind study in antidepressant-refractory depressed inpatients. *J Clin Psychiatry*. 2004;65(11):1505-10. PMID:15554763
66. Perlis RH, Alpert J, Nierenberg AA, et al. Clinical and sociodemographic predictors of response to augmentation, or dose increase among depressed outpatients resistant to fluoxetine 20 mg/day. *Acta Psychiatr Scand*. 2003;108(6):432-8. PMID:14616224
67. Rocca P, Marchiari L, Rasetti R, et al. A comparison of paroxetine versus paroxetine plus amisulpride in the treatment of dysthymic disorder: Efficacy and psychosocial outcomes. *Psychiatry Res*. 2002;112(2):145-52. PMID:12429360

68. Fava M, Alpert J, Nierenberg A, et al. Double-blind study of high-dose fluoxetine versus lithium or desipramine augmentation of fluoxetine in partial responders and nonresponders to fluoxetine. *J Clin Psychopharmacol.* 2002;22(4):379-87. PMID:12172337
69. Licht RW, Qvitzau S. Treatment strategies in patients with major depression not responding to first-line sertraline treatment. A randomised study of extended duration of treatment, dose increase or mianserin augmentation. *Psychopharmacol.* 2002;161(2):143-51. PMID:11981594
70. Appelberg BG, Syvalahti EK, Koskinen TE, et al. Patients with severe depression may benefit from buspirone augmentation of selective serotonin reuptake inhibitors: results from a placebo-controlled, randomized, double-blind, placebo wash-in study. *J Clin Psychiatry.* 2001;62(6):448-52. PMID:11465522
71. Ferreri M, Lavergne F, Berlin I, et al. Benefits from mianserin augmentation of fluoxetine in patients with major depression non-responders to fluoxetine alone. *Acta Psychiatr Scand.* 2001;103(1):66-72. PMID:11202131
72. Shelton RC, Tollefson GD, Tohen M, et al. A novel augmentation strategy for treating resistant major depression. *Am J Psychiatry.* 2001;158(1):131-4. PMID:11136647
73. Nemets B, Mishory A, Levine J, et al. Inositol addition does not improve depression in SSRI treatment failures. *J Neural Transm.* 1999;106(7-8):795-8. PMID:10907738
74. Baumann P, Nil R, Souche A, et al. A double-blind, placebo-controlled study of citalopram with and without lithium in the treatment of therapy-resistant depressive patients: A clinical, pharmacokinetic, and pharmacogenetic investigation. *J Clin Psychopharmacol.* 1996;16(4):307-14. PMID:8835706
75. Dinan TG. Lithium augmentation in sertraline-resistant depression: A preliminary dose-response study. *Acta Psychiatr Scand.* 1993;88(4):300-1. PMID:8256650
76. Thase ME, Trivedi MH, Nelson JC, et al. Examining the efficacy of adjunctive aripiprazole in major depressive disorder: A pooled analysis of 2 studies. *Prim Care Comp J Clin Psychiatry.* 2008;10(6):440-7.
77. Carta MG, Hardoy MC, Pilu A, et al. Improving physical quality of life with group physical activity in the adjunctive treatment of major depressive disorder. *Clin Pract Epidemiol Ment Health.* 2008;4(1):1-6.
78. Lynch TR, Cheavens JS, Cukrowicz KC, et al. Treatment of older adults with co-morbid personality disorder and depression: A dialectical behavior therapy approach. *Int J Geriatr Psychiatry.* 2007;22(2):131-43.
79. Zourkova A. Effect of mirtazapine and paroxetine on residual symptoms of depressive disorders and their effect on P450 CYP 2D6 activity. *Homeost Health Dis.* 2001;41(6):242-9.
80. Landén M, Eriksson E, Agren H, et al. Effect of buspirone on sexual dysfunction in depressed patients treated with selective serotonin reuptake inhibitors. *J Clin Psychopharmacol.* 1999;19(3):268-71.
81. Nelson JC, Mankoski R, Baker RA, et al. Effects of aripiprazole adjunctive to standard antidepressant treatment on the core symptoms of depression: A post-hoc, pooled analysis of two large, placebo-controlled studies. *J Affect Disord.* 2010;120(1-3):133-40. PMID:19656577
82. Reimherr F, Amsterdam J, Dunner D, et al. Genetic polymorphisms in the treatment of depression: speculations from an augmentation study using atomoxetine. *Psychiatry Res.* 2010;175(1-2):67-73. PMID:19969374
83. Martire LM, Schulz R, Reynolds CF, III, et al. Treatment of late-life depression alleviates caregiver burden. *J Am Geriatr Soc.* 2010;58(1):23-9. PMID:19943833
84. Bauer M, El-Khalili N, Datto C, et al. A pooled analysis of two randomised, placebo-controlled studies of extended release quetiapine fumarate adjunctive to antidepressant therapy in patients with major depressive disorder. [Review]. *J Affect Disord.* 2010;127(1-3):19-30. PMID:20884063

85. Greenlee A, Karp JF, Dew MA, et al. Anxiety impairs depression remission in partial responders during extended treatment in late-life. *Depress Anxiety*. 2010;27(5):451-6. PMID:20186975
86. Nelson JC, Thase ME, Trivedi MH, et al. Safety and tolerability of adjunctive aripiprazole in major depressive disorder: A pooled post hoc analysis (studies CN138-139 and CN138-163). *Prim Care Comp J Clin Psychiatry*. 2009;11(6):344-52.
87. Reynolds CFI, Dew MA, Martire LM, et al. Treating depression to remission in older adults: A controlled evaluation of combined escitalopram with interpersonal psychotherapy versus escitalopram with depression care management. *Int J Geriatr Psychiatry*. 2010;25(11):1134-41.
88. Rapaport MH, Gharabawi GM, Canuso CM, et al. Effects of risperidone augmentation in patients with treatment-resistant depression: Results of open-label treatment followed by double-blind continuation. *Neuropsychopharmacol*. 2006;31(11):2505-13.
89. Brent D, Emslie G, Clarke G, et al. Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: The TORDIA randomized controlled trial. *JAMA*. 2008;299(8):901-13. PMID:18314433
90. Heiligenstein JH, Hoog SL, Wagner KD, et al. Fluoxetine 40-60 mg versus fluoxetine 20 mg in the treatment of children and adolescents with a less-than-complete response to nine-week treatment with fluoxetine 10-20 mg: A pilot study. *Journal of Child & Adolescent Psychopharmacology*. 2006;16(1-2):207-17. PMID:16553541
91. Vitiello B, Brent DA, Greenhill LL, et al. Depressive Symptoms and clinical status during the treatment of adolescent suicide attempters (TASA) study. *J Am Acad Child Adolesc Psychiatry*. 2009;48(10):997-1004.
92. Brent DA, Emslie GJ, Clarke GN, et al. Predictors of spontaneous and systematically assessed suicidal adverse events in the treatment of SSRI-resistant depression in adolescents (TORDIA) study. *Am J Psychiatry*. 2009;166(4):418-26.
93. Asarnow JR, Emslie G, Clarke G, et al. Treatment of selective serotonin reuptake inhibitor-resistant depression in adolescents: Predictors and moderators of treatment response. *J Am Acad Child Adolesc Psychiatry*. 2009;48(3):330-9.
94. Brent DA, Greenhill LL, Compton S, et al. The Treatment of Adolescent Suicide Attempters Study (TASA): Predictors of suicidal events in an open treatment trial. *J Am Acad Child Adolesc Psychiatry*. 2009;48(10):987-96.
95. Stanley B, Brown G, Brent DA, et al. Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP): Treatment model, feasibility, and acceptability. *J Am Acad Child Adolesc Psychiatry*. 2009;48(10):1005-13.
96. Brent D, Melhem N, Ferrell R, et al. Association of FKBP5 polymorphisms with suicidal events in the Treatment of Resistant Depression in Adolescents (TORDIA) study. *Am J Psychiatry*. 2010;167(2):190-7. PMID:20008943
97. Goldstein BI, Shamseddeen W, Spirito A, et al. Substance use and the treatment of resistant depression in adolescents. *J Am Acad Child Adolesc Psychiatry*. 2009;48(12):1182-92.
98. Emslie GJ, Mayes T, Porta G, et al. Treatment of Resistant Depression in Adolescents (TORDIA): Week 24 outcomes. *Am J Psychiatry*. 2010;167(7):782-91. PMID:20478877
99. Sakolsky DJ, Perel JM, Emslie GJ, et al. Antidepressant exposure as a predictor of clinical outcomes in the Treatment of Resistant Depression in Adolescents (TORDIA) study. *J Clin Psychopharmacol*. 2011;31(1):92-7.
100. Shamseddeen W, Asarnow JR, Clarke G, et al. Impact of physical and sexual abuse on treatment response in the treatment of resistant depression in adolescent study (TORDIA). *J Am Acad Child Adolesc Psychiatry*. 2011;50(3):293-301.

101. Lynch FL, Dickerson JF, Clarke G, et al. Incremental cost-effectiveness of combined therapy vs medication only for youth with selective serotonin reuptake inhibitor-resistant depression: Treatment of SSRI-resistant depression in adolescents trial findings. *Arch Gen Psychiatry*. 2011;68(3):253-62.
102. Jaehne, M. E. Health care guideline: Major depression in adults in primary care 12th edition. Institute for Clinical Systems Improvement.
103. Qaseem A, Snow V, Denberg TD, et al. Using second-generation antidepressants to treat depressive disorders: A clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2008;149(10):725-33. PMID:19017591
104. Karasu B, Gelenberg A, Merriam A, et al. Practice guideline for treatment of patients with depression disorder second edition. *APA Practice Guidelines*. 2009;1-78.
105. Depression clinical practice guidelines. National Guideline Clearinghouse. 2004;1-20.
106. Depression: Management of depression in primary and secondary care. 23. 2004.
107. Steinman LE, Frederick JT, Prohaska T, et al. Recommendations for treating depression in community-based older adults. *Am J Prev Med*. 2007;33(3):175-81. PMID:17826575
108. Bauer M, Bschor T, Pfennig A, et al. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for biological treatment of unipolar depressive disorders in primary care. *World J Biol Psychiatry*. 2007;8(2):67-104. PMID:17455102
109. Davidson KW, Kupfer DJ, Bigger JT, et al. Assessment and treatment of depression in patients with cardiovascular disease: National Heart, Lung, and Blood Institute Working Group Report. *Psychosom Med*. 2006;68(5):645-50. PMID:17012516
110. Ellis P, Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. Australian and New Zealand clinical practice guidelines for the treatment of depression. *Aust NZ J Psychiatry*. 2004;38(6):389-407. PMID:15209830
111. Malhi GS, Adams D, Porter R, et al. Clinical practice recommendations for depression. *Acta Psychiatr Scand*. 2009;119(Suppl. 439):8-26.
112. Ravindran AV. If a patient does not respond to a full dose of fluvoxamine for at least 12 weeks, what alternatives should be considered? *J Psychiatry Neurosci*. 1998;23(2):136 PMID:9549254
113. Ravindran AV, Lam RW, Filteau MJ, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. V. Complementary and alternative medicine treatments. *J Affect Disord*. 2009;117(Suppl. 1):S54-S64
114. Parikh SV, Segal ZV, Grigoriadis S, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. II. Psychotherapy alone or in combination with antidepressant medication. *J Affect Disord*. 2009;117(Suppl. 1):S15-S25
115. Lam RW, Kennedy SH, Grigoriadis S, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. III. Pharmacotherapy. *J Affect Disord*. 2009;117(Suppl. 1):S26-S43
116. Conn DK, Gibson M, Feldman S, et al. National guidelines for seniors' mental health: The assessment and treatment of mental health issues in long-term care homes (focus on mood and behaviour symptoms). *Can J Geriatr*. 2006;9(Suppl. 2):S59-S64
117. R Mahendran, H L Yap. Clinical practice guidelines for depression. *Singapore Med J* 2005;46(11):610-5. 2005.
118. National Institute for Health and Clinical Excellence. Depression: The treatment and management of depression in adults. 2009;1-585. 2009.
119. National Institute for Health and Clinical Excellence. Computerised cognitive behaviour therapy for depression and anxiety. 2006;97. 2006.

120. Pilling S, Anderson I, Goldberg D, et al. Guidelines: Depression in adults, including those with a chronic physical health problem: Summary of NICE guidance. *Br Med J*. 2009;339(7728):1025-7.
121. Nutt DJ, Davidson JR, Gelenberg AJ, et al. International consensus statement on major depressive disorder. *J Clin Psychiatry*. 2010;71(Suppl E1):e08.
122. National Institute for Health and Clinical Excellence. Depression in adults with a chronic physical health problem: Treatment and management. NICE clinical guideline 91. London: NICE; 2009.
123. National Institute for Health and Clinical Excellence. Depression in adults (update): Depression: The treatment and management of depression in adults. Final Version of guideline 90. London: NICE; 2009.
124. Harter M, Klesse C, Bermejo I, et al. Unipolar depression: Diagnostic and therapeutic recommendations from the current S3/National Clinical Practice Guideline. *Deutsches Arzteblatt International*. 2010;107(40):700-8. PMID:21031129
125. Gelenberg A, Freeman M, Markowitz J et al. Practice guideline for the treatment of patients with major depressive disorder. American Psychiatric Association; 2010.
126. Birmaher B, Brent D, Bernet W, et al. Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *J Am Acad Child Adolesc Psychiatry*. 2007;46(11):1503-26. PMID:18049300
127. Zuckerbrot R, Cheung M.H, Jensen P, et al. Guidelines for adolescent Depression in primary care (GLAD-PC) I, Identification, assessment, and initial management. *Pediatr*. 2009;120(5):1299-312.
128. Hughes CW, Emslie GJ, Crismon ML, et al. Texas Children's Medication Algorithm Project: update from Texas Consensus Conference Panel on medication treatment of childhood major depressive disorder. *J Am Acad Child Adolesc Psychiatry*. 2007;46(6):667-86. PMID:17513980
129. Cheung AH, Zuckerbrot RA, Jensen PS, et al. Guidelines for adolescent depression in primary care (GLAD-PC): II. Treatment and ongoing management. *J Am Acad Pediatr*. 2007;120(5):e1313-e1326
130. Gallagher R. Evidence-based psychotherapies for depressed adolescents: A review and clinical guidelines. *Prim Psychiatry*. 2005;12(9):33-9.
131. National Institute for Clinical Excellence. Depression in Children and Young People : Identification and management in primary, community and secondary care. 2005:1-233. 2005.
132. Anderson IM, Ferrier IN, Baldwin RC, et al. Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2000 British Association for Psychopharmacology guidelines. *J Psychopharmacol (Oxf)*. 2008;22(4):343-96. PMID:18413657
133. New Zealand Guidelines Group. Identification of common mental disorders and management of depression in primary care. 2008:1-190. 2008.
134. Ioannidis JPA, Evans SJW, Gotzsche PC, et al. Better reporting of harms in randomized trials: An extension of the CONSORT statement. *Ann Intern Med*. 2004;141(10):781-8. ISI:000225206900005.

Introduction

Background

Depression is a complex mental illness that is associated with disability and reduced quality of life for the person with depression, as well as substantial societal burden. Pharmacological agents are one of several treatment modalities used for depression and one of the most frequently utilized classes of antidepressant medications are the selective serotonin reuptake inhibitors (SSRIs). The rate of treatment response following first-line treatment with SSRIs is moderate, however, varying from 40 to 60 percent; remission rates vary from 30 to 45 percent.¹ Up to one third of persons taking antidepressant medications will develop recurrent symptoms of depression while on therapy.² The definition of an adequate response to SSRI medications is not consistently operationalized, but it is generally accepted that a 50 percent decrease in symptom severity constitutes a response.³ Remission from depression is defined as being free or nearly free of symptoms for the current episode. This review evaluates treatment options for patients who fail to improve fully, who only improve partially, or who have no response to an SSRI medication.

Epidemiology of Depression in Adults and Adolescents

Major depressive disorder (MDD) is the occurrence of one or more major depressive episodes (MDE). An MDE is defined as a period of at least 2 weeks that is characterized either by depressed mood and/or markedly diminished interest or pleasure in all, or almost all, activities in addition to at least four other symptoms.⁴ Dysthymic disorder is characterized by a chronically depressed mood and at least two other depressive symptoms that occur most of the day, more days than not, for at least 2 years. The Diagnostic and Statistical Manual, 4th edition, Text Revision (DSM-IV-TR) includes specifiers that can be used to further describe the characteristics of MDE or dysthymic disorder, such as whether an episode of depression includes psychosis or occurs in the postpartum period. The operational definition for subsyndromal depression was defined by Judd⁵ for individuals who do not meet criteria for a diagnosis of minor depression, major depression, and/or dysthymia. The definition specifies the presence of two or more simultaneous symptoms of depression associated with evidence of social dysfunction for most or all of the time for at least 2 weeks. Depression is common in adults and adolescents and is characterized by chronic, recurrent episodes that have significant impact on disability and mortality.

There is increasing acceptance that symptoms that do not meet the full criteria for MDD, but that are persistent, may cause distress and disability in persons with these symptoms. The DSM-IV-TR describes two related subthreshold categories of dysthymia and minor depression. dysthymia is characterized by an overwhelming yet chronic state of depression, exhibited by a depressed mood for most of the days, for more days than not, for at least 2 years. In children and adolescents, mood can be irritable and duration must be at least 1 year. The person who suffers from this disorder must not have gone for more than 2 months without experiencing two or more of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, or feelings of hopelessness. In addition, no MDD episode has been present during the first 2 years (or 1 year in children and adolescents) and there has never been a manic episode, a mixed episode, or a

hypomanic episode, and criteria have never been met for cyclothymic disorder. Further, the symptoms cannot be due to the direct physiological effects of the use or abuse of a substance such as alcohol, drugs or medication, or a general medical condition. The symptoms must also cause significant distress or impairment in social, occupational, educational, or other important areas of functioning.

Prevalence of Depressive Disorders

Kessler reported estimates of 16 percent lifetime prevalence and 7 percent annual prevalence of depression in the United States for adults.⁶ These are slightly higher than European prevalence rates of 13 percent lifetime and 4 percent annual.⁷ European estimates of the prevalence of dysthymic disorder in adults based on DSM-IV-TR criteria, are 4 percent lifetime and 1 percent annual.⁷ Despite increases in provision of treatment for people with depression,⁸ a reduction in prevalence has not yet been discernable in those countries where before–after comparisons have been feasible.^{9,10} This may be in part because a substantial number of people with depression remain untreated or receive inadequate treatment.¹¹ The Netherlands Mental Health Survey and Incidence Study assessed episode duration in community residents with new-onset episodes. Although 50 percent of people recovered within 3 months, the recovery rate flattened over time, and the authors estimated that approximately 20 percent would have episodes lasting longer than 24 months.¹²

The prevalence of MDD in adolescents, 12 to 16 years of age, varies from 4 to 8 percent. There is an increased risk of depression following puberty, especially in girls relative to boys (2:1 ratio).^{13,14} Prevalence of MDD among adolescents has been reported to be as high as 20 percent.¹⁴

Although the literature is limited, the few studies that evaluate dysthymia in adolescents report disease prevalence varying from 1.6 percent to 8.0 percent.¹⁵ Adolescents with depression have high rates of comorbid psychiatric conditions (reports vary from 40 to 90 percent), including anxiety, attention deficit hyperactivity disorder and substance abuse problems.¹³

The Disease Burden Associated With MDD, Dysthymia

MDD is a leading cause of disability across the world.^{16,17} Specifically, depression is the second leading medical cause of long-term disability and the fourth leading cause of the global burden of disease, predicted to become the second highest cause of disability by 2020. The ongoing transition to a knowledge-based economy is expected to further magnify the impact of MDD on occupational functioning.¹⁸ Depressive disorders negatively affect quality of life (QOL); 63 percent of respondents with MDD had severe impairment in QOL, while 85 percent of those with double depression (MDD and dysthymic disorder) and 56 percent of those with dysthymic disorder had QOL impairment in the severe range.¹⁹ The economic burden of depressive disorders is estimated to be \$83.1 billion per year.²⁰

The National Comorbidity Survey Replication study in the United States found that role impairment in people with MDD was lowest in the occupational domain and highest in the social domain.⁶ About 60 percent of respondents with an MDE in the past year reported severe or very severe role impairment. Parental depression has a negative effect on the development of their children and on family dynamics,^{21,22} and intergenerational effects may amplify the impact of depression on population health.²³

Depression also has a negative impact on occupational functioning. In one study, depressed workers had significantly greater performance deficits than control workers who had rheumatoid

arthritis, with regard to performing mental tasks, time management, output tasks, and physical tasks.²⁴ When depressed workers were compared to workers with rheumatoid arthritis, the depressed employees were almost five times as likely to become unemployed than those with arthritis.²⁵ Depressed employees are also more likely to become unemployed or miss time at work than physically ill employees.²⁶

Depression exerts a negative impact on physical health; it reduces adherence to medical treatment,²⁷ reduces participation in preventive activities,²⁸ and increases the likelihood of risk factors such as obesity,²⁹ smoking,³⁰ and a sedentary lifestyle.³¹ MDD may be associated with immune dysfunction,³²⁻³⁶ cardiovascular disease,³⁷⁻³⁹ endocrine and neurological diseases, and a general increase in chronic disease incidence.⁴⁰ Mortality rates are high; approximately four percent of people with a mood disorder die by their own hand and about two thirds of suicides are preceded by depression.⁴¹

In adolescents, untreated depression results in significant disability in school performance, interpersonal relationships, risk of suicidal behavior and completion of suicide, risk of early pregnancy, occupational adjustment, and impaired social and family functioning.^{14,42}

Clinical Assessment, Management, and Response

Depression is frequently underdiagnosed in primary practice in both adults and adolescents. The World Health Organization (WHO) Psychological Problems in General Health Care study reported that primary care physicians diagnosed only 42 percent of adult patients with major depression. Possible benefits of screening and diagnostic tools to improve detection of depression in primary practice have been examined. Several tools are available for monitoring of depressive symptoms and there were no major differences between these instruments in a comparative study.⁴³ The Patient Health Questionnaire-9 item (PHQ-9)⁴⁴ or the Quick Inventory of Depressive Symptoms–Self Report (QIDS-SR) appear to be increasing in use, perhaps because of their brevity and strong alignment with DSM-IV-TR. The spectrum of depressive morbidity encountered by primary care physicians is broad. There is also recent evidence suggesting that diagnosis of depression in primary care may not be the major barrier to successful treatment; rather, it may be that patients are not receptive to suggested treatment for a condition that was not the reason for the visit to the physician. In primary care, the range of interventions offered may extend from close monitoring of mild episodes without immediate treatment (watchful waiting), through guided self-management, brief psychological or behavioral interventions, pharmacological management, and, if needed, referral to more specialized services or hospital admission.⁴⁵

Phases of Treatment of Major Depressive Episodes

Based on the work of Kupfer,⁴⁶ treatment for MDD is commonly divided into three phases: acute, continuation, and maintenance. Acute treatment is aimed at the elimination of symptoms of depression and the restoration of psychosocial functioning. Continuation is a prolongation of treatment from four to nine months, such that the episode of depression is considered completely resolved. For the continuation phase, the treatment aims to return patients to baseline function and quality of life, and to prevent recurrence of symptoms. For the maintenance phase when symptoms have been resolved, the treatment goal is to prevent recurrence of new episodes of MDD. In this context, relapse is understood to occur during the continuation phase, but recurrence during the maintenance phase.

The target goal for acute treatment should be remission, which is defined as a resolution of depressive symptoms (score within a normal range of the symptom scale). Response to treatment, usually defined as at least a 50 percent reduction in symptom levels,³ may not be sufficient as a target outcome because residual depressive symptoms are risk factors for relapse and negative predictors of long-term outcome.⁴⁷

Duration of First-Line Treatment Prior To Establishing Adequate Response

Embedded within the decision that a patient has not had an adequate response to treatment, is the issue of defining an adequate duration for that treatment. Antidepressant effect may begin within 1 to 2 weeks of initiation⁴⁸⁻⁵⁰ and early improvement is a prognostic factor for remission.⁵¹ In STAR*D, 93 percent of patients first achieved response after 8 or more weeks, while 41 percent of patients who ultimately remitted first attained remission between 4 and 8 weeks after initiating treatment.⁵²

Some guidelines suggest that patients with at least minimal improvement (≥ 20 percent improvement in scores on a depression rating scale after four to six weeks) should continue with the antidepressant for another two to four weeks before considering additional strategies.^{53,54} The American College of Physicians (ACP) recommends that clinicians modify treatment if the patient does not have an adequate response to pharmacotherapy within 6 to 8 weeks of the initiation of therapy for MDD.⁵⁵

Outcomes of Importance

There are a number of outcomes that are used within primary care and psychiatry to assess and monitor response to treatment. These scales include those that are self-report or completed by the clinician. Outcome assessment is usually conducted using validated interviewer-rated scales such as the Hamilton Depression Rating Scale (HAM-D)⁵⁶ or the Montgomery Åsberg Depression Rating Scale (MADRS).⁵⁷ Although limitations have been recognized to the use of the HAM-D in outpatient populations, it remains widely used.⁵⁸ Response is typically defined as >50 percent reduction in scores on these scales, while remission is defined as a score within the normal range.^{3,58,59} However, despite a number of well-validated instruments to assess depression symptoms, there is some suggestion that physicians in primary care may not routinely use these; based on qualitative analyses, factors that influenced the use of these standardized assessments were time constraints, clinician familiarity with the instrument, and lack of clinical evidence.⁶⁰ There is also some evidence that primary care physicians have a sensitivity varying from 48 to 50 percent when ruling in depression using unassisted methods (without the use of severity scales, diagnostic instruments, educational programs, or other organizational approaches).⁶¹

Defining Inadequate Response and Estimates Within the Population

Subjects who are classified as having failed treatment or as having an “inadequate response” are eligible for this review. Treatment failure subjects would ideally be defined as those subjects who are currently on SSRI treatment for the index episode at the time of entry into the study. At that point these subjects have been judged to have had an “inadequate response” at the time of entry into the study or just prior to randomization. An “inadequate response” is typically established using a standardized instrument, where the scores relative to baseline reflect an improvement of less than 50 percent.^{3,62} The term “inadequate response” is therefore

synonymous with terms such as “nonresponders,” “failure to respond,” and “treatment failure.” These terms primarily reflect the perspective of the clinician or researcher. Partial response refers to a change in baseline score from 25 to 49 percent. Nonresponse is defined as less than 25 percent change in baseline score.

The rate of treatment response following treatment with SSRIs is moderate, varying from 40 to 60 percent.¹ Up to two thirds of adult patients will not achieve remission with SSRI treatment.⁵² Up to one third of adults on drug treatment will develop recurrent symptoms of depression while on therapy.² Moreover, there is limited evidence identifying reliable predictors (demographic, clinical, or genetic characteristics) of individual response.⁶³

Within their systematic review evaluating the efficacy of treatment for adolescents, Williams, et al.,⁶⁴ showed that the rates of children failing to respond to an initial trial of SSRIs varied from 31 to 64 percent in eligible studies. Similarly, up to 60 percent of adolescents placed on combined treatment for depression (including pharmacological and behavioral therapies) respond positively to these interventions.⁴²

A portion of patients who have experienced an inadequate response from a clinical perspective may also go on to be defined as treatment resistant if they also fail to respond to subsequent treatment strategies. Treatment resistance is variably defined but usually refers to patients who have failed at least two trials of medication that have been of adequate dose and duration.⁶⁵ Some definitions suggest that the failures should be to medications of different classes, but this is not universally accepted.

Monitoring adherence to antidepressants is sometimes difficult, but nonadherence may account for up to 20 percent of patients classified as having treatment resistant depression.⁶⁶ Similarly, there is the potential for pseudoresistance or nonresponse to inadequate treatment. All this would suggest the difficulty of defining and capturing subjects who have had treatment failure and related subgroups. It may also reflect heterogeneity across studies evaluating the efficacy of SSRIs within this patient population.

Treatment After an Inadequate Response

Treatment strategies following an inadequate response to an SSRI vary and can include monotherapy or combined therapy. Monotherapy options include: (1) an optimization strategy (increasing the dose or extending the duration of the SSRI), (2) switching to another SSRI, (3) switching to another class of antidepressants, or (4) switching to a nonpharmacological intervention. Combination or add-on therapy options include: (1) combining the SSRI with an augmenting agent, (2) combining antidepressants, or, (3) combining the SSRI with a nonpharmacological therapy.⁶⁷ It is also an option to switch to a new antidepressant and simultaneously combine that antidepressant with a second pharmacological or nonpharmacological treatment. This is sometimes referred to as an acceleration strategy.

Evaluation of Current Clinical Practice Guidelines for Inadequate Response

Recognizing that clinicians have a number of treatment options when addressing patients with an inadequate response, we thought it would be important to identify and evaluate current recommendations within current guidelines regarding the optimal approach to treatment. Our goal was to critically appraise these current guidelines and compare any differences in recommendations.

Scope and Purpose of this Review

A variety of treatment strategies aimed at helping individuals who have inadequate responses to SSRIs have been studied in patients with depression. The primary goal of this comparative effectiveness review (CER) is to examine the evidence guiding clinical treatment decisions and ultimately to aid clinicians in their care of patients when SSRI therapy for an index episode does not result in an adequate treatment response. The Key Questions are as follows:

Key Question 1. Among adults and adolescents with major depressive disorder (MDD), dysthymia, or subsyndromal depression who are started on an SSRI and who are compliant with treatment but fail to improve either fully, partially, or have no response, what is the benefit (efficacy or effectiveness) of monotherapy and combined therapy?

Key Question 1a. How does the efficacy/effectiveness vary among the different monotherapies and combined therapies?

Key Question 2. What are the harms of each of the monotherapies or combined therapies among these adults and adolescents? How do the harms compare across different interventions?

Key Question 3. How do these therapies compare in different populations (e.g., different depressive diagnoses, disease severity, ages, gender, racial and socioeconomic group, and medical or psychiatric comorbidities)? These subgroups will be considered with respect to the different interventions.

Key Question 4. What is the range of recommended clinical actions following the failure of one adequate course of SSRI based on clinical practice guidelines published between 2004 and April 2011?

Methods

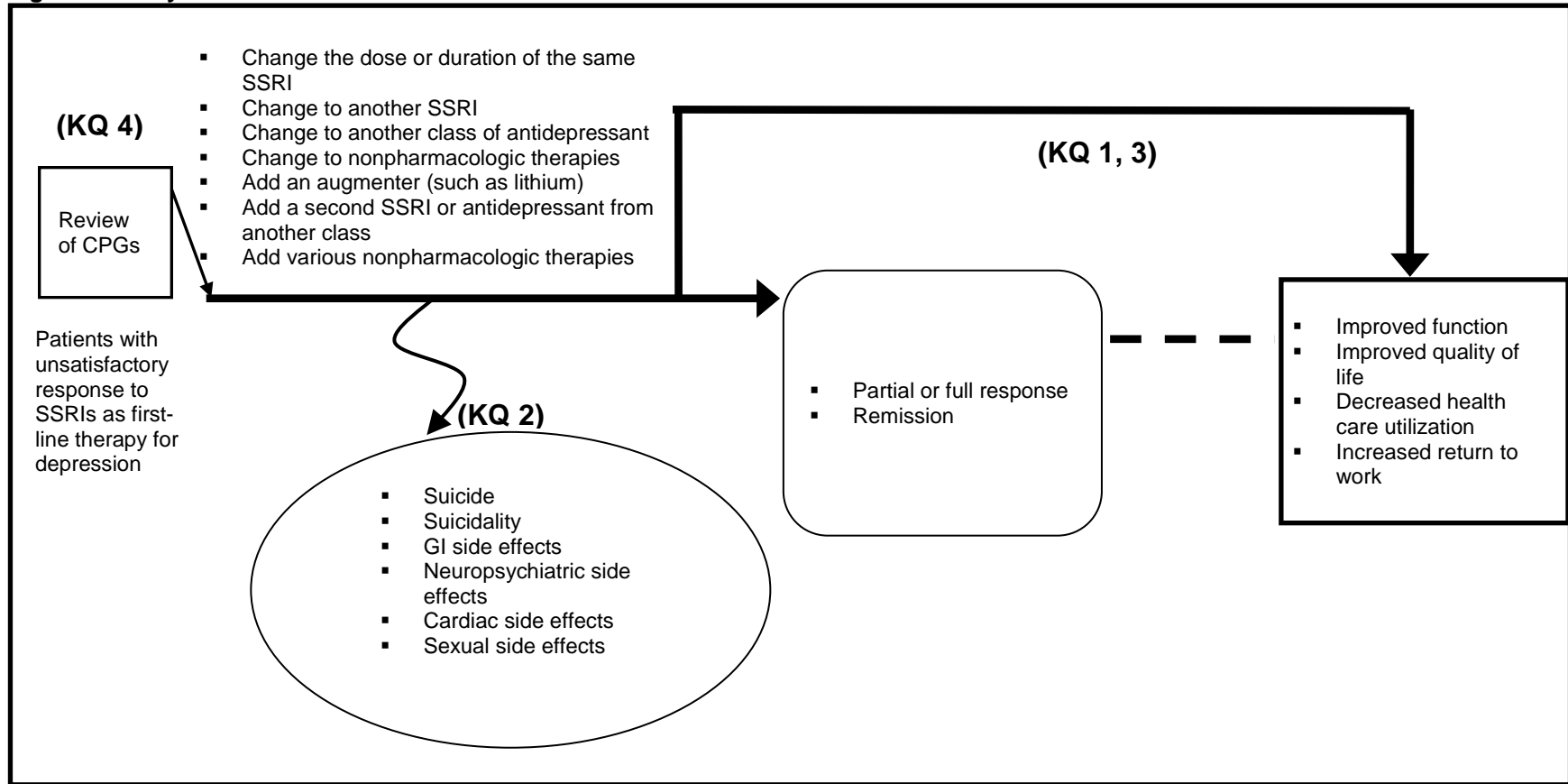
Topic Development

The topic of this report and preliminary Key Questions (KQs) were developed through a participatory process involving the public, the Scientific Resource Center for the Effective Health Care program of the Agency for Healthcare Research and Quality (AHRQ), and various stakeholder groups. We communicated with eight key informants who represented psychiatrists, primary care practitioners, consumer representatives, and researchers in the area when formulating the research questions. Additional study, patient, intervention, and eligibility criteria, as well as outcomes, were refined and agreed upon through discussions between the McMaster University Evidence-based Practice Center, the Technical Expert Panel (TEP) members, the AHRQ Task Order Officer (TOO), a patient representative, and comments received from the public. Upon completion of the topic refinement, the key questions were posted for public comment, which were then summarized and discussed with the TEP. Relevant modifications (additions or clarifications) were incorporated.

Analytic Framework

Following consultation with key informants, the AHRQ TOO, and the investigative team, the key research questions were developed. Figure 1 shows a flow diagram indicating the relationship between research questions in this CER. The first box in the figure shows the last question (KQ4) where clinical practice guidelines (CPGs) are evaluated. The other research questions are related to interventions used following the inadequate response to a selective serotonin reuptake inhibitors (SSRIs) for the index episode of depression. The treatment options following a failed response include the seven options (defined as interventions) for KQ1. Harms associated with any of these interventions are evaluated in KQ2 and can include suicide, sexual dysfunction, gastrointestinal effects, and neuropsychiatric effects. The study effects are evaluated in KQ1, KQ2, and KQ3, with the latter question considering subgroups related to different populations with depressive symptoms and other related factors potentially impacting treatment response. We note that intermediate outcomes, such as response and remission, may precede quality of life or societal outcomes.

Figure 1. Analytic framework



CPG = clinical practice guideline; GI = gastrointestinal; KQ = Key Question; SSRI = selective serotonin reuptake inhibitor

Search Strategy

For the primary studies, the search strategy was delimited to studies published from 1980 to April 13, 2011, as SSRIs first became available for treatment of depression in the early 1980s. The following electronic bibliographic databases were searched: MEDLINE[®], Cochrane Central[®], PsychINFO, Cochrane Database of Systematic Reviews, Embase[®], CINAHL[®], and AMED. The strategies used combinations of controlled vocabulary (medical subject headings, keywords) and text words. Appendix A details the strategies used to capture relevant citations. For the CPGs, the search was limited to those published from 2004 to April 2011.

A grey literature search was undertaken by the AHRQ Scientific Resource Center and identified potentially relevant citations or information by searching the Web sites as follows:

1. Health Technology Assessment agencies (Hayes Inc. Health Technology Assessment),
2. Regulatory information (United States Food and Drug Administration [FDA], Health Canada, Authorized Medicines for European Community),
3. Clinical trial registries (clinical.trials.gov, Current Controlled Clinical Trials, Clinical Study Results, WHO Clinical Trials),
4. Grants and federally funded research (National Institutes of Health, Health Services Research Projects in Progress [HSRProj]),
5. Abstracts and conference proceedings (Conference Papers Index, Scopus), and,
6. The New York Academy of Medicine's Grey Literature Index. Additionally, the sites of specialty organizations for CPG were searched and members of the TEP were queried for potentially relevant guidelines.

Review of reference lists of systematic reviews published from 2005 forward was also undertaken. Similarly, the reference lists of eligible studies at full text screening were reviewed for relevant references. Any potentially relevant citations were cross-checked with our citation database and any that were new were retrieved and screened at full text.

Study Selection

Types of Participants

Subjects who are classified as having failed treatment or as having an “inadequate response” were eligible for this review. Treatment failure subjects would ideally be defined as those subjects who are currently on SSRI treatment for the index episode at the time of entry into the study. At that point these subjects have been judged to have had an “inadequate response” at the time of entry into the study or just prior to randomization. An “inadequate response” is typically established using a standardized instrument, where the scores relative to baseline reflect an improvement of less than 50 percent.^{3,62} The term “inadequate response” is therefore synonymous with terms such as “nonresponse,” “failure to respond,” and “treatment failure.” These terms primarily reflect the perspective of the clinician or researcher. Partial response refers to a change in baseline score from 25 to 49 percent. “Nonresponse” is defined as a change in baseline score of less than 25 percent. For this CER, the term “unsatisfactory response” was used to reflect the patient's perception of their response to the intervention to treat their depression.

Specific eligibility is as follows: the study populations were eligible if they included adults (≥ 18 years) or adolescents (12 to 18 years) with major depressive disorder (MDD), dysthymia, or subsyndromal depression, who meet the following criteria:

- Currently on SSRI treatment for the index episode at the time of entry into the study,
- Have been judged to have had an “inadequate response” at the time of entry into the study (by any method),
- The SSRIs that patients did not respond to as a first-line therapy include the following: fluoxetine, citalopram, fluvoxamine, sertraline, escitalopram, and paroxetine,

OR

- The subjects who are recruited for entry into the study are to be placed on an SSRI for purposes of monitoring prospectively the adequacy of their response; subsequent evaluation includes an intervention for those that have been shown to not respond adequately to the SSRI.

Exclusion

The study populations were not eligible if adults (>18 years) and adolescents (12 to 18 years) with MDD, dysthymia, or subsyndromal depression met the following criteria:

- Are not receiving an SSRI at the time of entry into the study (including studies that included antidepressants but were not stratified for an SSRI subgroup),
- Are not recruited to evaluate the adequacy of response prospectively,
- Have post-partum depression, bipolar depression, depressive psychosis, dysphoria, mourning syndrome, postoperative depression, premenstrual dysphoric disorder, pseudodementia, puerperal depression, seasonal affective disorder,

OR

- Populations for whom the patho-physiological mechanism of depression is not comparable to those diagnosed with MDD, including patients having initially sustained a cerebrovascular accident, who suffer from dementias (including Alzheimer’s disease, vascular dementia, mild cognitive impairment), Parkinson’s disease, hypothyroidism, or Cushing’s syndrome

Types of Interventions

For KQs 1 to 4, the pharmacological and nonpharmacological interventions of interest are as follows:

Selective-Serotonin Reuptake Inhibitors (SSRIs): Fluoxetine (Fluoxetine Hydrochloride, Prozac, Prozac Weekly, Sarafem, Symbyax), Citalopram (Celexa, Citalopram Hydrobromide), Fluvoxamine (Fluvoxamine Maleate, Luvox, Luvox CR), Sertraline (Sertraline Hydrochloride, Zoloft), Paroxetine (Paroxetine Hydrochloride, Paxil, Paxil CR, Pexeva), Escitalopram (Escitalopram, Escitalopram Oxalate, Lexapro).

NonSSRI Antidepressants: Duloxetine Hydrochloride (Cymbalta), Venlafaxine (Effexor, Effexor XR, Pristiq), Desvenlafaxine Succinate (Pristiq), Phenelzine Sulfate (Nardil), Tranylcypromine Sulfate (Parnate), Emsam (Selegiline), Moclobemide (Manerix), Doxepin (Sinequan, Zonalon, Doxepin Hydrochloride), Clomipramine (Anafranil, Clomipramine Hydrochloride), Amitriptyline (Amitid, Amitril, Elavil, Endep, Etrafon 2-10, Etrafon 2-25, Etrafon-a, Etrafon-Forte, Limbitrol, Limbitrol DS, Perphenazine and Amitriptyline Hydrochloride combinations - Triavil 2-10, Triavil 2-25, Triavil 4-10), Maprotiline (Ludiomil), Desipramine (Norpramin, Pertofrane), Trimipramine (Surmontil, Trimipramine Maleate), Imipramine (Imipramine Hydrochloride, Imipramine Pamoate, Janimine, Prammine, Presamine, Tofranil, Tofranil-pm), Protriptyline Hydrochloride (Vivactil), Agomelatine (Valdoxan), Reboxetine (Edronax, Vestra), Norvale (Mianserin, Bolvidon, Tolvan), Trazodone (Desyrel,

Trazodone Hydrochloride, Trialodine), Mirtazapine (Remeron, Remeron Soltab), Nefazodone (Nefazodone Hydrochloride, Serzone), Bupropion (Aplenzin, Bupropion Hydrochloride, Wellbutrin, Wellbutrin SR, Wellbutrin XL, Zyban).

Non-pharmacological and complementary and alternative medicine (CAM) therapies: cognitive behavioral therapy (CBT), interpersonal therapy (IPT), and other psychotherapies (behavior therapy, counseling, problem-solving therapy, psychodynamic therapy, bibliotherapy, guided self-help, distraction therapy), light therapy, exercise (any type cardiovascular or strengthening or stretching and including yoga, hydrotherapy), CAM including whole body systems (e.g., acupuncture), mind-body medicine (e.g., meditation), manipulative and body-based practices (e.g., massage), energy medicine (e.g., reiki), biologically based practices (dietary supplements and herbal products (e.g., amino acids, vitamins and minerals, Inositol, herbs, methyl-folate (Deplin), omega-3 fatty acids, SAME)).

Augmenters (no formal indication for use as an antidepressant): Buspirone (Buspar), Gepirone (Ariza), Tandospirone (Sediel), Atypical Antipsychotics (Risperidone (Risperdal), Olanzapine (Zyprexa), Quetiapine (Seroquel), Aripiprazole (Abilify), Ziprasidone (Geodon)), Psychostimulants (Amphetamine (Adderall), Methylphenidate (Ritalin), Dopamine agonists (Bromocriptine (Parlodel), Cabergoline (Dostinex), Pergolide (Permax), Pramipexole (Mirapex), Ropinirole (Requip), Apomorphine (Apokyn), Rotigotine (Neupro), Other drugs (Lithium, Pindolol, Tryptophan), Anticonvulsants (Carbamazepine (Tegretol), Sodium Valproate, Lamotrigine (Lamictal)), Antiprogestational agents (Mifepristone (Mifeprex)), Sex Hormones (Androgens (e.g., Testosterone), Estrogens, Progesterone), Thyroid medications (tri-iodothyronine (T3), Amisulpride (Solian), Phenytoin (Dilantin, Phenytek), Modafinil (Provigil, Alerte, Modavigil, Modiodal, Modafinil, Carim, Armodafinil, Nuvigil), N-methyl-D aspartate (NMDA) NR2B subunit selective agonist CP-101606, mecamylamine hydrochloride (Inversine), Atomoxetine (Strattera)).

Studies that used electroconvulsive therapy, vagal nerve stimulation, or repetitive transcranial nerve stimulation as the intervention were excluded.

For KQ4, we evaluated CPGs that focus on guidelines at a national level or from key professional organizations published in English, but not limited to any country.

Types of Comparators

We identified and included studies with comparative intervention groups. From a design hierarchy perspective, comparative group designs provide stronger evidence for efficacy and effectiveness than noncomparative designs.

The interventions (either alone or in combination) may be compared with any of the following:

1. Placebo
2. Same SSRI dose but different MDD population (for example, mild vs. severe MDD)
3. Same SSRI of different dose or duration
4. Other SSRI
5. Other antidepressant (from a different drug class)
6. Nonpharmacological or CAM therapies as described above
7. Adjunct therapy: combination of an augmenter plus SSRI
8. Adjunct therapy: combination of nonpharmacological or CAM therapy plus SSRI
9. Adjunct therapy: combination of augmenter and nonpharmacological or CAM therapy

Types of Outcomes

Primary outcomes include the following:

1. Adequate Response: response to treatment is defined as a minimum of 50 percent change relative to baseline using a standardized instrument.^{3,62}
2. Remission: remission is defined as being free or nearly free of symptoms. It is typically established by achieving a threshold score using a standardized instrument.
3. Partial and Nonresponse: partial response refers to a change in baseline score from 25 to 49 percent. Nonresponse is defined as less than 25 percent change relative to baseline. We recognize that some of the studies will vary in their definition and this will be noted when detail is provided within the original study.
4. Speed of Response.
5. Relapse: relapse is defined as a return of symptoms satisfying the full syndrome criteria for an episode which occurs following a period of remission but before recovery. Relapse is the point at which recurrent symptoms are severe enough that the clinician determines an intervention is warranted. Relapse is related but distinct from the term recurrence. Recurrence is defined as the return of the disease after its apparent cessation (symptoms return after a period of remission).

Secondary outcomes include the following:

1. Quality of life
2. Adherence
3. Return to work
4. Global change as measured by global assessment scales
5. External service utilization

Additional Eligibility Criteria

Study Design

Inclusions:

1. Experimental studies with comparator groups (randomized and quasirandomized trials)
2. Observational studies with comparator groups (retrospective and prospective cohort, case control, and interrupted time series with comparison group)
3. Letters with study data and abstracts

Exclusions:

1. All other study designs (e.g., case series, qualitative studies)
2. Editorials, commentaries, and notes

Language of Publication

Non-English language publications were excluded.

Contacting Authors for Additional Data

For studies that included populations that had failed to respond to antidepressants that included SSRIs, study authors were contacted via email requesting additional stratified outcome data. Studies where the authors did not respond or contact could not be established were excluded.

Timing

There are no restrictions on study eligibility with respect to a minimum treatment interval.

Settings

Studies that recruited patients from primary care, outpatient, and inpatient mental health settings were included. There were no exclusions for study setting.

Clinical Practice Guideline Selection

We defined CPG as “systematically developed statements about specific clinical problems intended to assist practitioners and patients in making decisions about appropriate health care.”⁶⁸ We included full guidelines and consensus statements but we excluded algorithms with no background or description of the process by which the algorithm was developed.

Data Extraction

Relevant fields of information were extracted from individual studies by trained data extractors using standardized forms and a reference guide. Prior to performing the data extraction, a calibration exercise was undertaken using a convenience sample of five included studies. Key study elements were reviewed by a second person (study investigator) with respect to study outcomes, seminal population characteristics (past psychiatric history elements and definition of prior “treatment failure”), and characteristics of the intervention. Disagreements were resolved by consensus.

Extracted data included:

- Study characteristics: first author, country of research origin, study design, sample size, (e.g., sample size calculation, power estimate), clinical indications, and study duration or length of followup.
- Patient population: age, gender, racial composition, socioeconomic status (e.g., income, education), sleeping disturbances or levels, comorbidities (e.g., psychiatric and medical histories, use of CAM treatments concurrently or historically), definition of treatment failure, and severity and duration of the depressive disorder.
- Study interventions and comparators: type of intervention/comparator (e.g., pharmacological, nonpharmacological), dosage of intervention/comparator (e.g., type, dose, method of administration), frequency and treatment fidelity for psychotherapy related interventions, treatment duration (e.g., total duration of care), duration of followup, and characteristics of treatment providers.
- Outcomes: type of instrument or scale, primary or secondary outcome status, type of effect measure (e.g., endpoint or change score, measure of variance), definition of “adequate” treatment response, and type of statistical analysis (e.g., intention to treat).

Assessment of Methodological Quality of Individual Studies

We interpret methodological quality to include primarily elements of risk of bias related to the design and conduct of the study. In addition, we evaluated the presence of other key biases, such as the funding bias, and a specific form of selection bias related to “treatment failure” being determined prospectively.

We selected the Risk of Bias Tool by the Cochrane Collaboration⁶⁹ to assess randomized controlled trials (RCTs). The tool contains 12 items that include evaluation of the domains of

randomization, blinding, cointervention, and selective outcome reporting biases. Criteria for evaluation are standardized for these domains. Inconsistency amongst raters was minimized by providing adequate training and standardized instructions; disagreements were resolved by consensus.⁷⁰ We had selected the Newcastle Ottawa Quality Assessment Tool⁷¹ to assess risk of bias for observational studies but no study of this design was eligible. Additionally, we evaluated studies for adequacy of collecting and reporting harms using the McHarm Tool.^{72,73} This tool has been specifically designed for adverse events and captures domains related to the classification of harms, method of collection (active versus passive), and also the level of withdrawals due to adverse events. We used the AGREE II to assess the methodological quality of the CPG.⁷⁴ All tools can be viewed in Appendix B.

A study with low risk of bias was defined as a clinical trial fulfilling six or more of the 12 methodological quality criteria in the Risk of Bias Tool. A study with high risk of bias was defined as fulfilling fewer than six criteria. The classification of individual studies into categories of study limitations (high or low), were used to group studies for grading the strength of the evidence.

Applicability

We determined a priori the key attributes of applicability of our key research questions with respect to the population, intervention, comparator, and outcome in the context of a wider spectrum of patients (especially in primary care settings) that would likely benefit from these interventions in “real world” conditions.

Population characteristics to which these findings are applicable include:

- Men and woman older than 18 years of age and male and female adolescents aged 12 to 18 years
- People with a wide spectrum of previous episodes and variation in the course, including a first time episode of depression or several recurrences of MDD, dysthymia, or subsyndromal depression
- People with a complete spectrum of depression severity (mild to severe MDD and dysthymia)
- People with a wide spectrum of previous failures to SSRIs, from a first failed response for the current episode, to more than three failed responses to an SSRI for the current episode
- People with a wide spectrum of failed responses to previous antidepressant exposures for previous episodes of MDD, dysthymia, and subsyndromal depression

Population characteristics to whom the findings of this review are not applicable include:

- Adults or adolescents of either gender who have a primary diagnosis of bipolar disorder, schizophrenia, or major anxiety disorder

Intervention characteristics that these findings are applicable to include:

- For switches to new monotherapy treatment, antidepressant doses consistent with current recommended therapeutic dose ranges (as a minimum dose) applied for a minimum of 4 weeks,
- For combined therapy, there is variation in the doses for the added or augmenting agents; a clear trend for what ranges are applicable in this context.

The comparator treatments to which the research questions could ideally apply include those detailed in the comprehensive list of comparator treatments. Similarly, the outcomes selected for

this review would be applicable to those domains listed in the eligibility criteria; however, we would expect that these outcomes would be assessed using standardized instruments.

Data Synthesis

Qualitative Synthesis

For each trial, information on population characteristics (including history of treatment(s) for any previous episodes of depression, age of first diagnosis, etc.), study outcomes (both of benefit and of harm), sample sizes, settings, funding sources, treatments (type, dose, duration, and provider), methodological limitations, statistical analyses, and any important confounders is summarized in text and summary tables. We have stratified the presentation of results based on the type of depressive disorder (MDD, dysthymia, or subsyndromal depression) and by age (adolescent or adult).

Additionally, we grouped study results: (1) according to the index treatment categories (monotherapy or combined therapies) and the corresponding comparator treatment; (2) the specific grouping of the pharmacological treatment (SSRI, nonSSRI, augmenting agents); and (3) nonpharmacological treatment. Forest plots and summary tables were generated to display primary study outcomes of response and remission.

Summary tables were created for CPGs stratified by country of origin, where possible.

Quantitative Synthesis

The decision to pool individual study results was based on clinical judgment with regards to the comparability of study populations, treatments, and outcome measures. Specifically, methodological quality (high risk of bias vs. low risk of bias), clinical diversity (characteristics of the study population, gender, disease severity), treatment (pharmacological, nonpharmacological), intervention duration (2 weeks vs. 12 months), and outcome characteristics (different measuring scales) of individual studies were considered. The extent of heterogeneity was based on the clinical appropriateness of the populations and interventions.

After the final set of eligible studies were extracted, a decision was made to not undertake meta-analyses due to the clinical heterogeneity, predominately due to the different types of interventions and comparators. We presented data in forest plots to visually demonstrate comparative effects across the differing drug and nonpharmacological interventions but did not estimate summary effects. STATA (Version 10, StataCorp, College Station, Texas, United States) software was used to estimate the relative risks (RR) (using a random effects model) for the outcomes of response and remission.

Subgroup and Sensitivity Analysis

No meta-analyses were undertaken in this CER, as study populations, interventions, and comparators were not deemed sufficiently similar. However, we considered specific factors in the qualitative presentation of the review findings. Our search yielded only two eligible studies that did not include subjects with MDD, and, as such, the impact of the type of depressive disorder could not be explored. Primary studies and guidelines applicable to adults and adolescents were identified, and the results were presented stratified by these two age groups. Factors that had the potential to impact study outcomes or account for the clinical heterogeneity, such as gender, number of previous failures, method of determining treatment failure, dose and

duration characteristics of the intervention, and type of treatment provider were extracted and explored. We summarized these features within the clinical groupings of study interventions monotherapy versus monotherapy, monotherapy versus combined therapy, and combined therapies versus combined therapies. Methodological heterogeneity was also explored within each of these intervention groupings.

Rating the Body of Evidence

We assessed the overall strength of the evidence (SOE) across the literature using the rating approach as specified by the the AHRQ.⁷⁵ The SOE can be classified into four grades based on the AHRQ approach: high, moderate, low, or insufficient. Grading of the SOE is applied to individual outcomes, which in this CER are the primary outcomes of benefit (response and remission) and harm (suicidality, weight gain, and sexual dysfunction); partial and nonresponse was either omitted or poorly reported in most studies and as such was not included in the GRADE tables. A grading of “high” would reflect high confidence that the evidence shows the true effect, and that further research is very unlikely to change confidence in the estimate of the effect. A grading of “low” would reflect low confidence that the evidence shows the true effect, and that further research is likely to change confidence, or the magnitude in the estimate of the effect. A grading of “moderate” reflects a moderate level of confidence and that additional research may change confidence. A grading of “insufficient” reflects that the evidence is not available, or what evidence is available does not permit a conclusion of substance.

There are several factors that may decrease the overall grading of the SOE and these include: (1) study limitations (predominately risk of bias criteria) and the type of study design (experimental versus observational); (2) consistency of results (degree to which study results for an outcome are similar (variability across studies is easily explained, range of results is narrow); (3) directness of the evidence (assesses whether interventions can be linked directly to the health outcomes); and (4) precision (degree of certainty surrounding an effect estimate for a specific outcome). Additional factors that can be considered when evaluating the SOE can include: (1) dose response; (2) plausible confounding that would decrease the effect; (3) magnitude of the effect; and (4) publication bias and other factors related to relevance to intended populations.

The AHRQ approach to rating the SOE considers the link between the intervention and the outcomes with respect to the domain of directness. In the context of this CER, the links between intervention and the outcomes are all direct, thus, this domain does not assist in discriminating studies from each other. We have accounted for this by considering directness as per the GRADE approach,⁷⁶ regarding directness to the population, intervention, and comparator treatments as part of other considerations affecting the SOE. All of these factors were considered when grading the SOE and the overall ratings are detailed in summary tables.

Publication Bias

Although our search strategy is comprehensive and includes a grey literature search including sources for unpublished trials, there is always the potential for publication bias. Publication bias is important to assess in reviews with the use of drugs, as there is evidence to suggest that industry sponsorship may lead to negative trials not being published,⁷⁷ that reporting of adverse events are more favorable to the funder,⁷⁸ and that there may be delay in publication of negative findings.⁷⁸

Our grey literature search was undertaken by the AHRQ Scientific Resource Centre research librarian. Part of this extensive search included a large number of citations from regulatory

databases, such as the FDA and clinical trial registries. These sources were searched to identify unpublished or ongoing trials in an attempt to minimize publication bias. Since there were less than 10 studies focusing on any single intervention, no funnel plots were produced, nor was a meta-analysis undertaken.

Results

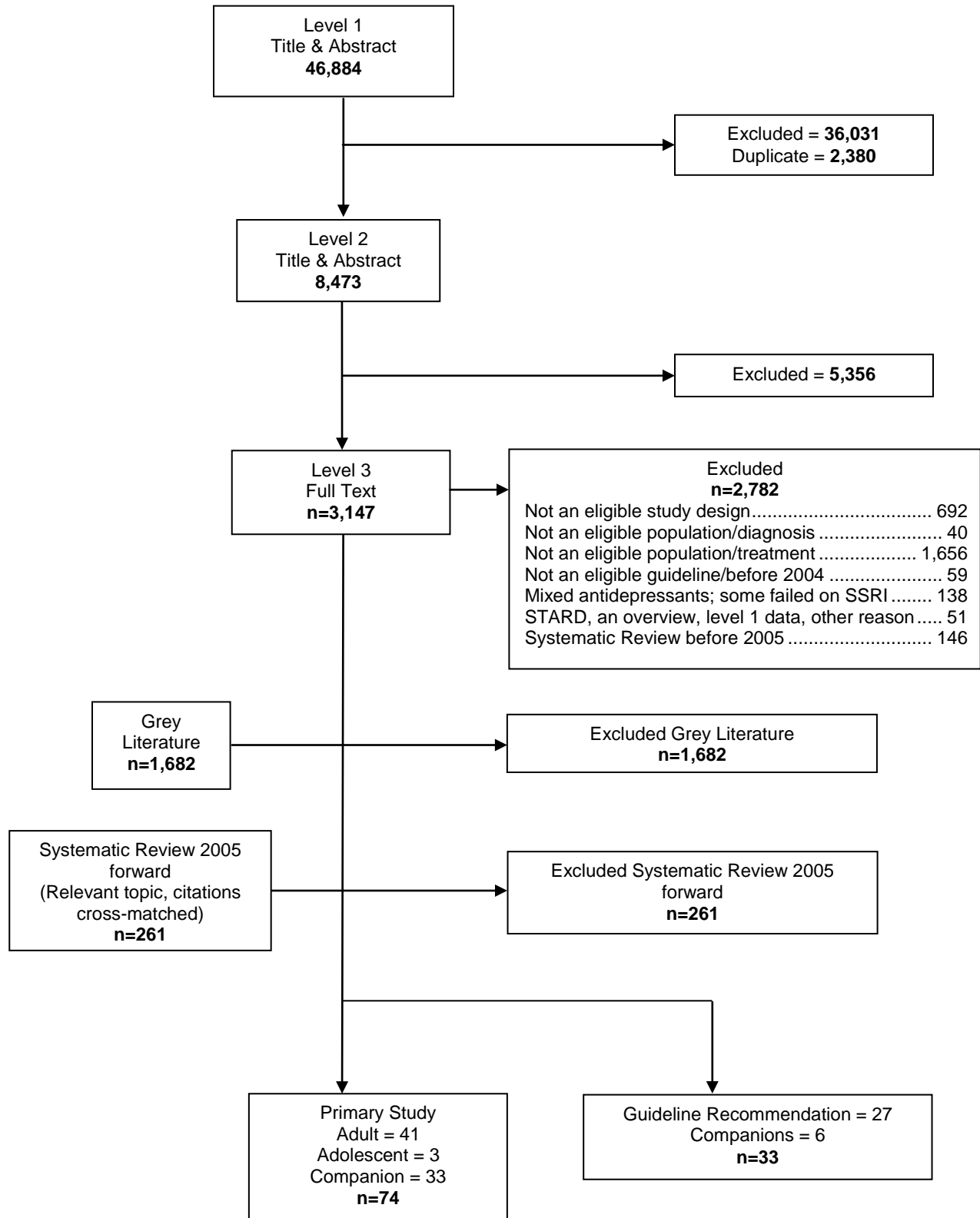
Figure 2 shows the number of citations retrieved in the search from bibliographic and grey literature sources. From an initial 46,884 citations from the seven databases, 2,380 were duplicates. Following the initial screen of title and abstract by two reviewers, 36,031 studies were excluded, indicating that the citation was any of the following: (1) a commentary, editorial or narrative review, (2) not published in English; or, (3) not focused on the treatment of depression. At the next level of title and abstract screening, an additional 8,473 citations were excluded as they were: (1) not a primary study, systematic review, or guideline, (2) not a population with major depressive disorder (MDD), dysthymia, or subsyndromal depression; or, (3) evaluated only electroconvulsive therapy, transcranial magnetic stimulation, or vagal nerve stimulation as treatments for depression. A total of 3,147 citations were then screened at full text. Figure 2 details the reasons for exclusion at full text. An additional 1,682 citations were derived from grey literature sources and reviewed for relevancy. Systematic reviews published from 2005 forward were screened for potentially relevant citations that may not have been captured by the search. Forty-four primary studies (74 publications)^{42,44,79-150} were eligible for adults and adolescents. Twenty-seven guidelines in 33 publications^{13,14,53-55,151-169,169-177} were eligible.

Publications that presented subgroup analyses, secondary analyses, re-analyses, results of different outcomes (not a primary outcome measure), or results for different time points on the same study cohort were considered to be secondary records (or companion publications) to the original studies. For example, there are multiple analyses and publications related to a single study cohort from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. In this study, subjects were evaluated prospectively (level 1) for response to a selective serotonin reuptake inhibitor (SSRI), and those who did not respond were followed forward for seven new treatment arms (level 2). Those that failed level two treatments received additional treatments up to level five. STAR*D is included here as a single study with 15 eligible publications; an additional 44 publications based on the STAR*D cohort were excluded because they described results from level 1 only (the prospective evaluation of citalopram efficacy) or because they were overview summaries.

Full text screening identified 148 studies with an appropriate design, but for which only a proportion of the sample comprised subjects that were initially treated with an SSRI. In most studies, initial treatment consisted of a variety of possible antidepressants that included, but were not limited to, SSRI medications. The corresponding authors of these studies were contacted by email and asked to provide data stratified for the subgroup treated with an SSRI. Seven authors of 10 publications from 6 studies^{79,94,95,105,108,109,115,126,127,131} provided additional information specific to the SSRI failed subjects and these data are reported in this review. For the remaining 138 studies, 22 authors indicated that they could not provide SSRI failed subject results, 93 did not respond to email contact by the specified cut-off date, and for 23, contact information could not be found Appendix C provides a list of excluded studies and the reasons for their exclusion.

We present the review findings by Key Question (KQ) and further stratified by adults and adolescents.

Figure 2. Flow of studies to final number of eligible studies



KQ1. Among adults and adolescents with Major Depressive Disorder, Dysthymia, and Subsyndromal Depression who are started on an SSRI and who are compliant with treatment but fail to improve either fully, partially, or have no response, what is the benefit (efficacy or effectiveness) of monotherapy and combined therapy?

KQ1a. How does the efficacy/effectiveness vary among the different monotherapies and combined therapies?

Forty-four unique studies were eligible for KQ1. Forty-one studies (61 publications)^{44,79-137,150} included adults and three studies (13 publications)^{42,138-149} included adolescents. With respect to the studies that evaluated adults, there were five studies^{107,150,178-180} for which results are not presented, and one for which on partial results are presented.¹¹² As well, seven of the STAR*D studies were not extracted: three studies¹⁸¹⁻¹⁸³ presented results for subjects after two or three additional treatment modifications following the first treatment failure (treatment levels three to five), three studies did not present data specific to any treatment,¹⁸⁴⁻¹⁸⁶ and one study¹⁸⁷ presented cost outcomes based on modeling rather than actual cost data. Four studies did not have data extracted¹⁷⁸⁻¹⁸⁰ or were only partially extracted,¹¹² as they included treatment protocols that evaluated prospective failure to subsequent nonSSRI or combination therapies prior to randomization to a new treatment (similar to level 3 and beyond in the STAR*D cohort), or participants were recruited because of previous failures including nonSSRI treatments.¹⁸⁰ The authors of these studies, and the authors from three STAR*D publications¹⁸¹⁻¹⁸³ were contacted and asked for results specific to the stream of patients that had failed an SSRI prior to the switch to the new intervention being tested; all authors responded and indicated that this information was not available. There were two additional studies^{107,150} that were not extracted: these studies used withdrawal designs (maintenance trials), in which subjects who had successfully responded to the combination of an SSRI and an augmenting agent were then randomized to maintain the current treatment or to switch back to monotherapy.

Similarly, from the three eligible studies that evaluated adolescents, two studies (10 publications) had data that could be extracted.^{42,138,140,141,144-149} One study^{139,142,143} (3 publications) called the Treatment of Adolescents Study (TADS), indicated that some subjects in the pharmacological arm were evaluated beyond the first prospective failure to an SSRI (phase 2 and 3), but did not present these results. The author was contacted and there was confirmation that this information was not available.

Treatment in Adults Who Have Had Inadequate Response to an SSRI

Key Messages

When altering doses or switching to a different monotherapy in patients with inadequate response to an SSRI:

- There is low quality evidence to determine whether a switch to a nonSSRI antidepressant is different than a switch to another SSRI to affect response and remission.
- There is low quality evidence to determine if a switch to a nonpharmacological treatment is different than a switch to another antidepressant.
- There is low quality evidence that increasing the dose of an antidepressant is different to maintaining standard doses to affect response and remission.
- The majority of studies did not design their protocols to test superiority.

Augmenting therapies in patients with inadequate response to an SSRI:

- There is low quality evidence that response and remission rates following switch to a different antidepressant (monotherapy) are comparable to the addition of another treatment (combined therapy) in patients with inadequate response to treatment with an SSRI.
- There is low quality evidence that the addition of an atypical antipsychotic medication is different to the addition of a placebo in patients who have had an inadequate response to an SSRI.
- There is insufficient evidence that the addition of other augmenting agents is superior to the addition of a placebo in patients who have had an inadequate response to an SSRI.

Combined therapies in patients with inadequate response to an SSRI:

- There is insufficient evidence that any combined therapy was superior to any other to affect response and remission.

Studies to date include a restricted range of patients, with a preponderance of white women between the ages of 40 and 50 and a relatively large number of past depressive episodes.

There were 41 studies evaluating adults and all but two included subjects with MDD; one study evaluated subjects with subsyndromal depression,¹²⁹ and one, subjects with dysthymia.¹¹⁷ As noted previously, five studies^{107,150,178-180} and seven STAR*D publications¹⁸¹⁻¹⁸⁷ did not have data that could be extracted. Additionally, three STAR*D publications^{81,99,102} and two studies^{115,116} present results on predictors of failed response in the population of interest and these are presented in KQ4. We present the study results for the eligible and extracted studies based on the type of treatment comparisons as follows: (1) monotherapy compared with monotherapy; (2) monotherapy compared with combined therapy; and, (3) combined therapy compared with combined therapy. Some studies evaluated more than two treatment arms, and presented monotherapy compared with monotherapy results, as well as monotherapy compared with combined therapy. As such, some studies are included in multiple sections.

Monotherapy Treatment Compared With Monotherapy Treatment in MDD

Overview of Study PICOT^a Characteristics

There were twelve studies (18 publications)^{44,81,85,88,90,99,100,102-104,106,110-112,115,119,121,122} that compared monotherapy interventions in subjects who had failed to respond to an SSRI. Three studies^{85,90,119} evaluated a switch to another antidepressant. Five studies^{88,112,119,121,122} had three treatment arms for which two arms compared single interventions directly. The STAR*D study^{44,81,99,100,102,110,111} (labeled as level 2 subjects within this study), evaluated four monotherapy interventions and one treatment included cognitive behavioral therapy (CBT). One study (two publications)^{103,106} evaluated two methods of switching to the same anti-depressant. Two studies^{104,119} compared dose escalations of an SSRI. One study¹¹⁵ included subjects who failed to respond to SSRI and nonSSRI antidepressants and the author subsequently provided some results specific to the failed SSRI subgroup.

In total, there were 2,611 participants in treatment arms evaluating single interventions within these 12 studies. The sample size in these studies varied from 18¹²² to 789;⁴⁴ the sample sizes per treatment arm varied from eight¹²² to 250.⁴⁴ Six studies (9 publications)^{44,85,88,90,100,103,106,110,119} exceeded a total sample size of 101 and one study¹²² had less than 30 subjects. For one study¹¹⁵ that had a mixed sample of response failures, 58 of 77 subjects were from the SSRI failure subgroup.

Population

Women were the majority of subjects in all studies and female gender distributions varied from 60 to 69 percent^{44,81,85,88,90,99,100,102,104,110,111,119} to greater than 70 percent.^{103,106,121,122} One study¹¹² reported gender characteristics for a larger sample (n=131) but not for the subgroup extracted for this review (n=41). Another study¹¹⁵ reported characteristics for a mixed sample (failure to respond to an SSRI and nonSSRI) and showed a larger proportion of women (approximately double). No studies reported either significant main effects of gender or significant interactions between gender and response rates across treatment groups.

The racial composition was predominately white race and varied from 60 percent,¹⁰⁴ 80 percent,^{44,100,110,111} 90 percent,⁹⁰ to 100 percent.^{103,106} Five studies did not report ethnicity.^{85,112,115,119,121} Although generally not evaluated, there were no differential patterns of response noted to be based on ethnicity.

Mean ages varied from 40 to 44 years in eight studies,^{44,85,88,90,104,112,119,122} 45 to 49 years in two studies (3 publications),^{103,106,121} and 54 years in another study.¹¹⁵

Characteristics of the “Inadequate Response” for Enrollment

Table 1 shows the manner in which failure to respond to an SSRI was established in the reported studies. Four studies determined failure retrospectively and study subjects were on an SSRI at the time of entry into the trial.^{85,90,103,106,121} Where inadequate response to the SSRI was determined prospectively, fluoxetine,^{88,122} citalopram,⁴⁴ paroxetine,^{104,112} and sertraline¹¹⁹ were

^aPICOT is an acronym encompassing the basic elements that must be considered in developing a research question: the patient population, intervention or interventions, comparators, outcomes, and timeframe under consideration.

the SSRIs for which failure was established. No study evaluated subjects specifically for failed response to escitalopram or fluvoxamine alone.

Two studies^{112,119} excluded subjects with a history of failure over a two week period to any intervention (antidepressant or augmenting agent) used in the current study. One study^{103,106} excluded subjects with a lack of response in the current episode to a serotonin–norepinephrine reuptake inhibitor (SNRI). This study evaluated two methods of switching from an SSRI to duloxetine (an SNRI). One study⁹⁰ excluded patients who had previously taken venlafaxine, another study⁸⁵ excluded subjects who had failed to respond to citalopram or venlafaxine and one study¹⁰⁴ excluded subjects who had failed to respond to paroxetine.

Table 1. Method of establishing failure to SSRI and intervention in studies comparing monotherapy strategies following SSRI non-response

	Change Dose/ Duration of Current SSRI	Switch to Other SSRI Medication	Switch to Non-SSRI Medication	Switch to Nonpharmacological Treatment
Prospective Trials				
Citalopram		Rush ⁴⁴	Rush ⁴⁴	Rush ⁴⁴
Escitalopram				
Fluoxetine			Thase ⁸⁸ Shelton ¹²²	
Fluvoxamine				
Paroxetine	Rhue ¹⁰⁴		Bondolfi ¹¹²	
Sertraline	Licht ¹¹⁹			
Retrospective Trials				
Medical record/ confirmation clinician			Thase ⁹⁰	
Patient Self Report	Lexon-Smith ⁸⁵		Lexon-Smith ⁸⁵	
On specific medication at study entry			Ferreri ¹²¹ (Fluoxetine) Perahia ^{103,106} (Any SSRI)	

SSRI = selective serotonin reuptake inhibitor

Mental Health Histories of Study Participants

Four studies, using the Hamilton Depression scale (HAMD) 17-item version, reported mean baseline scores that varied from 19 (SD 7.3),⁴⁴ 21 to 23 (SD 3.3 to 3.9),^{103,106} and 24 to 28.^{104,121} One study¹¹⁹ reported median HAMD scores of 23 (range 18 to 37). Another study⁹⁰ used the HAMD 21, and baseline scores varied from 22 to 23. One study¹²² reported only that the minimum severity for eligibility was a HAMD 21 item score of 20 or greater. Two studies^{85,88} reported Montgomery-Åsberg Depression Rating Scale (MADRS) mean score of 30 to 31. One study¹¹² reported baseline scores for a larger sample (n=131) but not the subgroup of interest (n=41).

The number of previous depressive episodes varied from a median of one episode (range zero to eight),¹¹² two episodes (range zero to 35),¹¹⁹ or seven to eight episodes (range 12 to 15) in the STAR*D cohort.⁴⁴ One study reported that approximately 72 percent of the study subjects had had at least one previous episode of depression.^{103,106} Another study⁸⁸ reported that 45 percent of the olanzapine group and 79 percent of the fluoxetine group of study subjects had had three or more lifetime episodes. One study⁸⁵ had approximately 39 percent of subjects with no previous failures and 33 percent that had greater than 3 previous failures; another study had approximately 60 percent of subjects who had failed during their first episode of depression.¹⁰⁴ Two studies^{90,122}

did not report the number of previous episode failures. A single study reported the proportion of subjects with recurrent depression as 75 percent.⁴⁴ Two from four retrospective studies^{90,121} described how previous episode failures were defined; previous failures were defined as those that required treatment with antidepressants. None of the studies specified how information on previous episodes was captured (e.g., by patient report, medical record, etc.).

Length of the current episode was reported as a median value in three studies and a mean in four studies. Two studies indicated the proportion of subjects over various time intervals in weeks⁸⁵ or months and years.¹⁰⁴ One study did not report the mean length of the current episode.¹²² Median values for length of the current episode varied from eight weeks (range 2 to 52 weeks),¹¹² and 16 to 20 weeks (range 0 to 960 weeks).¹¹⁹ Mean values varied from 28 to 32 weeks (range 0 to 42 weeks),^{103,106,121} 52 to 61 weeks (range 52 to 86 weeks),^{88,90} and 118 weeks (SD = 264 weeks).⁴⁴ No study specified the manner for collecting the length of the current episode.

No study in this grouping reported baseline use of complementary and alternative medicines (CAM) at baseline or endpoint. One study excluded subjects who had used St. John's Wort within the preceding 14 days.⁹⁰

Intervention and Comparators

Ten studies were labeled as randomized controlled trials (RCT); however, the STAR*D cohort had a small proportion of subjects who accepted the randomized arm and as such we classify this as a controlled clinical trial (CCT). The number of treatment arms varied from two^{103,106} to four.⁴⁴ Six studies had a prospective run in phase; the length of this phase varied between 4,¹¹² 6,^{104,119,122} 8,⁸⁸ and 12 weeks.⁴⁴ Two studies included a washout period before switching to the new intervention; one study⁹⁰ had an interval of 14 days (28 for fluoxetine) and another⁸⁵ had an optional interval of 4 to 7 days placebo.⁹⁰ Patient adherence was evaluated in only three studies; one study evaluated this as the number of pills consumed (varied from 94 to 97 percent adherence),⁸⁸ another as not maintaining therapeutic drug monitoring (78 percent adherence),¹¹² and one study evaluated pill counts and anamnesis.¹⁰⁴

Table 2 shows the comparison and treatment interventions for the studies evaluating monotherapy. The monotherapy included: (1) dose escalation with or without switching from an SSRI; (2) switch to another SSRI; (3) switch to an SNRI; (4) method of switching to an SNRI; (5) switch to an antidepressant; and (6) switch to an augmenting agent. There were three studies that evaluated dose escalations in sertraline (100mg/d and 200mg/d),¹¹⁹ paroxetine (20mg/d and 30 mg/d),¹⁰⁴ and venlafaxine (mean dose 148mg/d and 309mg/d).⁹⁰ Two of these dose comparison trials^{90,104} followed switches from another SSRI.

Two studies evaluated a switch to sertraline, which represented treatment with a different SSRI. One study⁴⁴ switched from citalopram to sertraline and used a maximal dose of 200mg/d (titrated from 50mg/d), and one study¹¹⁹ compared two doses of sertraline (100mg/d and 200mg/d). Another study switched from a noncitalopram SSRI to citalopram.¹⁰⁴

Four studies (five publications)^{44,85,103,106,112} evaluated a switch to the SNRI venlafaxine, venlafaxine extended release, bupropion, or duloxetine. Doses for venlafaxine varied from 37.5 to 375mg per day (extended release).^{44,85,90,112}

Two different methods of switching from the current SSRI to the new medication, duloxetine, were evaluated in one study (two publications),^{103,106} and as such the dose of 60mg per day was the same for both treatment arms. One study⁴⁴ evaluated the use of sustained release

bupropion at a maximal dose of 400mg per day (titrated from 150mg per day). This same study had treatment arms for venlafaxine and sertraline.

Two studies^{88,122} compared maintenance fluoxetine treatment to olanzapine monotherapy; the doses of fluoxetine were 50mg per day in one study⁸⁸ to a range of 20 to 60mg per day in the second study.¹²² Olanzapine dosages ranged from 6 to 18mg per day in one study⁸⁸ and 5 to 20mg per day in the second study.¹²² Another study¹²¹ evaluated mianserin at a dose of 60mg per day.

Table 2. Monotherapy studies showing the comparison and treatment interventions

Author	Monotherapy 1	Monotherapy 2
Switching and/or Changing Dose		
Licht ¹¹⁹ 2002	Sertraline	Sertraline (higher dose)
Ruhe ¹⁰⁴ 2009	Paroxetine	Paroxetine (higher dose)
Thase ⁹⁰ 2006	Venlafaxine	Venlafaxine (higher dose)
Switch to non-SSRI Antidepressant		
Perahia ^{103,106} 2008, 2009	Any SSRI*	Duloxetine (method of taper)
Rush ⁴⁴ 2006	Venlafaxine	Bupropion
Rush ⁴⁴ 2006	Sertraline	Venlafaxine
Bondolfi ¹¹² 2006	Paroxetine	Venlafaxine
Birkenhager ¹¹⁵ 2004	Tranylcypromine	Phenelzine
Lenox-Smith ⁸⁵ 2008	Citalopram	Venlafaxine
Switch to Augmenting Agent		
Thase ⁸⁸ 2007	Fluoxetine	Olanzapine
Shelton ¹²² 2001	Fluoxetine	Mianserin
Ferreri ¹²¹ 2001	Fluoxetine	Mianserin
Switch to Nonpharmacological Treatment		
Rush ⁴⁴ 2006	Venlafaxine/Sertraline/Bupropion	CBT
Thase ¹¹⁰ 2007	Venlafaxine/Sertraline/Bupropion	CBT

CBT = cognitive behavioral therapy; SSRI = selective serotonin reuptake inhibitor

Primary Outcomes

Three studies indicated that remission was the primary outcome, defined as a MADRS total score of less than 10,¹¹² HAMD-17 score less than 7,^{44,104} or the Quick Inventory of Depressive Symptoms Self Report (QIDS-SR-16) score less than 5.⁴⁴ Three studies indicated that the primary outcome was response based on a 50 percent reduction in the HAMD-17¹¹⁹ or HAMD-21.^{104,115} Five studies indicated that efficacy (as measured by a change in score and differences between groups) was the primary outcome, assessed using the HAMD-17,^{103,106} HAMD-21^{85,90} or MADRS scores.^{88,122} One study¹²¹ indicated that both response and remission as determined by the HAMD-17 were primary outcomes. All studies reported proportions of response (50 percent change relative to baseline) or remission (based on primary outcome threshold scores for specific instruments). Few studies evaluated outcomes other than response and remission (see efficacy section below).

Timing of the Interventions

Table 3 details the run-in and treatment intervals for the studies comparing monotherapy treatments. The majority of studies evaluated response to the new treatment for six weeks or greater. Similarly, the majority of studies evaluated prospective failure for six weeks or greater.

Table 3. Length of the run-in and treatment phases for all studies

Length of Treatment	2/3 Weeks	4/5 Weeks	6 Weeks	8 Weeks	>8 Weeks
Prospective Failure Run-In Phase		Bondolfi ¹¹²	Licht ¹¹⁹ Shelton ¹²² Ruhe ¹⁰⁴	Thase ⁸⁸	Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰
Prospective Failure Treatment Phase	Bondolfi ¹¹²	Licht ¹¹⁹	Thase ⁸⁸ Ruhe ¹⁰⁴		Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰ Shelton ¹²²
Retrospective Failure Studies		Birkenheger ¹¹⁵	Ferreri ¹²¹	Thase ⁹⁰	Perahia ^{103,106} Lenox-Smith ⁸⁵

Setting

The studies comparing monotherapies were conducted in Europe (Spain, Italy, France, and the United Kingdom),^{103,106} Switzerland,¹¹² Denmark and Iceland,¹¹⁹ France,¹²¹ the Netherlands,^{104,115} Australia,⁸⁵ Canada,⁸⁸ and the United States (three studies, nine publications).^{44,81,90,99,100,102,110,111,122}

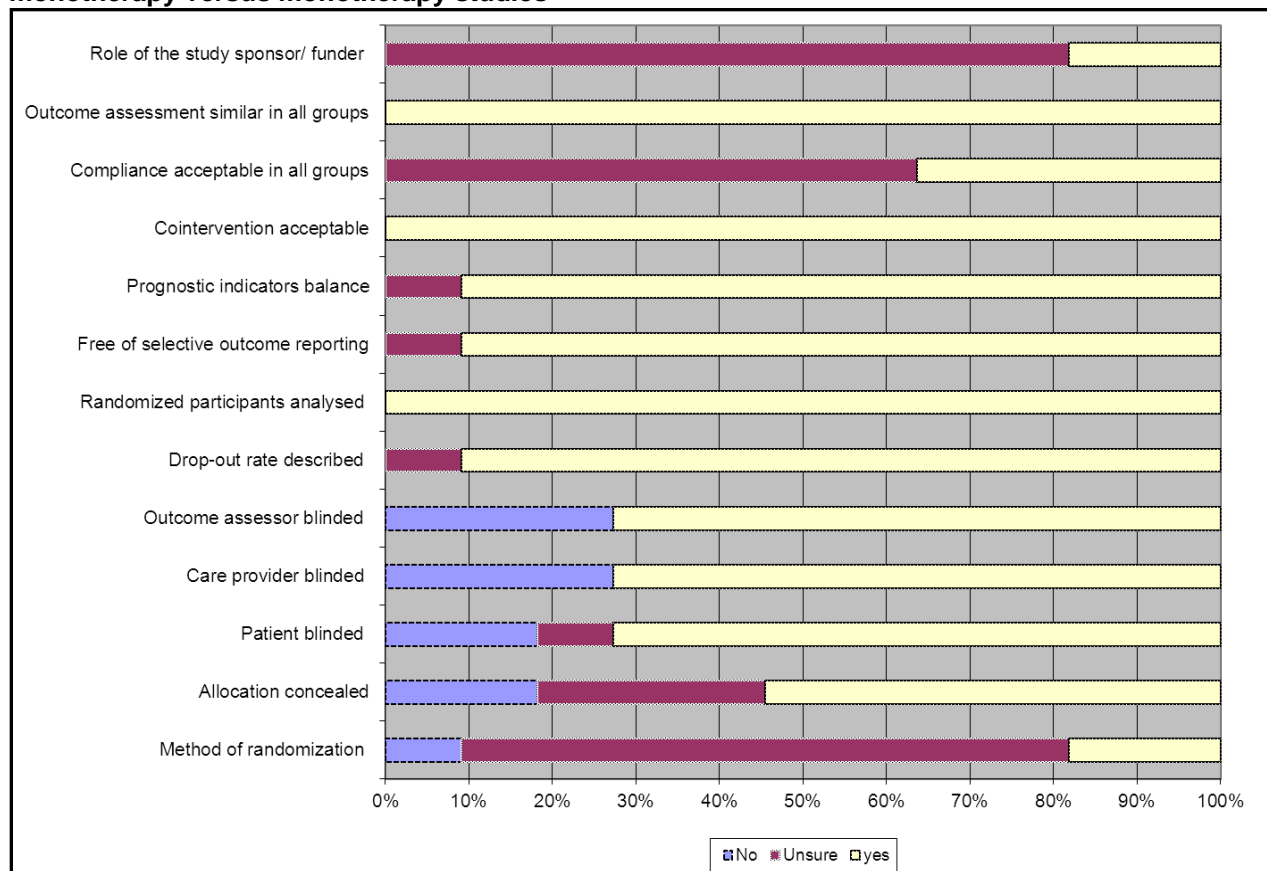
Study participants were all recruited from outpatient psychiatric settings^{44,88,103,106,112,119,122} and outpatient primary care.^{44,90,104} Two studies recruited from both outpatient and inpatient psychiatric settings.^{85,121} One study recruited subjects from an inpatient setting.¹¹⁵

Risk of Bias

Figure 3 shows the distribution of the evaluation for risk of bias using thirteen criteria. None of the seven studies clearly described the method of randomization. All studies were at low risk from biases associated with compliance to treatment, selective outcome reporting, showing reasons for dropouts, or for balancing of important prognostic factors at baseline. For the remaining criteria, only half the studies were at low risk of bias, particularly for randomization. In particular, the role of the funding agency was not specified in half the studies. All but two studies^{44,104} were funded by a pharmaceutical company with a financial interest in one of the drugs under investigation.

Three studies indicated that there was a washout period. One study⁹⁰ included a 14 day (28 days for fluoxetine) washout period before randomization to new interventions; a second study⁸⁵ allowed for an optional 4- or 7-day washout placebo. A third study¹¹⁵ had a one week washout from fluvoxamine. Lack of washout in the studies with olanzapine and fluoxetine^{88,122} may be problematic, as fluoxetine has a long half life (approximately 4 weeks) and the participants are therefore essentially on cotherapy for at least several weeks, even if they are only having olanzapine administered. Most SSRIs have a half life of no more than five days and any very early side effects from the new treatment could actually represent withdrawal from the SSRI, if in fact subjects were being switched. As a group, these monotherapy studies are considered to have moderate risk of bias given that half of the “risk of bias” items were not met or there was uncertainty.

Figure 3. Percent of studies achieving risk of bias using the risk of bias tool criteria in monotherapy versus monotherapy studies



Efficacy of Monotherapy Versus Monotherapy Treatments

Outcomes of Response and Remission

Overall, none of the therapeutic approaches (dose change with or without medication switch, or switch to different antidepressant, augmenting agent, or nonpharmacological therapy) showed any advantage over any other.

Table 4 shows the rates of response and remission for all monotherapy comparisons, but there are some limitations in directly comparing response and remission rates due to varying definitions across studies. As noted previously, all but one study⁹⁰ comparing various monotherapies defined “response” as a 50 percent change (improvement) relative to baseline for either the HAMD or MADRS; two studies had minor variations to this definition including: 1) 50 percent reduction and a score of 14 on the HAMD-17;¹¹⁵ and, 2) a 50 percent reduction on the HAMD or MADRS and CGI improvement (level 1 or 2).⁸⁵ One study defined response as a reduction in the HAMD score equivalent to the “decrease pretreatment.”⁹⁰ One study reported only response and remission rates for a subgroup of patients with a baseline score of greater than 31 on the HAMD-21 but not the total sample.⁸⁵ Thresholds for remission for studies using the HAMD varied from seven to eight and for the MADRS less than eight or 10.

From the three studies evaluating dose changes, only one trial¹¹⁹ had confidence intervals that did not cross the midpoint, suggesting that the lower dose of 100mg of sertraline plus placebo

was superior to 200mg of sertraline plus placebo; response rates of 70 percent compared to 54 percent and remission rates of 38 and 28 percent respectively were reported (Table 4).

In the studies that switched to other antidepressants, none were shown to confer any relative advantage in response and remission rates. As part of the STAR*D trial,^{44,110} few differences were shown for the outcomes of response or remission when patients were switched from citalopram to either another SSRI (sertraline) or a nonSSRI (bupropion or venlafaxine). Similarly, in this same trial, patients who were switched to another monotherapy medication (subgroup) had comparable rates of response to those that were switched to CBT alone.

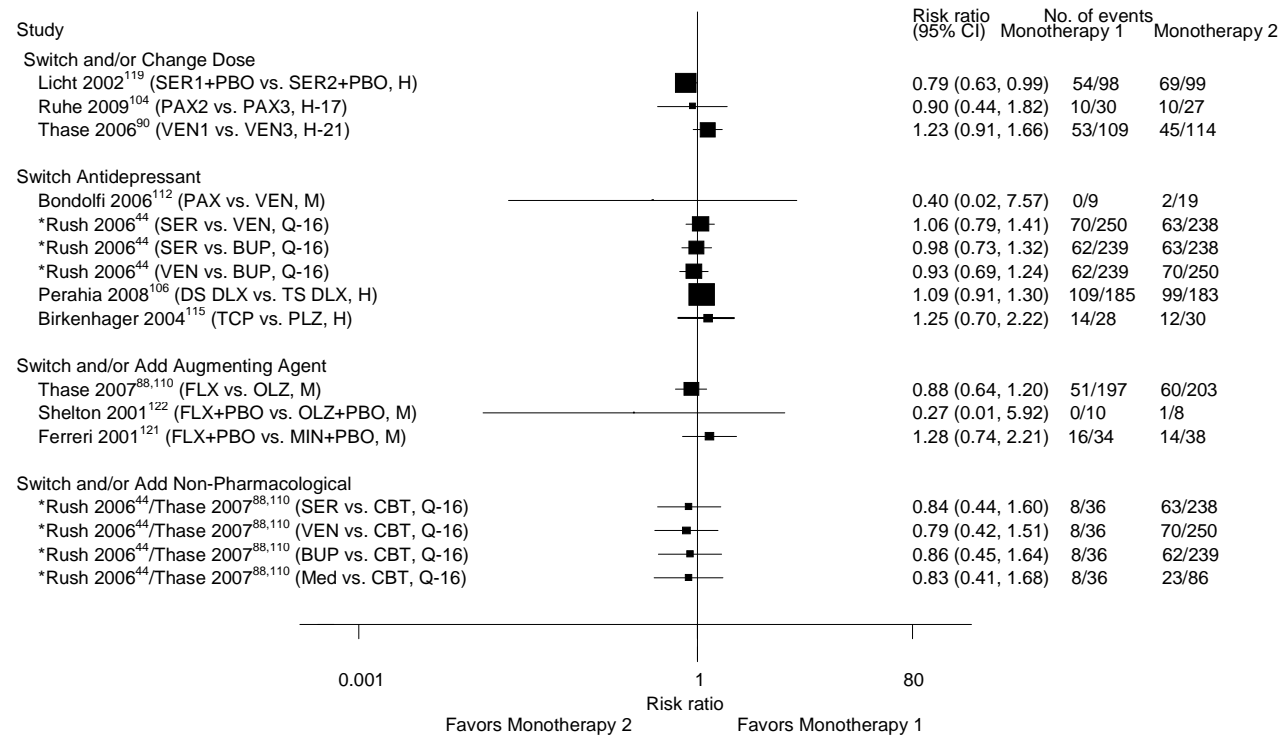
Figure 4 depicts the rates of response for studies comparing monotherapy treatments. Figure 5 depicts the rates of remission for studies comparing monotherapy treatments.

Other Outcomes

Three studies evaluated speed of response. The STAR*D showed no statistically significant differences for monotherapy treatments with respect to speed of response or remission.^{44,110} A second study⁸⁸ showed no statistically significant differences between the monotherapy arms with respect to speed of response. The third study⁹⁰ found no statistical differences between groups with differing doses of venlafaxine.

Only 4 of 12 studies evaluated quality of life outcomes and all studies^{44,88,103,104,106,110} showed no statistically significant differences in any of these measures between treatment arms. One study^{103,106} compared Visual Analogue Scale scores for pain (overall and various body parts); although there were no statistical differences between the two methods of switching to duloxetine, there were statistically significant decreases on the Visual Analogue Scale for pain, SF36-bodily pain scale, and the symptom questionnaire somatic scale.

Figure 4. Forest plot of monotherapy versus monotherapy interventions for the outcome of response

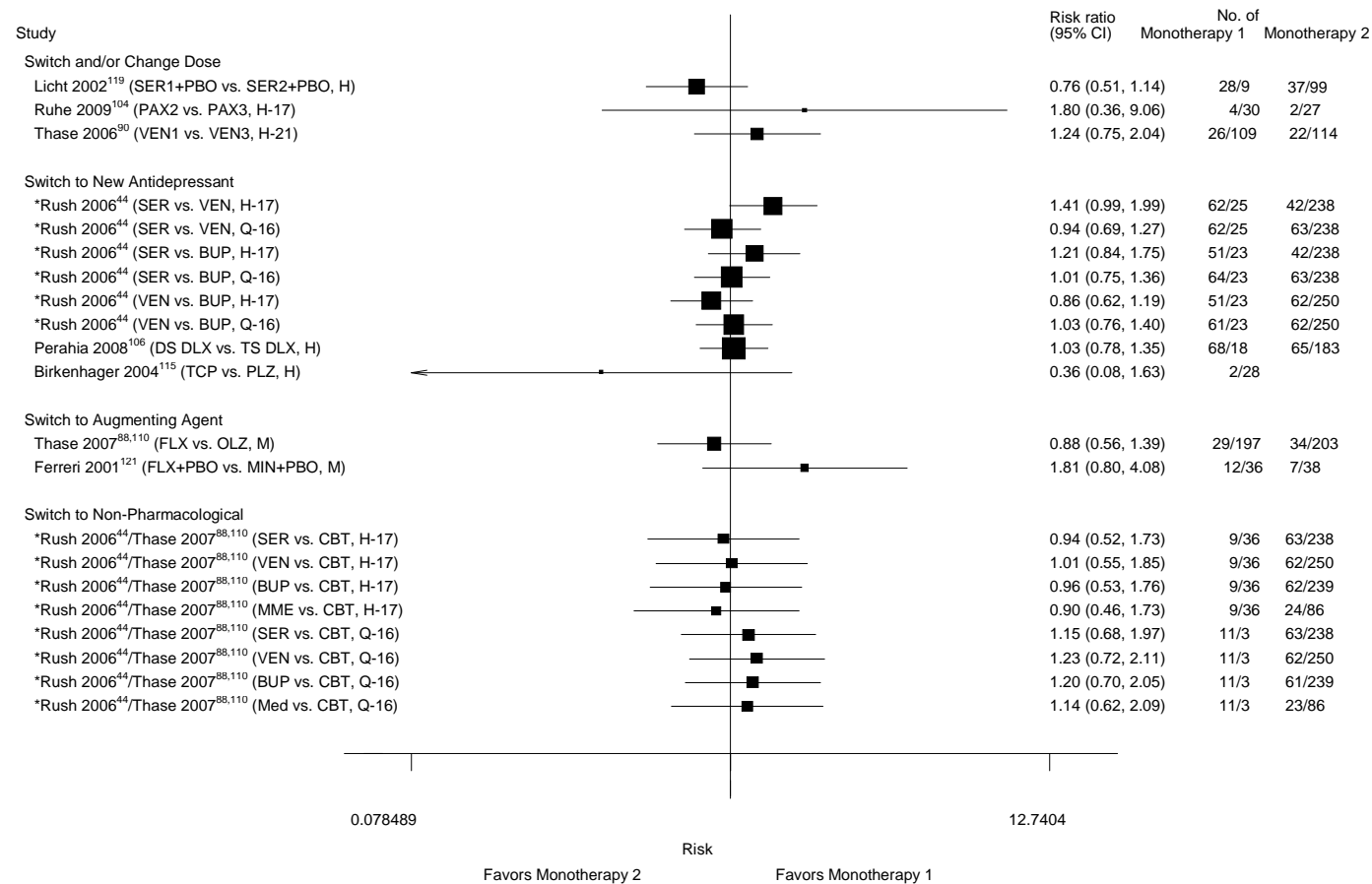


BUP = bupropion; BUS = buspirone; CBT = cognitive behavioral therapy; DS DLX = direct switch duloxetine; FLX = fluoxetine; H = Hamilton Depression Rating Scale; H-17 = Hamilton Depression Rating Scale – 17 item; H-21 = Hamilton Depression Rating Scale – 21 item; M = Montgomery-Asberg Depression Rating Scale (MADRS); MIN = mianserin; Med = medication; OLZ = olanzapine; PAX = paroxetine; PBO = placebo; PLZ = phenelzine; Q-16 = Quick Inventory of Depressive Symptoms Self Report (16); SER = sertraline; STS DLX = start-taper switch duloxetine; TCP = tranylcypromine; VEN = venlafaxine

*Represent STAR*D studies.

Note: Lenox-Smith 2006⁸⁵ did not provide data for the entire sample and is not included in this figure.

Figure 5. Forest plot of monotherapy versus monotherapy interventions for the outcome of remission



BUP = bupropion; CBT = cognitive behavioral therapy; DS DLX = direct switch duloxetine; FLX = fluoxetine; H = Hamilton Depression Rating Scale; H-17 = Hamilton Depression Rating Scale – 17 item; H-21 = Hamilton Depression Rating Scale – 21 item; M = Montgomery-Asberg Depression Rating Scale (MADRS); MIN = mianserin; Med = medication; OLZ = olanzapine; PAX = paroxetine; PBO = placebo; PLZ = phenelzine; Q-16 = Quick Inventory of Depressive Symptoms Self Report (16); SER = sertraline; TCP = tranylcypromine; STS DLX = start-taper switch duloxetine; VEN = venlafaxine

*Represent STAR*D studies.

Table 4. Summary of reported rates of response and remission for studies comparing monotherapy treatment to other monotherapy treatments

Study	Duration (Weeks)	Rating Scale	n*	Comparison and Dose (mg/d)	Response ^a n (%)	p Value	Remission ^b n (%)	p Value
Switch and/or Change Dose								
Licht ¹¹⁹ 2002	6	HAMD-NS	99	SER 100mg/d	69 (70)	0.03	37 (38)	0.19
			98	SER 200 mg/d	54 (64)		28 (29)	
Ruhe ¹⁰⁴ 2008	6	HAMD-17	30	PAX 20	10 (37.0)	0.788	2 (7.4)	0.673
			30	PAX 30-50	10 (33.3)		4 (13.3)	
Thase ⁹⁰ 2008	8	HAMD-21	119	VEN-ER 148mg/d	45 (39.0) [#]	NS	22 (19.0)	NS
			113	VEN-ER 309mg/d	53 (49.0) [#]		26 (24.0)	
Switch to NonSSRI								
Birkenhager ¹¹⁵ 2004	5	HAMD-NS	30	TCP 61mg/d	12 (40.0) [^]	NT	6 (20.0)	NT
			28	PLZ 79mg/d	14 (50.0) [^]		2 (7.1)	
Bondolfi ¹¹² 2006	4	MARDS	19	PAX 40mg/d	2 (10.5)		3 (15.7)	
			9	VEN 150mg/d	0 (0)		0 (0)	
Lenox-Smith ⁸⁵ 2006	12	HAMD-21	200	VEN-ER 75-300mg/d	NR [@]	0.953	NR	NR
			206	CIT 20-60mg/d	NR [@]		NR	
Rush ⁴⁴ 2006	12	HAMD-17 QIDS-SR16*	238	SER 50-200mg/d	63 (26.7) [*]	NS	42 (17.6) [*] 63 (26.4)	NS
			250	VEN 37.5-375mg/d	70 (28.2) [*]		62 (24.8) [*] 62 (24.8) [*]	
			239	BUP 150-400mg/d	62 (26.1) [*]		51 (21.3) [*] 61 (25.5) [*]	
Perahia ^{103,106} 2008, 2009	10	HAMD-17	183	direct switch DLX 60-120mg/d	99 (54.4)	NR	65 (35.7)	NR
			185	start-taper switch DLX 60-120mg/d	109 (59.6)		68 (37.2)	

Table 4. Summary of reported rates of response and remission for studies comparing monotherapy treatment to other monotherapy treatments (continued)

Study	Duration (weeks)	Rating Scale	n*	Comparison and Dose (mg/d)	Response n (%)	p value	Remission n (%)	p value
Add Augmenting Agent								
Thase ⁸⁸ 2007	8	MADRS	203	FLX 50mg/d	NR	NR	34 (16.7)	0.004
			197	OLZ 6-18mg/d	NR		29 (14.7)	
Shelton ¹²² 2001	8	MADRS	8	FLX 20-60mg/d	1 (10.0)	0.11	NR	NR
			8	OLZ 5-20mg/d	0 (0.0)		NR	
Ferrer ¹²¹ 2001	6	HADRS 17	38	FLX 20mg/d	14 (37.0)	0.1	7 (18.p4)	0.06
			34	MIN 60mg/d	16 (48.5)		12 (35.2)	
Add Non-Pharmacological								
Trivedi ¹¹³ 2006 Thase ¹¹⁰ 2007	12	HAMD-17 QIDS-SR16	238	SER 50-200mg/d	63 (26.7) [*]	NS	42 (17.6) 63 (26.4) [*]	NS
			250	VEN 37.5-375mg/d	70 (28.2) [*]	NS	62 (24.8) 62 (24.8) [*]	NS
			239	BUP 150-400mg/d	62 (26.1) [*]	NS	51 (21.3) 61 (25.5) [*]	NS
			36	CBT	8 (22.2) [*]	NS	9 (25.0) 11 (30.5) [*]	NS
			86	Medication	23 (26.7)	NS	24 (27.9) 23 (26.7) [*]	NS

BUP = bupropion; CBT = cognitive behavioral therapy; CIT = citalopram; DLX = duloxetine; FLX = fluoxetine; HAMD = Hamilton Depression Rating Scale; HAMD-NS = Hamilton Depression Rating Scale not specified; MADRS = Montgomery-Åsberg Depression Rating Scale; MIN = mianserin; NR = not reported; NS = not significant; NT = not tested; OLZ = olanzapine; PAX = paroxetine; PLZ = phenelzine; QIDS-SR16 = Quick Inventory of Depressive Symptoms Self Report (16); SER = sertraline; SSRI = selective serotonin reuptake inhibitors; TCP = tranylcypromine; VEN = venlafaxine; VEN-ER = venlafaxine extended release

*Response was defined as 50 percent change relative to baseline for the rating scale specified, unless noted within the table.

^bRemission was defined relative to the standard threshold value for the particular outcome.

^cThe QIDS-SR reported outcomes.

[#]A reduction in the HAMD score equivalent to the “decrease pretreatment”.⁹⁰

[^]50 percent reduction and a score of 14 on the HAMD-17.¹¹⁵

[@]50 percent reduction on the HAMD or MADRS and CGI improvement (level 1 or 2).⁸⁵

Monotherapy Versus Combined Therapy Interventions in MDD

There were 33 unique studies in 49^{44,79-84,86-89,91-102,105,108-114,118-124,126-128,130-137} publications that evaluated monotherapy versus combined therapies. Two studies were withdrawal studies and were not extracted.^{107,150} From the remaining 31 studies, five^{94,110,127,128,133,135,137} evaluated nonpharmacological interventions combined with SSRI use. For level 2 subjects, the STAR*D study^{44,81,99,100,102,110,111} evaluated four monotherapy interventions and three combined therapies; the CBT monotherapy and citalopram with CBT arms were compared with pharmacological therapies combined, and the results are presented in the nonpharmacological section below. A single study¹¹⁹ evaluated two doses of an SSRI and the same SSRI in combination with an augmenting agent. There were six studies that had subjects who failed to respond to SSRI and nonSSRI antidepressants and subsequently provided some results specific to the failed SSRI group.^{79,94,95,105,108,109,126,127,131} The majority of studies compared the use of a single antidepressant to a combined therapy, which included an antidepressant with augmenting agents.

In total there were 4,537 participants in studies comparing monotherapy to combined therapies. The total sample size in these studies varied from 9⁹⁶ to 1,439;^{44,81,110,111,113} the sample sizes per treatment arm varied from 4 subjects⁹⁶ to 307.¹³⁴ Thirteen studies^{44,79,87,88,92,97,100,101,105,109-111,114,118-121,126,130-135,137} exceeded a total sample size of 101 and 9 studies^{80,84,89,91,96,122,124,127,128} had fewer than 30 subjects.

Overview of Study PICOT Characteristics

Population

There were two studies that predominately evaluated a single gender. One study evaluated men, as the intervention was testosterone used as the augmenting agent.⁹¹ Another study evaluated only women being treated with antidepressants alone or combined with exercise.¹²⁷ The proportion of women in the other studies varied from greater than 70 percent in 13 studies,^{44,80,82-84,92,93,96,97,100,110,111,114,119,121,122,124,130,133,135,137} from 61 to 69 percent in 5 studies,^{87,88,98,101,120,123,132} from 51 to 59 percent in 2 studies,^{86,89} and from 45 to 49 percent in 2 studies.^{118,128} One study¹¹² reported gender characteristics for a larger sample (n=131) but not for the subgroup (step 3A to 3C) extracted for this review (n=41).

There were seven studies for which the authors provided some stratified results specific to the subgroup that had failed to adequately respond to an SSRI. However, demographic data were not provided or available. As such, we have assumed that the SSRI failure subgroup are comparable to the whole sample within the study, as they represented over 50 percent of the total sample. When considering the proportion of the study samples who failed to respond adequately to SSRI treatment, there were two studies^{95,108} where the sample was 55 to 59 percent, 60 to 69 percent in two studies^{127,134} and greater than 70 percent in three studies.^{79,94,105,109,126,131} In these seven studies, females represented the majority of the subjects in the following proportions; 1) greater than 80 percent in two studies,^{94,127} 2) from 70 to 79 percent in three studies,^{79,105,109,126,134} and 3) from 51 to 60 percent in two studies.^{95,108}

In the majority of studies, the proportion of men and women per treatment arm were similar with the exception of one small study⁸⁹ with 20 subjects, which showed differences between groups greater than 10 percent. Information on racial composition or ethnicity was not reported

in 18 studies.^{82,83,87,89,91,92,94,96-98,101,114,118-121,123,124,127,130,132-135,137} For the remaining studies, the majority of subjects were of the white race comprising between 75 to 89 percent of the sample in six studies^{44,86,88,95,100,108,110,111,113,128} and greater than 90 percent in seven studies.^{79,80,84,93,105,109,122,126,131,133-135,137}

Mean age for the total samples varied from 40 to 44 years in 11 studies,^{44,86,88,98,112-114,118-120,122,124} 45 to 49 years in 13 studies,^{79,84,87,89,91-95,97,101,105,108,109,121,126,130-132,134} 50 to 54 years in 2 studies,^{82,83,123} and greater than 60 years in 2 studies.^{128,133,135,137} One study did not report age characteristics of the very small sample (n=9).⁹⁶ Two studies reported an age range of 21 to 54,⁸⁰ and from 40 to 60 years.¹²⁷

Inadequate Response

Table 5 shows the manner in which failure to an SSRI had been established. Fifteen studies determined failure prospectively in an open label manner. For the majority of these, the subjects were currently on the same antidepressant to which they had shown a poor response. Fourteen studies determined inadequacy of response retrospectively. For studies where inadequate response was determined prospectively, the SSRI to which failure was established included three studies each for fluoxetine,^{88,118,122} and sertraline,^{86,87,101,119,132} and two each for citalopram,^{113,124} escitalopram,^{133,135,137} and paroxetine.^{80,112} Six studies^{79,95,105,108,109,126,128,131,134,188} used any combination of SSRIs; three studies^{79,95,105,109,126,131} specified that fluvoxamine was not one of the SSRI evaluated and these same studies also included escitalopram. No studies evaluated subjects specifically for failed response to fluvoxamine alone.

There were nine studies that excluded subjects because of past failures to specific interventions. Five studies excluded subjects who reported two,¹¹⁴ three, or more previous failures.^{79,80,87,101,105,109,126,131,132} Three studies excluded subjects with a history of failure over a two week period¹¹² or in the recent episode^{118,119} to any intervention (antidepressant or augmenting agent) used in the current study. Three studies excluded subjects who had an inadequate response to nonpharmacological interventions of electroconvulsive therapy (ECT)^{79,105,109,126,131} alone or with repetitive transcranial magnetic stimulation (rTMS) and vagal nerve stimulation (VNS)^{82,83} in a previous episode. The remaining 20 studies did not exclude or include subjects based on previous failures to any specific treatment.

Table 5. Method of establishing failure to SSRIs in studies comparing monotherapy to combination therapies

Determining Inadequate Response	MONOTHERAPY					COMBINED THERAPY			
	Dose or Duration Change	Switch to Other SSRI	Switch Non-SSRI	Switch to Augmenting Agent	Switch Nonpharm	Add Augmentor	Add Other SSRI	Add Non-SSRI AD	Add Nonpharm
<i>Prospective</i>									
Citalopram		Rush ^{44*}	Rush ^{44*}		Thase ^{110*}	Trivedi ^{113*} Baumann ¹²⁴		Trivedi ^{113*}	Thase ^{110*}
Escitalopram									Reynolds ^{133,135,137}
Fluoxetine						Thase ⁸⁸ Shelton ¹²² Fava ¹¹⁸		Fava ¹¹⁸	
Fluvoxamine									
Paroxetine			Bondolfi ¹¹²			Preskorn ⁸⁰ Bondolfi ¹¹²			
Sertraline	Licht ¹¹⁹					Michelson ⁸⁷ Dunner ⁸⁶ Licht ¹¹⁹			
Any SSRI						Mahmoud ¹⁰⁸ Keitner ⁹⁵ Thase ^{79,105,109,126}			Lynch ¹²⁸
<i>Retrospective</i>									
Medical chart									
Self report						George ⁸⁴			
Currently on SSRI or other antidepressant			Ferreri ¹²¹			George ⁸⁴ Shapira ⁸⁹ Seidman ⁹¹ Perry ⁹³ Landén ^{92,97,130} Fava ¹¹⁴ Fava ⁹⁸ Nemets ¹²³ Sokolski ⁹⁶ Appelberg ¹²⁰ Ferreri ¹²¹ Bauer ^{134,188}	Altamura ^{82,83}	Altamura ⁸³ Fava ⁹⁸	Carta ¹²⁷ Wiles ⁹⁴

AD = antidepressant; SSRI = selective serotonin reuptake inhibitors

*STAR*D publications.

Mental Health History

Table 6 shows the baseline severity reported for the different studies. As expected the baseline scores tended towards the latter quarter of the maximum instrument scores, which suggests that subjects had symptoms consistent with those with moderate to severe depression. Two studies did not provide baseline scores.^{80,112} The number of previous depressive episodes varied from a median of one episode (range zero to 8),¹¹² median of two (range zero to 35);¹¹⁹ or median of seven to eight (range 12 to 15) in the STAR*D cohort.^{44,110,113} The reported mean number of episodes varied from one to two previous episodes,^{93,94} and three to six.^{95,105,123,124,126,131} Another study⁸⁸ reported that 45 percent of the olanzapine group and 79 percent of the fluoxetine group of study subjects had three or more lifetime episodes. Twenty-one studies did not report the number of previous failed episodes.^{79,80,82-84,86,87,89,91,92,96-98,101,108,109,114,118,120,122,126-128,130,132-135,137}

Two studies (three publications)^{79,109,126} reported the number of prior adequate antidepressant trials for the current episode and this varied from one adequate trial (67 percent) to three adequate trials (eight percent). Two studies^{95,124} showed some differences between treatment groups with respect to previous episodes, with the risperidone group having fewer previous failures. How previous episodes were defined and captured was not apparent in the majority of studies. No study in this grouping reported use of CAM at baseline or endpoint.

Table 6. Distribution of baseline scores for primary outcomes as a proxy for severity of MDD

Disease Specific Scale	Baseline Scores				
	10 - 14	15 - 19	20 - 25	26 - 30	>31
MADRS			Appelberg ¹²⁰	Thase ⁸⁸ Landén ⁹² Landén ^{97,130} Thase ^{79,105,109,126,131,136} Thase ¹²⁶ Keitner ⁹⁵ Appelberg ¹²⁰ Bauer ^{134,188}	Dunner ⁸⁶ Appelberg ¹²⁰
BDI				Perry ⁹³	Wiles ⁹⁴
HAMD-NS		Lynch ¹²⁸	Licht ¹¹⁹	Perry ⁹³	
HAMD-31			Fava ¹¹⁴		
HAMD-24			Seidman ⁹¹	Nemets ¹²³	Shapira ⁸⁹
HAMD-21		George ⁸⁴	Shelton ^{122*} Altamura ⁸² Altamura ⁸³ Sokolski ⁹⁶ Baumann ¹²⁴		
HAMD-17	Fava ¹¹⁴	George ⁸⁴ Keitner ⁹⁵ Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰ Reynolds ^{133,135,137}	Michelson ^{87,101,132} Mahmoud ¹⁰⁸ Fava ⁹⁸ Fava ¹¹⁸ Dunner ⁸⁶	Ferreri ¹²¹	

Table 6. Distribution of baseline scores for primary outcomes as a proxy for severity of MDD (continued)

Disease Specific Scale	Baseline Scores				
	10 - 14	15 - 19	20 - 25	26 - 30	>31
QIDS-SR16	Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰				
Other	Carta ¹²⁷				

BDI = Beck Depression Inventory; HAMD = Hamilton Depression Rating Scale; HAMD-NS = Hamilton Depression Rating Scale not specified; MADRS = Montgomery-Åsberg Depression Rating Scale; QIDS-SR16 = Quick Inventory of Depressive Symptoms Self Report (16)

*Baseline scores were not provided but subjects must have had a score of 21 or greater for entry to the study.

Note that two studies^{80,112} did not provide baseline scores and some studies provided scores for more than one instrument.

Intervention and Comparator

All but three studies^{44,110,113} employed an RCT design with at least some level of blinding. There were five studies^{94,110,127,128,133,135,137} that evaluated the use of nonpharmacological interventions including CBT,^{94,110} dialectical behavior therapy (DBT),¹²⁸ interpersonal therapy (IPT)^{133,135,137} and exercise.¹²⁷ The remaining studies used pharmacological agents combined predominately with augmenting agents and a new SSRI or other antidepressants.

Table 7 shows that approximately one quarter of the studies had prospective run-in phases and treatment phases that exceeded 8 weeks. Two of the retrospective failure studies provided treatment for this same interval. One study evaluated the Step 3 of the treatment algorithm after only 2 weeks of treatment switch.

Table 7. Details the length of the run-in and treatment phases for all studies

Length of Treatment	2/3 Weeks	4/5 Weeks	6 Weeks	8 Weeks	>8 Weeks
Prospective failure run-in phase		Keitner ⁹⁵ Bondolfi ¹¹² Baumann ¹²⁴	Preskorn ⁸⁰ Dunner ⁸⁶ Mahmoud ¹⁰⁸ Licht ¹¹⁹ Shelton ¹²²	Michelson ^{87,101,132} Lynch ¹²⁸ Thase ⁸⁸ Fava ¹¹⁸ Berman ¹⁰⁹ Marcus ^{105,131} Thase ¹²⁶ Berman ⁷⁹	Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰
Prospective failure treatment phase	Bondolfi ¹¹²	Preskorn ⁸⁰ Keitner ⁹⁵ Licht ¹¹⁹ Baumann ¹²⁴ Fava ¹¹⁸	Dunner ⁸⁶ Thase ⁸⁸ Mahmoud ¹⁰⁸ Thase ^{79,105,109,126,131,136} Reynolds ^{133,135,137}	Michelson ^{87,101,132}	Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰ Shelton ¹²² Lynch ¹²⁸
Retrospective failure studies	Altamura ⁸² Altamura ^{83†}	Shapira ⁸⁹ Wiles ⁹⁴ Sokolski ⁹⁶ Landén ⁹⁷ Landén ⁹² Landén ¹³⁰ Nemets ¹²³ Fava ⁹⁸	Seidman ⁹¹ Perry ⁹³ Appelberg ¹²⁰ Ferrer ¹²¹ Bauer ^{134,188}	George ⁸⁴ Carta ¹²⁷ Fava ¹¹⁴	

†Indicates treatment was 5 days.

Table 8 shows the combined interventions and all other treatment comparisons. Two studies included one treatment arm that evaluated an increased dose of sertraline¹¹⁹ or the addition of intravenous citalopram.^{82,83} Four studies had one treatment arm that evaluated a combination therapy that included the nonSSRI antidepressants clomipramine,^{82,83} bupropion,¹¹³ and desipramine.^{98,118}

The majority of studies evaluated combination therapies that included augmenting agents (26 from 33 studies). From studies with at least one treatment arm using a combination therapy that included an augmenting agent, there were five drugs or classes of drugs for which there was more than one study, and these included atypical antipsychotics (respiradone, olanzapine, aripiprazole, quetiapine), lithium, buspirone, mianserin, and pindolol. There were four studies^{98,112,118,124} with at least one treatment arm evaluating the effect of adding lithium; doses varied from 600mg/d,^{98,118} to 800mg/d,¹²⁴ and one study did not report the dose.¹¹² There were five studies evaluating atypical antipsychotics;^{88,95,108,122,134} the doses were similar for studies evaluating olanzapine at 5-6mg/d,^{88,122} but varied from 0.5mg/d⁹⁵ to 1mg/d in studies assessing risperidone.¹⁰⁸ There were three studies (seven publications)^{44,92,97,110,113,120,130} evaluating buspirone employing final doses that varied from 47mg/d⁹⁷ to 60mg/d.¹¹³ Two studies evaluated the use of mianserin^{119,121} with doses of 30mg/d¹¹⁹ and 60mg/d.¹²¹ The augmenting agent pindolol was also evaluated in two studies; the dose was not reported in one study⁹³ and was 7.5mg/d in the second study.⁹⁶

Table 8. Monotherapy versus combined therapy studies showing the comparison and treatment interventions grouped by type of intervention

Study	Monotherapy	Combined Therapy
Licht, ¹¹⁹ 2002	Sertraline + Placebo Sertraline (higher dose) + Placebo	<i>Sertraline + Mianserin</i>
Altamura, ^{82,83} 2008	SSRI + Placebo (saline)	SSRI + Citalopram (intravenous)
Add nonSSRI Antidepressant		
Altamura, ^{82,83} 2008	SSRI + Placebo (saline)	SSRI + Clomipramine (intravenous)
Trivedi, ¹¹³ 2006 Rush, ⁴⁴ 2006* Thase, ¹¹⁰ 2007*	Switching to new monotherapy (Bupropion/Venlafaxine/Sertraline/CBT)	Citalopram + Bupropion
Fava, ¹¹⁸ 2002	Fluoxetine + Placebo	Fluoxetine + Desipramine <i>Fluoxetine + Lithium</i>
Fava, ⁹⁸ 1994	Fluoxetine	Fluoxetine + Desipramine <i>Fluoxetine + Lithium</i>
Add Augmenting Agent		
Preskorn, ⁸⁰ 2008	Paroxetine + Placebo	Paroxetine + CP-101606
George, ⁸⁴ 2008	Current SSRI + placebo	Current SSRI + Mecamylamine Hydrochloride
Michelson, ^{87,101,132} 2007	Sertraline + Placebo	Sertraline + Atomoxetine
Shapira, ⁸⁹ 2006	SSRI (Fluoxetine/Fluvoxamine/Paroxetine) + Placebo	Current SSRI + Phenytoin
Seidman, ⁹¹ 2005	SSRI + Placebo injection	Current SSRI + Testosterone injection

Table 8. Monotherapy versus combined therapy studies showing the comparison and treatment interventions grouped by type of intervention (continued)

Study	Monotherapy	Combined Therapy
Berman, ¹⁰⁹ 2007 Marcus, ^{105,131} 2008 Thase, ¹²⁶ Berman, ⁷⁹	Switched to new SSRI Escitalopram/Fluoxetine/Sertraline/ Venlafaxine + Placebo	Switched to new SSRI (Escitalopram/ Fluoxetine/ Sertraline/Venlafaxine) + Aripiprazole
Fava, ¹¹⁴ 2005	SSRI + placebo	SSRI + Modafinil
Nemets, ¹²³ 1999	SSRI + placebo (glucose)	SSRI + Inositol
Dunner, ⁸⁶ 2007	Sertraline	Sertraline + Ziprasidone 60mg/d <i>Sertraline + Ziprasidone 80mg/d</i>
<i>Buspirone</i>		
Appelberg, ¹²⁰ 2001	SSRI + placebo	SSRI + Buspirone
Landén, ⁹⁷ 1998 Landén, ⁹² 2005 Landén, ¹³⁰ 1999	Citalopram or Paroxetine	Citalopram or Paroxetine + Buspirone
Rush, ⁴⁴ 2006 Trivedi, ¹¹³ 2006 Thase, ¹¹⁰ 2007	Switching to new monotherapy (Sertraline/ Venlafaxine/Bupropion/CBT)	Citalopram + Buspirone
Study	SSRI	Add SSRI
<i>Mianserin</i>		
Licht, ¹¹⁹ 2002	Sertraline Dose 1 + Placebo Sertraline Dose 2 + Placebo	Sertraline + Mianserin
Ferreri, ¹²¹ 2001	Fluoxetine	Fluoxetine + Mianserin
<i>Lithium</i>		
Baumann, ¹²⁴ 1996	Citalopram + Placebo	Citalopram + Lithium
Bondolfi, ¹¹² 2006	Paroxetine	Paroxetine + Lithium Switch to Venlafaxine
Fava, ¹¹⁸ 2002	Fluoxetine + Placebo	Fluoxetine + Lithium Fluoxetine + Desipramine
Fava, ⁹⁸ 1994	Fluoxetine	Fluoxetine + Lithium Fluoxetine + Desipramine
<i>Atypical Anti-psychotics</i>		
Thase, ⁸⁸ 2007	Fluoxetine Olanzapine	Fluoxetine + Olanzapine
Shelton, ¹²² 2001	Olanzapine + Placebo Fluoxetine + Placebo	Fluoxetine + Olanzapine
Keitner, ⁹⁵ 2009		SSRI + Risperidone
Mahmoud, ¹⁰⁸ 2007	SSRI + Placebo	SSRI + Risperidone
Bauer ^{134,188} 2010	Any SSRI + Placebo	Any SSRI + Quetiapine XR 150 mg Any SSRI + Quetiapine XR 300 mg
<i>Pindolol</i>		
Perry, ⁹³ 2004	Fluoxetine/Sertraline/Paroxetine + placebo (lactose powder)	Fluoxetine/Sertraline/Paroxetine + Pindolol
Sokolski, ⁹⁶ 2004	Paroxetine + Placebo	Paroxetine + Pindolol

Table 8. Monotherapy versus combined therapy studies showing the comparison and treatment interventions grouped by type of intervention (continued)

Study	Monotherapy	Combined Therapy
<i>Adding Non-pharmacological Treatment</i>		
Wiles, ⁹⁴ 2008	Any SSRI	SSRI + CBT
Carta, ¹²⁷ 2008	Any SSRI	SSRI + Exercise
Lynch, ¹²⁸ 2007	Paroxetine/Sertraline/Fluoxetine	SSRI + DBT
Thase, ¹¹⁰ 2007 Rush, ⁴⁴ 2006 Trivedi, ¹¹³ 2006	Switching to new monotherapy (Sertraline/ Venlafaxine/Bupropion/CBT)	Citalopram + CBT
Reynolds ^{133,135,137} 2010	Increase Escitalopram dose + Education	Increase Escitalopram dose + Education + Interpersonal Therapy

CBT = cognitive behavioral therapy; DBT = dialectical behavior therapy; SSRI = selective serotonin reuptake inhibitors

*Indicates that comparison arm is not the SSRI prior to the switch.

Outcomes

The majority of studies reported change scores as the primary outcome of choice. All but two studies used the MADRS, HAMD, BDI, or QID-SD-16 for at least one primary outcome; other outcomes used included the CGI,^{92,97,114,120,130} and the WHOQOL Brief Psychiatric inventory.¹²⁷ Only three studies explicitly stated that remission was the primary outcome, defined as a MADRS total score of less than 10,¹¹² HAMD-17 score less than seven for 3 consecutive weeks,^{133,135,137} or the QIDS-SR-16 score less than five.^{44,110,113} All other studies either specified that the endpoint change score relative to baseline was the primary outcome, or did not report which measure was the primary one to evaluate efficacy.

Setting

The studies were conducted in Denmark and Iceland,¹¹⁹ Switzerland,¹¹² France,¹²¹ Italy,^{82,83,127} Finland,¹²⁰ Norway and Sweden,^{92,97,130} United Kingdom,⁹⁴ Israel,^{89,123} Canada,^{86,88} and United States.^{44,79,80,84,86-88,91,93,95,96,98,101,105,108-110,113,114,118,122,124,126,128,131-135,137}

Three studies did not report the setting.^{87,88,92,97,101,130,132} From the remaining 28, all studies included subjects from outpatient psychiatric, tertiary, or primary care settings with the exception of one study¹²⁴ that included patients with a minimum of 4 weeks inpatient hospitalization.

Risk of Bias Assessment

Figure 6 shows that method of randomization, compliance with treatment, and the role of the funder were at high risk of bias for over 75 percent of the 28 studies evaluating monotherapies versus combination therapies. Allocation concealment was not achieved by approximately 30 percent of studies. Overall, these studies would be categorized as having a moderate risk of bias.

Adherence with treatment was evaluated in only three studies^{94,112,114} that reported some aspect of compliance with treatment; the remaining studies did not. A single study¹²⁰ from 28 employed a washout phase (2 weeks) prior to switching to the new treatment.

Figure 6. Percent of studies achieving risk of bias using the risk of bias tool criteria in studies comparing monotherapy to combined therapy

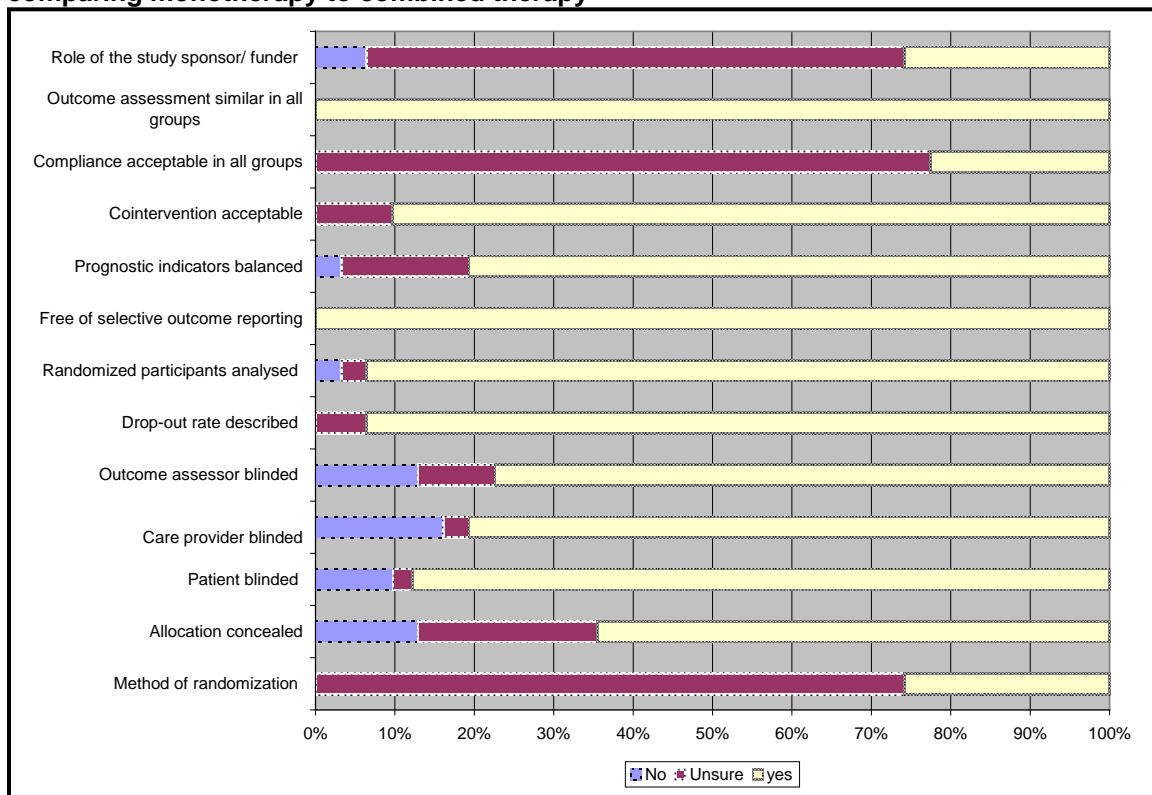


Table 9 shows the distribution of studies with respect to the source of funding. Eighteen studies were funded solely by industry and 10 solely by nonindustry sources. One study⁸⁴ was funded by both, and five studies did not report the source of funding. As indicated in Figure 6, the role of the study sponsor was not clearly specified in approximately 75 percent of the 28 studies evaluated here.

Table 9. Sources of funding for studies evaluating monotherapies relative to combined therapies

Funding Source	MONOTHERAPY [*]		COMBINED THERAPY			
	Dose or Duration Change	Switch to non-SSRI	Add Augmentor	Add Other SSRI	Add non-SSRI AD	Add Nonpharm
Industry		Thase ⁸⁸ Shelton ¹²² Licht ¹¹⁹ Ferrer ¹²¹ Bondolfi ¹¹²	Preskorn ⁸⁰ Michelson ^{87,101,132} Landén ⁹² Landén ⁹⁷ Landén ¹³⁰ Berman ¹⁰⁹ Marcus ^{105,131} Thase ¹²⁶ Berman ⁷⁹ [these are all companions] Shelton ¹²² Keitner ⁹⁵ Mahmoud ¹⁰⁸ Fava ¹¹⁴ Appelberg ¹²⁰ Licht ¹¹⁹ Thase ⁸⁸ Dunner ⁸⁶ Bauer ¹³⁴			
Non-industry		Rush ⁴⁴	Shapira ⁸⁹ Fava ⁹⁸ Trivedi ¹¹³ Fava ¹¹⁸ Baumann ¹²⁴ Rush ⁴⁴		Fava ⁹⁸ Fava ¹¹⁸	Wiles ⁹⁴ Carta ¹²⁷ Lynch ¹²⁸ Thase ¹¹⁰ Reynolds ^{133,135,137}
Both			George ⁸⁴			
Not Reported			Seidman ⁹¹ Perry ⁹³ Nemets ¹²³ Sokolski ⁹⁶	Altamura ⁸² Altamura ⁸	Altamura ⁸² Altamura ⁸	

SSRI = selective serotonin reuptake inhibitors

^{*}No studies reported: Switch to another SSRI, Switch to Augmenting Agent, or Switch to NonPharm.

Efficacy of Monotherapy Versus Combined Therapy

Outcomes of Response and Remission

Figures 7 to 10 and Table 10 detail the rates of response and remission reported within the studies in this grouping. The rates of response and remission for all studies cannot be directly compared across studies, as different primary outcomes were used and there is some variation in thresholds for these outcomes. Response was defined as 50 percent change from baseline in all but one study that used the HAMD, BDI, or the MADRS; one study using the HAMD defined response as a 30 percent change.⁹⁸ Three studies^{92,97,114,120,130} using the CGI defined response as a change to “improved” or “very improved.” Three studies did not specify definitions for response or remission.^{89,123,127} Thresholds for remission for studies using the HAMD varied from seven to eight and for the MADRS less than 8 or 10. Only one study provided some data for partial responders (greater than 25 percent but less than 50 percent).⁸⁸

Although the majority of studies that could be examined in this systematic review involved comparisons between monotherapy against combination therapy, the wide array of agents used in the combination treatments make identification of trends difficult.

In general, these studies involved one of two study designs. The most commonly employed design involved establishing a cohort of patients who had an inadequate response to an SSRI and then randomizing that group to either maintenance of the SSRI and placebo treatment or maintenance of the SSRI in combination with an active intervention. The “monotherapy” group therefore reflects patients who received ongoing treatment with an SSRI that had been deemed to be ineffective or inadequate at a specified point in treatment. Far fewer studies employed a design in which patients who had an inadequate response to an SSRI were then switched to another treatment and then compared against the combination of the original SSRI plus a new intervention. The STAR*D trial exemplified this latter type of design in which a portion of patients were switched to a new antidepressant treatment following an inadequate response to citalopram, while another portion remained on citalopram and had another treatment added (buspirone, bupropion, or CBT).

In the STAR*D trial, the data did not confirm the noninferiority or superiority of either a switch to monotherapy or the addition of another treatment (Figure 8). Although not statistically significant, there appeared to be a slight, but consistent, favoring of the combination treatment approach. In another trial with a small number of participants,^{82,83} adding either citalopram or clomipramine to another SSRI resulted in greater rates of response compared to adding a placebo. The additional treatments were all provided by intravenous infusion over five days, however, and extrapolation of these results is problematic as oral preparations of the same compounds might not have resulted in a similar pattern of results.

The greatest number of studies in this comparison group involved the treatment strategies of adding an intervention or placebo to ongoing therapy with the SSRI to which patients had shown an inadequate response (Figures 7 and 10). Note that studies within these figures have been categorized by drug classes (SSRI, nonSSRI, augmenting agents, nonpharmacological). Additionally, we have grouped the studies using augmentation agents based on the number of trials per drug or drug class; interventions that had more than one study included lithium, buspirone, mianserin, atypical antipsychotics, and nonpharmacological therapies. Although there were two studies where pindolol was used as the augmenting agent, one did not provide response or remission rates for the monotherapy group.⁹⁶

For buspirone and the outcome of remission, we are limited to the different treatment arms of the STAR*D study (comparing sertraline relative to citalopram combined with buspirone), which showed a potentially small difference, but this was not for the outcome of response (see Figure 9). This may be an effect of the outcome used to define remission, as no advantage was seen for the QIDS-SR outcome. Studies evaluating the addition of mianserin show no relative advantage to the monotherapy comparator treatment for either the outcome of response or remission.

Atypical Antipsychotics

Overall, none of the augmenting agents showed any relative difference or advantage over the monotherapy comparator for the outcomes of benefit, with the exception of the atypical antipsychotics. Trials of fluoxetine in combination with olanzapine^{88,122} and risperidone¹⁰⁸ in combination with SSRI treatment show some relative advantage over monotherapy in patients with MDD for both response and remission. Note that two studies^{95,108} provided subgroup data specific to the SSRI failed group. As such the studies were not randomized for this subgroup and

therefore balance between groups was not maintained. Two studies (five publications)^{79,105,109,126,131} evaluated the benefits of adding aripiprazole in patients who had failed to respond to both SSRI and nonSSRI antidepressants. Although response and remission rates for the SSRI subgroup were not reported, a subgroup analysis (based on a pooled analysis)^{79,126,131,136} indicated that patients on an SSRI combined with aripiprazole showed consistently greater MADRS total score relative to placebo (-8.6 versus -5.5 treatment difference -3.1, 95% CI: -4.5 to -1.7). Another two studies evaluated the use of quetiapine (at two different doses) as an augmenting agent and undertook a pooled analysis.¹³⁴ This pooled analysis did not report response and remission rates but mean change scores for the SSRI subgroup (MADRS total scores at week 6 quetiapine XR 150 and 300mg/day, compared with placebo as adjunct to SSRIs [-14.8, -14.7 and -12.7, respectively; p<0.05, for each dose]).

Nonpharmacological Therapies

Evaluation of CBT as an add-on therapy showed no advantage when considering any monotherapy comparator; however, most of these data were derived from the STAR*D study. Similarly, a study in older adults showed no advantage of adding on interpersonal therapy to escitalopram.^{133,135,137}

Other Outcomes

Eight studies attempted to evaluate quality of life outcomes and some used more than one type of scale; all were selected as secondary outcome measures. Four studies used the Sheehan Disability Scale,^{88,95,105,108,109,131} four used the Endicott Enjoyment and Satisfaction Scale,^{44,91,95,108,110,113} and two also used some form of the SF36/SF12.^{44,88,110,113} The STAR*D also included a measure of work productivity.^{44,88,110,113} Note that four of these studies^{95,105,108,109,131} provided stratified findings for the SSRI failed subgroup; data for quality of life outcomes was not provided. All other studies showed no differences between groups for these outcomes.

Table 10. Summary of reported rates of response and remission for studies comparing monotherapy treatment to combined therapy

Study	Duration (Weeks)	Rating Scale	n*	Comparison and Dose (mg/d)	Response ^a n (%)	p Value	Remission ^b n (%)	p Value
Adding SSRI								
Altamura 2008 ^{82,83}	5 day	HAMD-21	18	SSRI + PBO (saline)	0 (0)	<0.0001		
			18	SSRI + CIT 10mg in 250ml of saline	9 (50)		NR	
Adding Non-SSRI								
Altamura 2008 ^{82,83}	5 day	HAMD-21	18	SSRI + PBO (saline)	0 (0)	<0.0001		
			18	SSRI + CM 25mg in 250ml of saline (intravenous)	11 (61.1)		NR	
Fava 2002 ¹¹⁸	12	HAMD-17	33	FLX 40-60mg/d + PBO	14 (42.4)	0.2		
			34	FLX 20mg/d, DES 25-50mg/d	10 (29.4)			
Fava 1994 ⁹⁸	4	HAMD-17	15	FLX 40-60mg/d	8 (53) [#]	0.24		
			12	FLX 20mg + DES 25-50mg/d	3 (25) [#]			

Table 10. Summary of reported rates of response and remission for studies comparing monotherapy treatment to combined therapy (continued)

Study	Duration (Weeks)	Rating Scale	n*	Comparison and Dose (mg/d)	Response ^a n (%)	p Value	Remission ^b n (%)	p Value
Rush 2006 ⁴⁴	12	HAMD-17 QIDS-SR-16 [*]	238	SER 50-200mg/d	63 (26.7) [*]	NR	42 (17.6) 63 (6.4)	
			250	VEN 37.5-375mg/d	70 (28.2) [*]		62 (24.8) 62 (24.8)	
			239	BUP 150-400mg/d	62 (26.1) [*]		51 (21.3) 61 (25.5)	
Trivedi 2006 ¹¹³	12	HAMD-17 QIDS-SR-16 [*]	279	CIT + BUP, 200-400mg/d	88 (31.8) [*]		83 (29.7) 108 (38.7) [*]	0.93 0.16 [*]
Preskorn 2008 ⁸⁰	6	HAMD-NS	15	PAX 40mg + PBO	3 (20)	<0.10		
				PAX 40mg + CP-101,606 infusion/duration to 1.5 hours and the dose to 0.5mg/kg per hour	12 (80)			
George 2008 ⁸⁴	8	HAMD-17	10	SSRI + PBO	1 (10)	0.15		
			11	SSRI + ME, 5mg/d	5 (45.4)			
Adding Augmenting Agents								
Michelson 2007 ^{87,101,132}	8	MPS	74	SER 100mg/d + PBO			28 (37.8)	0.865
			72	SER 100mg/d + AM 40mg/d			29 (40.3)	
Shapira 2006 ⁸⁹	4	HAMD-21	9	SSRI + PBO	7 (9)	0.02		
			11	SSRI + PI	2 (11)			
Seidman 2005 ⁹¹	6	HAMD-24	13	SSRI + PBO volume matched, (injection)	3 (23.1)	0.226		
			13	SSRI + TE 200-600mg/d	7 (53.8)			
Berman 2007 ¹⁰⁹	8	MADRS	176	New SSRI + PBO	NR for SSRI subgroup		NR for SSRI subgroup	
			182	New SSRI + ARI, 5-15	NR for SSRI subgroup		NR for SSRI subgroup	
Marcus 2008 ^{105,131}	8	MADRS	191	SSRI + PBO	NR for SSRI subgroup		NR for SSRI subgroup	
			190	SSRI + ARI 5-20mg/d (5-11mg ?)	NR for SSRI subgroup		NR for SSRI subgroup	
Fava 2005 ¹¹⁴	8	HAMD- 17 CGI-I [*]	153	SSRI + PBO	48 (32) [*]	>0.09	55 (36)	0.2
			158	SSRI + MOD 100-200	64 (41) [*]		68 (44)	
Nemets 1999 ¹²³	4	HAMD 24	18	SSRI original dose + PBO	NR			
			18	IN 12gm/d, SSRI original dose;	NR			
Dunner 2007 ⁸⁶	8	MADRS	20	SER 100-200mg/d	4 (19)	NS		
			21	SER 100-200mg/d + ZI 40-80mg/d	6 (32)			
			19	SER 100-200mg/d + ZI 80-160mg/d	2 (10)			

Table 10. Summary of reported rates of response and remission for studies comparing monotherapy treatment to combined therapy (continued)

Study	Duration (Weeks)	Rating Scale	n*	Comparison and Dose (mg/d)	Response ^a n (%)	p Value	Remission ^b n (%)	p Value
Add Atypical Antipsychotics								
Thase 2007 ⁸⁸	8	MADRS	203	FLX 50mg/d			34 (16.7)	0.012
			197	OLZ 6-18mg/d			29 (14.7)	
			198	OLZ 6-18mg/d + FLX50mg/d			54 (27.3)	
Shelton 2001 ¹²²	8	MADRS	8	FLX 20-60mg/d	1 (10)	0.006 vs. com		
			8	OLZ 5-20mg/d	0 (0)	0.003 vs. com		
			10	OLZ 5-20mg/d, FLX 20-60mg/d	6 (60)	0.007		
Mahmoud 2007 ¹⁰⁸	6	HAMD-17	74	SSRI + PBO	18 (24.3)	NR	4 (5)	NR
			82	SSRI + RIS 0.25-1mg/d	37 (45.70)		21 (25)	
Keitner 2009 ⁹⁵	4	MADRS	22	SSRI dose maintained + PBO			5 (22.7)	0.011
			47	RIS 0.5-3mg/d + antidepressant dose maintained			24 (51)	
Adding BUS								
Rush 2006 ⁴⁴	12	HAMD-17 QIDS-SR-16 [*]	238	SER 50-200mg/d	63 (26.7) [*]	NR	42 (17.6) 63 (6.4)	
			250	VEN 37.5-375mg/d	70 (28.2) [*]		62 (24.8) 62 (24.8) [*]	
			239	BUP 150-400mg/d	62 (26.1) [*]		51 (21.3) 61 (25.5) [*]	
Trivedi 2006 ¹¹³	12	HAMD-17 QIDS-SR-16 [*]	286	CIT + BUS, 200-400mg/d	77 (27) [*]		86 (30.1) 94 (32.9) [*]	0.93 [*] 0.16 [*]
Appelberg 2001 ¹²⁰	6	MADRS	51	CIT 40mg/d/FLX 35.4mg/d + PBO	16 (31)	0.034		
			51	CIT 40mg/d/FLX 35.4mg/d + BUS 35-47mg/d	17 (33)			
Landén 1998 ⁹⁷	4	CGI-S, CGI-I	60	CIT 46.1mg/d or PAX 39.8mg/d + PBO	28 (46.7)	NS		
			57	CIT 46.1mg/d or PAX 39.8mg/d + BUS 49mg/d	29 (50.9)			
Adding Li								
Fava 1994 ⁹⁸	4	HAMD-17	15	FLX 40-60mg/d	8 (53)	0.24		
			14	FLX 20mg/d + LI 300-600mg/d	4 (29)			
Fava 2002 ¹¹⁸	12	HAMD-17	33	FLX 40-60mg/d + PBO	14 (42.4)	0.2		
			34	FLX 20mg/d, LI 300-600mg/d	8 (23.5)			
Baumann 1996 ¹²⁴	4	HAMD-21	14	CIT 40-60mg/d	2 (14)	0.05		
			10	CIT 40-60mg/d, LI 800mg/d;	6 (60)			
Bondolfi 2006 ¹¹²	4	MADRS	19	PAX 40mg/d	2 (10.5)	NR	3 (15.7)	NR
			9	VEN 150mg/d	0 (0)		0 (0)	
			13	PAX 30mg/d + LI	1 (7.8)		0 (0)	

Table 10. Summary of reported rates of response and remission for studies comparing monotherapy treatment to combined therapy (continued)

Study	Duration (Weeks)	Rating Scale	n*	Comparison and Dose (mg/d)	Response ^a n (%)	p Value	Remission ^b n (%)	p Value
Adding Pindolol								
Perry 2004 ⁹³	6	HAMD	17	SSRI + PBO FLX 20-60mg, PARO20-40mg, SER 50mg	6 (35.2)	1		
			21	SSRI + PI Total = only SSRI doses given, PI dose not reported; Group 1 = FLX 20-60mg, PAX 20mg, SER 150-200mg	5 (23.8)			
Sokolski 2004 ⁹⁶	4	HAMD	5	PAX 40mg/d + PBO	NR	0.001		
			4	PAX 40mg/d + PI 7.5mg/d	3 (75)			
Adding MIN								
Licht 2002 ¹¹⁹	6	HAMD-NS	99	SER 100mg/d + PBO	69 (70)	0.64	37 (38)	0.38
			98	SER 200mg/d + PBO	54 (64)	0.03	28 (29)	0.19
			98	SER 100mg/d + MIN	66 (67)		43 (44)	
Ferrerri 2001 ¹²¹	6	HAMD 17	38	FLX 20mg/d	14 (37)	0.1	14 (36)	0.06
			34	MIN 60mg/d	16 (48.5)		6 (18)	
			32	FLX 20mg/d + MIN 60-60mg/d	20 (62.5)		14 (44)	
Adding Non-Pharmacological								
Carta 2008 ¹²⁷	32	WHOQOL-Bref	10	SSRI	NR		NR	
			20	SSRI + Exercise	NR		NR	
Lynch 2007 ¹²⁸	54	HAMD-NS	12	SSRI			6 (50)	NR
			20	SSRI + DBT			12 (60)	
Wiles 2008 ⁹⁴	16	BDI	9	SSRI	0			
			14	SSRI + CBT	8 (56)			
Reynolds 2010 ¹³⁷	10	SCID/DSM-IV	60	SSRI + IPT	49(82)	0.20	35(58)	0.14
			64	SSRI	49(77)		29(45)	

Table 10. Summary of reported rates of response and remission for studies comparing monotherapy treatment to combined therapy (continued)

Study	Duration (Weeks)	Rating Scale	n*	Comparison and Dose (mg/d)	Response ^a n (%)	p Value	Remission ^b n (%)	p Value
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Rush 2006 ⁴⁴	12	HAMD-17 QIDS-SR-16 [*]	238	SER 50-200mg/d	63 (26.7) [*]	NR	42 (17.6) 63 (6.4)	
			250	VEN 37.5-375mg/d	70 (28.2) [*]		62 (24.8) 62 (24.8) [*]	
			239	BUP 150-400mg/d	62 (26.1) [*]		51 (21.3) 61 (25.5) [*]	
			36	Medications Monotherapy	8 (22.2)		9 (25) 11 (30.5)	
			86	CBT	23 (26.7)		24 (27.9) 24 (27.9)	
			65	CIT + CBT	23 (35.4)		15 (23) 20 (20.7)	

AM = atomoxetine; ARI = aripiprazole; BDI = Beck Depression Inventory; BUP = bupropion; BUS = buspirone; CBT = cognitive behavioral therapy; CGI-I = Clinical Global Impression – Improvement scale; CGI-S = Clinical Global Impression – Severity scale; CIT = citalopram; CM = clomipramine; DES = desipramine; DLX = duloxetine; FLX = fluoxetine; HAMD = Hamilton Depression Rating Scale; HAMD-NS = Hamilton Depression Rating Scale not specified; LI = lithium; MADRS = Montgomery-Åsberg Depression Rating Scale; ME = mecamyline hydrochloride; MIN = mianserin; MOD = modafinil; MPS = Maier Philipp core mood severity subscale; NR = not reported; NS = not significant; NT = not tested; OLZ = olanzapine; PAX = paroxetine; PBO = placebo; PI = pindolol; PLZ = phenelzine; QIDS-SR16 = Quick Inventory of Depressive Symptoms Self Report (16) RIS = risperidone; SER = sertraline; SSRI = selective serotonin reuptake inhibitors; TCP = tranylcypromine; TE = testosterone; VEN = venlafaxine; VEN-ER = venlafaxine extended release; WHOQOL-Bref = World Health Organization Quality of Life 26 item scale; ZI = ziprasidone

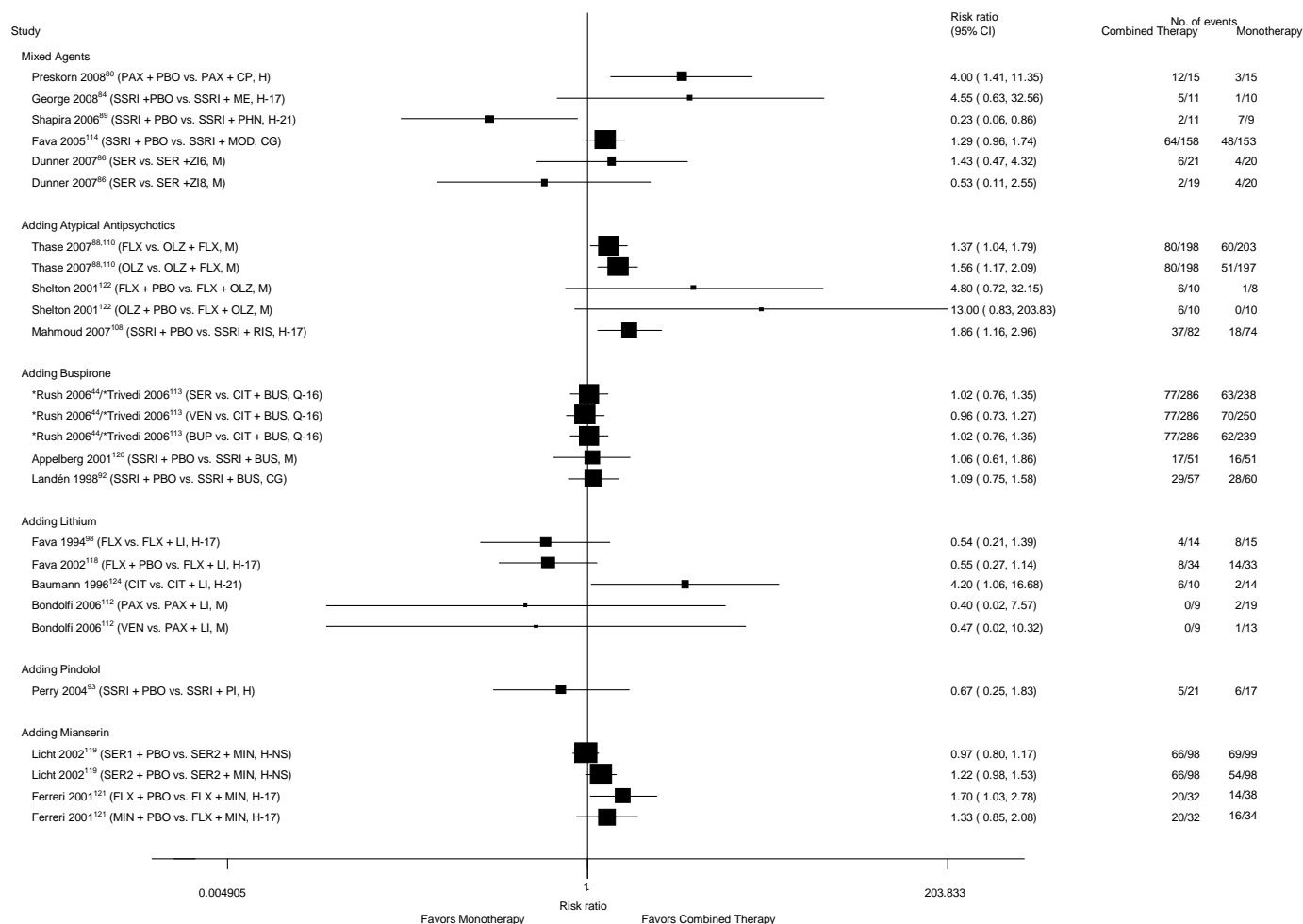
^aResponse was defined as 50 percent change relative to baseline unless noted within the table.

^bRemission was defined as the standard threshold value for the particular outcome.

^{*}The QIDS-SR reported outcomes.

[#]Response as a 30 percent change from baseline on the HAMD.

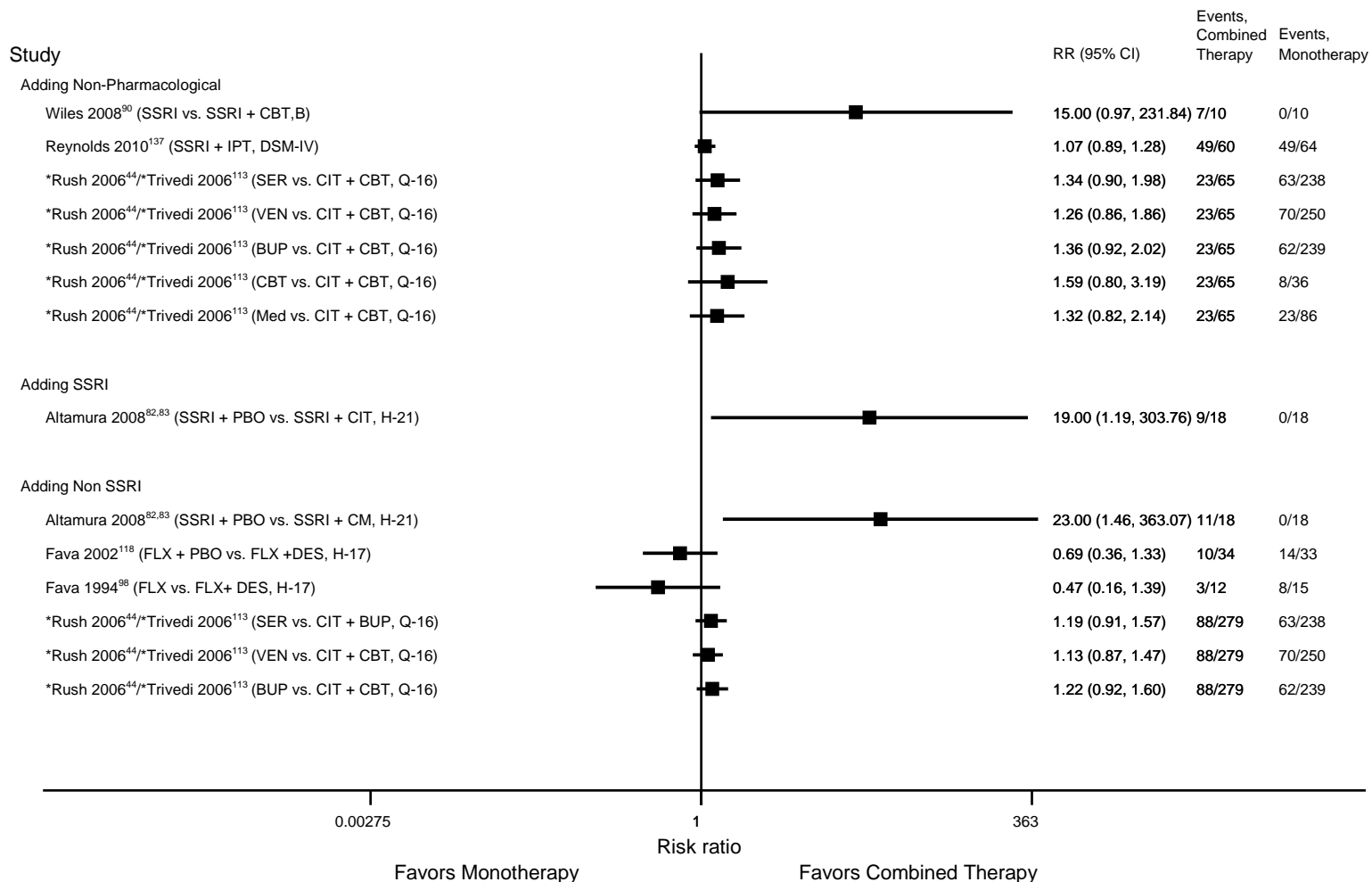
Figure 7. Forest plot showing monotherapy versus combined therapy for the outcome of response for augmenting agents



BUP = bupropion; BUS = buspirone; CG = Clinical Global Impressions-Improvement (CGI-I) Scale; CIT = citalopram; CP = CP 101,106 (NMDA receptor antagonist); FLX = fluoxetine; H = Hamilton Depression Rating Scale; H-17 = Hamilton Depression Rating Scale – 17 item; H-21 = Hamilton Depression Rating Scale – 21 item; H = Hamilton Depression Rating Scale; LI = lithium; M = Montgomery-Asberg Depression Rating Scale (MADRS); ME = mecamylamine hydrochloride; MIN = mianserin; MOD = modafinil; OLZ = olanzapine; PAX = paroxetine; PBO = placebo; PHN = phenytoin; PI = pindolol; Q-16 = Quick Inventory of Depressive Symptoms Self Report (16); RIS = risperidone; SER = sertraline; SSRI = selective serotonin reuptake inhibitors; VEN = venlafaxine; Z80 = ziprasidone 80mg; Z160 = ziprasidone 160mg

*Represent STAR*D studies.

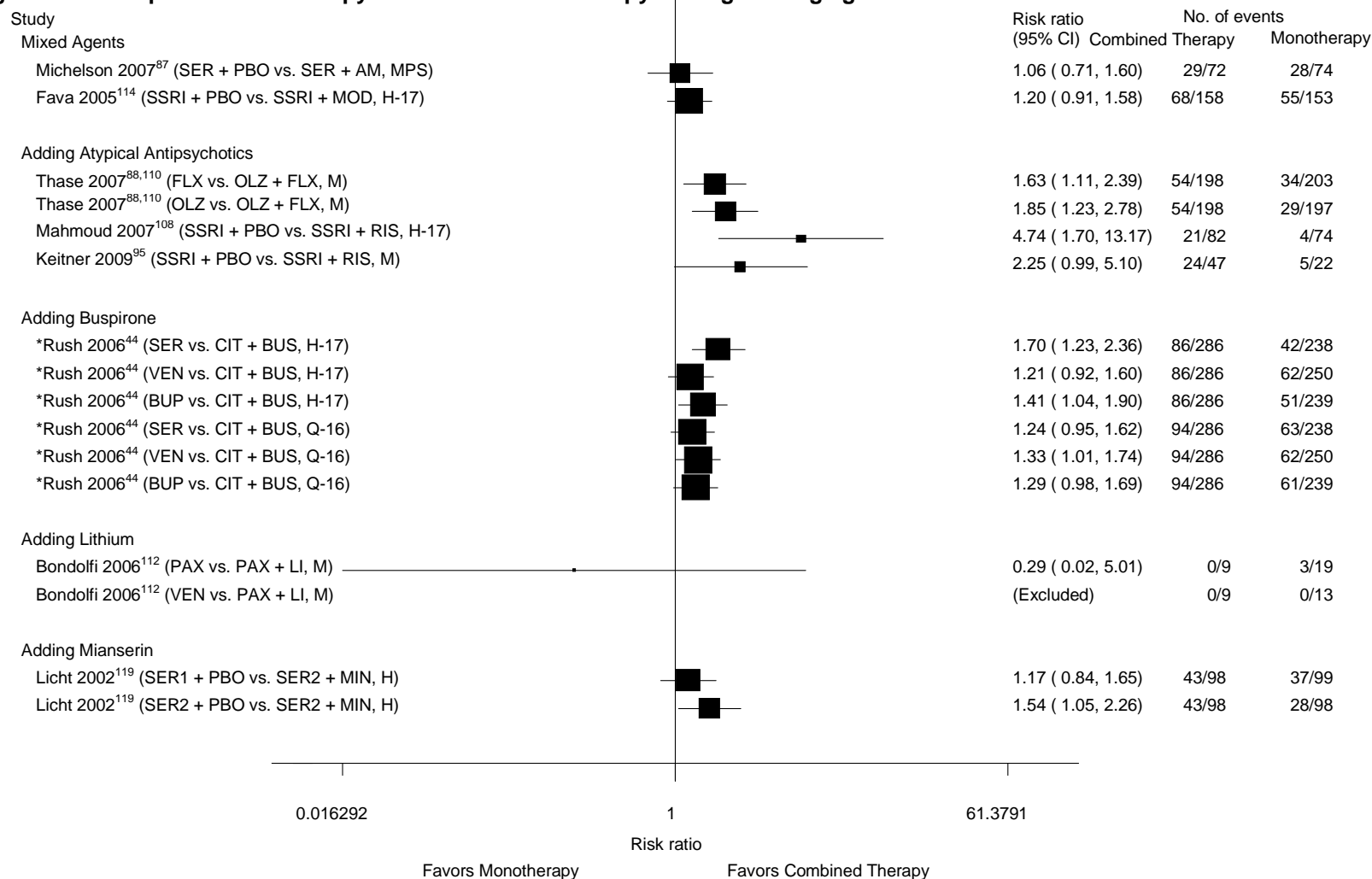
Figure 8. Forest plot of monotherapy versus combined therapies for the outcome of response for all interventions but augmenting agents



Abbreviations: B = Beck Depression Inventory; BUP = bupropion; CBT = cognitive behavioral therapy; CIT = citalopram; CM = clomipramine; DES = desipramine; DSM-IV = the Diagnostic and Statistical Manual of Mental Disorders – 4th edition; FLX = fluoxetine; H-17 = Hamilton Depression Rating Scale – 17 item; H-21 = Hamilton Depression Rating Scale – 21 item; IPT = interpersonal therapy; Med = medication; PBO = placebo; Q-16 = Quick Inventory of Depressive Symptoms Self Report (16); SER = sertraline; SSRI = selective serotonin reuptake inhibitors; VEN = venlafaxine

*Represent STAR*D studies.

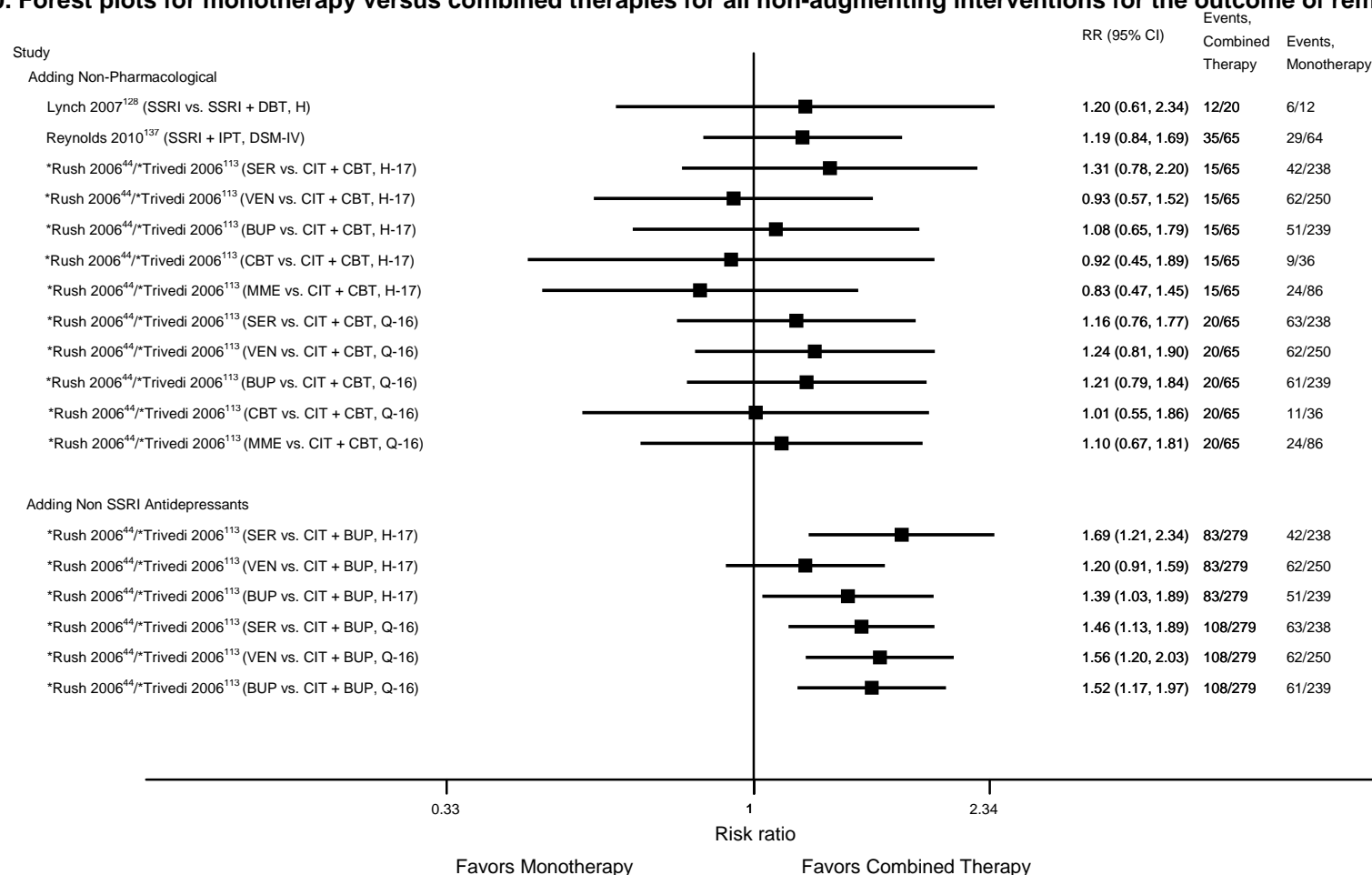
Figure 9. Forest plot of monotherapy versus combined therapy for augmenting agents for the outcome of remission



Abbreviations: AM = atomoxetine; BUP = bupropion; BUS = buspirone; CIT = citalopram; FLX = fluoxetine; H-17 = Hamilton Depression Rating Scale – 17 item; H = Hamilton Depression Rating Scale; LI = lithium; M = Montgomery-Asberg Depression Rating Scale (MADRS); MIN = mianserin; MOD = modafinil; MPS = Maier Philipp core mood severity subscale; OLZ = olanzapine; PAX = paroxetine; PBO = placebo; Q-16 = Quick Inventory of Depressive Symptoms Self Report (16); RIS = risperidone; SER = sertraline; SSRI = selective serotonin reuptake inhibitors; VEN = venlafaxine

*Represent STAR*D studies.

Figure 10. Forest plots for monotherapy versus combined therapies for all non-augmenting interventions for the outcome of remission



BUP = bupropion; CBT = cognitive behavioral therapy; CIT = citalopram; DBT = dialectical behavior therapy; DSM-IV = the Diagnostic and Statistical Manual of Mental Disorders – 4th edition; H-17 = Hamilton Depression Rating Scale – 17 item; H = Hamilton Depression Rating Scale; IPT = interpersonal therapy; Med = medication; Q-16 = Quick Inventory of Depressive Symptoms Self Report (16); SER = sertraline; SSRI = selective serotonin reuptake inhibitors; VEN = venlafaxine

*Represent STAR*D studies.

Combined Therapy Versus Combined Therapy Interventions

There were six studies^{86,98,110,113,118,125,125} with treatment arms that compared combination therapies with each other. All studies were RCTs with the exception of one study which did not randomize subjects, and the STAR*D study.^{44,113} The STAR*D cohort^{110,113} for level 2 subjects evaluated three combined therapy interventions and only these arms (citalopram plus CBT with two combined drug therapy interventions) are compared in this section. Two studies^{86,125} compared different doses of the same combination drug therapies.

In total there were 832 participants in the treatment arms evaluating combined interventions and the sample sizes varied from 11¹²⁵ to 650 participants.^{110,113} The sample sizes per treatment arm varied from 5 subjects¹²⁵ to 286 subjects.¹¹³ One study^{44,110} exceeded a total sample size of 101 and two studies^{98,125} had less than 30 subjects.

Overview of Study PICOT Characteristics

Population

The proportion of women in the sample varied from 47 percent,^{86,118} between 50 and 62 percent,^{98,113,125} and greater than 70 percent.^{82,83} Racial composition was not reported in four studies;^{82,83,98,118,125} two studies reporting ethnicity had approximately 78 percent^{110,113} and over 90 percent⁸⁶ of the participants of the white race. Mean age of study subjects varied from 40 to 44 years in four studies,^{86,98,110,113,118} and ages ranged from 37 to 59 years,¹²⁵ and 51 to 58 years^{82,83} in the remaining studies.

Inadequate Response

Table 11 shows the manner in which failure to respond to an SSRI had been established. Three studies^{82,83,98,125} determined failure retrospectively, and study subjects were currently on the same SSRI prior to the switch to the new intervention. In the three studies that determined inadequate response prospectively, fluoxetine,¹¹⁸ citalopram,^{110,113} and sertraline⁸⁶ were the SSRIs for which failure was established. No study evaluated subjects specifically for prospective failed response to escitalopram, paroxetine, or fluvoxamine alone.

Table 11. Method of establishing failure to SSRI in studies comparing combination therapies to other combination therapies

Determining Inadequate Response	Add Augmentor	Add Other SSRI	Add non-SSRI AD	Add Nonpharm
Prospective				
Citalopram	Trivedi ^{113*}		Trivedi ^{113*}	Thase ^{110*}
Escitalopram				
Fluvoxamine				
Fluoxetine	Fava ¹¹⁸		Fava ¹¹⁸	
Paroxetine				
Sertraline	Dunner ⁸⁶			
Any SSRI				
Retrospective				
Currently on an SSRI or other AD	Fava ⁹⁸ Dinan ¹²⁵	Altamura ^{82,83}	Altamura ⁸² Fava ⁹⁸	

AD = antidepressant; SSRI = selective serotonin reuptake inhibitors

*STAR*D study.

Mental Health History

Table 12 shows that five studies used the HAMD 17 or 21 item instruments to evaluate baseline severity; one study did not report baseline scores.¹²⁵ It is notable that several studies^{44,110,113} included patients of mild to moderate severity based on the HAMD criteria, while others included patients with marked depression. The number of previous depressive episodes were reported as a median of seven to eight (range 12 to 15) in the STAR*D cohort^{110,113} and not reported in five studies.^{82,83,86,98,118,125}

Table 12. Distribution of baseline scores for primary outcomes as a proxy for severity of MDD

Disease-Specific Scale	Baseline Score 10 - 14	Baseline Score 15 - 19	Baseline Score 20 - 25	Baseline Score 26 - 30	Baseline Score >31
MADRS					
BDI					
HAMD-NS					
HAMD-31					
HAMD-24					
HAMD-21			Altamura ⁸² Altamura ⁸³		
HAMD-17		Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰	Fava ⁹⁸ Fava ¹¹⁸ Dunner ⁸⁶		
QIDS-SR16	Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰				
Other					

BDI = Beck Depression Inventory; HAMD = Hamilton Depression Rating Scale; HAMD-NS = Hamilton Depression Rating Scale not specified; MADRS = Montgomery-Åsberg Depression Rating Scale; QIDS-SR16 = Quick Inventory of Depressive Symptoms Self Report (16).

Note that one study¹²⁵ did not provide baseline scores and some studies provided scores for more than one instrument. No study in this grouping reported baseline use of CAM at baseline or endpoint.

Intervention

All but one study¹²⁵ employed an RCT design and the STAR*D is considered a CCT. The STAR*D cohort^{99,100,102,110,111,113} for level 2 subjects, evaluated three combined therapy interventions and only these arms are compared in this section. Two studies¹²⁵ compared two doses of the same combination therapy. Table 13 shows the duration of the study intervention. Two studies evaluated combined therapy for approximately one week,^{82,83,125} and the remaining studies varied treatment length from 4 to 12 weeks.

Table 13. Details of the length of the run-in and treatment phases for all studies

Length of Treatment	2/3 Weeks	4/5 Weeks	6 Weeks	8 Weeks	>8 Weeks
Prospective Failure Run-In Phase			Dunner ⁸⁶	Fava ¹¹⁸	Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰
Prospective Failure Treatment Phase		Fava ¹¹⁸	Dunner ⁸⁶		Trivedi ¹¹³ Rush ⁴⁴ Thase ¹¹⁰
Retrospective Failure Studies	Dinan ^{125#} Altamura ⁸² Altamura ^{83##}	Fava ⁹⁸			

#Indicates treatment was for one week.

##Indicates treatment was for 5 days.

Table 14 shows the types of combination therapies evaluated in these six studies. Two studies included an arm evaluating the nonSSRI desipramine,^{98,118} and one each evaluating clomipramine^{82,83} and bupropion.¹¹³ The augmenting agents used in these studies included buspirone, lithium, and ziprasidone. Two studies^{86,125} compared different doses of the same combination studies involving sertraline with either lithium and ziprasidone. The doses for both lithium (400-800mg) and ziprasidone (60 mg and 80 mg) are in the low to moderate range. It is unlikely that lithium at 400mg/d would result in therapeutic blood levels, but low doses of lithium have been commonly employed in augmentation trials. The STAR*D cohort compared two drug combination therapies with citalopram or CBT.^{110,113}

Table 14. Combined therapy versus combined therapy studies showing the comparison and treatment interventions grouped by type of intervention

Study	Combined Therapy 1	Combined Therapy 2
Altamura 2008 ⁸² Altamura 2008 ⁸³	SSRI + Citalopram (intravenous)	SSRI + Clomipramine (intravenous)
Rush 2006 ⁴⁴ Trivedi 2006 ¹¹³ Thase 2007 ¹¹⁰	Citalopram + Bupropion	Citalopram + Buspirone
Add Augmenting Agent		
Dinan 1993 ¹²⁵	Sertraline + Lithium 400mg	Sertraline + Lithium 800mg
Dunner 2007 ⁸⁶	Sertraline + Ziprasidone 60mg/d	Sertraline + Ziprasidone 80mg/d
Fava 2002 ¹¹⁸ Fava 1994 ⁹⁸	Fluoxetine + Desipramine	Fluoxetine + Lithium
Adding Nonpharmacological Treatment		
Thase 2007 ¹¹⁰ Rush 2006 ⁴⁴ Trivedi 2006 ¹¹³	Citalopram + Buspirone Citalopram + Bupropion	Citalopram + CBT

CBT = cognitive behavioral therapy; SSRI = selective serotonin reuptake inhibitors

Outcome

A single study^{110,113} specified that remission was the primary outcome. All other studies indicated that the change or endpoint score was the primary outcome.

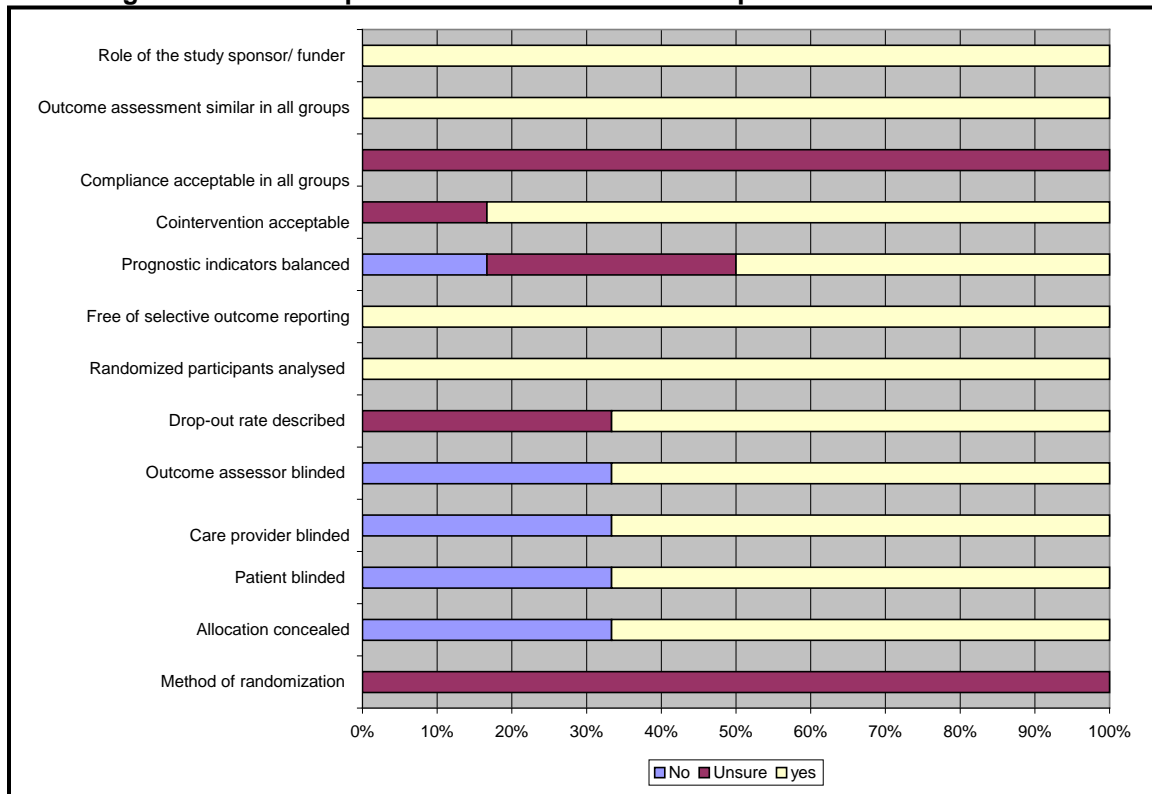
Setting

The six studies were conducted in the United Kingdom,¹²⁵ Italy,^{82,83} Canada,⁸⁶ and the United States (four studies).^{86,98-100,102,110,111,113,118} All studies included subjects in outpatient psychiatric or outpatient primary care.¹¹⁸

Risk of Bias

Figure 11 shows that studies evaluating combined therapies were at high risk of bias for randomization, reporting compliance, and balancing prognostic indicators. The role of the funder was clarified in all studies and funding for the studies came from nonindustry sources in three studies,^{98,113,118} industry in one study,⁸⁶ and two did not reported the source.^{82,83,125} Overall these studies would be categorized as having a moderate level of risk of bias. None of the studies employed a washout phase or monitored compliance of subjects.

Figure 11. Percent of studies achieving risk of bias using the risk of bias tool criteria for studies evaluating combined therapies relative to combined therapies



Efficacy of Combined Therapy Versus Combined Therapy

Response and Remission

Table 15 and Figures 12 and 13 report the rates of response and remission for studies evaluating combined treatments relative to other combined treatments. Figure 12 illustrates that when the combination of citalopram plus buspirone was compared against the combination of citalopram and CBT, there was a nonsignificant pattern favoring the combination of medications in the STAR*D trial. There appeared to be no differences between combinations of therapies in

this large trial. When considering speed of response, there was a significant difference of 15 days for the group with CBT augmentation and only for the outcome of remission ($p = 0.022$).

Other Outcomes

The STAR*D study was the single trial to include quality of life measures and showed no significant differences between groups.

Table 15. Summary of reported rates of response and remission for studies evaluating combined therapy to other combined therapy treatments

Study	Durat ion (Wee ks)	Rating Scale	n*	Comparison and Dose (mg/d)	Respon se ^a n (%)	p Value	Remission ^b n (%)	p Value
Adding Non-SSRI								
Altamura 2008 ^{82,83}	5 days	HAMD- 21	18	SSRI+CIT 10mg in 250ml of saline	9 (50)			
			18	SSRI+ CM 25mg in 250ml of saline (intravenous)	11 (61.1)			
Trivedi 2006 ¹¹³	12	HAMD- 17 QIDS- SR-16*	28 6	CIT +BUS 15-60mg/d	77*		86 (30.1) 94 (32.9)*	0.93 0.16*
			27 9	CIT +BUP, 200-400mg/d	62 (22.2)*		83 (29.7) 108 (38.7)*	
Augmenting Agents								
Dinan 1993 ¹²⁵	1	HAMD- NS	6	SER 100-200mg/d + LI 400mg/d	4			
			5	SER 100-200mg/d + LI 800mg/d	3			
Dunner 2007 ⁸⁶	8	MADRS	21	SER 100-200 mg/d + ZI 40-80mg/d	6 (32)			
			19	SER 100-200 mg/d + ZI 80-160mg/d	2 (10)			
Fava 2002 ¹¹⁸	12	HAMD- 17	34	FLX 40-60mg/d + placebo DES	10 (29.4)			
			34	FLX 20mg/d, LI 300- 600mg/d	8 (23.5)			
Fava 1994 ⁹⁸	4	HAMD- 17	12	FLX 20mg + DES 25- 50mg/d	3 (25)			
			14	FLX 20mg/d + LI 300- 600mg/d	4 (29)			
Adding Nonpharmacological								
Trivedi 2006 ¹¹³ Thase 2007 ¹¹⁰	12	HAMD- 17 QIDS- SR-16*	28 6	CIT + BUS 15-60mg/d	77 (27)*		83 (29.7) 94 (32.8)*	0.93
			23 9	CIT + BUP, 200- 400mg/d	62 (26.1)*		94 (39.3)	
Thase 2007 ¹¹⁰	12	HAMD- 17 QIDS- SR-16*	11 7	Medications Combined	33 (28.2)*		39 (33.3) 39 (33.3)*	
			65	CIT + CBT	23 (35.4)*		15 (23.1) 20 (30.8)*	

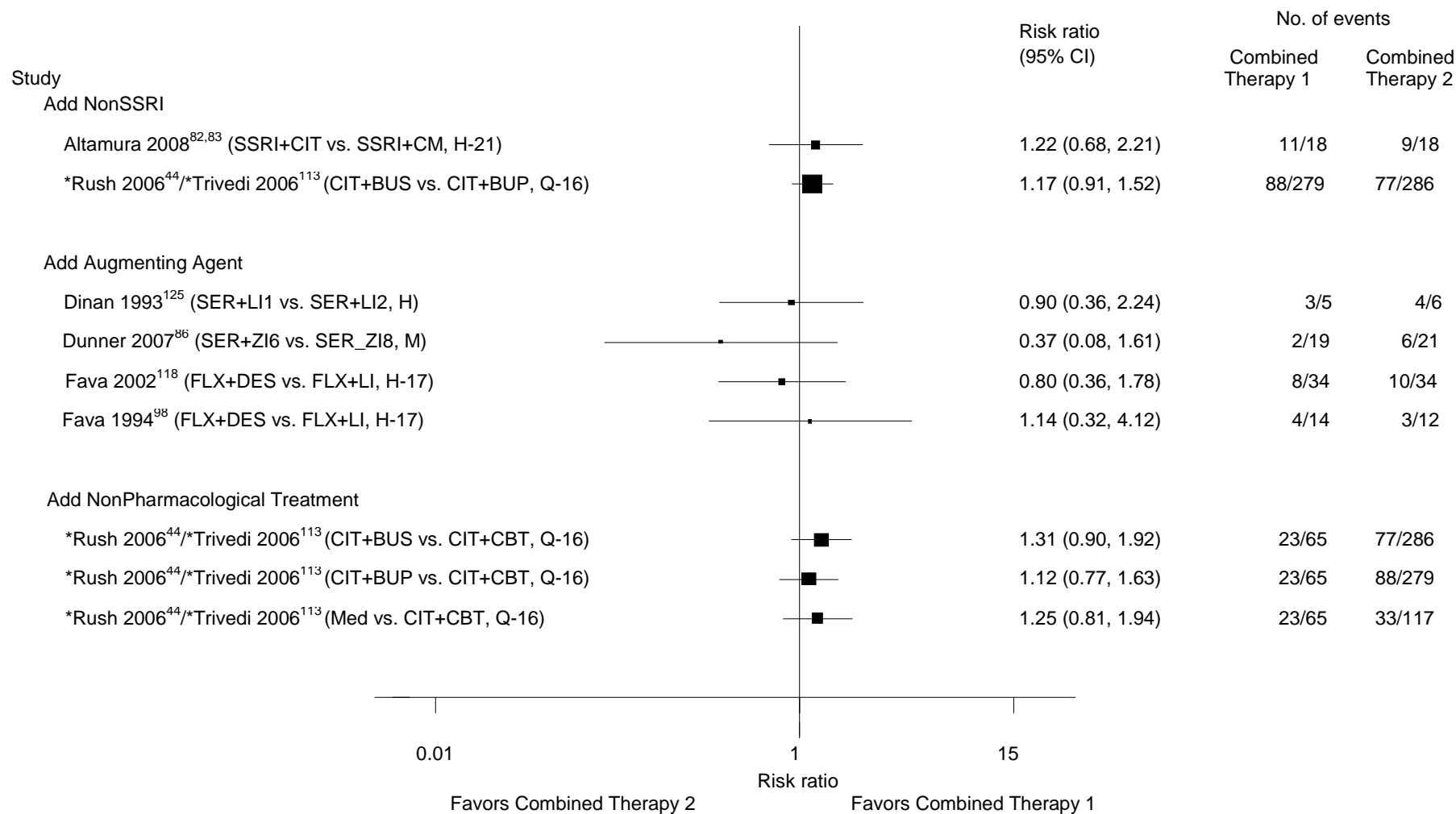
BUP = bupropion; CBT = cognitive behavioral therapy; CIT = citalopram; CM = clomipramine; DES = desipramine; FLX = fluoxetine; HAMD = Hamilton Depression Rating Scale; ME = mecamylamine hydrochloride; n = sample size; p = Probability; PBO = placebo; PI = pindolol; SSRI = selective serotonin reuptake inhibitors; QIDS-SR16 = Quick Inventory of Depressive Symptoms Self Report (16); TE = testosterone; VEN = venlafaxine

*The QIDS-SR reported outcomes.

^aNote that response was defined as 50 percent change relative to baseline unless noted within the table.

^bRemission was defined as the standard threshold value for the particular instrument.

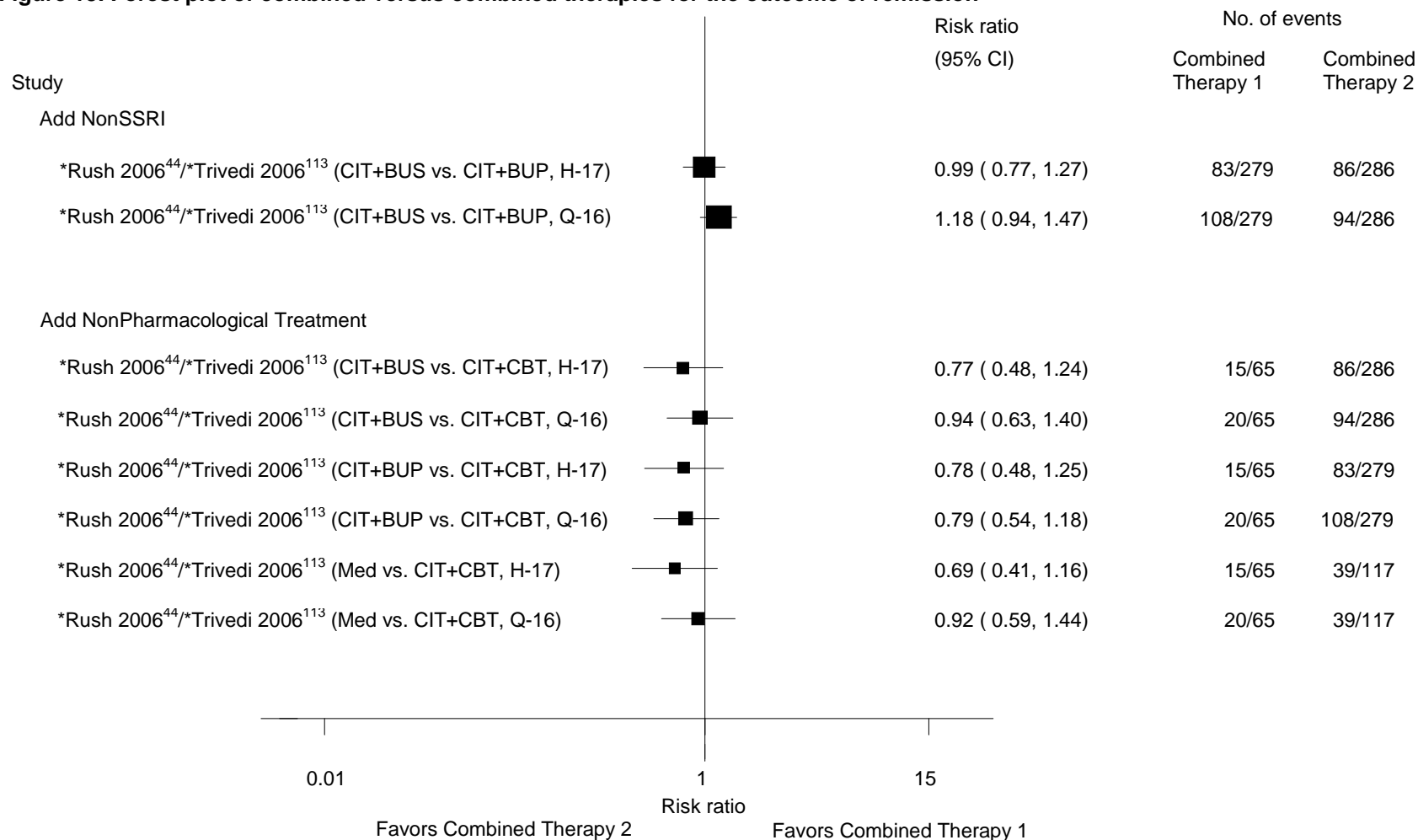
Figure 12. Forest plots of the combined versus combined therapies for the outcome of response



BUP = bupropion; BUS = buspirone; CBT = cognitive behavioral therapy; CIT = citalopram; CM = clomipramine; Med = medication; DES = desipramine; FLX = fluoxetine; H = Hamilton Depression Rating Scale; H-17 = Hamilton Depression Rating Scale – 17 item; H-21 = Hamilton Depression Rating Scale – 21 item; LI = lithium; M = Montgomery-Asberg Depression Rating Scale (MADRS); Q-16 = Quick Inventory of Depressive Symptoms Self Report (16); SER = sertraline; SSRI = selective serotonin reuptake inhibitors

*Represent STAR*D studies.

Figure 13. Forest plot of combined versus combined therapies for the outcome of remission



BUP = bupropion; BUS = buspirone; CBT = cognitive behavioral therapy; CIT = citalopram; H-17 = Hamilton Depression Rating Scale – 17 item; Med = medication;
Q-16 = Quick Inventory of Depressive Symptoms Self Report (16)

*Represent STAR*D studies.

Interventions in Patients With Subsyndromal Depression or Dysthymia

Overview of Study PICOT Characteristics: Subsyndromal Depression

Population

A single study¹²⁹ evaluated patients described as those “with residual symptoms of a depressive disorder” and characterized by a score greater than seven but less than 10 on the HAMD-21 items. These subjects were classified as having subsyndromal depression following an acute episode. Seventy percent of the subjects were women and ethnicity was not reported. Mean age was 39 years.

Inadequate Response

There were no specific criteria reported for previous failure to paroxetine other than having residual symptoms and having been treated for 42 to 300 days.

Mental Health History

Failure of response to paroxetine was determined prospectively over a 4-week period. The subjects’ failure to respond to the current treatments were retrospective but the manner of determining this was not reported. Similarly, the history of any previous inadequate responses to treatment or length of the current episode was not reported.

Intervention and Comparators

In this study, subjects who had residual symptoms while on paroxetine were randomized to a continuation of paroxetine (20 to 40mg/d) or switched to mirtazapine (15 to 30mg/day) for an average of 36 days.

Outcomes

The primary outcomes in this study were rated on the HAMD-21. Changes in metabolic rate values and changes in the Arizona Sexual Experience Scale (ASEX) score showed no differences between groups.

Setting

This study was conducted in the Czech Republic and the setting from which patients were recruited was not reported.

Risk of Bias: Subsyndromal Depression

In this study, the type of randomization process and the degree of compliance was not clearly reported; all other categories were acceptable.

Efficacy of Treatment: Subsyndromal Depression

The findings of this study do not report differences between groups; rather, it is reported that 70 percent of subjects had a positive effect on residual symptoms but no mean change scores

were given. Differences between groups were shown on the ASEX Scale in favor of mirtazapine starting from the first week of treatment ($p = 0.004$).

Overview of Study PICOT Characteristics: Dysthymia

Population

One study¹¹⁷ evaluated subjects with dysthymia as diagnosed by the DSM-IV structured clinical interview and with a score of 12 or more on the HAMD-21 scale. Subjects with MDD or other types of depression (e.g., partial remission from depression) were excluded. Sixty-eight percent of the sample were women and the mean age was 42 years. Ethnicity was not reported.

Inadequate Response

Subjects were not excluded because of failures (other than the current response to paroxetine). The number of previous episodes of failure to treatment was not reported, but the mean duration of the depression was approximately 12 years with an onset at approximately 29 years of age.

Mental Health History

The subjects' failure to the current treatment was retrospective but the manner of determining this was not reported. Similarly, the history of any previous inadequate responses to treatment or length of the current episode was not reported.

Intervention and Comparators

Subjects were randomized to either paroxetine (40mg/d) or paroxetine (20mg/d) and amisulpride (50mg/d).

Outcomes

The primary outcome for the study was response (defined as 50 percent change from baseline) for the HAMD (type not specified) and a score of one or two on the CGI-2. Remission was a secondary outcome and was not explicitly defined, but was assumed to be defined as a score on the HAMD.

Setting

The study was conducted in Italy and subjects were recruited from outpatient settings.

Risk of Bias: Dysthymia

This paper was at low risk of bias and there was only uncertainty around the role of the study sponsor.

Efficacy of Treatment in Dysthymia

Fifty-four percent of subjects on paroxetine alone and 56 percent in the combined group achieved response (50 percent change) on the HAMD-NS. Remission was defined as a score of seven or less and those achieving remission were 32 percent for paroxetine alone and 44 percent for the combination treatment group. Neither response nor remission was shown to be statistically different between the treatment groups.

Adolescents

Overview of Study PICOT Characteristics: Adolescents

There were three studies (13 publications)^{42,138-149} evaluating adolescents who had not responded to previous SSRI treatment, and from these one trial^{139,142,143} could not have data extracted. This study did have “Phase II” subjects (those who had an inadequate response) and two of the three study arms were eligible for this review (medication or CBT). Proportions of subjects who reached this stage were reported and contact with the authors confirmed that data are not currently available for Phase II subjects. The two other trials evaluated dose escalation of fluoxetine¹³⁸ or switch to other antidepressants with and without the addition of CBT.^{42,140,141,144-149}

Population

Two studies evaluated children or adolescents with MDD. In the dose escalation study^{42,138} the eligibility criteria included children (aged 8 to 12 years) and adolescents (age 13 to 18 years). The mean age was 12 and 14 in the two groups respectively, but there were significantly more children (less than 13 years old) in the lower dose group. The majority (60 percent) were males and of Caucasian ethnicity (87 to 93 percent). In the Treatment for Resistant Depression in Adolescents (TORDIA) study,^{42,140,141,144-149} the majority of the sample (68 to 72 percent) were female adolescents from age 12 to 18; the average age was 16 years (SD 1.6) and predominately (>80 percent) of white race.

Inadequate Response

In the TORDIA trial, subjects who were currently taking an SSRI were established retrospectively. In this trial, subjects who had previously failed two or more adequate trials of an SSRI, who had a history of nonresponse to venlafaxine, or nonresponse to CBT (≤ 7 sessions), were excluded. Potential participants who were receiving CBT or were on other medications with psychoactive properties were also excluded. Inadequate response was defined as less than 30 percent change on the Children’s Depression Rating Scale–Revised (CDRS-R) for those who still had a score greater than or equal to 40 on this scale, and were in treatment on an SSRI for a minimum of 8 weeks. In the dose escalation study,¹³⁸ inadequate response was similarly defined as a CDRS-R score with less than a 30 percent change after 8 weeks at the base dose of 20mg/d.

Mental Health History

The dose escalation study¹³⁸ did not provide details of the previous mental health history; eligibility for this trial required moderate severity (CDRS-R score greater than 40) and a CGI of at least four. In the TORDIA trial,^{42,140,141,144-149} mean CDRS-R scores at baseline varied from 58 to 60 (19 to 22 on the Beck Depression Inventory–BDI) and CGI scores from 4.4 to 4.5. Approximately 74 percent of participants were in a first episode of depression; the mean duration of the current episode varied from 21 to 24 months. Approximately 25 percent of participants had a history of suicide attempts (varying from 21 to 27 percent). The level of comorbidity was significant in this group and approximated 36 percent for anxiety disorder and post-traumatic stress disorder (21 to 24 percent post-traumatic stress disorder alone), 14 to 18 percent for attention deficit hyperactivity disorder, and 27 to 32 percent for dysthymia. However, there were no differences in rates of comorbidity between the four treatment groups.

Intervention and Comparators

The initial dose of 20mg/d of fluoxetine was increased to 40mg/d in the dose-escalated group; this could be increased to 60mg/d after 4 weeks. The length of treatment was 10 weeks. In the TORDIA trial, study subjects were randomized to four treatment arms that included venlafaxine alone (up to 150mg/d), venlafaxine combined with CBT, citalopram, fluoxetine, or paroxetine (up to 40mg/d for all SSRIs) alone, or with CBT. CBT consisted of up to 12 (60 to 90 minute) sessions and one quarter to one half consisted of sessions with the family. The reported mean number of sessions was 8.3 across treatment groups. Subjects were tapered off the initial SSRI. All participants received family psychoeducation which consisted of providing information about depression, adverse events, and coping with mood disorders. The treatment interval was 12 weeks. After 12 weeks of treatment, responders could continue in their assigned treatment arm, and no-responders received open-label treatment for an additional 12 weeks (24 weeks total). Open treatment was not controlled and could result in a switch to a new antidepressant, dose increase (for those not at the maximum dose), augmentation, or the addition of CBT or other psychotherapy.

Outcome

Both studies had two primary outcomes based on “adequate clinical response” defined as a score of two or less on the CGI Improvement subscale and a 50 percent improvement on the CDRS-R.

Setting

These studies were conducted in the United States and subjects were recruited from clinical sources and public advertisements (newspapers and radio) for both studies.

Risk of Bias in Studies With Adolescents

The dose escalation trial¹³⁸ was generally well conducted, but the two treatment groups had some differences at baseline, even though the mean age was similar. Additionally, the primary author is employed by the study sponsor. The TORDIA trial had some potential threats to validity with regards to the method of allocation, concealment and blinding of the outcome assessor; there was low risk of bias in all other aspects of the study. A washout period for subjects on an SSRI other than fluoxetine was undertaken for 2 weeks prior to switching to the new intervention. The method of assessing compliance with the treatment was not reported, but the proportion of subjects who did not comply was reported. Overall, the TORDIA trial had a low risk of bias.

In the TORDIA trial, treatment fidelity for the CBT was well detailed and approximately 94 percent of reviewed tapes were found to be acceptable by on-site supervisors and by an external consultant.

Efficacy of Treatment in Adolescents

Response and Remission

In the dose escalation study,¹³⁸ response was achieved by 5 of 15 and 10 of 14 subjects in the low- and high-dose groups respectively; the study was not powered to detect differences between groups although the investigators noted that there were no statistically significant differences

between the groups. Similarly, there were no significant differences between groups when considering mean CGI improvement scores.

Table 16 details the study findings for the TORDIA trial findings at 12 weeks.^{144,145,147,148} There were no statistically significant differences between the medication alone groups. There was a statistically significant difference between the CBT groups in favor of including CBT for all outcomes. The main effect of CBT was consistent even after controlling for baseline severity factors (BDI scores and post-traumatic stress).

At the 24-week followup, adolescents within the TORDIA trial showed continued improvement.^{146,149} After 12 weeks of treatment, responders could continue in their assigned treatment arm, and nonresponders received open-label treatment for an additional 12 weeks (24 weeks total). Open treatment was not controlled and could result in a switch to a new antidepressant, dose increase (for those not at the maximum dose), augmentation, or the addition of CBT or other psychotherapy. From the original sample (n=334) only 78.1 percent (n=261) were assessed at 24 weeks. The findings at 24 weeks suggest that the likelihood of remission was higher and time to remission was faster for those who showed clinical response at 12 weeks, relative to those who did not show response by 12 weeks (61.6 percent versus 18.3 percent).¹⁴⁶ Among all participants, failure to achieve remission at week 24 was associated with higher baseline depression, hopelessness, anxiety, and family conflict.¹⁴⁶

Table 16. Results from TORDIA trial for ITT sample at 12 weeks

ITT Sample	SSRI (n=168)	Venlafaxine (n=166)	No CBT (n=168)	CBT (n=166)
Response* (%)	79 (47.0)	80 (40.5)	68 (40.5)	91 (54.8)
CGI-I ≤2 (%)	86 (51.2)	92 (55.4)	80 (47.6)	98 (59.0)
Change CDRS-R ≥50 (%)	86 (51.8)	86 (51.8)	79 (47.0)	191 (60.8)

CBT = cognitive behavioral therapy; CDRS-R = Children's Depression Rating Scale- Revised; CGI-I = Clinical Global Impression – Improvement scale; ITT = intention to treat analysis; SSRI = selective serotonin reuptake inhibitors

*Response defined as "adequate clinical response" on the CGI-I.

Other Outcomes

Using the Children's Global Adjustment Scale, functional status was assessed in the TORDIA trial and no main effects or interactions were shown. For responders at week 12, 19.6 percent relapsed at 24 weeks; predictors of relapse were similar to those for lack of eventual remission and included higher baseline depression (via interview and self-report), poorer functioning, and presence of dysthymia.¹⁴⁶

A cost-effectiveness analysis was undertaken at 24 weeks within the TORDIA trial.¹⁴⁹ The analysis would suggest that adolescents receiving CBT with medication achieved 8.3 more depression free days, and 11 more depression improved days across 24 weeks of treatment. However, combination therapy was significantly more expensive than medication switch alone.¹⁴⁹

Strength of Evidence Ratings

Adults With MDD

We applied the criteria for grading the strength of evidence (SOE) to the studies and found that all studies directly evaluated the outcomes of remission and response and, as such, were not deficient in this domain. There was some variation in consistency of the effect depending on the

treatment strategy. In general, most studies had relatively few participants, and when studies were considered as a group, there was difficulty in demonstrating a clinically useful conclusion. Studies were not designed to establish equivalence, noninferiority, or superiority. The majority of the studies showed no differences between treatment groups, suggesting uncertainty about these differences. Even when studies were sufficiently powered for the primary outcome, a statistically significant difference between groups was rarely found, making clinical interpretation difficult with respect to selection of an optimal strategy relative to the standard or usual treatment.

The outcomes of harms are detailed in KQ2. When we evaluated the SOE of the studies that reported the harms of suicidality, weight gain, and sexual dysfunction, all treatment strategies in KQ1 were consistently rated as insufficient. Overall, we found few studies that reported on the harms of interest. The inability to distinguish if the studies measured these harms, or simply did not report them (either because no events occurred or they occurred at the lowest frequencies), made rating SOE problematic. We considered the measurement of these critical and important harms to be necessary for all studies given the potential of these serious adverse events in MDD and with most treatment approaches.

There were several issues with regard to applicability of the eligible studies. Overall, the studies were comprised of adult subjects that were not representative of the broader population who experience MDD and who might experience a failed response to an SSRI. Subjects were predominately white women between the ages of 40 to 50, and who had had more than one previous failure to treatment. For combined therapies, there was some concern about the dose and augmenting agent selection and the likely use of many of these in the context of primary care.

Monotherapy Versus Monotherapy in MDD

The grading of SOE for adults with MDD who have failed to respond to an SSRI is shown in Table 17. With respect to monotherapy compared with monotherapy interventions, we grouped all treatment approaches together, given the small number of studies and the various drugs and CBT. There were several important study limitations, in particular the lack of adequate randomization and the sample sizes of the studies. The confidence intervals were generally small and the effect sizes of similar magnitude were rated as consistent. All statistical testing undertaken in these studies showed no significant differences between groups, suggesting no advantage of any one monotherapy over another. None of the studies in this grouping explicitly stated that the trials were designed for establishing superiority. Overall, however, our rating of the SOE for all monotherapy strategies (dose escalation, switching to another antidepressant, or psychological intervention) was low. This suggests that future research would likely affect the estimates of effect sizes established in these studies.

Monotherapy Versus Combined Therapies in MDD

The SOE ratings for the studies comparing monotherapies to combined therapies is detailed in Tables 18 to 26. We considered these augmenting studies both as a single group (Table 18) and as subgroups related to the number of studies evaluating specific agents. There were four subgroups we considered with respect to specific classes of agents and these included: atypical antipsychotics, individual agents (e.g., buspirone, lithium, mianserin), and then all other agents were categorized as a single group for SOE rating.

When we considered all studies with augmenting agents (12 different types) as a single group, we rated the studies evaluating monotherapies relative to adding augmenting agents as insufficient SOE. The degree of similarity for the effect sizes was rated as inconsistent, despite the fact that almost all agents showed no relative difference relative to the monotherapy; the estimates tended to have wide confidence intervals and were not consistently overlapping. The large number of treatment agents, differing treatment intervals, population characteristics, and the wide range of sample sizes contributed to this grading of insufficient (Table 18).

When considering atypical antipsychotic medications alone, a SOE rating of low for the outcome of response and remission was given^{88,95,108,122} (Table 19). There was a consistent effect favoring combined treatment with atypical antipsychotics. One study with a small sample size showed very large confidence intervals¹²² for the outcome of response. Two studies^{95,108} showed larger confidence intervals for remission and this may be related to the “subgroup” data specific to the failed SSRI group that we requested from the study authors. The original study data included larger sample sizes as subjects with failed response to nonSSRI medications were included. For this reason, we rated these four studies as having consistency in showing the same direction of effect (favoring combined therapy), but as imprecise because of the nonoverlapping confidence intervals (as well as a small sample size in a single study and “some” studies).

The studies that used buspirone as the augmenting agent were separated into those that switched to a different antidepressant monotherapy (Table 20) versus those that added buspirone to the current SSRI (to which subjects had an inadequate response) (Table 21). The SOE was graded as insufficient for the latter category, as the studies were deemed to have a greater number of study limitations relative to the STAR*D trial^{44,113} that evaluated switching to new monotherapies. The STAR*D trial showed no difference when adding buspirone relative to the different monotherapies after switching to a new antidepressant.

The remaining groupings for augmenting agents for lithium (Table 22), mianserin (Table 23), and “other agents” combined (Table 24) were all graded as insufficient SOE due to the small sample sizes and significant study limitations. It is difficult to determine any level of confidence in the effects of these agents despite the fact that none were shown to be any different relative to the comparator monotherapy.

We grouped all studies that maintained the current SSRI and then compared this treatment arm with one where a different SSRI, nonSSRI, or nonpharmacological treatment was added (Table 25). This group of studies was rated as low for the outcome of response because of the differing agents and the small sample sizes. For the outcome of remission, a grading of insufficient was given, as the study limitations were significant. There were two studies that compared switching from the current SSRI to a new monotherapy treatment and then compared this with the new agent combined with any other drug. The studies that evaluated switching to a new antidepressant and then adding aripiprazole would have been included in this group, had we been able to acquire the rates of response and remission for the SSRI failed group. For the two studies that did provide these outcomes, one study¹¹² had wide confidence intervals and effect size because of the small sample size; the other study was the STAR*D cohort and had multiple treatment arms and comparisons. The evidence is graded as low and the findings suggest no relative advantage to switching to a new drug or CBT relative to adding buspirone or bupropion (Table 26).

Combined Therapy Versus Combined Therapy in MDD

A rating of insufficient for the SOE was given to the studies that compared combined therapies relative to other combined therapies (Table 27). The STAR*D study was the single study in this group reporting the outcome of remission. The studies comparing combinations relative to other combinations were consistent in that the relative risks were generally of the same magnitude and the effect sizes showed that no one combined therapy was different than any other, given the study limitations.

Table 17. SOE: Monotherapy versus monotherapy (pharmacological and nonpharmacological)

Quality Assessment							Summary of Findings			Importance	
							No. of Patients		Effect		Quality
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Mono 1	Mono 2	RR or (%)		
Outcome Response											
10 ^{44,88,90,103,104,106,110,112,115,119,121,122}	RCT/CCT	Limitations	Consistent	Direct	Imprecise	Diverse drug therapies Issues with applicability to populations in primary care	1225	1507	RR range (0. 27 to 1.28)	Insufficient	Critical
Outcome Remission											
8 ^{44,88,90,103,104,106,110,115,119,121}	RCT/CCT	Limitations	Consistent	Direct	Imprecise	Diverse drug therapies Issues with applicability to populations	1209	1534	RR range (0. 36 to 1.81)	Insufficient	Critical
Outcome of Suicidality											
2 ^{44,103,106,113}	RCT/CCT	Limitations	N/A	Direct	NA	A/E NR in 9/11 studies Diverse drug therapies	N/A	N/A	% range (0.0 to 2.1)	Insufficient	Critical
Outcome of Weight Gain											
2 ^{88,103,106,119,121}	RCT/CCT	Limitations	N/A	Direct	N/A	A/E NR in 7/11 studies Diverse drug therapies	N/A	N/A	% range (2.0 to 39.7)	Insufficient	Important
Outcome of Sexual Dysfunction											
2 ^{90,103,106}	RCT/CCT	Limitations	N/A	Direct	N/A	A/E NR in 9/11 studies Diverse drug therapies	N/A	N/A	% range (2.1 to 9.0)	Insufficient	Important

A/E = adverse event; CCT = clinical controlled trial; N/A = not applicable; No. = number; NR = not reported; RCT = randomized controlled trial; RR = relative risk

Table 18. Monotherapy versus combined therapy (maintaining SSRI or switching AD versus adding any augmenting pharmacological agents)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
18 ^{44,80,84,86,88,89,93,97,98,108,112-114,118-122,124}	RCT/ CCT	Study limitations	Inconsistent	Direct	Imprecise	Diverse augmenting agents (n=12) Applicability issues with population, interventions, and comparators	1137	1904	RR range 0.40 to 13.0	Insufficient	Critical
Outcome Remission											
8 ^{44,87,88,95,101,108,112-114,119,132}	RCT/CCT	Study limitations	Inconsistent	Direct	Imprecise	Diverse augmenting agents (n=7) Applicability issues with population, interventions, and comparators	1679	951	RR range 0.72 to 4.7	Insufficient	Critical
Outcome of Suicidality											
2 ^{44,89,113}	RCT/CCT	Study Limitiations	N/A	Direct	N/A	Diverse augenting agents	N/A	N/A	% range (0.83 to 1.4)	Insufficient	Critical
Outcome of Weight Gain											
3 ^{88,119,121}	RCT/CCT	Study Limitations				Diverse augmenting agents	N/A	N/A	% range (0.0 to 39.7)	Insufficient	Important
Outcome of Sexual Dysfunction											
1 ⁸⁴	RCT	Study limitations	N/A	Direct	N/A		N/A	N/A	% range (10 to 45)	Insufficient	Important

AD = antidepressant; A/E = adverse event; CCT = clinical controlled trial; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk

Table 19. Monotherapy versus combined therapy (maintaining SSRI and adding or switching atypical antipsychotics agents)*

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
3 ^{88,108,122}	RCT	Study Limitations	Consistent	Direct	Imprecise	"Some" studies*	290	492	RR range 1.37 to 13.0	Low	Critical
Outcome Remission											
3 ^{88,95,108}	RCT	Study Limitations	Consistent	Direct	Imprecise	"Some" studies*	327	496	RR range 1.63 to 4.74	Low	Critical
Outcome of Suicidality											
0	RCT	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Weight Gain											
1 ⁸⁸	RCT	Study Limitations	N/A	Direct	N/A		N/A	N/A	% range (6.8 to 35)	Insufficient	Important
Outcome of Sexual Dysfunction											
0	RCT	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Important

A/E = adverse event; N/A = not applicable; No. = number; RCT = Randomized controlled trial; RR = relative risk

*Two studies had some proportion of the enrolled subjects that had failed to an SSRI alone. Request for stratified information was not provided for adverse events. Abbreviations:

Table 20. Monotherapy versus combined therapy (switching AD and adding Buspirone)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
							Combined Therapy	Mono-therapy	RR or (% A/E)		
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations					
Outcome Response											
1 ^{44,113}	RCT	Study Limitations	Consistent	Direct	Imprecise	STAR*D	286	727	RR range (0.96 to 1.02)	Low	Critical
Outcome Remission											
1 ^{44,113}	RCT	Study Limitations	Consistent	Direct	Imprecise	STAR*D	286	727	RR range (1.21 to 1.70)	Low	Critical
Outcome of Suicidality											
1 ^{44,113}	N/A	Study Limitations	N/A	Direct	N/A	STAR*D	N/A	N/A	% range (0.83 to 1.4)	Insufficient	Critical
Outcome of Weight Gain											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Sexual Dysfunction											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical

AD = antidepressant; A/E = adverse event; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk; STAR*D = sequenced treatment alternatives to relieve depression

Table 21. Monotherapy versus combined therapy (maintaining SSRI and adding Buspirone)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
2 ^{97,120}	RCT/CCT	Study Limitations	Consistent	Direct	Imprecise		108	111	RR range 1.06 to 1.09	Insufficient	Critical
Outcome Remission											
0	N/A	N/A	N/A	Direct	N/A	From 2 studies none reported outcome	N/A	N/A	N/A	Insufficient	Critical
Outcome of Suicidality											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Weight Gain											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Sexual Dysfunction											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical

A/E = adverse event; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk; SSRI = selective serotonin reuptake inhibitors

Table 22. Monotherapy versus combined therapy (maintaining SSRI and adding Lithium agents)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
3 ^{98,112,118,124}	RCT	Study Limitations	Inconsistent	Direct	Imprecise		67	81	RR range 0.40 to 4.20	Insufficient	Critical
Outcome Remission											
1 ¹¹²	RCT	Study Limitations	N/A	Direct	Imprecise		9	32	N/A	Insufficient	Critical
Outcome of Suicidality											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Weight Gain											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Sexual Dysfunction											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical

A/E = adverse event; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk; SSRI = selective serotonin reuptake inhibitors

Table 23. Monotherapy versus combined therapy (maintaining SSRI and adding Mianserin agents)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
2 ^{119,121}	RCT	Study Limitations	Inconsistent	Direct	Imprecise		130	269	RR range 0.97 to 1.70	Insufficient	Critical
Outcome Remission											
1 ¹¹⁹	RCT	Study Limitations	N/A	Direct	Imprecise	Dose study	98	197	RR range 1.17 to 1.54	Insufficient	Critical
Outcome of Suicidality											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Weight Gain											
2 ^{119,121}	RCT	Study Limitations	N/A	Direct	N/A		N/A	N/A	% range (2.0 to 15.8)	Insufficient	Critical
Outcome of Sexual Dysfunction											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical

A/E = adverse event; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk; SSRI = selective serotonin reuptake inhibitors

Table 24. Monotherapy versus combined therapy (maintaining SSRI and adding other augmenting agents)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
6 ^{80,84,86,89,93,114}	RCT	Study Limitations	Inconsistent	Indirect	Imprecise		235	227	0.23 to 4.55	Insufficient	Critical
Outcome Remission											
2 ^{87,101,114,132}	RCT	Study Limitations	Consistent	Indirect	Imprecise		230	227	1.06 to 1.20	Insufficient	Critical
Outcome of Suicidality											
1 ⁸⁹	RCT	Study limitations	N/A	Direct	N/A		N/A	N/A	% range (10 to 45)	Insufficient	Important
Outcome of Weight Gain											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Important
Outcome of Sexual Dysfunction											
1 ⁸⁴	RCT	Study limitations	N/A	Direct	N/A		N/A	N/A	% range (10 to 45)	Insufficient	Important

A/E = adverse event; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk; SSRI = selective serotonin reuptake inhibitors

Table 25. Monotherapy versus combined therapy (maintaining SSRI and adding another treatment, nonSSRI, SSRI and nonpharmacological)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
4 ^{82,83,94,98,118}	RCT	Study limitations	Inconsistent	Direct	Imprecise	Diverse interventions Issues with applicability	74	76	RR range 0.47 to 19.00	Insufficient	Critical
Outcome Remission											
1 ¹²⁸	RCT	Study limitations	N/A	Direct	Imprecise		20	12	1.20 [CI 0.61 to 2.34]	Insufficient	Critical
Outcome of Suicidality											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Weight Gain											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Sexual Dysfunction											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical

A/E = adverse event; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk; SSRI = selective serotonin reuptake inhibitors

Table 26. Monotherapy versus combined therapy (switching monotherapy versus adding another treatment, nonSSRI, SSRI, and nonpharmacological)

Quality Assessment							Summary of Findings				
							No. of Patients		Effect	Quality	Importance
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combined Therapy	Mono-therapy	RR or (% A/E)		
Outcome Response											
2 ^{44,106,110,113}	RCT/ CCT	Study Limitations	N/A	Direct	Imprecise	STAR*D	353	776	RR range 0.4 to 1.02	Low	Critical
Outcome of Remission											
1 ^{44,110,113}	RCT/CCT	Study Limitations	N/A	Direct	Imprecise	STAR*D	344	763	1.21 to 1.70	Low	Critical
Outcome of Suicidality											
1 ^{44,110,113}	N/A	N/A	N/A	Direct	N/A	STAR*D	N/A	N/A	% range (0.83 to 1.4)	Insufficient	Critical
Outcome of Weight Gain											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical
Outcome of Sexual Dysfunction											
0	N/A	N/A	N/A	Direct	N/A		N/A	N/A	N/A	Insufficient	Critical

A/E = adverse event; CCT = controlled clinical trial; N/A = not applicable; No. = number; RCT = randomized controlled trial; RR = relative risk; SSRI = selective serotonin reuptake inhibitors; STAR*D = sequenced treatment alternatives to relieve depression

Table 27. Combined therapy versus combined therapy (pharmacological and nonpharmacological)

Quality Assessment							Summary of Findings				Importance
							No. of Patients		Effect	Quality	
No. of Studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other Considerations	Combo 1	Combo 2	RR or (% A/E)		
Outcome Response											
6 ^{44,82,83,86,98,10,118,125}	RCT/CCT	Limitations	Consistent	Direct	Imprecise	Diverse interventions	434	377	RR range 0.37 to 1.36	LOW	Critical
Outcome Remission											
6 ^{44,82,83,86,98,10,118,125}	RCT/CCT	Limitations	Consistent	Direct	Imprecise	Diverse interventions	344	286	RR range 0.69 to 1.0	LOW	Critical
Outcome of Suicidality											
1 ¹¹³	RCT/CCT	Limitations	N/A	Direct	N/A		N/A	N/A	% range (0.4 and 1.4)	Insufficient	Critical
Outcome of Weight Gain											
0	RCT/CCT	Limitations	N/A	Direct	N/A		N/A	N/A	NR	Insufficient	Important
Outcome of Sexual Dysfunction											
0	RCT/CCT	Limitations	N/A	Direct	N/A		N/A	N/A	NR	Insufficient	Important

A/E = adverse event; CCT = clinical controlled trial; N/A = not applicable; No. = number; NR = not reported; RCT = randomized controlled trial; RR = relative risk

Adults With Dysthymia and Subsyndromal Depression

The studies evaluating these populations were each limited to a single trial. One study with patients with subsyndromal depression¹²⁹ had significant risk of bias and poor reporting; as such we rate this as insufficient SOE. The study on dysthymia¹¹⁷ had low risk of bias, but had a very small sample size, and the study subjects were predominately middle aged white females. For this reason we have judged this study as insufficient SOE.

Adolescents

From two studies reporting outcomes on children and adolescents, one was a pilot study evaluating dose escalation.¹³⁸ The TORDIA trial^{42,141,144-149} evaluating efficacy of monotherapy relative to combined therapy was at low risk of bias and evaluated and reported harms well. Study findings showed no significant differences between groups. Although the intent of the trial was specified as establishing the superiority of the venlafaxine monotherapy arm, the margins of superiority and the statistical analysis for this were not reported. The SOE was judged as a low grade.

KQ2. What are the harms of each of the monotherapies or combined therapies among these adults and adolescents? How do the harms compare across different interventions?

Key Messages

Harms for interventions used in both adults and adolescents with MDD that had failed to respond to an SSRI were predominantly derived from RCTs that evaluated treatment strategies in this population; no observational studies were eligible. A clear trend for harms was difficult to specify across the differing interventions in adults. Harms were well evaluated in the one study of adolescents and a pilot dose escalation study.

Reporting and collecting of harms was problematic, particularly for predefining harms including serious and severe events, and reporting the total number of events per group in the studies with adults. The studies evaluating harms in adolescents provided high quality evidence for harms within this population when receiving pharmacological and psychological treatment.

Severe events and serious events (including suicidality) were inconsistently reported in studies with adult MDD populations.

A limited number of studies undertook statistical evaluation comparing harms between groups.

Harms in Adults With MDD, Dysthymia, and Subsyndromal Depression

From the 41 studies evaluating adults, all but one study included subjects with MDD; two studies evaluated subjects with subsyndromal depression¹²⁹ and dysthymia.¹¹⁷ As noted previously, five studies^{107,150,178-180} and seven STAR*D publications¹⁸¹⁻¹⁸⁷ did not have data that could be extracted. No observational studies with the required patient population and evaluation of harms was eligible for this CER. The summary of harms thus reflects those reported within the eligible studies.

We present the harms evidence for the eligible and extracted studies based on the type of treatment comparisons as follows: (1) monotherapy compared with monotherapy; (2) monotherapy compared with combined therapy; and, (3) combined therapy compared with combined therapy. Some studies evaluated more than two treatment arms, and are included in multiple sections, dependent on the drugs used.

Description of Studies Reporting Harms in Adults With MDD

Monotherapy Versus Monotherapy in Adult MDD

In the six studies having at least one monotherapy treatment arm, all but one study¹¹² reported some aspect of safety and tolerability. None of the studies were specifically designed to compare the effect of harms between different monotherapies. One study¹¹⁵ included a proportion of subjects who had failed to respond to an SSRI; following email contact with the author, stratified information for outcomes of benefit (not harm) were provided.

The method of assessing adverse events differed greatly among studies, with a limited number of studies using standardized methods or scales. Figure 14 shows the ratings on the McHarm scale for evaluating risk of bias and reporting within comparative studies. Forty percent of the studies indicated that the harms reported were those that were observed in 2 or 3 percent,^{103,106} 5 percent,^{85,119} or 10 percent of subjects;^{88,90} the remaining studies did not specify, or were unclear as to why the harms reported were included. None of the studies provided any a priori definitions of the harms, or of serious or severe events. Similarly, the mode of how harms were collected or the training of the person collecting them was not specified. Generally, the number of subjects who withdrew were specified per treatment arm; however, the number of specific adverse events per treatment arm were not well specified (50 percent).

Figure 14. Ratings of studies evaluating monotherapies using the McHarm criteria for risk of bias and reporting of harms

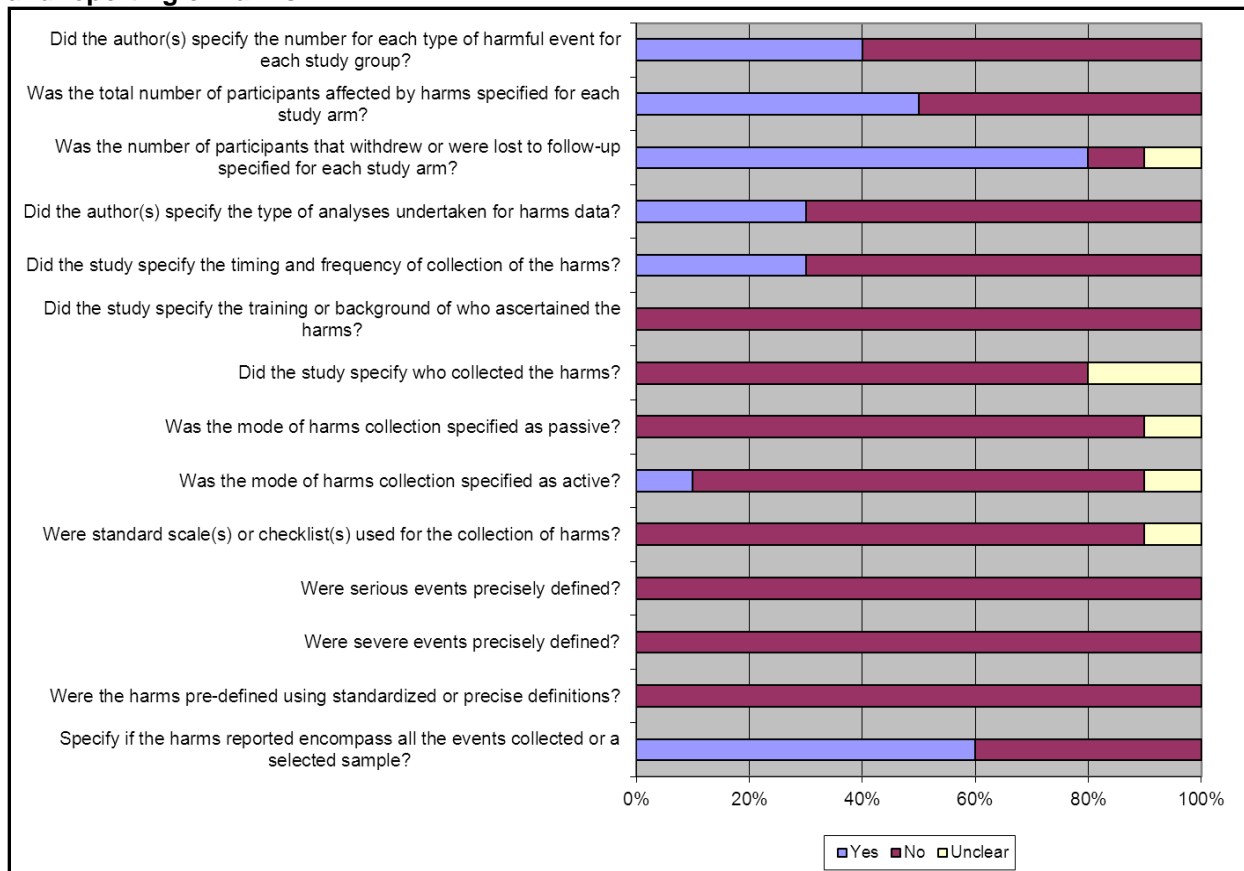


Table 28 shows the rates of reported harms as a function of the treatment arm. Seven main categories of harms were selected to include within the summary table, but others were reported within the studies. The STAR*D cohort reported only the frequency of events as a range from one to 100 percent, not specifying the types of events as individual frequencies, and similarly identified numbers of serious events as having “at least” one event.^{110,113} One study explicitly identified that no serious events had occurred,⁸⁸ and three studies (five publications) identified suicide events had explicitly not occurred;^{44,103,106,110,113} for the STAR*D, trials we assumed that serious psychiatric events encompassed suicidality. Rates of discontinuation due to adverse events were variable. In studies with open label prospective failure components, the number of patients who had adverse events and did not proceed to the next phase was not consistently reported. In studies with historical failure, the proportion of subjects who had experienced inadequacy due to intolerance because of harms was not detailed.

Two studies reported on both serious and suicide related events.^{44,103,106,110} Other adverse events not reported in Table 28 include dry mouth,^{88,103,106,119,121} dizziness,^{103,106,121} and fatigue.^{88,121} Increased appetite or weight gain was reported in two studies.^{88,122}

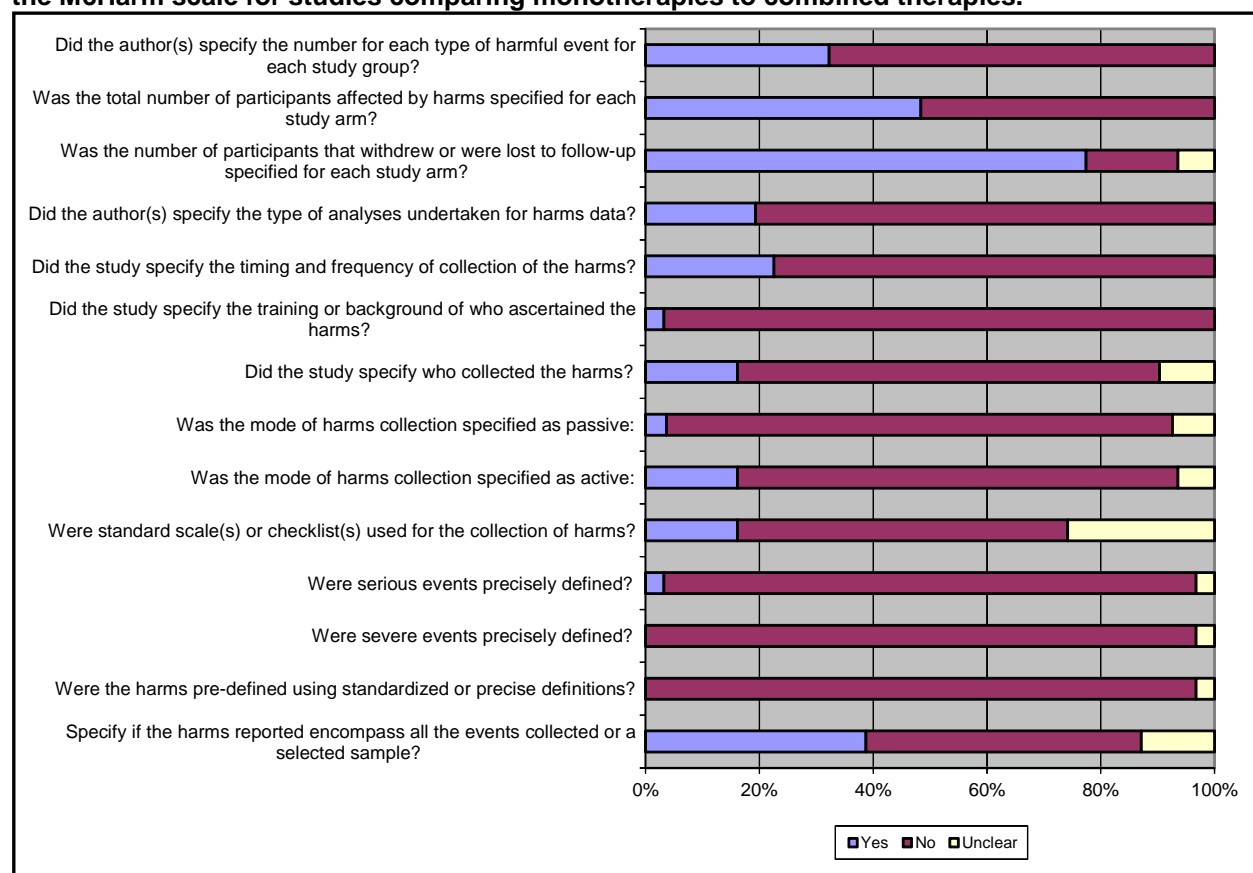
Four studies^{88,103,106,119,122} evaluated statistical differences in rates of harms, however, two of these primarily evaluated the comparisons for the monotherapy group relative to the combined therapy group.^{88,119} Another study^{103,106} evaluated differences between two methods of switching from an SSRI to duloxetine; no statistical differences were found between the two methods.

Monotherapies Versus Combined Therapies in Adult MDD

Table 29 details the reporting of harms in studies comparing monotherapies to combined therapies. One study¹¹² reported harms when evaluating monotherapies relative to combined therapies. Only one study¹¹⁴ was designed to assess the effect of therapies for both efficacy and harms in patients who had excess sleepiness and fatigue despite previous adequate SSRI treatment. The subjects in this trial were partial responders for the current episode. This study included specific measures of sleepiness and fatigue as part of the primary outcomes.

The method of assessing adverse events differed greatly among studies, with a limited number of studies using standardized methods or the use of scales to assess harms. Figure 15 shows the ratings on the McHarm scale for evaluating risk of bias and reporting within comparative studies. Eleven studies (40 percent) indicated that the harms reported were those that were observed in two to three percent,¹⁰⁸ five percent,^{79,87,101,105,109,114,119,126,131,132} or 10 percent of subjects;^{86,88,124} however, three of these studies did not report harms specific to the SSRI subgroup.^{79,105,108,109,126,131} The remaining studies did not specify why the harms reported were included or were unclear (20 percent). All but one study⁸⁰ provided a priori definitions for serious harms. Similarly, definitions for predefining the harms or how these would be classified as severe were not detailed in any study (Figure 16). The mode of collecting harms was unclear or not identified in all but three studies,^{91-93,97,130} which collected reports of harms, or their training was rarely specified. Generally, the number of subjects who withdrew were specified per treatment arm, and the total number of adverse events was generally reported.

Figure 15. Percent of studies evaluated using the criteria for risk of bias for adverse events using the McHarm scale for studies comparing monotherapies to combined therapies.



Fifteen of 29 studies indicated that some type of statistical comparison between groups had been undertaken; however, only five studies^{44,87,93,101,122,124,132} specified the type of analyses and the remaining ones did not.^{79,84,88,95,97,105,108,109,114,119,120,126,131} One study⁸⁸ showed that weight gain, dry mouth, somnolence, peripheral edema, and hypersomnia differed between the combined fluoxetine and olanzapine group relative to the fluoxetine group; rates were higher in the combined group. In this same study no differences in rates of adverse events were shown between the combined group relative to olanzapine monotherapy. Another study evaluating olanzapine showed differences relative to baseline but not between treatment groups.¹²²

Another study¹¹⁹ evaluated differences between two monotherapy doses, or sertraline and sertraline combined with mianserin; statistical differences were shown only for the adverse event of sedation, with rates being higher in the combined therapy group. One study¹¹⁴ showed statistical differences in nausea and feeling jittery for the combined SSRI and modafinil group.

There were four studies^{79,95,105,108,109,126,131} that provided stratified outcomes of benefit for the SSRI subgroup alone. However, these studies did not provide stratified event rates for harms; as such, the rates of harms are not detailed as they reflect mixed antidepressant effect. For two studies^{79,105,109,131} the pooled analyses publication¹²⁶ indicated that there were no differences between groups due to the antidepressant; this pooled analysis found that the combined therapy group with aripiprazole had approximately twice the incidence of adverse events (akathisia, restlessness, insomnia, fatigue, blurred vision, and constipation). The harms in another study⁹⁵ were evaluated statistically and did not differ between antidepressants alone or combined with risperidone groups. Another study found rates of events to be similar between antidepressants

versus antidepressants combined with risperidone, but differences were not evaluated statistically.

Other adverse events not reported in Table 30 include dry mouth,^{86-88,101,103,106,114,118,119,121,132} dizziness,^{79,86,96,105,109,114,121,126,131} and fatigue.^{79,82,83,88,105,109,121,126,131} Increased appetite was reported in two studies,^{87,88,101,132} and cardiovascular problems (hypotension, tachycardia, or bradycardia) were identified in five studies.^{80,82-84,96,114} For nonpharmacological therapies, most studies assumed that there were no adverse events to report with exercise,¹²⁷ cognitive behavioral therapy,⁹⁴ or dialectical behavior therapy.¹²⁸

Combined Therapies Versus Combined Therapies in Adult MDD

From the six studies comparing combined therapies, none were designed to assess the effect of therapies on harms. The method of assessing adverse events differed greatly among studies with a limited number of studies using standardized methods or the use of scales to assess harms. Figure 16 shows the ratings on the McHarm scale for evaluating risk of bias specific to harms. A single study from the six specified that the harms reported represented those that were present in at least 10 percent of subjects.⁸⁸ The remaining studies did not specify, or were unclear as to, why the harms reported were included (85 percent). No study predefined the harms, or the severe or serious harms. The mode of collecting harms, who collected the harms reports, or their training was generally not specified. Generally, the number of subjects who withdrew were specified per treatment arm, and the total number of adverse events were reported.

Figure 16. Percent of studies evaluated using the criteria for risk of bias for adverse events using the McHarm scale for combined therapies alone.

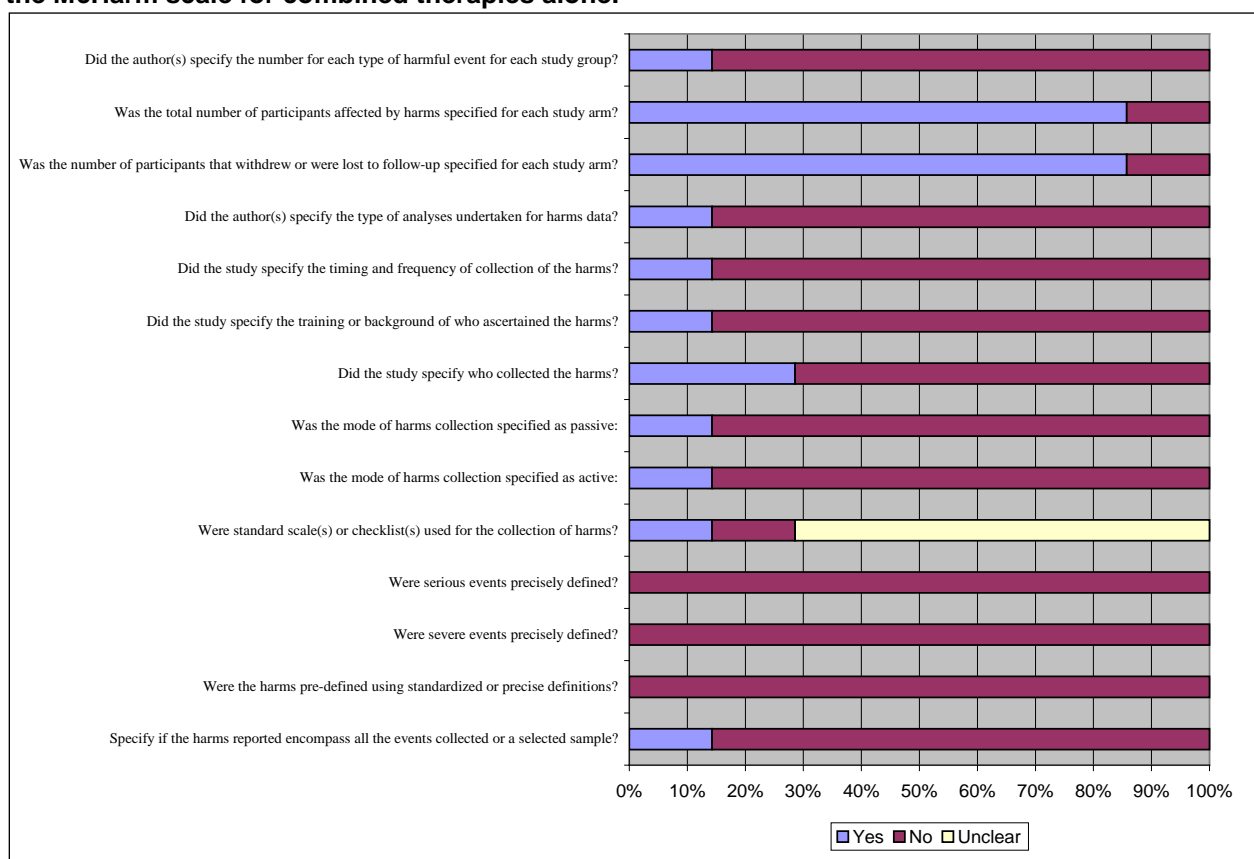


Table 30 shows the rates of reported harms as a function of the treatment arm. The STAR*D cohort reported only the frequency of events and did not specify the type of events or serious events. Two studies explicitly identified that serious events had occurred,^{44,110,113} or that suicide events had explicitly occurred. Rates of discontinuation due to adverse events were variable.

A single study¹¹³ reported evaluating statistical differences between groups. Other adverse events not reported in Table 30 include dry mouth,^{86,118} dizziness,⁸⁶ and fatigue,^{82,83} and cardiovascular problems (hyper- and hypotension, tachycardia, or bradycardia) were identified in one study.^{82,83}

Description of Harms in Studies With Dysthymia and Subsyndromal Depression

One study¹¹⁷ evaluated patients with dysthymia and found no differences between treatment groups (paroxetine vs. paroxetine + amisulpride). The presence of galactorrhoea and menstrual disorders were noted in 18 and 9 percent of female patients, respectively. These adverse events were not observed in the paroxetine alone group. Other harms reported included low rates of gastrointestinal problems, sexual dysfunction, dry mouth and headache, and some sexual dysfunction. Consistent with studies already described, this study did not predefine harms, serious or severe, and indicated that harms were assessed through “spontaneous” notification (passive methods). Nor was the training of the person collecting harms specified or the frequency and timing of collection. This study did account for all study withdrawals and adequately reported the total number of adverse events and as a function of groups for each type of harm.

The single study¹²⁹ evaluating harms in patients with subsyndromal depression (following an acute episode) primarily assessed safety and not efficacy. In addition, the study evaluated the relationship between adverse events and the corresponding metabolic status of the isoenzyme CYP 2D6; the rationale for this is that paroxetine is a potent inhibitor of this enzyme which may lead to increased adverse reactions. Adverse effects were measured using the Udvalg for Kliniske Undersøgelser (UKU) Side Effect Rating Scale and the ASEX Scale. The study showed no statistical difference in the UKU scale, and the ASEX scale showed an improvement from the first week of treatment in the mirtazapine group. Two subjects from the mirtazapine group discontinued due to problems with insomnia; no dropouts were reported for the paroxetine group.

Description of Harms in Studies With Adolescents

The TORDIA trial found no statistical differences between treatments with regard to the frequency of events, any serious adverse events (including suicide related symptoms), or dropouts related to adverse events at 12 weeks.^{42,140,141,144-149} Sleeping difficulty was the only psychiatric adverse event that occurred in greater than 5 percent of the subjects. Some harms showed a tendency for increased rates with the use of venlafaxine and these included skin rash and cardiovascular events;⁴² self-injury was also higher in those with higher suicidal ideation.¹⁴⁰ Further analysis of suicidal adverse events showed that predictors of suicidal adverse events were linked with poor response to treatment at 12 weeks.¹⁴⁰ The harms in the TORDIA study were collected using standardized instruments (4-item Kiddie Schedule of Affective Disorders and the Side Effects form for Children and Adolescents) and collected in an active manner. Reports of serious effects or worsening symptoms were reviewed weekly with the investigative team. Once any concerns for safety were raised, participants were monitored weekly. All

subjects completed the standardized safety scales at each pharmacological visit. The reporting of harms was clear, but severe harms were not defined a priori. Withdrawals were well described.

In the dose escalation study¹³⁸ there were no statistically significant differences between the lower or higher dose groups with respect to solicited or unsolicited adverse events.

The dose escalation study¹³⁸ used the Side-Effects Checklist and the reported harms were coded according to standardized terms. Description of serious events was not specified. Harms were assessed every two weeks.

Table 28. Summary of reported rates of harms for studies comparing monotherapy treatments

Study	Duration (Weeks)	n*	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache n (%)	Sexual Dysfunc-tion n (%)	With-drawals due To A/E n (%)	Serious Events n (%)	Suicide n (%)
Switch and/or Change Dose													
Licht ¹¹⁹ 2002	6	99	SER 100 + PBO	NR	12 (12.2)	16 (16.4)	4 (4.1)	3 (3.1)	2 (2)	NR	45 (45)	NR	NR
		98	SER 200 + PBO	NR	16 (16.3)	16 (16.3)	10 (10.2)	2 (2)	7 (7.1)	NR	54 (55)	NR	NR
Ruhe ¹⁰⁴ 2008	6	30	PAX 20 + PBO	7 (23.3)	NR	NR	NR	NR	NR	NR	0 (0)	NR	NR
		30	PAX 30-50 + PBO	5 (16.7)	NR	NR	NR	NR	NR	NR	4 (13)	NR	NR
Thase ⁹⁰ 2006	8	119	VEN-ER 148mg/d	NR	20 (17)	35 (29)	19 (16)	NR	37 (31)	10 (8)	13 (11)	NR	NR
		113	VEN-ER 309mg/d	NR	23 (20)	31 (27)	31 (27)	NR	47 (42)	10 (9)	15 (13)	NR	NR
Switch Antidepressant													
Birkenhager ¹¹⁵ 2004	5	30	TCP 61mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		28	PLZ 79mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Bondolfi ¹¹² 2006	4	19	PAX 40mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		9	VEN 150mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lenos-Smith ⁸⁵ 2006	12	200	VEN-ER 75-300mg/d	11 (5.5)	NR	28 (14.1)	9 (4.6)	NR	31 (15.6)	NR	NR	NR	NR
		206	CIT 20-60mg/d	16 (7.6)	NR	34 (16.6)	15 (7.3)	NR	32 (15.6)	NR	NR	NR	NR
Rush ⁴⁴ 2006	12	238	SER 50-200mg/d	NR	NR	NR	NR	NR	NR	NR	NR	11 (4.6)	2 (0.84)
		250	VEN 37.5-375mg/d	NR	NR	NR	NR	NR	NR	NR	NR	5 (2)	0
		239	BUP 150-400mg/d	NR	NR	NR	NR	NR	NR	NR	NR	6 (2.5)	2 (0.83)
Perahia ^{103,106} 2008	10	183	direct switch duloxetine 60-120mg/d	NR	8 (4.3)	33 (18)	13 (7.1)	2 (2.1)	24 (13.1)	6 (3.2)	100 (54.6)	5 (2.7)	2 (2.1)
		185	start-taper switch duloxetine 60-120mg/d	NR	13 (7)	37 (20)	15 (8.2)	6 (3.2)	18 (9.7)	2 (2.1)	93 (50.3)	2 (2.1)	0

Table 28. Summary of reported rates of harms for studies comparing monotherapy treatments (continued)

Study	Duration (weeks)	n*	Comparison and dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI problems n (%)	Sleep problems n (%)	Weight gain n (%)	Head-ache (n %)	Sexual dysfunction n (%)	With-drawals due to A/E n (%)	Serious events n (%)	Suicide n (%)	
Adding Augmenting Agent														
Thase ⁸⁸ 2007	8	203	FLX 50mg/d	NR	(5.3)	NR	(2.4)	(6.8)	(19.4)	NR	NR	(0)	NR	
		197	OLZ 6-18mg/d	NR	(12.1)	NR	(11.1)	(39.7)	(13.1)	NR	NR	(0)	NR	
Shelton ¹²² 2001	8	8	FLX 20-60mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
		8	OLZ 5-20mg/d	NR	NR	NR	NR	NR	NR	NR	1 (12.5)	NR	NR	
Ferrerri ¹²¹ 2001	6	38	FLX 20mg/d	NR	0	0	NR	0	3 (7.8)	NR	8 (21)	NR	NR	
		34	MIN 60mg/d	NR	5 (14.7)	3 (8.3)	NR	2 (5.8)	2 (5.8)	NR	0	NR	NR	
Adding Nonpharmacological														
Trivedi ¹¹³ 2006 Thase ¹¹⁰ 2007	12	238	SER 50-200mg/d	NR	NR	NR	NR	NR	NR	NR	NR	11 (4.6)	2 (0.84)	
		250	VEN 37.5-375mg/d	NR	NR	NR	NR	NR	NR	NR	NR	5 (2)	0	
		239	BUP 150-400mg/d	NR	NR	NR	NR	NR	NR	NR	NR	6 (2.5)	2 (0.83)	
		86	Monotherapy Medications	NR	NR	NR	NR	NR	NR	NR	NR	23 ⁺ (27)	2 [^]	NR
		36	CBT	NR	NR	NR	NR	NR	NR	NR	NR	6 (17)	0	NR

A/E = adverse event; BUP = bupropion; CBT = cognitive behavioral therapy; CIT = citalopram; FLX = fluoxetine; GI = gastrointestinal; MIN = mianserin; mg/d = milligrams per day; n = sample size; NR = not reported; OLZ = olanzapine; PAX = paroxetine; PBO = placebo; PLZ = phenelzine; SER = sertraline; TCP = tranylcypromine; VEN = venlafaxine; VEN-ER = venlafaxine extended release

*Complete study sample size.

^At least one serious event and includes a combination of events requiring hospitalization for psychiatric event (including for suicidal ideation), death or medical event.

Table 29. Summary of reported rates of harms for studies comparing monotherapy to combined therapies

Study	Duration (Weeks)	n*	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
Adding SSRI													
Altamura ^{82,83} 2008	5 days	18	SSRI + PBO (saline)	0	3 (18.2)	2 (11.1)	0	NR	0	NR	7 (39)	NR	NR
		18	SSRI + CIT 10mg in 250ml of saline	2 (11.1)	0	0	3 (16.7)	NR	1 (5.6)	NR	9 (50)	NR	NR
Adding Non-SSRI Antidepressants													
Altamura ^{82,83} 2008	5 days	18	SSRI + PBO (saline)	NR	3 (18.2)	2 (11.1)	NR	NR	NR	NR	7 (39)	NR	NR
		18	SSRI + CM 25mg in 250ml of saline (intravenous)	NR	4 (22.2)	5 (27.8)	NR	NR	NR	NR	13 (72)	NR	NR
Fava ¹¹⁸ 2002	12	33	FLX 40-60mg/d + PBO	0	6 (18.2)	18 (54.5)	NR	NR	14 (42.5)	NR	NR	NR	NR
		34	FLX 20mg/d, DES 25-50mg/d	10 (39.4)	9 (26.5)	6 (47.1)	NR	NR	0	NR	NR	NR	NR
Fava ⁹⁸ 1994	4	15	FLX 40-60mg/d	0	NR	NR	NR	NR	NR	NR	NR	NR	NR
		12	FLX 20mg + DES 25-50mg/d	1 (8)	NR	NR	NR	NR	NR	NR	NR	NR	NR
Rush ⁴⁴ 2006	12	238	SER 50-200mg/d	NR	NR	NR	NR	NR	NR	NR	NR	11 (4.6)	2 (0.84)
		250	VEN 37.5-375mg/d	NR	NR	NR	NR	NR	NR	NR	NR	5 (2)	0
		239	BUP 150-400mg/d	NR	NR	NR	NR	NR	NR	NR	NR	6 (2.5)	2 (0.83)
Trivedi ¹¹³ 2006	12	279	CIT + BUP, 200-400mg/d	NR	NR	NR	NR	NR	NR	NR	10 (3.6)	11 (3.9)	1 (0.36)

Table 29. Summary of reported rates of harms for studies comparing monotherapy to combined therapies (continued)

Study	Duration (Weeks)	n*	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
<i>Augmenting Agents</i>													
Preskorn ⁸⁰ 2008	6	15	PAX 40mg + PBO	NR	NR	NR	NR	NR	NR	NR	2 (13)	NR	NR
		15	PAX 40mg + CP-101606 infusion/ duration to 1.5h and the dose to 0.5mg/kg/h	NR	NR	NR	NR	NR	NR	NR	6 (40)	NR	NR
George ⁸⁴ 2008	8	10	SSRI + PBO	NR	NR	6 (60)	NR	NR	NR	1 (10)	NR	NR	NR
		11	SSRI + Mecamylamine Hydrochloride, 5mg/d	NR	NR	10 (91)	NR	NR	NR	5 (45)	NR	NR	NR
Michelson ^{87,101, 132} 2007	8	74	SER 100mg/d + PBO	0/74	NR	12 (16)	1 (1.3)	NR	6 (8)	NR	NR	NR	NR
		72	SER 100mg/d + AM 40mg/d	4 (5.6)	NR	18 (25)	8 (11)	NR	4 (5.6)	NR	NR	NR	NR
Shapira ⁸⁹ 2006	4	9	SSRI + PBO	1 (11.1)	NR	NR	NR	NR	NR	NR	NR	0	0
		11	SSRI + PHN	1 (1.11)	NR	NR	NR	NR	NR	NR	NR	1 (1.11)	1 (1.11)
Seidman ⁹¹ 2005	6	13	SSRI + PBO volume matched (injection)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		13	SSRI + TE 200-600mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Fava ¹¹⁴ 2005	8	153	SSRI + PBO	NR	NR	13 (9)	7 (5)	NR	NR	NR	NR	NR	NR
		158	SSRI + MOD 100-200	NR	NR	21 (13)	7 (4)	NR	NR	NR	NR	NR	NR

Table 29. Summary of reported rates of harms for studies comparing monotherapy to combined therapies (continued)

Study	Duration (Weeks)	n*	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
Nemets ¹²³ 1999	4	18	SSRI original dose + PBO	NR	NR	1/19 (5.2)	NR	NR	NR	NR	1 (5.5)	NR	NR
		18	IN 12gm/d, SSRI original dose	NR	NR	1/23 (43)	NR	NR	NR	NR	2 (11.1)	NR	NR
Dunner ⁸⁶ 2007	8	20	SER 100-200mg/d	0	2 (100)	0	1 (5)	NR	1 (5)	NR	8 (40)	NR	NR
		21	SER 100-200 mg/d + ZI 40-80mg/d	5 (22.7)	5 (22.7)	4 (18.10)	8 (36.4)	NR	4 (18.2)	NR	21 (100)	NR	NR
		19	SER 100-200 mg/d + ZI 80-160mg/d	3 (26.3)	3 (15.8)	5 (26.4)	6 (31.6)	NR	3 (15.8)	NR	16 (84)	NR	NR
Adding Atypical Antipsychotics													
Thase ⁸⁸ 2007	8	203	FLX 50mg/d	NR	(5.3)	NR	(2.4)	(6.8)	(19.4)	NR	NR	0	NR
		197	OLZ 6-18mg/d	NR	(12.1)	NR	(11.1)	(39.7)	(13.1)	NR	NR	0	NR
		198	OLZ 6-18mg/d + FLX 50mg/d	NR	(17.5)	NR	(10.5)	(35)	(2.5)	NR	NR	2 (1)	NR
Shelton ¹²² 2001	8	8	FLX 20-60mg/d	NR	NR	NR	NR	NR	NR	NR	0	NR	NR
		8	OLZ 5-20mg/d	NR	NR	NR	NR	NR	NR	NR	1 (12.5)	NR	NR
		10	OLZ 5-20mg/d, FLX 20-60mg/d	NR	NR	NR	NR	NR	NR	NR	0	NR	NR
Adding BUS													
Rush ⁴⁴ 2006	12	238	SER 50-200mg/d	NR	NR	NR	NR	NR	NR	NR	NR	11 (4.6)	2 (0.84)
		250	VEN 37.5-375mg/d	NR	NR	NR	NR	NR	NR	NR	NR	5 (2)	0
		239	BUP 150-400mg/d	NR	NR	NR	NR	NR	NR	NR	NR	6 (2.5)	2 (0.83)
Trivedi ¹¹³ 2006	12	286	CIT + BUS, 200-400mg/d	NR	NR	NR	NR	NR	NR	NR	12 (4.2)	12 (4)	4 (1.4)
Appelberg ¹²⁰ 2001	6	51	CIT 40mg/d/FLX 35.4mg/d + PBO	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Table 29. Summary of reported rates of harms for studies comparing monotherapy to combined therapies (continued)

Study	Duration (Weeks)	n*	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
		51	CIT 40mg/d/FLX 35.4mg/d + BUS 35-47mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Landén ^{92,97,130} 1998	4	60	CIT 46.1mg/d or PAX 39.8mg/d + PBO	NR	30 (58)	NR	NR	NR	23 (44)	NR ^{\$}	NR	NR	NR
		57	CIT 46.1mg/d or PAX 39.8mg/d + BUS 49mg/d	NR	29 (48)	NR	NR	NR	23 (38)	NR [#]	NR	NR	NR
Adding Li													
Fava ⁹⁸ 1994	4	15	FLX 40-60mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		14	FLX 20mg/d + LI 300-600mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Fava ¹¹⁸ 2002	12	33	FLX 40-60mg/d + PBO	NR	6 (18.2)	18 (54.5)	NR	NR	14 (42.5)	NR	NR	NR	NR
		34	FLX 20mg/d, LI 300-600mg/d	NR	11 (32.4)	17 (50)	NR	NR	9 (26.5)	NR	NR	NR	NR
Baumann ¹²⁴ 1996	4	14	CIT 40-60mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		10	CIT 40-60mg/d, LI 800mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Bondolfi ¹¹² 2006	4	19	PAX 40mg/d;	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		9	VEN 150mg/d	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		13	PAX 30mg/d + LI;	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Table 29. Summary of reported rates of harms for studies comparing monotherapy to combined therapies (continued)

Study	Duration (Weeks)	n*	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
Adding Pindolol													
Perry93 2004	6	17	SSRI + PBO FLX 20-60mg, PAX 20-40mg, SER 50mg	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		21	SSRI + PI Total = only SSRI doses given, PI dose not reported; Group 1 = FLX 20-60mg, PAX 20mg, SER 150-200mg;	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sokolski96 2004	4	5	PAX 40mg/d + PBO	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		4	PAX 40mg/d + PI 7.5mg/d	NR	NR	NR	NR	NR	NR	NR	2 (50)	NR	NR
Adding MIN													
Licht119 2002	6	99	SER 100mg/d + PBO	NR	12 (12.2)	16 (16.4)	4 (4.1)	3 (3.1)	2 (2)	NR	45 (45)	NR	NR
		98	SER 200mg/d + PBO	NR	16 (16.3)	16 (16.3)	10 (10.2)	2 (2)	7 (7.1)	NR	54 (55)	NR	NR
		98	SER 100mg/d + MIN	NR	45 (45.9)	13 (13.2)	9 (9.2)	8 (8.2)	5 (5.1)	NR	75 (77)	NR	NR
Ferreri121 2001	6	38	FLX 20mg/d	NR	0	0	NR	0	3 (7.8)	NR	8 (21)	NR	NR
		34	MIN 60mg/d	NR	5 (14.7)	3 (8.3)	NR	2 (5.8)	2 (5.8)	NR	0	NR	NR
		32	FLX 20mg/d + MIN 60-60mg/d	NR	3 (9.8)	1 (3.1)	NR	5 (15.8)	0	NR	2 (6.3)	NR	NR

Table 29. Summary of reported rates of harms for studies comparing monotherapy to combined therapies (continued)

Study	Duration (Weeks)	n*	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
<i>Adding Nonpharmacological</i>													
Carta ¹²⁷ 2008	32	10	SSRI	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		20	SSRI + Exercise	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lynch ¹²⁸ 2007	54	12	SSRI	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		20	SSRI + DBT	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Wiles ⁹⁴ 2008	16	9	SSRI	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
		14	SSRI + CBT	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Rush ⁴⁴ 2006	12	238	SER 50-200mg/d	NR	NR	NR	NR	NR	NR	NR	NR	11 (4.6)	2 (0.84)
		250	VEN 37.5-375mg/d	NR	NR	NR	NR	NR	NR	NR	NR	5 (2)	0
		239	BUP 150-400mg/d	NR	NR	NR	NR	NR	NR	NR	NR	6 (2.5)	2 (0.83)
Thase ¹¹⁰ 2007	12	86	Medications Monotherapy	NR	NR	NR	NR	NR	NR	NR	23* (27, 652, 75306)	2^	NR
		36	CBT	NR	NR	NR	NR	NR	NR	NR	6 (17)	0^	NR
		65	CIT + CBT	NR	NR	NR	NR	NR	NR	NR	6 (9)	4^	NR
		117	Combined medications	NR	NR	NR	NR	NR	NR	NR	22 (19)	4^	NR

A/E = adverse event; BUP = bupropion; BUS = buspirone; CM = clomipramine; CIT = citalopram; CBT = cognitive behavioral therapy; DBT = dialectical behavior therapy; DES = desipramine; FLX = fluoxetine; GI = gastrointestinal; IN = inositol; LI = lithium; MIN = mianserin; MOD = modafinil; n = sample size; NR = not reported; OLZ = olanzapine; PAX = paroxetine; PBO = placebo; PHN = Phenytoin; PI = pindolol; SER = sertraline; SSRI = selective serotonin reuptake inhibitors; TE = testosterone; VEN = venlafaxine; ZI = ziprasidone

*Exited because of intolerance.

At least one serious event and includes a combination of events requiring hospitalization for psychiatric event (including for suicidal ideation), death or medical event.

^Indicates the patients reporting remittance from sexual dysfunction at 4 weeks (n=47) but not proportion that had dysfunction with the use of buspirone.

§Reported only baseline prevalence of sexual dysfunction.

Table 30. Summary of reported rates of harms for studies comparing combined therapy to other combined therapies

Study	Duration (Weeks)	n	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
Adding Non-SSRI													
Altamura ^{82,83} 2008	5 days	18	SSRI + CIT 10mg in 250ml of saline	2 (11.1)	0	0	3 (16.7)	NR	1 (5.6)	NR	9 (50)	NR	NR
		18	SSRI + CM 25mg in 250ml of saline (intravenous)	0	3 (18.2)	2 (11.1)	0	NR	0	NR	7 (39)	NR	NR
Trivedi ¹¹³ 2006	12	286	CIT + BUS 15-60mg/d	NR	NR	NR	NR	NR	NR	NR	12 (4.2)	12 (4)	4 (1.4)
		279	CIT + BUP, 200-400mg/d	NR	NR	NR	NR	NR	NR	NR	10 (3.6)	11 (3.9)	1 (0.36)
Augmenting Agents													
Dinan ¹²⁵ 1993	1	6	SER 100-200mg/d + LI 400mg/d	NR	NR	1 (16.1)	NR	NR	NR	NR	1 (16.1)	NR	NR
		5	SER 100-200mg/d + LI 800mg/d	NR	NR	3 (60)	NR	NR	NR	NR	3 (60)	NR	NR
Dunner ⁸⁶ 2007	8	21	SER 100-200mg/d + ZI 40-80mg/d	5 (22.7)	5 (22.7)	4 (18.10)	8 (36.4)	NR	4 (18.2)	NR	21 (100)	NR	NR
		19	SER 100-200 mg/d + ZI 80-160mg/d	3 (26.3)	3 (15.8)	5 (26.4)	6 (31.6)	NR	3 (15.8)	NR	16 (84)	NR	NR
Fava ¹¹⁸ 2002	12	33	FLX 20mg/d, DES 25-50mg/d	10 (39.4)	9 (26.5)	6 (47.1)	NR	NR	0	NR	NR	NR	NR
		34	FLX 20mg/d, LI 300-600mg/d	0	11 (32.4)	17 (50)	NR	NR	9 (26.5)	NR	NR	NR	NR
Fava ⁹⁸ 1994	4	12	FLX 20mg + DES 25-50mg/d	1 (8)	NR	NR	NR	NR	NR	NR	NR	NR	NR
		14	FLX 20mg/d + LI 300-600mg/d	0	NR	NR	NR	NR	NR	NR	NR	NR	NR

Table 30. Summary of reported rates of harms for studies comparing combined therapy to other combined therapies (continued)

Study	Duration (Weeks)	n	Comparison and Dose (mg/d)	Anxiety n (%)	Sedation n (%)	GI Problems n (%)	Sleep Problems n (%)	Weight Gain n (%)	Head-ache (n (%))	Sexual Dysfunction n (%)	Withdrawals Due To A/E n (%)	Serious Events n (%)	Suicide n (%)
<i>Adding Nonpharmacological</i>													
Trivedi ¹¹³ 2006 Thase ¹¹⁰ 2007	12	286	CIT + BUS 15-60mg/d	NR	NR	NR	NR	NR	NR	NR	12 (4.2)	12 (4)	4 (1.4)
		239	CIT + BUP, 200-400mg/d	NR	NR	NR	NR	NR	NR	NR	10 (3.6)	11 (3.9)	1 (0.36)
Thase ¹¹⁰ 2007	12	117	Medications Combined	NR	NR	NR	NR	NR	NR	NR	22 (19)	4 [^]	NR
	12	65	CIT + CBT	NR	NR	NR	NR	NR	NR	NR	6 (9)	4 [^]	NR

A/E = adverse event; BUP = bupropion; BUS = buspirone; CM = clomipramine; CIT = citalopram; CBT = cognitive behavioral therapy; DES = desipramine; FLX = fluoxetine; GI = gastrointestinal; LI = lithium; mg/d = milligrams per day; NR = not reported; SER = sertraline; SSRI = selective serotonin reuptake inhibitors; ZI = ziprasidone

[^]At least one serious event and includes a combination of events requiring hospitalization for psychiatric event (including for suicidal ideation), death or medical event.

KQ3. How do these therapies compare in different populations (e.g., different depressive diagnoses, disease severity, ages, gender, racial and socioeconomic group, and medical or psychiatric comorbidities)? These subgroups will be considered with respect to the different interventions.

Key Messages

Overall, there is small number of studies that have evaluated the impact of disease type, disease severity, previous comorbidities, age, gender, and race on treatment outcomes.

There is some evidence from the STAR*D level 2 cohort that would suggest that persons with concurrent anxiety symptoms have less likelihood of achieving remission.

There is some evidence from the TORDIA trial that milder depression, less family conflict, and absence of suicidal behavior are associated with greater likelihood of a positive treatment response at 12 weeks in adolescents.

Given that there was one study each for adults with dysthymia and subsyndromal depression, this review is limited in its ability to meaningfully compare conclusions across populations with different depressive disorders. There are 7 studies (13 publications) that undertook stratified or subgroup analyses evaluating factors that may impact treatment outcomes in adults,^{81,88,92,97,99,102,114-116,118-120,130} and 1 (3 publications) for adolescents.^{42,140,141}

Comparison Across Different Treatment Populations in Adults

Baseline Disease Severity

Six studies evaluated the impact of disease severity on treatment outcomes in adults. One study¹¹⁴ undertook a subgroup analysis on subjects with baseline HAMD-17 score greater than 17, and found that the group with combined treatment (SSRI + modafinil) had a statistically significant greater reduction ($p = 0.05$) relative to the SSRI group alone. Another study¹²⁰ found that subjects with an initially higher MADRS score tended to show greater reductions in MADRS overall ($p = 0.04$), or within the first 2 weeks of treatment (MADRS >30) in the combined therapy group (fluoxetine/citalopram + buspirone) relative to subjects in the SSRI group with higher initial scores). One study (3 publications)^{115,116,118} found that a lower baseline HAMD-17 score was predictive of response for the fluoxetine group ($p = 0.008$) and the lithium augmentation group ($p = 0.04$) but not the desipramine group; a reanalysis found that the odds ratio (OR) for augmentation strategy relative to a dose increase in fluoxetine (OR = 0.85 [95% CI 0.76 to 0.96]).¹¹⁵ One of these studies found that the age of onset of depression was predictive of response ($p = 0.009$).^{115,116,118}

Analysis of level 2 STAR*D cohort found that subjects with severe depression (QID-SR 16 or greater) were less likely to achieve remission (OR = 0.34 [95% CI 0.22 to 0.52]); however, this aspect was not valuable in assisting clinicians in recommending any monotherapy treatment (sertraline, venlafaxine, or bupropion).⁸¹ Greater baseline symptom severity was also associated with greater rates of attrition.¹⁰²

Two studies evaluated baseline HAMD scores (>23)¹¹⁹ and baseline severity^{92,97,130} and showed that these did not affect treatment response.

Previous History of Failure

Two studies^{81,88} evaluated previous history of failure. One study undertook a subgroup analysis evaluating the drug class of previous failure (SSRI versus other); this study showed differences with the combined olanzapine-fluoxetine group achieving a statistically significant greater reduction on the MADRS relative to the fluoxetine or olanzapine monotherapy groups.⁸⁸ This trend was observed in the nonSSRI group for those with at least one previous failure, but only for olanzapine and not fluoxetine.⁸⁸

In the STAR*D level 2 cohort, intolerance to citalopram (OR = 1.57 (95% CI 1.11 to 2.21)) or response to citalopram during level 1 (OR = 2.78 [95% CI 1.77 to 4.38]) increased the likelihood of remission; however, this was not practically helpful to clinicians in selecting one monotherapy treatment over the other.⁸¹

Comorbidities

The STAR*D cohort analysis for level 2 subjects on monotherapies (sertraline, venlafaxine, and bupropion), showed that remission was less likely in patients with other concurrent psychiatric disorders (specifically panic or post-traumatic disorders, generalized anxiety disorders, obsessive compulsive disorders, social phobia, or anxious or melancholic features).⁸¹ The overall OR for presence of anxious, atypical, or melancholic features were 0.30 (95% CI 0.20 to 0.45), 1.04 (95% CI 0.67 to 1.61), and 0.43 (95% CI 0.25 to 0.73), respectively.⁸¹

A more detailed analysis of the STAR*D level 2 cohort showed that the rates of remission were significantly less for anxious patients relative to nonanxious patients across all five pharmacological treatment arms (both monotherapy and combined therapy).⁹⁹ Logistic regressions, however, indicated only a moderate effect of anxiety, suggesting that there was no advantage of one treatment over another in subjects with anxious depression.⁹⁹

One study showed no significant difference on treatment response for subjects with melancholic features.¹¹⁹

Age

Two studies showed no statistical difference when the impact of age on treatment response was evaluated.^{116,118,119} Analysis of the STAR*D level 2 cohort showed that an age younger than 35 increased the likelihood of remission (OR varying from 1.43 [95% CI 0.78 to 3.59] to 1.81 [95% CI 0.97 to 3.38]).⁸¹ In contrast, younger age was associated with attrition for the augmentation treatment group.¹⁰²

Gender

Three studies evaluated gender^{92,97,116,118,119,130} and showed no statistical difference on treatment response. The STAR*D cohort at level 2 estimated an OR of 0.96 (95% CI 0.69 to 1.35); overall, gender was not an important factor in helping to select the optimal monotherapy.⁸¹

Race

Nonwhite races were associated with greater rates of attrition for level 2 STAR*D subjects;¹⁰² conversely, white race was associated with greater likelihood of remission.⁸¹

Comparison Across Different Populations in Adolescents

Neither of the two studies evaluating children and adolescents assessed specific subgroups with respect to baseline severity, previous failures, age, and race as predictors of response. The

TORDIA trial^{142,138,140,141,144-149} provided some evidence for other predictors of treatment response and showed that milder depression, less family conflict, and absence of suicidal behavior were associated with greater likelihood of a positive treatment response at 12 weeks. Conversely, a subgroup with substance abuse impairment was shown to be associated with greater depression severity at baseline, older age, family conflict, physical/sexual abuse, and comorbid oppositional defiant disorder.¹⁴⁵ No relationship was observed between FKBP5 polymorphisms and suicidal events.¹⁴⁴

In the context of combined treatment of CBT with antidepressants, adolescents with no history of abuse and few comorbidities had a greater probability of a positive response.¹⁴¹ Compared with adolescents with a history of physical or sexual abuse, those without had a threefold rate (OR = 2.8 95% CI 1.6 to 4.7) of positive response to combination therapy versus monotherapy.¹⁴⁸ Those with a history of sexual abuse had similar response rates to either combination (with CBT) or medication therapy.¹⁴⁸ In contrast, those with physical abuse had a lower rate of response to combination therapy relative to antidepressants alone; even after adjustment for other clinical predictors, adolescents with a history of physical abuse seemed to predict a poorer outcome for combination therapy.¹⁴⁸ Older youths (age 18 to 19) (OR 3.7 [95% CI 1.2 to 12.0]) with more comorbidities are more likely to benefit from combined treatment.¹⁴¹ In the TORDIA trial, adolescents who had not responded by 6 weeks had their antidepressant dose increased. A dose increase at 6 weeks for those on citalopram or fluoxetine were most likely to result in a response when it led to a change in plasma concentration greater than or equal to the the geometric mean.¹⁴⁷ This was not the case for paroxetine or venlafaxine.¹⁴⁷

KQ4. What is the range of recommended clinical actions following the failure of one adequate course of SSRI based on current clinical practice guidelines published between 2004 and A?

Key Messages

There were 27 clinical practice guidelines (CPGs) (18 for adults, seven for adolescents, and two including both) providing recommendations for patients with MDD. Four CPGs for adults and three for adolescents did not provide any recommendations for patients with previous inadequate responses. Four guidelines included patients with dysthymia and subsyndromal depression but no recommendations for these subgroups who had failed previous treatment for both adults and adolescents. The majority of the CPGs did not specify a definition for inadequate response.

All CPGs for adults and adolescents were applicable to patients from primary care and outpatient settings; a smaller number indicated applicability to inpatient settings. For adults, the majority of CPGs did not specify any type of antidepressant when recommending switching to monotherapy strategies. Increasing the dose and duration was frequently recommended but the interval or change in dose was not specified in the majority of guidelines.

When combined therapy was recommended there was a greater tendency to specify the drug for adding to antidepressants. However, there was great variability in the augmenting agents recommended.

For adolescents, there was an approximately equal number of CPGs that specified which agents to consider for monotherapy and which to consider for combined therapies. There was a preference to commence treatment using nonpharmacological interventions. Some guidelines cited adult evidence as the evidentiary basis for suggesting treatment strategies.

Recognizing that clinicians have a number of treatment options to addressing patients with an inadequate response, we thought it would be important to evaluate current recommendations within CPGs regarding the optimal approach to treatment in patients with inadequate response. Our goal was to identify and critically appraise the “rigor” of these recommendations, and contrast and compare them for this failed response subgroup.

There were a total of 27 CPGs (33 publications) eligible for review.^{13,14,53-55,151-177,189} There were seven CPGs that were specific only to adolescents,^{13,14,172-176} 18 CPG (24 publications) for adults alone,^{53-55,151-171} and two applicable to both adults and adolescents.^{177,189}

Note that CPGs can be published as a comprehensive single document with numerous recommendations for different interventions, or as multiple documents related to different interventions but sponsored by the same organization and published in the same year. For the purposes of this review, we grouped publications based on unique content; any documents that summarized guidelines or specified recommendations for subgroups of patients included in the primary document were considered as companion publications to the main CPGs. There are six guidelines published by the National Institute of Clinical Excellence (NICE) for adults that are interrelated, and from these we evaluated only two publications as representative CPGs (guidelines 90¹⁶⁴ and 97¹⁶²). NICE guideline 90 is an update of the evidence and recommendations for subjects with MDD;¹⁶⁴ summaries and quick references of these recommendations are published in guideline 23.^{168,169} NICE guideline 91¹⁷¹ is a summary of recommendations for depression in adults with chronic physical health problems and refers to recommendations in guidelines 90¹⁶⁴ and 97.¹⁶² NICE guideline 97¹⁶² specifies recommendations for CBT. One companion paper summarizes recommendations for guidelines 90 and 91.¹⁷⁰ Similarly, the American Psychological Association (APA) has updated their guidelines¹⁶⁶ and the previous guideline¹⁶⁷ was considered a companion.

There were six publications^{53,54,159,190-192} related to the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines, three were recommendations^{53,54,159} and three publications^{54,191,192} provide supporting documentation for the methods used in the guidelines. One publication is a summary companion paper¹⁵⁸ of another CPG from the American College of Physicians (ACP).⁵⁵ In the guidelines for adolescents, two publications^{172,174} are from the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) and two are from the United States Preventative Services Task Force (USPSTF).^{13,14}

Figure 2 shows that 59 guidelines were excluded because of the following: 1) publication prior to 2004 (n=45); 2) exclusive focus on diagnosis or screening rather than treatment (n=7); 3) not a population of interest (n=4); and, 4) an algorithm (n=3).

CPGs Specific for MDD, Dysthymia, and Subsyndromal Depression in Adults

Characteristics of CPGs for Adults

Table 31 shows the characteristics of the CPGs as a function of country of origin, setting, and intended users. All 18 CPGs were applicable to adults with MDD. Four CPGs make note of dysthymia or subthreshold depression,^{55,164,177,189} but not all provide recommendations for those that had failed response to previous treatments. Similarly, an earlier version of the APA guideline¹⁶⁷ discusses these subtypes but the most recent update focuses only on MDD.¹⁶⁶

Dysthymia and Subsyndromal Depression

One CPG provided a general definition of dysthymia (not distinguishing this from minor depression) and recommended second- and third-line interventions following lack of sufficient response to a pharmacological agent or a psychological intervention.¹⁸⁹ One CPG considered subthreshold persistent symptoms as a distinct subgroup of patients and noted the lack of clarity in studies that included subjects traditionally diagnosed with dysthymia (although the studies they evaluated used this classification, some studies do not distinguish this from minor depression).¹⁶⁴ The lack of consistency in defining dysthymia and subthreshold depressive symptoms is noted, as is the potential lack of natural discontinuity between subthreshold depressive symptoms and MDD in the context of routine clinical practice. This CPG provided recommendations for those patients who had failed to respond to low-intensity psychosocial interventions or other interventions; it is not clear if other interventions includes failure to an SSRI.¹⁶⁴ This CPG does not recommend the use of pharmacological treatment for subthreshold symptoms and as such would not make recommendations for dysthymia patients who have failed pharmacological treatment.

Three guidelines discuss dysthymia but do not provide any recommendations for treatment in those who fail to respond: one CPG specifies dysthymia as distinct from MDD (and can be present concurrently (double depression));¹⁶⁷ however, in the update of this guideline there was no further discussion of dysthymia.¹⁶⁶ Another CPG indicates that dysthymia is distinct from MDD, and is characterized by persistent symptoms for greater than 2 years and further includes this diagnostic category under the label of subthreshold depression (includes minor depression and other nonspecified categories).¹⁷⁷ One CPG summarizes evidence on pharmacological treatment that includes both MDD and dysthymia but presents no recommendations specific to dysthymia.⁵⁵

MDD Populations

All of the CPGs for adults with MDD were applicable to patients from primary care and outpatient settings; six guidelines indicating applicability to inpatient settings (Table 31). All of the CPGs were intended primarily for, or were applicable to, primary care practitioners, with the exception of one CPG that was developed specifically for psychiatrists.¹⁵⁶ The majority of guidelines were undertaken in the United States (n=6), one was developed by the Singapore Ministry of Health,¹⁶¹ one was an international consensus statement at a meeting sponsored by a drug manufacturer,¹⁶³ one developed in Germany,¹⁶⁵ and one by the World Federation of Biological Psychiatry.¹⁵⁴

All but two of the 18 guidelines considered a variety of treatment interventions for adult MDD; these two CPGs evaluated solely pharmacological interventions,⁵⁵ and computerized CBT.¹⁶² The other CPGs gave treatment recommendations that included a variety of pharmacological, psychological, and CAM interventions. However, the majority of recommendations were not applicable to patients who had had inadequate responses to previous pharmacological treatment. When recommendations were specific to patients who had previous inadequate response, none were distinguished by different classes of antidepressants.

Table 31. Characteristics of included CPGs showing country, disorder type included, setting, and intended guideline users

	Adult United States	Adult Canada	Adult United Kingdom	Adult New Zealand/ Australia	Adult Other
Disorder					
MDD	Jaehne ¹⁵¹ Qaseem ⁵⁵ Steinman ¹⁵³ Davidson ¹⁵⁵ Gelenburg ¹⁶⁶	Ravindran ⁵⁴ Parikh ⁵³ Lam ¹⁵⁹ Conn ¹⁶⁰	Anderson ¹⁷⁷ NICE ^{164,168-171} NICE ¹⁶²	Ellis ¹⁵⁶ Malhi ¹⁵⁷ NZGG ¹⁸⁹	Bauer ¹⁵⁴ Mahendran ¹⁶¹ Nutt ¹⁶³ 2010 Harter ¹⁶⁵
Dysthymia/ Subthreshold depression*	Karasu ^{167*} Qaseem ^{55*}		Anderson ^{177*} NICE ^{164,168-171}	NZGG ¹⁸⁹	
Setting					
Primary Care	Jaehne ¹⁵¹ Qaseem ⁵⁵ Horsley ¹⁹³ USPSTF ¹⁶⁸ Steinman ¹⁵³ Davidson ¹⁵⁵ Gelenburg ¹⁶⁶	Ravindran ⁵⁴ Parikh ⁵³ Lam ¹⁵⁹ Conn ¹⁶⁰	Anderson ¹⁷⁷ NICE ^{164,168-171} NICE ¹⁶²	Ellis ¹⁵⁶ Malhi ¹⁵⁷	Bauer ¹⁵⁴ Mahendran ¹⁶¹ Nutt ¹⁶³ 2010 Harter ¹⁶⁵
Outpatient MH	Jaehne ¹⁵¹ Qaseem ⁵⁵ Anderson ¹⁷⁷ Gelenburg ¹⁶⁶	Parikh ⁵³ Conn ¹⁶⁰	Anderson ¹⁷⁷ NICE ^{164,168-171} NICE ¹⁶²	Ellis ¹⁵⁶ Malhi ¹⁵⁷ Harter ¹⁶⁵	
Inpatient MH	Qaseem ⁵⁵ Gelenburg ¹⁶⁶	Parikh ⁵³ Conn ¹⁶⁰	Anderson ¹⁷⁷	Ellis ¹⁵⁶	
Other					
Intended Users					
Primary Care Physicians	Jaehne ¹⁵¹ Qaseem ⁵⁵ Horsley ¹⁹³ USPSTF ¹⁶⁸ Steinman ¹⁵³ Davidson ¹⁵⁵ Gelenburg ¹⁶⁶	Ravindran ⁵⁴ Parikh ⁵³ Lam ¹⁵⁹ Conn ¹⁶⁰	Anderson ¹⁷⁷ NICE ¹⁶⁹ NICE ¹⁶²	Malhi ¹⁵⁷	Bauer ¹⁵⁴ Mahendran ¹⁶¹ Nutt ¹⁶³ 2010 Harter ¹⁶⁵
Mental Health Specialists	Jaehne ¹⁵¹ Qaseem ⁵⁵ Horsley ¹⁹³ USPSTF ¹⁶⁸ Steinman ¹⁵³ Davidson ¹⁵⁵ Gelenburg ¹⁶⁶	Parikh ⁵³ Lam ¹⁵⁹ Conn ¹⁶⁰	Anderson ¹⁷⁷ NICE ¹⁶⁹	Ellis ¹⁵⁶ Malhi ¹⁵⁷	Mahendran ¹⁶¹ Harter ¹⁶⁵
Allied Mental Health disciplines	Jaehne ¹⁵¹	Parikh ⁵³			

NICE = National Institute for Clinical Excellence; NZGG = New Zealand Guidelines Group; USPSTF = United States Preventive Task Force Services

*Dysthymia population included in the CPG but no recommendations are specific to dysthymia patients who failed to respond to treatment on an SSRI.

Inadequate Response

From 18 CPGs, eight defined response as a 50 percent or greater reduction in symptoms (as measured on a standardized rating scale), and partial response as a 25 to 50 percent reduction in symptoms.^{53,54,151,154,159,166,177,189} One CPG specified that the measure should be a change in the

Patient Health Questionnaire – 9.¹⁸⁹ The CANMAT CPG recommendations^{53,54,159} were intermingled with order of treatment and lack of adequate response. First line treatment is identified as those interventions for which there is the best evidence of efficacy balanced with good safety and tolerability. Second- and third-line treatments are defined as those reserved for situations where first-line treatments are not indicated, cannot be used, or when first-line treatments are not effective. As such, for the CANMAT guidelines specific to CAM⁵⁴ and psychological therapies¹⁵⁹ the ‘failed to respond populations’ are not identified clearly within the body of the recommendations; we must assume that second- and third-line therapies are applicable to those that failed previous pharmacological treatments. One CPG notes the inconsistency in defining lack of response, but opts to categorize patients in the context of next step treatment options.¹⁶⁴ Four CPGs did not include recommendations specific to failed response populations, and as such, a definition may not have been necessary.^{153,155,160,162} The remaining nine CPGs did not report a specific definition, and as such inadequate response and suggest variable operationalization of this for clinicians.^{55,152,154,156,157,165,169,177} One CPG emphasizes that response should be assessed with the use of a structured measure, but provides no recommendation as to the measure or threshold for definition.¹⁶⁶

For those CPGs that did report a formal definition of inadequate response, only two provided clear indications for differential treatment strategies for those with partial versus nonresponse.^{151,166} Eight CPG indicated that the definition of inadequate response was linked to failure following time intervals varying from 2 to 4 weeks,^{154,161,165,177} 4 to 6 weeks of significant improvement,¹⁸⁹ 4 to 8 weeks,^{166,167} and 6 to 8 weeks of partial improvement.^{55,161}

Quality Assessment of CPGs for Adults

Table 32 shows the domain scores for the AGREE II ratings of the CPGs for adults. The AGREE II is based on six domains of methodology for the guideline process and one item with an overall assessment. All CPGs scored high for *scope and purpose* (Domain 1) (range 69 to 100 percent).

Stakeholder involvement (Domain 2) showed scores varying from 39 to 92 percent, and the lowest score was for a CPG sponsored by CANMAT^{53,54,159,190-192} making recommendations for the use of complementary and alternative treatments for MDD. Only six from 18 CPG indicated that patient’s views and preferences had been sought (score five or greater).^{151,154,156,162,164,165}

For the domain of *rigor of development* (Domain 3), scores varied from zero to 85 percent; all but three CPG^{151,162,164} did not indicate a process for updating the guideline. For the domain of *clarity of presentation* (Domain 4), scores were generally high and varied from 61 to 94 percent. This domain evaluated whether the recommendations were clear and unambiguous, such that options were clearly presented, and key recommendations easily identifiable. However, the scores for the items within this domain were based on all recommendations within the CPG and were not specific to those applicable to patients who failed to respond to antidepressants.

When considering the *applicability* domain (Domain 5), scores were highly variable from zero to 89 percent. The majority of CPGs scored poorly for two criteria within this domain: 1) consideration of potential resource implications of applying their recommendations, and 2) presenting monitoring or auditing criteria. For the domain regarding *editorial independence* (Domain 6), scores were highly variable and ranged from four to 96 percent. In particular, potential competing interests of the guideline development group were not consistently recorded.

Note that although the AGREE II evaluates the methodology of the guideline process, it cannot evaluate the clinical merit (taking into account the methods for summarizing the evidence)

and overall quality of the recommendations themselves. All of the CPGs had methods to establish the strength of the evidence, but they could not be compared with each other. Most systems of grading the strength of the evidence included aspects of study design, number of studies, or confidence of treatment; most included a level that reflected consensus or expert opinion for some recommendations.

Table 32. Scores from the AGREE II for CPG for adults

Author	Organization	Scope and Purpose (Domain 1)	Stakeholder Involvement (Domain 2)	Rigor of Development (Domain 3)	Clarity of Presentation (Domain 4)	Applicability (Domain 5)	Editorial Independence (Domain 6)
Jaehne 2009 ¹⁵¹	Institute for Clinical Systems Improvement	97.22	88.89	82.29	75.00	68.18	95.83
Qaseem 2008 ⁵⁵	American College of Physicians	94.44	58.33	59.38	77.78	11.36	87.50
National Guideline Clearing House 2004 ¹⁵²	Kaiser Permanente	97.22	63.89	80.21	94.44	2.08	79.17
Steinman 2007 ¹⁵³	Centre for Disease Control	97.22	63.89	66.67	94.44	65.91	50.00
Davidson 2006 ¹⁵⁵	National Heart, Lung, and Blood Institute	91.67	61.11	42.71	80.56	0.00	12.50
Ravindran 2009 ⁵⁴	Canadian Network for Mood and Anxiety Treatments	86.11	38.89	68.75	80.56	2.27	70.83
Parikh 2009 ⁵³	Canadian Network for Mood and Anxiety Treatments	94.44	58.33	69.79	61.11	9.09	50.00
Lam 2009 ¹⁵⁹	Canadian Network for Mood and Anxiety Treatments	97.22	63.89	85.42	77.78	0.00	70.83
Conn 2006 ¹⁶⁰	Canadian Coalition for Seniors™ Mental Health	100.00	58.33	82.29	83.33	9.09	37.50
Anderson 2008 ¹⁷⁷	British Association for Psychopharmacology	91.67	58.33	72.92	91.67	2.27	12.50
NICE CBT 2009 ¹⁶⁴	National Institute for Clinical Excellence	97.22	88.89	77.08	88.89	70.45	50.00
NICE 2006 ¹⁶²	National Institute for Clinical Excellence	94.44	83.33	78.13	69.44	88.64	45.83
Ellis 2004 ¹⁵⁶	RANZCP	100.00	91.67	82.29	91.67	25.00	66.67
Malhi 2009 ¹⁵⁷	NSCCMHDA	100.00	66.67	69.79	91.67	11.36	66.67
New Zealand Guidelines Group 2008 ¹⁸⁹	Ministry of Health & New Zealand Guidelines Group	100.00	66.67	69.79	88.89	43.18	100.00
Bauer 2007 ¹⁵⁴	World Federation of Societies of Biological Psychiatry	91.67	83.33	81.25	88.89	20.45	12.50
Mahendran 2005 ¹⁶¹	Ministry of Health Singapore	94.44	41.67	0.00	66.67	0.00	4.17
Nutt 2010 ¹⁶³	International Consensus Group on Depression	94.44	69.44	12.5	77.78	54.45	66.67
Gelenburg 2010 ¹⁶⁶	American Psychiatric Association	97.22	55.56	84.38	80.56	27.27	91.67
Harter 2010 ¹⁶⁵	Association of Scientific Medical Societies of Germany and the German Association for Psychiatrists and Psychotherapy	69.44	61.11	48.96	80.56	27.27	91.67

NSCCMHDA = Northern Sydney Central Coast Mental Health Drug & Alcohol; RANZCP = Royal Australian and New Zealand College of Psychiatrists

Recommendations of CPGs for Adults

Four CPGs specific to MDD^{153,155,160,162} did not provide any recommendations for adult patients who had failed to respond to treatment. Two of these CPGs were specific to elderly patients in the community,¹⁵³ and in long term care homes.¹⁶⁰ One CPG had recommendations for patients with depression and cardiovascular disease,¹⁵⁵ but none for those who had inadequate response to treatment. One CPG provided recommendations on the use of computerized CBT and was recommended for clients, which included only subjects with MDD or subthreshold symptoms that were not applicable to those who had failed previous treatment.¹⁶²

Table 33 shows the recommended strategies for both monotherapy and combined therapies. Attempts were made to identify any recommendations with regard to specific medications that were highlighted; however, for some guidelines it was not clear if the text following the recommendation (e.g., “switch antidepressants”) was a selective summary of the available evidence or an actual recommendation for action. The CANMAT CPGs recommended a stepped approach to treatment, intending a particular sequence of interventions (for example, second- and third-line therapies); however, there were several options within each of these categories.^{53,54,159} Two other guidelines specified a stepped approach¹⁶⁴ or second- and third- line agents,¹⁸⁹ but were less explicit as to which agents to consider. Other CPGs did not explicitly indicate an order of treatment other than cautioning to optimize initial treatment. Similarly, two CPGs did not explicitly recommend a change in dose or duration.^{55,154} Two other CPG distinguished between partial versus nonresponse and specified different treatment approaches to these.^{159,166}

Table 33. Recommendations for treatment in CPG that identified strategies for those that failed response

Study	Starting Interval ^a (Weeks)	Monotherapy					CombinedTherapy				
		Dose or Duration Change	Switch Other SSRI	Switch Non-SSRI	Switch to Augmenting Agent	Switch Nonpharm & CAM	Add Augmentor	Add Other SSRI	Add Non-SSRI AD	Add Nonpharm & CAM	Add Other
United States											
Jaehne ¹⁵¹ 2009	6	X	X	X		PSY ⁺ LT ⁺ AC ⁺ ECT ⁺ VNS ⁺ DBS ⁺ rTMS ⁺ MST	NS ⁺ TCA + T3 ⁺ TCA + LI ⁺ AD + ARI ⁺ AD + AAP ⁺		SSRI + BUP ⁺ SSRI + MIR ⁺ SSRI + TCA ⁺		
Kaiser Permanente ¹⁵² 2004	NS	X	X	X		PSY	SSRI + LI (300 to 600mg/d)		SSRI + DES	PSY	
Qaseem ⁵⁵ 2008	6 to 8		CIT, FLX, FU, PAX, SER	MIR			X	X	X	X	
Gelenburg ¹⁶⁶ 2010 Karasu ¹⁶⁷ 2009	4 to 8	X	X	X	QTP	PSY+ rTMS ECT	AD + LI or T3, or BUS or AAP (OLZ. ARI. RIS. QTP) or MOD or STIM	X	AD (non-MAO) + BUP SSRI + TCA or MIR MIR + VEN	PSY+ VNS ECT	
New Zealand/ Australia											
Ellis ¹⁵⁶ 2004	NS	X	AD	AD		CBT	TCA + LI SSRI + LI or T3 or PI		SSRI + TCA		
Malhi ¹⁵⁷ 2009	2 to 6	X	AD	AD		ECT	AD + LI or T3, or AAP or BE				
New Zealand Guidelines Group ¹⁸⁹ 2008	3 to 6	X	AD/ VEN [^]	AD/ TCA [^]			AD + LI				

Table 33. Recommendations for treatment in CPG that identified strategies for those that failed response (continued)

Study	Starting Interval ^a (Weeks)	Monotherapy					Combined Therapy				
		Dose or Duration Change	Switch Other SSRI	Switch NonSSRI	Switch to Augmenting Agent	Switch Nonpharm & CAM	Add Augmentor	Add Other SSRI	Add NonSSRI AD	Add Nonpharm & CAM	Add Other
Canada											
Lam ¹⁵⁹ 2009	1 to 4	X	ES SER VEN	DLX MIR MIL AMI or CM or MAO			AD + ARI or LI or OLZ or RIS AD + QTP or T3 AD + BUS or MOD or ZI or STIM	X	AD + BUP or MIR or MIN		
Parikh ⁵³ 2009	NS					BIB BAC CBT/CBASP IPT MBCT				CBT IPT	
Ravindran ⁵⁴ 2009						OM3 SAM-e DHEA FA				CBT or IPT LT EX Yoga SleepD	
United Kingdom											
Anderson ¹⁷⁷ 2008	4 to 8	X	X	X		CBT PSY EX ECT rTMS VNS ABNS	SSRI + LI or OLZ or ARI, TCA + T3 AD + LTG or TRP, or MOD, STIM	AD + MIR		CBT PSY ES or AG or OM3 or FA	
National Institute for Health and Clinical Excellence ¹⁶⁴ 2010	6 to 8	X	X	X			AD + ARI or LI or OLZ or RIS or MIR or QTP	X	AD + MIR		

Table 33. Recommendations for treatment in CPG that identified strategies for those that failed response (continued)

Study	Starting Interval ^a (Weeks)	Monotherapy					Combined Therapy				
		Dose or Duration Change	Switch Other SSRI	Switch NonSSRI	Switch to Augmenting Agent	Switch Nonpharm & CAM	Add Augmentor	Add Other SSRI	Add NonSSRI AD	Add Nonpharm & CAM	Add Other
Other											
Bauer ¹⁵⁴ 2007	2 to 4		AD	AD			AD + LI or T3, or AAP	X	X		
Mahendran ¹⁶¹ 2005	4 to 8	X	X	X			AD + LI or T3				
Nutt ¹⁶³ 2010	4	X	X	X		ECT	AD + LI or AAP or T3		AD + BU or MIR or MIN		
Harber ¹⁶⁵ 2010	3 to 4 6 for elderly	X	X	X or TRP or VEN			AD + LI or MIN	SSRI + MIR	TCA + MIR		

AAP = atypical antipsychotics; ABNS = ablative neurosurgery; AD = antidepressant; AC = acupuncture; AG = antigluco-corticoids; AMI = amitriptyline; ARI = aripiprazole; BAC = behavioral activation therapy; BE = benzodiazepine; BIB = bibliotherapy; BUS = buspirone; BUP = bupropion; CBASP = cognitive-behavioral analysis system of psychotherapy; CBT = cognitive behavioral therapy; CIT = citalopram; CM = clomipramine; DBS = deep brain stimulation; DES = desipramine; DHEA = dehydroepiandrosterone; DLX = duloxetine; ECT = electroconvulsive therapy; ES = estrogen; EX = exercise; FA = folic acid; FLX = fluoxetine; FU = fluvoxamine; IPT = Interpersonal therapy; LI = lithium; LT = light therapy; LTG = lamotrigine; MAO = monoamine oxidase inhibitor; MBCT = mindfulness-based cognitive therapy; MIN = mianserin; MIL = milnacipram; MIR = mirtazapine; MOD = modafinil; MST = magnetic seizure therapy; NS = Not significant; OLZ = olanzapine; OM3 = omega-3; PAX = paroxetine; PSY = Psychotherapy; QTP = quetiapine; RIS = risperidone; rTMS = repetitive transcranial magnetic stimulation; SAM-e = S-adenosyl-L-methionine; SER = sertraline; SleepD = sleep deprivation; SSRI = selective serotonin reuptake inhibitors; STIM = Stimulants; T3 = Tri-iodothyronine; TCA = tricyclic antidepressants; TRP = tryptophan; VEN = venlafaxine; VNS = vagal nerve stimulation; ZI = ziprasidone

^aThe time interval indicates the number of weeks following the first-line therapy attempt to initiate new treatment strategy.

X – Specified as a possible treatment approach for those with inadequate response.

*Applicable to Partial responders or treatment resistance and may require consultation with a specialist.

^Only for those that have failed two previous courses of antidepressants.

+Depression focused psychotherapy.

CPGs Specific to MDD and Dysthymia in Adolescents

Characteristics of CPG for Adolescents

There were seven CPGs that were specific only to adolescents,^{13,14,172-176} and two applicable to both adults and adolescents.^{177,189} Table 34 shows the characteristics of the adolescent CPGs, as a function of country of origin, setting, and intended users.

All seven CPGs applicable to adolescents included those with MDD. Two CPG had some recommendations applicable to patients with dysthymia^{13,177} and one also specified treatment for subsyndromal depression¹³ in adolescents. However, none of the recommendations were specific to those who had failed previous treatment.

All CPGs for adolescents were applicable to patients from primary care and outpatient settings, two guidelines indicating applicability to inpatient settings^{13,177} (Table 34). All CPG were intended primarily for or applicable to primary care practitioners, and three to specialists^{13,175,177} and allied mental health workers.¹³

The majority of guidelines were undertaken in the United States (n=6),^{13,14,172-175} two in the United Kingdom,^{176,177} and one in Australia and New Zealand.¹⁸⁹

Table 34. Characteristics of CPG based on the type of disorder, the setting, and intended users

	Adolescent United States	Adolescent United Kingdom	Adolescent New Zealand/Australia
Disorder			
MDD	Zuckerbrot ¹⁷² Cheung ¹⁷⁴ U.S. Preventive Services ¹⁴ Birmaher ¹³ Hughes ¹⁷³ Gallagher ¹⁷⁵	Anderson ¹⁷⁷ National Institute for Clinical Excellence ¹⁷⁶	New Zealand Guidelines Group ¹⁸⁹
Dysthymia	Birmaher ¹³	Anderson ¹⁷⁷	
Subsyndromal		Anderson ¹⁷⁷	
Setting			
Primary Care	Zuckerbrot ¹⁷² Cheung ¹⁷⁴ U.S. Preventive Services ¹⁴ Birmaher ¹³ Hughes ¹⁷³ Gallagher ¹⁷⁵	Anderson ¹⁷⁷ National Institute for Clinical Excellence ¹⁷⁶	New Zealand Guidelines Group ¹⁸⁹
Outpatient MH	Birmaher ¹³ Gallagher ¹⁷⁵	Anderson ¹⁷⁷	
Inpatient MH	Birmaher ¹³	Anderson ¹⁷⁷	

Table 34. Characteristics of CPG based on the type of disorder, the setting, and intended users (continued)

	Adolescent United States	Adolescent United Kingdom	Adolescent New Zealand/Australia
<i>Intended Users</i>			
Primary Care Physicians	Zuckerbrot ¹⁷² Cheung ¹⁷⁴ U.S. Preventive Services ¹⁴ Birmaher ¹³ Hughes ¹⁷³ Gallagher ¹⁷⁵	Anderson ¹⁷⁷ National Institute for Clinical Excellence ¹⁷⁶	New Zealand Guidelines Group ¹⁸⁹
Mental Health Specialists	Birmaher ¹³ Gallagher ¹⁷⁵	Anderson ¹⁷⁷	
Allied Mental Health Disciplines	Birmaher ¹³		

CPG = clinical practice guidelines; MDD = major depressive disorder; MH = mental health

Inadequate Response

Only two CPGs provided definitions of inadequate response and this was characterized as failure of remission over a period of at least 2 weeks and less than 2 months, with no or very few depressive symptoms using a children's global assessment scale/interviews¹³ or as failure to have a significant level of improvement from 4 to 6 weeks.¹⁸⁹

Quality Assessment of CPGs for Adolescents

Table 35 shows the domain scores for the AGREE II ratings of the CPGs. One guideline rated poorly across three domains (Domains 3 to 5) (range 0 to 33 percent).¹⁷⁵ All CPGs for adolescents scored high for *scope and purpose* (Domain 1) (range 89 to 100 percent).

The remaining domains showed highly varying scores from four to 97 percent in the stakeholder involvement (Domain 2), and the views of the patients and public were sought in only two CPG^{173,176} (score six or greater). For the domain of *rigour of development* (Domain 3), scores varied from 21 to 92 percent; only one CPG¹⁷⁶ indicated a process for updating the guideline. There was moderate variability observed in the *clarity of presentation* (Domain 4) (range 33 to 97 percent); this domain evaluated whether the recommendations were clearly presented and would suggest that most did this well.

When considering the *applicability* domain (Domain 5), scores varied from zero to 77 percent; the majority of CPGs scored poorly for two criteria within this domain: 1) consideration of potential resource implications of applying their recommendations; and, 2) presenting monitoring or auditing criteria. For the domain regarding *editorial independence* (Domain 6), scores were highly variable and ranged from 13 to 100 percent; in particular, the competing interests of the guideline development group were not consistently recorded.

As expected, the CPGs for adolescents had varying methods to establish the strength of the evidence and they could not be compared with each other. Similar to adult rating systems, most CPGs used grading systems that included aspects of study design (e.g., RCT), number of studies, or confidence of treatment; most included a level that reflected consensus or expert opinion for some recommendations.

Table 35. The AGREE II ratings for the 6 domains in CPG applicable to adolescents

Year	Organization	Scope and Purpose (Domain 1)	Stakeholder Involvement (Domain 2)	Rigor of Development (Domain 3)	Clarity of Presentation (Domain 4)	Applicability (Domain 5)	Editorial Independence (Domain 6)
United States							
Zuckerbrot 2009 ¹⁷²	American Academy of Pediatrics	91.67	61.11	79.17	86.11	66.67	75.00
Cheung 2007 ¹⁷⁴	Guidelines for Adolescent Depression in Primary Care	100.00	63.89	81.25	80.56	22.92	50.00
U.S. Preventive Services 2009 ¹⁴	U.S. Preventive Services Task Force	88.89	58.33	34.38	33.33	33.33	20.83
Hughes 2007 ¹⁷³	Texas Department of State Health Services	100.00	91.67	47.92	91.67	37.50	62.50
Birmaher 2007 ¹³	American Academy of Child and Adolescent Psychiatry	91.67	55.56	65.63	80.56	37.50	16.67
Gallagher 2005 ¹⁷⁵	NR	100.00	41.67	21.88	33.33	0.00	66.67
United Kingdom							
Anderson 2008 ¹⁷⁷	British Association for Psychopharmacology	91.67	58.33	72.92	91.67	2.08	12.50
National Institute for Clinical Excellence 2005 ¹⁷⁶	National Institute for Clinical Excellence	100.00	97.22	92.71	97.22	77.08	91.67
Australia New Zealand							
New Zealand Guidelines Group 2008 ¹⁸⁹	Ministry of Health & New Zealand Guidelines Group	100.00	66.67	69.79	88.89	39.58	100.00

NR = not reported

Recommendations of CPG for Adolescents

Three of eight CPGs for adolescents did not provide any specific recommendations for adolescents who had failed to respond to previous treatment.^{14,172,175} One component of a CPG from the GLAD-PC focused only on identification and initial management.¹⁷² One CPG focused only on psychotherapy interventions and did not provide any recommendations specific to those who failed previous treatment.¹⁷⁵ Another CPG from the USPSTF focused primarily on recommendations for screening and initial management.¹⁴ One guideline indicates that there is lack of evidence for the management of next steps of treatment for adolescents and provides no further indications.¹⁷⁷

Two CPG provided recommendations following failure of psychological interventions. One CPG¹⁸⁹ that evaluated treatment for MDD in both adult and adolescent populations, directed primary care practitioners to refer to secondary mental health services following lack of substantial improvement after six to eight weeks of supportive and psychological therapies. Similarly, the recommendation was to seek adolescent psychiatric consultation if the use of an antidepressant was desired. Two CPGs^{13,176} provided recommendations for patients who had

failed to respond to psychotherapy or had more complicated depressions; failure to respond to pharmacological treatment was not clarified for mild depression and recommended only for moderate to severe MDD.

Table 36 shows the proposed treatment options for adolescents with MDD. Three CPGs^{13,173,194} note the lack of evidence for adolescents, but cite adult evidence as the rationale for the treatment strategy of switching and augmentation in particular. One CPG makes clear recommendations to avoid the use of paroxetine and venlafaxine in adolescents 12 to 18 years of age.¹⁷⁶

Table 36. Recommendations for treatment in CPGs that identified strategies for those that failed response (n=5) in adolescents

		Monotherapy					Combined Therapy				
	Starting Interval (weeks)	Dose or Duration Change	Switch Other SSRI	Switch Non-SSRI	Switch to Augmenting Agent	Switch Nonpharm	Add Augmentor	Add Other SSRI	Add Non-SSRI AD	Add Nonpharm	Add Other
United States											
Cheung 2007 ¹⁷⁴	6-8	X	X	X^		PSY					CON
Hughes 2007 ¹⁷³	NS	X	CIT, ESC, PAX, FLX, SER	# BUP, VEN MIR, DUL		ECT®	# SSRI + LI		# SSRI + BUP, MIR		
Birmaer 2007 ¹³	2 – 8	X	X	X		CBT or IPT	AD + LI or T3			AD + CBT or IPT	
United Kingdom											
National Institute for Clinical Excellence 2005 ¹⁷⁶			SER, CIT	X^						SSRI + PSY	CON
New Zealand/Australia											
Dudley 2008 ¹⁹⁴	4	FLU	SER, CIT			CBT ECT®	% SSRI + LI or T3				% CON

AD = antidepressant; BUP = bupropion; CBT = cognitive behavioral therapy; CIT = citalopram; CON = consultation with mental health specialist; DUL = Duloxetine; ESC = escitalopram; FLX = fluoxetine; IPT = Interpersonal therapy; LI = lithium; MIR = Mirtazapine; NS = Not significant; PAX = paroxetine; PSY = Psychotherapy; SER = sertraline; SSRI = selective serotonin reuptake inhibitors; VEN = venlafaxine; T3 = Tri-iodothyronine

* not recommended for preadolescents.

[^] not ideally recommended but can be considered.

X – detailed as a possible treatment approach for those with inadequate response.

Must have failed two SSRI and augmentation precedes switch to nonSSRI.

@ECT if pharmacological treatment fails or depression is severe.

% Considered only for severe or psychotic cases.

The time interval indicates the number of weeks following the first-line therapy attempt to initiate new treatment strategy.

Discussion

Overview

Pharmacological agents are one of several treatment modalities used to treat major depressive disorder (MDD). One of the most frequently utilized classes of antidepressant medications is the selective serotonin reuptake inhibitors (SSRIs). However, the rates of treatment response following first-line treatment with SSRIs is moderate, varying from 40 to 60 percent; remission rates may vary from 30 to 45 percent.¹ This CER has summarized the evidence for management of patients subsequent to a trial of an SSRI that did not result in an adequate response.

KQ1. Among adults and adolescents with Major Depressive Disorder, Dysthymia, and Subsyndromal Depression, who are started on an SSRI and who are compliant with treatment but fail to improve either fully, partially, or have no response, what is the benefit (efficacy or effectiveness) of monotherapy and combined therapy?

KQ1a. How does the efficacy/effectiveness vary between the different monotherapies and combined therapies?

Adults

This CER has identified and shown that the evidence comparing varying treatment strategies following failed response to an SSRI are of low quality or are insufficient overall. The evidence for single treatments (monotherapies) compared either with the same or lower doses, switching to different agents, or augmentation or combination therapies following inadequate response to SSRIs is limited with respect to the number of studies, the agents evaluated, and their methodological quality. As such, many relatively straightforward clinical questions remain to be addressed. When patients are being treated with an antidepressant and are not improving, the first step is often to ‘optimize’ the treatment, most often defined as an adequate dose for an adequate duration of time; there is, however, no consensus on exactly how long a patient should be treated with a medication before there is a decision made that the response has been inadequate.

The issue of determining what defines an inadequate trial of an SSRI is therefore not straightforward; while most studies used adequate doses of medications (as defined when the medication receives an indication from a regulatory authority) the duration of treatment with the SSRI before a judgment is made regarding the inadequacy of the response, was highly variable across the trials that were reviewed. The duration of treatment with an SSRI prior to the determination of an inadequate response ranged from a mean of approximately 4 to 12 weeks. Although adequate doses may be those defined in product monographs, there has been uncertainty regarding the maximal dose to which many common antidepressants should be prescribed. Despite this, a survey conducted a decade ago suggested that the preferred intervention of clinicians following inadequate response to an SSRI was a dose increase. Only three studies have examined whether an increase in dose in this population is associated with a comparable probability of response or remission relative to maintaining standard doses (either as a continuation of the original SSRI or as switch to a new antidepressant); direct comparison of

dose changes relative to selecting another strategy, such as a medication switch or an add-on therapy, was not evaluated in the eligible studies within this review.

Once a decision is made to move beyond optimizing the SSRI regimen, clinicians have several options available, including switching to a new medication (either of the same antidepressant class or a different class), adding a second antidepressant, or adding another agent that itself might not be recognized as an antidepressant in monotherapy. In recent years, the line between ‘augmentation’ agents and ‘antidepressant’ medications has been questioned, leading some investigators to suggest that the standard terminologies of ‘combination’ therapy (to refer to multiple antidepressant treatments, either pharmacological or other, being used at the same time) and ‘augmentation’ therapy (to refer to an antidepressant used in conjunction with another nonantidepressant therapy) should be collapsed and called ‘add-on’ therapy. Regardless of preferences for nomenclature, this review has highlighted that there is an extremely limited evidence base to support clinical decisionmaking about any of these strategies or which agents to select. The variation amongst CPGs reflects this uncertainty.

A common treatment approach following inadequate response to first treatment is to switch medications. Despite the large cohort of patients in the STAR*D trial, there remains insufficient or low quality evidence to determine whether a patient who elects to have a medication switch following an inadequate response to one SSRI can be switched to another SSRI with equal likelihood of response or remission compared to a switch to a medication from another class. The STAR*D trial suggested that this might be the case, at least when comparing sertraline, venlafaxine, and bupropion, but given the frequency with which this question arises in clinical practice, a more substantive evidentiary base on which to make this decision appears warranted.

Another common clinical issue following inadequate treatment response is whether to add a medication, either another antidepressant or a nonantidepressant agent, traditionally called an augmenting agent. Adding a second antidepressant to an SSRI is not uncommon in clinical practice, particularly if patients have had a partial response (at least 20 percent improvement).

Altamura and colleagues^{82,83} have compared intravenous citalopram with intravenous clomipramine following inadequate response to SSRIs, but these trials were preliminary and the short term use of intravenous medication does not address the more typical situation in which patients have a second oral medication added to the SSRI.

Traditional augmentation strategies comprised the bulk of studies meeting criteria for inclusion in this review. Most trials investigated whether adding a new agent to ongoing SSRI treatment was preferable to adding a placebo to ongoing SSRI treatment. Therefore, in most instances what was compared was monotherapy with the initial SSRI against cotherapy with the original SSRI and a new agent. Although the majority of studies fell into this category, there are a limited number of studies for any particular augmenting agent, limiting the strength of the results. The array of agents studied meant that it was difficult to make informed decisions regarding specific classes of medications. Additionally, there are very few studies that examined augmentation compared with switching strategies, which is a clinically relevant question. That is, many clinicians would likely find it helpful to understand the conditions under which it is preferable to add a second treatment rather than switch medications. At least one previous report suggested that clinicians tend to switch medications when there has been minimal response to the treatment and augment when there has been partial response, but whether this approach results in optimal outcomes is not known.¹⁹⁵

The use of atypical antipsychotics has recently gained prominence in the clinical community. Olanzapine was one of the first atypical antipsychotic medications evaluated. Other atypical

antipsychotic medications have since been studied as potential add-on, and even monotherapy, treatments for MDD. Aripiprazole has been studied as an add-on therapy for patients not responding to antidepressant medications,^{105,109,126,131} but the results are not reported in these publications, as SSRI-specific subgroup data are reported only as mean change scores rather than remission and response rates. In the United States, this agent now has an indication as an add-on therapy for patients who do not have adequate response to antidepressant treatment. Similarly, quetiapine, another atypical antipsychotic medication, has been studied as add-on therapy in MDD, but the studies were not restricted to SSRI treated patients and the data could not be disaggregated in order to examine the effectiveness of this approach for patients treated only with SSRIs.^{196,197} A recent pooled analysis not eligible for our review due to publication date, reports showing statistically significant differences in mean scores for the SSRI subgroup favoring quetiapine.¹⁹⁸

A meta-analysis examined the role of atypical antipsychotic medications as add-on therapies in MDD.¹⁹⁹ The authors reported that the mean odds ratios (ORs) were similar for the various atypical agents studied (olanzapine, quetiapine, risperidone, and aripiprazole); they further reported that they could not appreciate that trial duration or method of establishing treatment resistance influenced the pattern or magnitude of the reported results. The OR reported for response in that meta-analysis (OR 1.69, 95% CI 1.46 to 1.59) is comparable to the relative risk (RR) in the risperidone trial by Mahmoud and colleagues¹⁰⁸ (RR 1.86, 95% CI 1.16 to 2.96), and more modest than the preliminary results presented by Shelton and colleagues for olanzapine in combination with fluoxetine (RR 13.0, 95% CI 0.83 to 203.0).¹²²

Although lithium was once described as the single agent with the most extensive evidence base for use as an augmenting agent in MDD,²⁰⁰ surveys suggested that it did not have wide uptake in the United States as an agent for treating people with unipolar depression.²⁰¹ The results of lithium trials in this evidence review do not support its position as a leading augmentation strategy for this population. We recognize that the trials examined here represent only the portion of lithium trials in which patients were treated with SSRIs initially (meeting the criteria for inclusion in this review). Lithium may, however, have anti-suicide properties²⁰² or other features that may make it attractive as an add-on agent in some patients with MDD, such as its low potential to induce a mood switch or cycling in depressed patients with strong genetic vulnerability to bipolar disorder.

There is an extremely limited evidentiary base on which to make conclusions regarding the relative efficacies of various combination treatment approaches for patient with an inadequate response to an SSRI. One treatment strategy is to use a combination of treatment modalities, such as a medication in combination with cognitive behavioral therapy (CBT). The STAR*D trial attempted to measure the value of both CBT as monotherapy and CBT in combination with ongoing citalopram treatment, but the number of patients electing CBT or agreeing to the possibility of being randomized to CBT was small compared to the overall sample size, and this limits conclusions that can be drawn about CBT from the STAR*D trial. A number of issues related to the provision of CBT in the STAR*D trial have been suggested to account for the relatively small number of patients who found CBT an acceptable option, and these may have limited the generalizability of the patients willing to enter that arm. Another eligible trial of a modified cognitive therapy administered to patients as an augmenting agent following nonresponse to antidepressant medication, found that psychotherapy was not different to next step pharmacotherapies that were described to have “closely paralleled those in the STAR*D study.” A relevant question for clinicians is whether patients who do not have an adequate

response to treatment with an antidepressant would do better with an additional medical or with a talk therapy; studies to date do not provide evidence that there are reliable differences in the expected outcomes between these approaches. A caveat to that statement, however, is that patients in both STAR*D and the recent REVAMP trial had many past episodes of depression and it is therefore unknown whether younger patients or those earlier in their course of illness would be more likely to benefit from the addition of CBT than the more chronic group.⁸⁴ The TORDIA trial of adolescents with depression who received CBT in combination with medication suggested that this combination might be beneficial in those with a low past illness burden.^{42,140,141}

A large number of studies included a portion of patients treated with SSRIs and a portion treated with other antidepressant medications. Response and remission rates were not reported as a function of baseline therapy for most studies and although there was a systematic process for contacting authors of the studies, very few were able to provide response and remission data for the subgroup of patients treated with SSRIs. Even registration trials of new add-on treatments for patients not responding to an antidepressant medication have not examined whether the add-on agent is equally effective when added to a range of antidepressant classes. This resulted in the exclusion of a large number of studies containing relevant data because the data for SSRI treated patients could not be disaggregated from those treated with other antidepressants. There appears to be an assumption amongst investigators in this field that response and remission will be comparable regardless of the class of background medication. We are not aware of clinical or neurobiological data to convincingly support this assumption and we suggest that perhaps the assumption should be revisited. It is likely that the major disincentive to examining the effectiveness of various add-on therapies as a function of the antidepressant class used as cotherapy is that it will add to required sample sizes. It is possible that if extant studies were examined by disaggregating the various antidepressants employed as the primary treatment, that a preliminary investigation of whether add-on treatments are equally effective for all antidepressant classes could be conducted.

Depressive symptoms that do not meet full DSM criteria for a major depressive episode can be persistent and disabling. The DSM-IV has provided classification for dysthymia, but there is little evidence that dysthymia is distinct from subthreshold depressive symptoms apart from the extended duration of symptoms required for the diagnosis of dysthymia.¹⁶⁴ The PROSPECT trial evaluated treatment of subthreshold symptoms in the elderly, and combined patients with subsyndromal depression (two symptoms), dysthymia, and minor depression as a single group.²⁰³ It would be useful for investigators to expand the evidence base examining whether distinctions between these subthreshold groups are important. It would also be useful for future treatment studies if a consensus could be reached regarding how to define treatment response or nonresponse when few symptoms are present at baseline.

Finally, the majority of studies did not state an intention to evaluate equivalency, noninferiority, or superiority relative to the standard treatment. Even if the trials had attempted to establish these differences, there are several challenges that need to be considered. The first challenge is specifying *a priori* the margins for defining equivalence, noninferiority, and superiority. There is a need to engage in consensus work to establish acceptable boundaries for these margins. Following this, appropriate power and statistical analyses to establish the equivalence, noninferiority, or superiority also need to be adequately reported.²⁰⁴ Additionally, an underlying assumption to such trial analyses, is that the standard treatment is efficacious. This assumption is problematic in those studies where one arm of the trial is a continuation of the

same intervention to which failed response is established. Similarly, studies that switch subjects to new treatments as the standard arm also challenge the assumption of efficacy.

Adolescents

Only three trials were identified that were of relevance to the adolescent population. The subset of relevant patients could not be extracted from one study (TADS),¹³⁹ leaving two studies of children and adolescents that addressed the question of next line treatment for young people who have not had an adequate response to an SSRI. The TORDIA study appears to emphasize the role for CBT in treating youth. Results continue to emerge from the TORDIA trial^{146-149,205} and will likely provide further information describing the effective components of care for adolescents who have treatment resistant depression. The single trial evaluating dose escalation in children and adolescents would suggest that a dose increase did not show any significant differences in either outcomes of benefit or harm; however, this trial was not adequately powered.¹³⁸ While the TORDIA trial represents a major advance in the recognition of the need to have data on second-line treatment approaches for adolescents with MDD, much more work is required to determine the most effective ways to optimize short- and long-term outcomes for adolescents with depression. The apparent benefit of CBT in combination with medication that was observed in the TORDIA trial was not similarly apparent in either the STAR*D or REVAMP trials. The TORDIA trial explicitly states that almost three in four patients were receiving their first treatment for MDD, while the STAR*D participants had a much higher average burden of illness, and the REVAMP participants were specifically chosen to have chronic depression. This raises the question of whether the effectiveness of CBT is determined in part by the illness history and burden of participants; it has been suggested that this might be the case for CBT in patients with bipolar disorder²⁰⁶ and is worthy of further investigation in unipolar depression. Access to CBT is limited in many jurisdictions, and as such, clinicians may choose to reserve the therapy for those who are in a stage of illness where there is a reasonable probability that it will be associated with superior results than other, more accessible, treatment modalities.

KQ2. What are the harms of each of the monotherapies or combined therapies among these adults and adolescents? How do the harms compare across different interventions?

It is difficult to summarize any specific trend observed for harms in adults across all the different interventions in the eligible studies within this CER. In general, the types of the events reported were consistent with the use of antidepressants and these were generally classified as mild and relatively transient. The findings from this CER have shown that most treatment strategies show no relative differences and that either strategy (the standard or comparator) are likely of modest or uncertain benefit. In this context, evaluation of the harms takes on greater importance. That is, if there is no meaningful difference in the potential outcomes of benefit, the margins between benefits and harms become narrower. Given that many of the treatments that were evaluated likely have no difference (or are potentially equivalent), evaluation of the harms profile also takes on a greater importance in judging the relative efficacy of the two interventions. However, the limitations observed in collecting and reporting harms across the studies constrains the judgments made regarding the margin of difference between harms and benefits and the relative differences in safety profiles of likely equivalent treatments. The inability to distinguish if the studies did not measure these harms, rather simply not reporting them (either because no events occurred or they occurred at the lowest frequencies) makes rating

strength of evidence (SOE) problematic. We considered the measurement of suicidality critical, and therefore necessary for all studies, given the potential of a serious event in MDD and with most treatment approaches. The atypical antipsychotic medications carry a substantial burden of short- and long-term side effects, along with a need for routine metabolic monitoring. Other augmentation agents, such as lithium and tri-iodothyronine, also have short- and long-term harms associated and also require the need for routine bloodwork and possibly other monitoring. Because the short- or long-term harms have not been systematically compared across agents, it is not possible to make a relative determination regarding the potential for harms between agents added as a second-line treatment. There are other potential harms, such as the lethality of a medication in overdose, that are relevant to prescribing physicians but are not routinely captured in clinical trials.

All but one study¹¹² reported some aspect of safety and tolerability, and similarly, only one study was partially designed to evaluate harms as a primary outcome.¹¹⁴ No observational studies evaluating inadequate response to SSRIs were eligible for this review; as such, potentially long-term consequences of these treatment strategies (e.g., increasing the dose or adding an augmenting agent) typically evaluated in such studies are therefore not known. Recognizing that from a statistical perspective, it may be difficult to evaluate statistical differences when event rates are low, we found that the majority of studies did not undertake such tests when comparing differences between groups. Thus, establishing clinically important differences in harms profiles (largely reported as frequencies) is based mainly on judgements.

Rates of discontinuation due to adverse events were variable. The duration of a study can have an important influence on the reported rate of discontinuation. In studies with open-label prospective failure components, the number of patients who had adverse events and did not proceed to the next phase, were not consistently reported. In studies with historical failure, the proportion of subjects who had experienced inadequacy of response due to intolerance because of harms, was not sufficiently detailed. Some studies excluded subjects with any history of drug reactions. Thus, intolerance was not distinguished from inadequate response in these retrospective studies. Disentangling this issue may prove to be helpful in understanding who may achieve a more favorable response in second-line treatment approaches.

Washout periods were included in very few study protocols. For interventions with a switch to new interventions, this may be problematic as early side effects from these new treatments may reflect symptoms related to withdrawal from the previous SSRI or medication rather than reflecting the harms associated with the new treatment.

The method of assessing adverse events differed greatly among studies, with a limited number utilizing standardized scales specific to harms, or reporting adequate details about the protocols and methods used to assess harms. *A priori* definitions of serious or severe harms were consistently not specified within eligible studies. Details regarding the qualifications of the assessor or how harms were decided to be linked to the treatment were almost always lacking. Both of these factors suggest the high risk of bias due to misclassification. Future clinical trials should conform to CONSORT reporting standards for harms.²⁰⁷

The two studies evaluating harms in adolescents used standardized harms reporting instruments and provided details about the frequency of assessment, assessor characteristics and sufficient details about how the harms were collected to allow for replication of the methods. This suggests a higher sensitivity for adequate collection and reporting of harms in this younger population. However, the potential for long-term adverse events within this population is not known, as no observational studies specific to the failed SSRI group were identified.

KQ3. How do these therapies compare in different populations (e.g., different depressive diagnoses, disease severity, age, gender, racial and socioeconomic group, and medical or psychiatric comorbidities)? These subgroups will be considered with respect to the different interventions.

There are seven studies in adults and one for adolescents with MDD that undertook stratified or subgroup analyses evaluating factors that may impact treatment outcomes. The findings for baseline severity are inconsistent, with two studies suggesting no impact and three showing that higher baseline scores were linked to a greater change in scores, or that those with more severe depression are less likely to achieve remission. It is important to note that many studies excluded subjects with psychiatric comorbidities, particularly subjects with anxiety disorders, bipolar disorder, or depression with psychotic features. The STAR*D cohort showed that those with concurrent anxiety related psychiatric comorbidities were less likely to achieve remission, and that the various treatments did not benefit the anxious group any differently. No clear trend emerges for previous history of failure, age, gender, or race. From a clinical perspective, all of these factors have face validity as potentially important treatment modifiers. One could argue that there is a greater need to evaluate these characteristics as potential prognostic factors in populations who have failed to respond. The link with risk factors for predicting failed initial response (first episode) may provide important information for subsequent management of these patient populations.

Neither of the two studies evaluating children and adolescents assess specific subgroups with respect to age or severity. An analysis of the TORDIA trial^{42,140,141,144-149} on predictors of treatment response showed that milder depression, less family conflict, and absence of suicidal behavior were associated with greater likelihood of a positive treatment response at 12 weeks. There was some evidence that there was a differential response to combined treatment in adolescents with a history of sexual and physical abuse; this suggests that specialized clinical approaches may need to be considered in this subgroup of patients.

KQ4. What is the range of recommended clinical actions following the failure of one adequate course of an SSRI based on current clinical practice guidelines published between 2004 and April 2011?

To our knowledge, a comparison of CPGs on managing MDD, dysthymia, and subsyndromal depression in general, much less for those who failed to respond to antidepressant treatment, has not yet been undertaken. This CER evaluated 27 CPGs published in English, limited to those applicable in the national context or from large national professional associations. Seven CPG that were specific only to adolescents, 18 CPG to adults alone, and two were applicable to both adults and adolescents. All guidelines were applicable to patients with MDD but only four CPGs included recommendations for patients with dysthymia and subsyndromal depression. None of the four guidelines with recommendations for this subgroup provided recommendations for those who had failed to respond to previous treatment, possibly reflecting a lack of consensus for treatment in general or recognition for management of this subgroup of depressive disorders. This also raises the issue of interpreting “failed” response in a group for which the range of change is much smaller (fewer symptoms at baseline) relative to those with MDD for which the outcomes were originally designed.

From these CPGs, four did not provide any recommendations for subjects who had an inadequate response. These guidelines were not excluded, as our interest was in identifying the relative proportion of guidelines that did not address the population of interest.

From 18 CPGs in adults, the majority did not report any specific definitions for adequate response or remission within the guideline. For CPGs that did report a formal definition of inadequate response, only two CPGs provided clear indications for differential treatment strategies for those with partial versus nonresponse. This would suggest that the clinical and research community may require both consensus work and knowledge translation strategies to establish standardized definitions for failed or inadequate response. Concomitant to this issue is work to either select a single instrument or to allow for cross referencing between instruments. It is not clear that a 50 percent change in response relative to baseline on the PHQ-9 is similar to a 50 percent change on the HAMD-31.

Evaluation with the AGREE II instrument showed very high variation in the domains of rigour of development, applicability, and editorial independence. This was amplified for the guidance targeted at groups that had inadequate responses to initial treatment. This AGREE II criterion assessed whether the recommendations were clear and unambiguous, such that treatment options were distinctly presented, and key recommendations easily identifiable. The wide variation in strategies recommended across CPGs would seem to match the insufficiency of the evidence shown in our review for many treatment strategies. Although some CPGs clearly stated the limitations of the evidence, others did not and often selectively reported findings from studies to match the recommended course of action. The uncertainty of the evidence needs to be better highlighted in these CPGs.

The operational definition of CPGs is “systematically developed statements about specific clinical problems intended to assist practitioners and patients in making decisions about appropriate health care”⁶⁸ presented some challenges. Our review excluded algorithms, which aim to provide guidance with regard to treatment strategies, methods of implementation, and treatment steps.²⁰⁸ Algorithms are often included in CPGs, but are not in and of themselves a guideline and the process of development may be preceded by a review of the evidence. The use of algorithms in clinical practice may be as prevalent as the use of CPGs, for example, the Texus Algorithm for MDD.²⁰⁷ Future developers of CPGs may wish to develop algorithms that can be incorporated into their guidelines that are evidence-based or at the least identify that they represent best practices.

Most CPGs failed to note or include any patient representation (a key stakeholder) in the development process. Although the CPGs generally rated as acceptable (higher scores) for attempting to link the evidence with the recommendations, the clinical sensibility of these treatment strategies are not addressed by the AGREE II. A variety of grading systems were used and comparison across different CPGs was problematic. The lack of clear guidance for some treatment options further compounded interpretations across guidelines.

The recommendations for most CPGs were stated broadly (switch or augment) and the link between the presentation of the evidence and the specific treatment recommendations was problematic in most CPGs. Few provided clear specification that there was insufficient evidence; rather, any available evidence was summarized with valuations of the strength of the evidence. For adults, the majority of CPGs did not indicate specific types of antidepressants when recommending switching to monotherapy strategies. Increases in the dose and duration of treatment was frequently recommended but the treatment interval or change in dose was not specified. When combined therapy was recommended there was a greater tendency to specify the

medication to be added. However, there was great variability across CPGs in the augmenting agents recommended. The lack of specificity and the relatively high degree of variability is most likely related to the limitations of the evidentiary base.

Guidelines for adolescents scored equally poorly on the AGREE II domain for clarity of presentation of the recommendations. Three of seven guidelines cited adult evidence to justify recommendations for some pharmacological strategies, particularly the use of augmentation agents. Only two CPGs provided definitions of inadequate response. Two guidelines considered failure following nonpharmacological interventions rather than inadequate response to antidepressants, which may reflect a preferential tendency to adopt nonpharmacological strategies in youth. In general, the CPGs for adolescents had a greater tendency to specify the medications to consider for both monotherapy and combined therapy. However, all noted the limitations of the evidence applicable to adolescents.

Applicability

The study populations in the eligible literature were relatively homogenous but were limited to predominately white or Caucasian women within a relatively narrow age range, often with mild to moderate depression. Additionally, there was a tendency to exclude patients who had medical and psychiatric comorbidities. The majority of the participants in the studies often had greater than two past episodes and high numbers (greater than two) past treatment failures on antidepressants. As such, the study subjects represent a narrow spectrum of patients with MDD who are likely to fail to respond when presenting to clinicians in primary care settings. As noted previously, there were few studies evaluating patients with dysthymia and subsyndromal depression, or in children and adolescents.

The dose range of many of the SSRIs and other antidepressants were within standard ranges used as monotherapy or as add-on agents. However, there was some variability in dosing for some augmentation agents and a general lack of rationale for the selected doses of these agents. There are limited data confirming that the doses selected for nonantidepressant augmentation agents reflect the optimum doses of those medications, in the context of augmenting another agent in a person with MDD. In some instances, the rigour of the nonpharmacological treatments may not be consistent with those seen in outpatient settings that patients might access. For example, within the TORDIA trial, the type of CBT was intensive and had high fidelity, but it is not clear if accessing therapists with expertise in working with adolescents is feasible in all jurisdictions. The variation in treatment duration across studies is potentially problematic; this may reflect a lack of consensus as to what constitutes an adequate treatment duration. The assumption has been that treatment duration with combined pharmacological agents are similar to those for antidepressants (a minimum of 4 to 6 weeks).

There is the additional problem of regulatory approval for many of the drugs used as augmenting agents. Some of these drugs do not have any approval by the U.S. Food and Drug Administration (Agomelatine (Valdoxan), Reboxetine (Edronax, Vestra), Norvale (Mianserin, Bolvidon, Tolvan), and many others do not have approval as augmenting agents, suggesting their off label use.

The outcomes used in most studies (for example, the MADRS or HAM-D) are clinician administered; fewer studies used self-report instruments (for example, the QID-SR16 or the PHQ-9). The feasibility of using such instruments in primary care is a consideration that is recognized in the clinical literature.¹⁵¹ Most of these studies were undertaken in outpatient mental health or primary care settings and are therefore applicable to the settings to which the

majority of patients will be seen by practitioners. Conversely, the findings of this review may not be applicable to patients in different settings such as inpatient or specialized psychiatric contexts. However, we note that characteristics of inpatient and outpatient settings differ within health care systems and countries; it is conceivable that important patient characteristics (e.g., severity, duration) may not actually differ between some inpatient and outpatient settings.

There are some special considerations with respect to the monitoring of harms in primary care settings. Although we found the majority of studies did not provide sufficient detail regarding the collection of harms, there is a tendency to monitor harms more rigourously and with the use of standardized instruments in the studies. For example, the TORDIA trial had employed rigorous methods for monitoring harms (for example, weekly monitoring for those displaying any adverse events) and this may be difficult to replicate in primary care settings.

Comparative Effectiveness Review Limitations

This CER has several constraints in its methodology in the context of the literature search. Although over 40,000 citations were screened, the citations were limited to those published in the English language. In addition, the search was limited to publications from 1980 forward, as SSRIs were not in use prior to this time. In consultation with the TEP and partners, issues around predictors of response were considered and it was recognized that the scope of the review was sufficiently large to prohibit evaluation of predictors of response.

We identified a large number of studies that had patients who had failed to respond to a variety of antidepressants; those studies that clearly included only 100 percent of patients who failed on a nonSSRI, or those who had failed on combination therapies prior to entry into the study, were excluded. However, there was a subset of studies that had some proportion who may have failed treatment on an SSRI prior to entry. Attempts were made to contact all authors (n=167 studies) of these studies, who were asked to provide subgroup data specific to the SSRI failed group. Some authors declared that they could not provide us with stratified analyses and these studies were excluded. The contact information for some authors was incorrect, and several attempts to find information related to the publication investigators was made; for some of these, direct contact with the authors was not successful and these studies were excluded as well. Some of the authors did not respond to emails, and after two attempts we excluded these publications as well. A limited number of authors provided us with some stratified results for outcomes and we acknowledge that some of the findings from these stratified analyses may be compromised as the study designs were not such to ensure balance between the SSRI and nonSSRI failed subjects.

A search of the grey literature identified approximately 350 links to regulatory agency documentation, and 171 of these were directly related to drugs found within our eligible studies. The aim in searching these sources was to identify unpublished trials and for potential deviations for reporting of study findings. However, none of these sources provided additional information to identify unpublished trials and evaluate the potential for reporting biases; this was primarily limited by the population (previous failure to SSRI). Previous research specific to antidepressants has shown significant differences in the information reported to the FDA, relative to the same study publication in peer review journals.²⁰⁹ Our search of clinical trial registries identified that only 11 from 44 of our eligible studies (adults and adolescents) had been registered within the sources we were able to search.^{42,44,80,87-89,101,103-106,108-110,113,126,131,132,140,141}

Moreover, the abbreviated information within the registry trials was not helpful in identifying selective reporting of outcomes or deviations to the stated protocols (for example, reporting

information on early phases of the trial or not detailing any subsequent protocol modifications). Trial registries are dependent on investigators to voluntarily update information and may not reflect the most updated source of trial protocol information.

Summary/Conclusions

KQ1. Among adults and adolescents with Major Depressive Disorder, Dysthymia, and Subsyndromal Depression, who are started on an SSRI and who are compliant with treatment but fail to improve either fully, partially, or have no response, what is the benefit (efficacy or effectiveness) of monotherapy and combined therapy?

KQ1a. How does the efficacy/effectiveness vary between the different monotherapies and combined therapies?

1. Studies in adults with MDD and an inadequate response to an SSRI included a preponderance of subjects with multiple past depressive episodes and multiple past unsuccessful treatment trials. The generalizability of these data to people with few past episodes of depression may be limited.
2. Studies in adults with MDD and an inadequate response to an SSRI included a high proportion of whites and women and tended to have an average patient age in the early forties.
3. Studies in adults examining treatment for a major depressive episode following inadequate response to an SSRI examined monotherapy compared with monotherapy, monotherapy with combination therapy or combinations of therapies. The majority of studies compared monotherapy (usually ongoing treatment with the initial SSRI) with a combination of therapies (usually ongoing treatment with the initial SSRI in addition to a nonantidepressant medication).
 - a. The number of studies comparing single medications against each other (monotherapy compared with monotherapy) following an inadequate response to an SSRI is extremely limited. Extant studies are limited in type of agents utilized, sample sizes, and population characteristics. The extant data do not support a difference between various single agent therapies for the outcomes of response and remission.
 - i. **Strength of Evidence:** There is insufficient evidence to evaluate the benefits of changing the dose, switching to a different SSRI, a nonSSRI antidepressant, a nonantidepressant medication, or a nonpharmacological treatment following an inadequate response to an SSRI. With respect to harms there is also insufficient evidence from the studies that were reviewed but the known differential adverse effect profiles amongst different drug categories may provide guidance in making a comparative benefit-risk assessment.
 - b. The largest number of eligible studies examined monotherapy with combination therapy. The majority of studies compared outcomes following ongoing treatment with placebo added to the initial SSRI (the agent to which the subject had not responded by a defined time interval) with outcomes when an active agent was added to the initial SSRI.

- i. Strength of Evidence: There is insufficient evidence to evaluate the benefits of ongoing monotherapy with an SSRI as opposed to combination treatment involving the addition of another antidepressant medication to the initial SSRI.
 - ii. Strength of Evidence: There is low grade evidence that comparable results are achieved following switch to an alternate antidepressant medication (monotherapy with a new antidepressant) when compared with adding a nonantidepressant treatment to the initial SSRI (traditional augmentation approach).
 - iii. Strength of Evidence: There is low grade evidence that adding an atypical antipsychotic medication to ongoing SSRI treatment is associated with higher response and remission rates compared with adding a placebo to ongoing SSRI treatment.
 - iv. Strength of Evidence: There is insufficient evidence for the benefit of other augmentation agents (buspirone, lithium, mianserin, other pharmacological agents, and psychological interventions).
- c. Studies examining combinations of treatment were also extremely limited in number, types of medications, and homogeneity of populations. Extant data do not suggest that any specific combination of active treatments is different to another specific combination of treatments.
 - i. Strength of Evidence: There is insufficient evidence to evaluate the benefits or harms of specific combinations of treatments relative to alternative combinations.
- 4. Studies examining response and remission rates in children and adolescents to treatment subsequent to an inadequate SSRI response were extremely limited. Of three potential trials, data could only be extracted from two and one was a pilot study evaluating dose escalation. The TORDIA trial was of high quality and the results did not show a difference when monotherapy treatments were compared; a switch from the inadequate SSRI to another SSRI was associated with comparable outcomes to a switch to an SNRI. The trial did, however, report that combination therapy of a medication and CBT was superior to monotherapy with a medication.
 - a. Strength of evidence: There is low grade evidence to support the use of CBT in combination with an antidepressant following inadequate response to an SSRI for adolescents (age 12 to 18) with MDD.
- 5. Studies examining response and remission rates in patients specifically selected to have subsyndromal symptoms associated with inadequate response to SSRI were also extremely limited. Only one trial was eligible and that trial had metabolic parameters as the primary outcomes interest.
 - a. Strength of evidence: There is insufficient evidence to support the use of specific treatments for patients with subsyndromal symptoms following an inadequate response to SSRI medications.
- 6. Studies examining patients with dysthymia, but not MDD, and an inadequate response to an SSRI medication were extremely limited. Only one trial was eligible and that trial did not report a difference between treatment with paroxetine 40mg compared with paroxetine 20mg and amisulpride.
 - a. Strength of evidence: There is insufficient evidence to support the use of various treatment approaches for patients with dysthymia who have inadequate response to an SSRI.

KQ2. What are the harms of each of the monotherapies or combined therapies among these adults and adolescents? How do the harms compare across different interventions?

1. Harms for interventions used in both adults and adolescents with MDD who had failed to respond to an SSRI were derived from RCTs that evaluated treatment strategies in this population; no observational studies were eligible. A clear trend for harms was difficult to specify across the differing interventions in adults. Harms were evaluated and reported in a comprehensive and unbiased manner in the single study in adolescents.
2. Reporting and collecting of harms was problematic, particularly for predefining harms including serious and severe events and reporting total number of events per group in the studies with adults. The single study evaluating harms in adolescents provided high quality evidence for harms within this population when receiving pharmacological and psychological treatment.
3. The studies included were short term treatment trials. Harms that may not be apparent in short term clinical trials might emerge with long term use of agents. The relative potential for long term harms and monitoring burden of various agents was not evaluable in the short term treatment trials included here.

KQ3. How do these therapies compare in different populations (e.g., different depressive diagnoses, disease severity, ages, gender, racial and socioeconomic group, and medical or psychiatric comorbidities)?

1. There are a limited number of studies that have evaluated the impact of disease type, disease severity, previous comorbidities, age, gender, and race in the treatment of adults and adolescents who have failed to respond to an SSRI.
2. Only two studies have evaluated psychiatric comorbidities, and findings from the STAR*D cohort of level two adult patients would suggest that patients with anxiety related disorders (particularly anxious patients) are less likely to achieve remission.
3. There is high quality evidence from the TORDIA trial suggesting that mild depression, less family conflict, and the absence of suicidal behavior is associated with a greater likelihood of response in adolescents.

KQ4. What is the range of recommended clinical actions following the failure of one adequate course of an SSRI based on current clinical practice guidelines published between 2004 and April 2011?

1. The majority of clinical practice guidelines (CPGs) for adults were applicable to patients with MDD for outpatient and primary care settings. The majority of CPGs provided recommendations for patients who had failed previous treatments, but did not specify definitions of “inadequate response.”
2. No recommendations for persons with dysthymia or subsyndromal depression who had failed previous treatment were found in the limited number of CPGs that included this population.
3. Recommendations for monotherapy, including dose or interval changes, switching to a different SSRI, or a nonSSRI, were nonspecific as to the drug, interval, or dose change.

4. Recommendations for combination therapy tended to recommend specific types of antidepressants and augmenting agents. However, there was inconsistency across CPGs with regard to the types of augmenting agents to use.

Future Research Recommendations

Future research should attempt to incorporate the following recommendations for primary studies evaluating patients who have failed to respond to an SSRI:

Population

1. Include a broader representation of adult patients with respect to age (>50 and <40), gender (equal proportion of men), and ethnicity (increased proportion of non-white or non-Caucasian, or provide broader representation of all ethnic groups).
2. Include patients derived from primary care settings to incorporate a complete spectrum of participants who have failed to respond to an SSRI.
3. Give detailed specifications of how previous history of failed treatment was determined. The number of previous failures and, where possible, the antidepressant to which subjects had not responded and any factors associated with intolerance to antidepressants.
4. Specify previous mental health history including age at first diagnosis, length of current episode, and number of previous episodes at baseline.
5. Collect information about the presence of other medical and mental health comorbidities at baseline.
6. Collect information on the use of complimentary and alternative medicine (CAM) therapies that have the potential to confound and contaminate study interventions.

Comparator and Study Design

7. Determine treatment failure using a two-part study, the first part of which involves treating patients with SSRIs to prospectively determine failure. This confers methodological advantages in minimizing bias and allows the disentanglement of failure of response due to adverse events, compliance, or physiological response.
8. Specify the intent of the trial as attempting to establish equivalence, noninferiority, or superiority. Justification for the margin of inferiority or superiority should be detailed. Ideally, designing trials to establish superiority is preferred as this would assist clinicians in selecting treatment strategies.
9. Establish a sufficient sample size to show expected margins of difference between groups.
10. Establish a sufficient sample size to evaluate potentially important confounders such as age, gender, and baseline severity.
11. Consideration for possible additional studies that include subjects with dysthymia who have failed to respond to a previous SSRI. The validity of treating this diagnostic group needs to be considered, and if meriting treatment, then the evidence base should increase.
12. Consideration for possible additional studies with subjects with subsyndromal depression who have failed to respond to a previous SSRI. A clear definition of this subgroup (relative to dysthymia or minor depression) should be established. The validity of treating this diagnostic group needs to be considered, and if meriting treatment, then the evidence base should increase.

13. Increase the number of studies with children (ages 8 to 12) and adolescents (greater than 12 to 18 years). This patient population is increasing and needs to be adequately evaluated.

Intervention

14. Establish a clear rationale for the dose used for augmenting agents.
15. Establish efficacy across a range of antidepressant classes with new add-on treatments for patients not responding to an antidepressant medication. The assumption among investigators in this field is that response and remission will be comparable regardless of the class of background medication; the clinical or neurobiological data to support this assumption should be confirmed or revisited.
16. Evaluate the potential benefits of CAM therapies, either as monotherapy or augmenting agents.
17. The concomitant use of CAM therapies (co-interventions) that have the potential to confound interventions should be restricted or monitored (as are other pharmacological agents).
18. Long-term benefits and harms of various add-on agents will be apparent only with long-term followup. There are few studies examining the optimal duration of various treatment strategies beyond the achievement of remission. Future studies should examine whether the short-term benefits of various approaches are sustained and whether the harms of various approaches are acceptable.

Outcomes

19. Specifying primary and secondary outcomes.
20. Consider the inclusion of outcomes other than response or remission, but also include outcomes such as quality of life and speed of response.
21. Report the proportions of subjects who are classified as nonresponders (<20 percent) and partial responders (20 to 49 percent change from baseline) in addition to the sum of the proportion who did not achieve response.
22. Report the definition of adequate response and remission
23. Conform to CONSORT²⁰⁷ reporting standards for harms. As such, severe and serious events (including suicidality) should be defined *a priori* and the use of standardized instruments or terminology for reporting harms should be adopted. Long-term trials may be required to capture harms adequately.

Other

24. Studies with a sufficient sample size to explore these potential subgroups (age, gender, baseline severity, ethnicity, and type of depression) should be considered.
25. Register within clinical trial registries in order to evaluate the potential for publication bias and selective outcome reporting. Researchers should endeavor to regularly update information reported within these registries.

Future recommendations for the development of CPGs for adults, children, and adolescents should include the following:

1. A clear definition of inadequate response for both pharmacological and nonpharmacological treatments and standardized methods for establishing this in real world settings.
2. The addition of patient representation in the CPG development process.
3. Greater clarity with regards to recommended actions and the link with the evidence. Clinicians using the CPGs should be clear when evidence is insufficient.
4. Clear identification of when the recommendations are based on best practice recommendations (as when the evidentiary base is insufficient or weak) relative to when the evidence is sufficient.
5. The impact of contextual factors, such as practice setting (inpatient versus outpatient) or type of clinician (e.g., primary care practitioner, psychiatrist).

References

1. Carvalho AF, Cavalcante JL, Castelo MS, et al. Augmentation strategies for treatment-resistant depression: A literature review. *J Clin Pharm Ther.* 2007;32(5):415-28. ISI:000249450400001
2. Souery D, Papakostas GI, Trivedi MH. Treatment-resistant depression. *J Clin Psychiatry.* 2006;67(Suppl. 6):16-22.
3. McIntyre RS, Fallu A, Konarski JZ. Measurable outcomes in psychiatric disorders: Remission as a marker of wellness. *Clin Ther.* 2006;28(11):1882-91. PM:17213009
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders IV. 1994. <http://allpsych.com/disorders/dsm.html>
5. Judd LL, Rapaport MH, Paulus MP, et al. Subsyndromal symptomatic depression: A new mood disorder? *J Clin Psychiatry.* 1994;55 Suppl:18-28. PM:8077164
6. Kessler RC, Berglund P, Demler O, et al. The epidemiology of major depressive disorder - Results from the National Comorbidity Survey Replication (NCS-R). *J Am Med Assoc.* 2003;289(23):3095-105. ISI:000183560400024
7. Alonso J, Angermeyer MC, Bernert S, et al. Prevalence of mental disorders in Europe: Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatr Scand.* 2004;(Suppl 420):21-7. PM:15128384
8. Beck CA, Patten SB. Adjustment to antidepressant utilization rates to account for depression in remission. *Compr Psychiatry.* 2004;45(4):268-74. PM:15224269
9. Brugha T, Jenkins R, Bebbington P, et al. Risk factors and the prevalence of neurosis and psychosis in ethnic groups in Great Britain. *Soc Psychiatry Psychiatr Epidemiol.* 2004;39(12):939-46. PM:15583900
10. Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med.* 2005;352(24):2515-23. PM:15958807
11. Gonzalez HM, Vega WA, Williams DR, et al. Depression care in the United States: too little for too few. *Arch Gen Psychiatry.* 2010;67(1):37-46. PM:20048221
12. Spijker J, de Graaf R, Bijl RV, et al. Duration of major depressive episodes in the general population: Results from The Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Br J Psychiatry.* 2002;181:208-13. PM:12204924
13. Birmaher B, Brent D, Bernet W, et al. Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *J Am Acad Child Adolesc Psychiatry.* 2007;46(11):1503-26. PM:18049300
14. US Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force Recommendation Statement. *J Am Acad Pediatr.* 2009;123(4):1223-8. PMID:19336383
15. Birmaher B, Ryan ND, Williamson DE, et al. Childhood and adolescent depression: A review of the past 10 years, Part II. *J Am Acad Child Adolesc Psychiatry.* 1996;35(12):1575-83.
16. Murray CJ, Lopez AD. Evidence-based health policy--lessons from the Global Burden of Disease Study. *Science.* 1996;274(5288):740-3. PM:8966556
17. World Health Organization. The World Health Report 2001: Mental health: New understanding, new hope. 2001 Oct 4. <http://www.who.int/whr/2001/en/>
18. The Standing Senate Committee on Social Affairs SaT. Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada. 2006. <http://www.parl.gc.ca/39/1/parlbus/commbu/s/senate/com-e/soci-e/rep-e/rep02may06-e.htm>
19. Rapaport MH, Clary C, Fayyad R, et al. Quality-of-life impairment in depressive and anxiety disorders. *Am J Psychiatry.* 2005;162(6):1171-8. PM:15930066

20. Greenberg PE, Kessler RC, Birnbaum HG, et al. The economic burden of depression in the United States: How did it change between 1990 and 2000? *Clin Psychiatry*. 2003;64(12):1465-75.
21. Tompson MC, Pierre CB, Boger KD, et al. Maternal depression, maternal expressed emotion, and youth psychopathology. *J Abnorm Child Psychol*. 2010;38(1):105-17. PM:19693663
22. Eckshtain D, Ellis DA, Kolmodin K, et al. The effects of parental depression and parenting practices on depressive symptoms and metabolic control in urban youth with insulin dependent diabetes. *J Pediatr Psychol*. 2010;35(4):426-35. PM:19710249
23. Ramchandani P, Stein A. The impact of parental psychiatric disorder on children: Avoiding stigma, improving care. *Br Med J*. 2003;327(7409):242-3.
24. Adler DA, McLaughlin TJ, Rogers WH, et al. Job performance deficits due to depression. *Am J Psychiatry*. 2006;163(9):1569-76. PM:16946182
25. Lerner D, Adler DA, Chang H, et al. The clinical and occupational correlates of work productivity loss among employed patients with depression. *J Occup Environ Med*. 2004;46(6 Suppl):S46-S55 PM:15194895
26. Hoge CW, Lesikar SE, Guevara R, et al. Mental disorders among U.S. military personnel in the 1990s: Association with high levels of health care utilization and early military attrition. *Am J Psychiatry*. 2002;159(9):1576-83. PM:12202280
27. Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: Impact of depressive symptoms on adherence, function, and costs. *Arch Intern Med*. 2000;160(21):3278-85. PM:11088090
28. Aro AR, de Koning HJ, Absetz P, et al. Psychosocial predictors of first attendance for organised mammography screening. *J Med Screen*. 1999;6(2):82-8. PM:10444726
29. McIntyre RS, Soczynska JK, Konarski JZ, et al. The effect of antidepressants on glucose homeostasis and insulin sensitivity: Synthesis and mechanisms. *Expert Opin Drug Saf*. 2006;5(1):157-68. PM:16370964
30. Murphy JM, Horton NJ, Monson RR, et al. Cigarette smoking in relation to depression: Historical trends from the Stirling County Study. *Am J Psychiatry*. 2003;160(9):1663-9. PM:12944343
31. Van Gool CH, Kempen GI, Penninx BW, et al. Relationship between changes in depressive symptoms and unhealthy lifestyles in late middle aged and older persons: Results from the Longitudinal Aging Study Amsterdam. *Age Ageing*. 2003;32(1):81-7. PM:12540353
32. Kop WJ. The integration of cardiovascular behavioral medicine and psychoneuroimmunology: New developments based on converging research fields. *Brain Behav Immun*. 2003;17(4):233-7. PM:12831824
33. Corcos M, Guilbaud O, Hjalmarsson L, et al. Cytokines and depression: An analogic approach. *Biomed Pharmacother*. 2002;56(2):105-10. PM:12000135
34. Kop WJ, Gottdiener JS, Tangen CM, et al. Inflammation and coagulation factors in persons > 65 years of age with symptoms of depression but without evidence of myocardial ischemia. *Am J Cardiol*. 2002;89(4):419-24. PM:11835923
35. Musselman DL, Miller AH, Porter MR, et al. Higher than normal plasma interleukin-6 concentrations in cancer patients with depression: preliminary findings. *Am J Psychiatry*. 2001;158(8):1252-7. PM:11481159
36. Penninx BW, Kritechevsky SB, Yaffe K, et al. Inflammatory markers and depressed mood in older persons: Results from the Health, Aging and Body Composition study. *Biol Psychiatry*. 2003;54(5):566-72. PM:12946885
37. Taylor CB, Youngblood ME, Catellier D, et al. Effects of antidepressant medication on morbidity and mortality in depressed patients after myocardial infarction. *Arch Gen Psychiatry*. 2005;62(7):792-8. PM:15997021
38. Wassertheil-Smoller S, Shumaker S, Ockene J, et al. Depression and cardiovascular sequelae in postmenopausal women. The Women's Health Initiative (WHI). *Arch Intern Med*. 2004;164(3):289-98. PM:14769624

39. Gilmour H. Depression and risk of heart disease. *Health Reports* Vol.19, no.3, 82-003-XPE. Statistics Canada; 2008. http://dsp-psd.pwgsc.gc.ca/collection_2008/statcan/82-003-X/82-003-XIE2008003.pdf
40. Patten SB, Williams JV, Lavorato DH, et al. Major depression as a risk factor for chronic disease incidence: Longitudinal analyses in a general population cohort. *Gen Hosp Psychiatry*. 2008;30(5):407-13. PM:18774423
41. Seguin M, Lesage A, Chawky N, et al. Suicide cases in New Brunswick from April 2002 to May 2003: The importance of better recognizing substance and mood disorder comorbidity. *Can J Psychiatry*. 2006;51(9):581-6. PM:17007225
42. Brent D, Emslie G, Clarke G, et al. Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: The TORDIA randomized controlled trial. *JAMA*. 2008;299(8):901-13. PMID:18314433
43. Williams JW, Jr., Pignone M, Ramirez G, et al. Identifying depression in primary care: A literature synthesis of case-finding instruments. *Gen Hosp Psychiatry*. 2002;24(4):225-37. PM:12100833
44. Rush AJ, Trivedi MH, Wisniewski SR, et al. Bupropion-SR, sertraline, or venlafaxine-XR after failure of SSRIs for depression. *N Engl J Med*. 2006;354(12):1231-42. PMID:16554525
45. Bilsker D, Goldner EM, Jones W. Health service patterns indicate potential benefit of supported self-management for depression in primary care. *Can J Psychiatry*. 2007;52(2):86-95. PM:17375863
46. Kupfer DJ. Long-term treatment of depression. *J Clin Psychiatry*. 1991;52(Suppl. 5):28-34.
47. Paykel ES, Ramana R, Cooper Z, et al. Residual symptoms after partial remission: An important outcome in depression. *Psychol Med*. 1995;25(6):1171-80. PMID:8637947
48. Papakostas GI, Perlis RH, Scalia MJ, et al. A meta-analysis of early sustained response rates between antidepressants and placebo for the treatment of major depressive disorder. *J Clin Psychopharmacol*. 2006;26(1):56-60.
49. Posternak MA, Zimmerman M. Is there a delay in the antidepressant effect? A meta-analysis. *J Clin Psychiatry*. 2005;66(2):148-58.
50. Taylor MJ, Freemantle N, Geddes JR, et al. Early onset of selective serotonin reuptake inhibitor antidepressant action: Systematic review and meta-analysis. *Arch Gen Psychiatry*. 2006;63(11):1217-23. PM:17088502
51. Wade A, Friis Andersen H. The onset of effect for escitalopram and its relevance for the clinical management of depression. *Curr Med Res Opin*. 2006;22(11):2101-10. PM:17076970
52. Trivedi MH, Greer TL, Grannemann BD, et al. Exercise as an augmentation strategy for treatment of major depression. *J Psychiatr Pract*. 2006;12(4):205-13. PMID:16883145
53. Parikh SV, Segal ZV, Grigoriadis S, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. II. Psychotherapy alone or in combination with antidepressant medication. *J Affect Disord*. 2009;117(Suppl. 1):S15-S25
54. Ravindran AV, Lam RW, Filteau MJ, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. V. Complementary and alternative medicine treatments. *J Affect Disord*. 2009;117(Suppl. 1):S54-S64
55. Qaseem A, Snow V, Denberg TD, et al. Using second-generation antidepressants to treat depressive disorders: A clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2008;149(10):725-33. PM:19017591
56. Hamilton M. A rating scale for depression. *J Neurol Neurosurg Psychiatry*. 1960;23:56-62. PM:14399272

57. Montgomery SA, Asberg M. A new depression scale designed to be sensitive to change. *Br J Psychiatry*. 1979;134:382-9. PM:444788
58. Uher R, Farmer A, Maier W, et al. Measuring depression: Comparison and integration of three scales in the GENDEP study. *Psychol Med*. 2008;38(2):289-300. PM:17922940
59. Riedel M, Moller HJ, Obermeier M, et al. Response and remission criteria in major depression - A validation of current practice. *J Psychiatr Res*. 2010;44(15):1063-8. PM:20447651
60. Biak S, Gonzales J, Bowers B. Reinvention of depression instruments by primary care clinicians. *Ann Fam Med*. 2010;8(3):224-30.
61. Michell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: A meta-analysis. *Lancet*. 2009;374(9690):609-19.
62. Frank E, Prien RF, Jarrett RB, et al. Conceptualization and rationale for consensus definitions of terms in major depressive disorder - Remission, recovery, relapse, and recurrence. *Arch Gen Psychiatry*. 1991;48(9):851-5. ISI:A1991GF52300010
63. Gartlehner, G, Hansen, R. A., Thieda, P. et al. Comparative effectiveness of second-generation antidepressants in the pharmacologic treatment of adult depression. Comparative Effectiveness Review Number 7. www.effectivehealthcare.ahrq.gov/reports/final.cfm
64. Williams AL, Girard C, Jui D, et al. S-adenosylmethionine (S-AMe) as treatment for depression: A systematic review. *Clin Invest Med*. 2005;28(3):132-9. PMID:16021987
65. Souery D, Amsterdam J, de Montigny C, et al. Treatment resistant depression: Methodological overview and operational criteria. *Eur Neuropsychopharmacol*. 1999;9(1-2):83-91. PMID:10082232
66. Berlim MT, Fleck MP, Turecki G. Current trends in the assessment and somatic treatment of resistant/refractory major depression: An overview. *Ann Med*. 2008;40(2):149-59. ISI:000253505400007
67. Fava M. Diagnosis and definition of treatment-resistant depression. *Biol Psychiatr*. 2003;53(8):649-59. ISI:000182360400004
68. Field M and Lohr K. Institute of Medicine. Guidelines for clinical practice: From development to use. Washington, DC: National Academy Press; 1992.
69. Higgins JPT. Cochrane Handbook for Systematic Reviews of Interventions Version 5.0.2. 2008. <http://www.cochrane-handbook.org/>
70. Hartling L, Ospina M, Liang Y, et al. Risk of bias versus quality assessment of randomised controlled trials: Cross sectional study. *Br Med J*. 2009;339:1-6. PM:19841007
71. Wells, GA, Shea, B, O'Connell, D et al. The Newcastle-Ottawa Scale (NOS) for assessing the quality of nonrandomised studies in meta-analyses. Last Accessed February 1, 2009. http://www.ohri.ca/programs/clinical_epidemiology/oxford.htm
72. Santaguida P and Raina P. Development of a quality assessment scale specific to harms in studies evaluating the efficacy of health technologies: Manual for using the McHarm. 2010. <http://hiru.mcmaster.ca/epc/mcharm.pdf>
73. Chou R, Aronson N, Atkins D, et al. AHRQ series paper 4: Assessing harms when comparing medical interventions: AHRQ and the effective health-care program. *J Clin Epidemiol*. 2010;63(5):502-12. PM:18823754
74. The AGREE Next Steps Consortium. Appraisal of guidelines for research and evaluation II (AGREE II). The AGREE Research Trust; 2009. www.agreetrust.org/?o=1397
75. Owens DK, Lohr KN, Atkins D, et al. AHRQ series paper 5: Grading the strength of a body of evidence when comparing medical interventions--agency for healthcare research and quality and the effective health-care program. *J Clin Epidemiol*. 2010;63(5):513-23. PM:19595577

76. GRADE working group. Grading the quality of evidence and the strength of recommendations. www.gradeworkinggroup.org.
77. Heres S, Davis J, Maino K, et al. Why olanzapine beats risperidone, risperidone beats quetiapine, and quetiapine beats olanzapine: An exploratory analysis of head-to-head comparison studies of second-generation antipsychotics. *Am J Psychiatry*. 2006;163(2):185-94.
78. Blumenthal D, Campbell E, Anderson M, et al. Withholding research results in academic life science - Evidence from a national survey of faculty. *JAMA*. 1997;277(15):1224-8.
79. Berman RM, Fava M, Thase ME, et al. Aripiprazole augmentation in major depressive disorder: A double-blind, placebo-controlled study in patients with inadequate response to antidepressants. *CNS Spect*. 2009;14(4):197-206. PMID:19407731
80. Preskorn SH, Baker B, Kolluri S, et al. An innovative design to establish proof of concept of the antidepressant effects of the NR2B subunit selective N-methyl-D-aspartate antagonist, CP-101,606, in patients with treatment-refractory major depressive disorder. *J Clin Psychopharmacol*. 2008;28(6):631-7. PMID:19011431
81. Rush AJ, Wisniewski SR, Warden D, et al. Selecting among second-step antidepressant medication monotherapies: Predictive value of clinical, demographic, or first-step treatment features. *Arch Gen Psychiatry*. 2008;65(8):870-80. PMID:18678792
82. Altamura AC, Dell'Osso B, Buoli M, et al. Intravenous augmentative citalopram versus clomipramine in partial/nonresponder depressed patients: A short-term, low dose, randomized, placebo-controlled study. *J Clin Psychopharmacol*. 2008;28(4):406-10. PMID:18626267
83. Altamura AC, Dell'Osso B, Buoli M, et al. Short-term intravenous citalopram augmentation in partial/nonresponders with major depression: A randomized placebo-controlled study. *Int Clin Psychopharmacol*. 2008;23(4):198-202. PMID:18545057
84. George TP, Sacco KA, Vessicchio JC, et al. Nicotinic antagonist augmentation of selective serotonin reuptake inhibitor-refractory major depressive disorder: A preliminary study. *J Clin Psychopharmacol*. 2008;28(3):340-4. PMID:18480694
85. Lenox-Smith AJ, Jiang Q. Venlafaxine extended release versus citalopram in patients with depression unresponsive to a selective serotonin reuptake inhibitor. *Int Clin Psychopharmacol*. 2008;23(3):113-9. PMID:18408525
86. Dunner DL, Amsterdam JD, Shelton RC, et al. Efficacy and tolerability of adjunctive ziprasidone in treatment-resistant depression: A randomized, open-label, pilot study. *J Clin Psychiatry*. 2007;68(7):1071-7. PMID:17685744
87. Michelson D, Adler LA, Amsterdam JD, et al. Addition of atomoxetine for depression incompletely responsive to sertraline: A randomized, double-blind, placebo-controlled study. *J Clin Psychiatry*. 2007;68(4):582-7. PMID:17474814
88. Thase ME, Corya SA, Osuntokun O, et al. A randomized, double-blind comparison of olanzapine/fluoxetine combination, olanzapine, and fluoxetine in treatment-resistant major depressive disorder. *J Clin Psychiatry*. 2007;68(2):224-36. PMID:17335320
89. Shapira B, Nemets B, Trachtenberg A, et al. Phenytoin as an augmentation for SSRI failures: A small controlled study. *J Affect Disord*. 2006;96(1-2):123-6. PMID:16814397
90. Thase ME, Shelton RC, Khan A. Treatment with venlafaxine extended release after SSRI nonresponse or intolerance: A randomized comparison of standard- and higher-dosing strategies. *J Clin Psychopharmacol*. 2006;26(3):250-8. PMID:16702889
91. Seidman SN, Miyazaki M, Roose SP. Intramuscular testosterone supplementation to selective serotonin reuptake inhibitor in treatment-resistant depressed men: Randomized placebo-controlled clinical trial. *J Clin Psychopharmacol*. 2005;25(6):584-8. PMID:16282843

92. Landen M, Hogberg P, Thase ME. Incidence of sexual side effects in refractory depression during treatment with citalopram or paroxetine. *J Clin Psychiatry*. 2005;66(1):100-6. PMID:15669895
93. Perry EB, Berman RM, Sanacora G, et al. Pindolol augmentation in depressed patients resistant to selective serotonin reuptake inhibitors: A double-blind, randomized, controlled trial. *J Clin Psychiatry*. 2004;65(2):238-43. PMID:15003079
94. Wiles NJ, Hollinghurst S, Mason V, et al. A randomized controlled trial of cognitive behavioural therapy as an adjunct to pharmacotherapy in primary care based patients with treatment resistant depression: A pilot study. *Behav Cognit Psychother*. 2008;36(1):21-33.
95. Keitner GI, Garlow SJ, Ryan CE, et al. A randomized, placebo-controlled trial of risperidone augmentation for patients with difficult-to-treat unipolar, non-psychotic major depression. *J Psychiatr Res*. 2009;43(3):205-14.
96. Sokolski KN, Conney JC, Brown BJ, et al. Once-daily high-dose pindolol for SSRI-refractory depression. *Psychiatry Res*. 2004;125(2):81-6.
97. Landén M, Björling G, Agren H, et al. A randomized, double-blind, placebo-controlled trial of buspirone in combination with an SSRI in patients with treatment-refractory depression. *J Clin Psychiatry*. 1998;59(12):664-8.
98. Fava M, Rosenbaum JF, McGrath PJ, et al. Lithium and tricyclic augmentation of fluoxetine treatment for resistant major depression: A double-blind, controlled study. *Am J Psychiatry*. 1994;151(9):1372-4.
99. Fava M, Rush AJ, Alpert JE, et al. Difference in treatment outcome in outpatients with anxious versus nonanxious depression: A STAR*D report. *Am J Psychiatry*. 2008;165(3):342-51. ISI:000253779400014
100. Rush AJ, Warden D, Wisniewski SR, et al. STAR*D: Revising conventional wisdom. *CNS Drugs*. 2009;23(8):627-47. PMID:19594193
101. Amsterdam JD, Williams D, Michelson D, et al. Tachyphylaxis after repeated antidepressant drug exposure in patients with recurrent major depressive disorder. *Neuropsychobiol*. 2009;59(4):227-33. PMID:19571597
102. Warden D, Rush AJ, Wisniewski SR, et al. What predicts attrition in second step medication treatments for depression?: A STAR*D Report. *Int J Neuropsychopharmacol*. 2009;12(4):459-73. PMID:18611293
103. Perahia DG, Quail D, Desai D, et al. Switching to duloxetine in selective serotonin reuptake inhibitor non- and partial-responders: Effects on painful physical symptoms of depression. *J Psychiatr Res*. 2009;43(5):512-8. PMID:18707693
104. Ruhe HG, Booij J, Weert HC, et al. Evidence why paroxetine dose escalation is not effective in major depressive disorder: A randomized controlled trial with assessment of serotonin transporter occupancy. *Neuropsychopharmacol*. 2009;34(4):999-1010. PMID:18830236
105. Marcus RN, McQuade RD, Carson WH, et al. The efficacy and safety of aripiprazole as adjunctive therapy in major depressive disorder: A second multicenter, randomized, double-blind, placebo-controlled study. *J Clin Psychopharmacol*. 2008;28(2):156-65. PMID:18344725
106. Perahia DG, Quail D, Desai D, et al. Switching to duloxetine from selective serotonin reuptake inhibitor antidepressants: A multicenter trial comparing 2 switching techniques. *J Clin Psychiatry*. 2008;69(1):95-105. PMID:18312043
107. Alexopoulos GS, Canuso CM, Gharabawi GM, et al. Placebo-controlled study of relapse prevention with risperidone augmentation in older patients with resistant depression. *Am J Geriatr Psychiatry*. 2008;16(1):21-30. PMID:17928573
108. Mahmoud RA, Pandina GJ, Turkoz I, et al. Risperidone for treatment-refractory major depressive disorder: A randomized trial. *Ann Intern Med*. 2007;147(9):593-602. PMID:17975181

109. Berman RM, Marcus RN, Swanink R, et al. The efficacy and safety of aripiprazole as adjunctive therapy in major depressive disorder: A multicenter, randomized, double-blind, placebo-controlled study. *J Clin Psychiatry*. 2007;68(6):843-53. PMID:17592907
110. Thase ME, Friedman ES, Biggs MM, et al. Cognitive therapy versus medication in augmentation and switch strategies as second-step treatments: A STAR*D report. *Am J Psychiatry*. 2007;164(5):739-52. PMID:17475733
111. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: A STAR*D report. *Am J Psychiatry*. 2006;163(11):1905-17. PMID:17074942
112. Bondolfi G, Aubry JM, Golaz J, et al. A stepwise drug treatment algorithm to obtain complete remission in depression: A Geneva study. *Swiss Med Week*. 2006;136(5-6):78-85. PMID:16633950
113. Trivedi MH, Fava M, Wisniewski SR, et al. Medication augmentation after the failure of SSRIs for depression. *N Engl J Med*. 2006;354(12):1243-52. PMID:16554526
114. Fava M, Thase ME, DeBattista C. A multicenter, placebo-controlled study of modafinil augmentation in partial responders to selective serotonin reuptake inhibitors with persistent fatigue and sleepiness. *J Clin Psychiatry*. 2005;66(1):85-93. PMID:15669893
115. Birkenhager TK, van den Broek WW, Mulder PG, et al. Efficacy and tolerability of tranylcypromine versus phenelzine: A double-blind study in antidepressant-refractory depressed inpatients. *J Clin Psychiatry*. 2004;65(11):1505-10. PMID:15554763
116. Perlis RH, Alpert J, Nierenberg AA, et al. Clinical and sociodemographic predictors of response to augmentation, or dose increase among depressed outpatients resistant to fluoxetine 20 mg/day. *Acta Psychiatr Scand*. 2003;108(6):432-8. PMID:14616224
117. Rocca P, Marchiario L, Rasetti R, et al. A comparison of paroxetine versus paroxetine plus amisulpride in the treatment of dysthymic disorder: Efficacy and psychosocial outcomes. *Psychiatry Res*. 2002;112(2):145-52. PMID:12429360
118. Fava M, Alpert J, Nierenberg A, et al. Double-blind study of high-dose fluoxetine versus lithium or desipramine augmentation of fluoxetine in partial responders and nonresponders to fluoxetine. *J Clin Psychopharmacol*. 2002;22(4):379-87. PMID:12172337
119. Licht RW, Qvitzau S. Treatment strategies in patients with major depression not responding to first-line sertraline treatment. A randomised study of extended duration of treatment, dose increase or mianserin augmentation. *Psychopharmacol*. 2002;161(2):143-51. PMID:11981594
120. Appelberg BG, Syvalahti EK, Koskinen TE, et al. Patients with severe depression may benefit from buspirone augmentation of selective serotonin reuptake inhibitors: results from a placebo-controlled, randomized, double-blind, placebo wash-in study. *J Clin Psychiatry*. 2001;62(6):448-52. PMID:11465522
121. Ferreri M, Lavergne F, Berlin I, et al. Benefits from mianserin augmentation of fluoxetine in patients with major depression non-responders to fluoxetine alone. *Acta Psychiatr Scand*. 2001;103(1):66-72. PMID:11202131
122. Shelton RC, Tollefson GD, Tohen M, et al. A novel augmentation strategy for treating resistant major depression. *Am J Psychiatry*. 2001;158(1):131-4. PMID:11136647
123. Nemets B, Mishory A, Levine J, et al. Inositol addition does not improve depression in SSRI treatment failures. *J Neural Transm*. 1999;106(7-8):795-8. PMID:10907738
124. Baumann P, Nil R, Souche A, et al. A double-blind, placebo-controlled study of citalopram with and without lithium in the treatment of therapy-resistant depressive patients: A clinical, pharmacokinetic, and pharmacogenetic investigation. *J Clin Psychopharmacol*. 1996;16(4):307-14. PMID:8835706

125. Dinan TG. Lithium augmentation in sertraline-resistant depression: A preliminary dose-response study. *Acta Psychiatr Scand*. 1993;88(4):300-1. PMID:8256650
126. Thase ME, Trivedi MH, Nelson JC, et al. Examining the efficacy of adjunctive aripiprazole in major depressive disorder: A pooled analysis of 2 studies. *Prim Care Comp J Clin Psychiatry*. 2008;10(6):440-7.
127. Carta MG, Hardoy MC, Pilu A, et al. Improving physical quality of life with group physical activity in the adjunctive treatment of major depressive disorder. *Clin Pract Epidemiol Ment Health*. 2008;4(1):1-6.
128. Lynch TR, Cheavens JS, Cukrowicz KC, et al. Treatment of older adults with co-morbid personality disorder and depression: A dialectical behavior therapy approach. *Int J Geriatr Psychiatry*. 2007;22(2):131-43.
129. Zourkova A. Effect of mirtazapine and paroxetine on residual symptoms of depressive disorders and their effect on P450 CYP 2D6 activity. *Homeost Health Dis*. 2001;41(6):242-9.
130. Landén M, Eriksson E, Agren H, et al. Effect of buspirone on sexual dysfunction in depressed patients treated with selective serotonin reuptake inhibitors. *J Clin Psychopharmacol*. 1999;19(3):268-71.
131. Nelson JC, Mankoski R, Baker RA, et al. Effects of aripiprazole adjunctive to standard antidepressant treatment on the core symptoms of depression: A post-hoc, pooled analysis of two large, placebo-controlled studies. *J Affect Disord*. 2010;120(1-3):133-40. PMID:19656577
132. Reimherr F, Amsterdam J, Dunner D, et al. Genetic polymorphisms in the treatment of depression: speculations from an augmentation study using atomoxetine. *Psychiatry Res*. 2010;175(1-2):67-73. PMID:19969374
133. Martire LM, Schulz R, Reynolds CF, III, et al. Treatment of late-life depression alleviates caregiver burden. *J Am Geriatr Soc*. 2010;58(1):23-9. PMID:19943833
134. Bauer M, El-Khalili N, Datto C, et al. A pooled analysis of two randomised, placebo-controlled studies of extended release quetiapine fumarate adjunctive to antidepressant therapy in patients with major depressive disorder. [Review]. *J Affect Disord*. 2010;127(1-3):19-30. PMID:20884063
135. Greenlee A, Karp JF, Dew MA, et al. Anxiety impairs depression remission in partial responders during extended treatment in late-life. *Depress Anxiety*. 2010;27(5):451-6. PMID:20186975
136. Nelson JC, Thase ME, Trivedi MH, et al. Safety and tolerability of adjunctive aripiprazole in major depressive disorder: A pooled post hoc analysis (studies CN138-139 and CN138-163). *Prim Care Comp J Clin Psychiatry*. 2009;11(6):344-52.
137. Reynolds CFI, Dew MA, Martire LM, et al. Treating depression to remission in older adults: A controlled evaluation of combined escitalopram with interpersonal psychotherapy versus escitalopram with depression care management. *Int J Geriatr Psychiatry*. 2010;25(11):1134-41.
138. Heiligenstein JH, Hoog SL, Wagner KD, et al. Fluoxetine 40-60 mg versus fluoxetine 20 mg in the treatment of children and adolescents with a less-than-complete response to nine-week treatment with fluoxetine 10-20 mg: A pilot study. *Journal of Child & Adolescent Psychopharmacology*. 2006;16(1-2):207-17. PMID:16553541
139. Vitiello B, Brent DA, Greenhill LL, et al. Depressive Symptoms and clinical status during the treatment of adolescent suicide attempters (TASA) study. *J Am Acad Child Adolesc Psychiatry*. 2009;48(10):997-1004.
140. Brent DA, Emslie GJ, Clarke GN, et al. Predictors of spontaneous and systematically assessed suicidal adverse events in the treatment of SSRI-resistant depression in adolescents (TORDIA) study. *Am J Psychiatry*. 2009;166(4):418-26.
141. Asarnow JR, Emslie G, Clarke G, et al. Treatment of selective serotonin reuptake inhibitor-resistant depression in adolescents: Predictors and moderators of treatment response. *J Am Acad Child Adolesc Psychiatry*. 2009;48(3):330-9.

142. Brent DA, Greenhill LL, Compton S, et al. The Treatment of Adolescent Suicide Attempters Study (TASA): Predictors of suicidal events in an open treatment trial. *J Am Acad Child Adolesc Psychiatry*. 2009;48(10):987-96.
143. Stanley B, Brown G, Brent DA, et al. Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP): Treatment model, feasibility, and acceptability. *J Am Acad Child Adolesc Psychiatry*. 2009;48(10):1005-13.
144. Brent D, Melhem N, Ferrell R, et al. Association of FKBP5 polymorphisms with suicidal events in the Treatment of Resistant Depression in Adolescents (TORDIA) study. *Am J Psychiatry*. 2010;167(2):190-7. PMID:20008943
145. Goldstein BI, Shamseddeen W, Spirito A, et al. Substance use and the treatment of resistant depression in adolescents. *J Am Acad Child Adolesc Psychiatry*. 2009;48(12):1182-92.
146. Emslie GJ, Mayes T, Porta G, et al. Treatment of Resistant Depression in Adolescents (TORDIA): Week 24 outcomes. *Am J Psychiatry*. 2010;167(7):782-91. PMID:20478877
147. Sakolsky DJ, Perel JM, Emslie GJ, et al. Antidepressant exposure as a predictor of clinical outcomes in the Treatment of Resistant Depression in Adolescents (TORDIA) study. *J Clin Psychopharmacol*. 2011;31(1):92-7.
148. Shamseddeen W, Asarnow JR, Clarke G, et al. Impact of physical and sexual abuse on treatment response in the treatment of resistant depression in adolescent study (TORDIA). *J Am Acad Child Adolesc Psychiatry*. 2011;50(3):293-301.
149. Lynch FL, Dickerson JF, Clarke G, et al. Incremental cost-effectiveness of combined therapy vs. medication only for youth with selective serotonin reuptake inhibitor-resistant depression: Treatment of SSRI-resistant depression in adolescents trial findings. *Arch Gen Psychiatry*. 2011;68(3):253-62.
150. Rapaport MH, Gharabawi GM, Canuso CM, et al. Effects of risperidone augmentation in patients with treatment-resistant depression: Results of open-label treatment followed by double-blind continuation. *Neuropsychopharmacol*. 2006;31(11):2505-13.
151. Jaehne, M. E. Health care guideline: Major depression in adults in primary care 12th edition. Institute for Clinical Systems Improvement.
152. Depression clinical practice guidelines. National Guideline Clearinghouse. 2004;1-20.
153. Steinman LE, Frederick JT, Prohaska T, et al. Recommendations for treating depression in community-based older adults. *Am J Prev Med*. 2007;33(3):175-81. PMID:17826575
154. Bauer M, Bschor T, Pfennig A, et al. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for biological treatment of unipolar depressive disorders in primary care. *World J Biol Psychiatry*. 2007;8(2):67-104. PMID:17455102
155. Davidson KW, Kupfer DJ, Bigger JT, et al. Assessment and treatment of depression in patients with cardiovascular disease: National Heart, Lung, and Blood Institute Working Group Report. *Psychosom Med*. 2006;68(5):645-50. PMID:17012516
156. Ellis P, Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. Australian and New Zealand clinical practice guidelines for the treatment of depression. *Aust NZ J Psychiatry*. 2004;38(6):389-407. PMID:15209830
157. Malhi GS, Adams D, Porter R, et al. Clinical practice recommendations for depression. *Acta Psychiatr Scand*. 2009;119(Suppl. 439):8-26.
158. Ravindran AV. If a patient does not respond to a full dose of fluvoxamine for at least 12 weeks, what alternatives should be considered? *J Psychiatry Neurosci*. 1998;23(2):136 PMID:9549254

159. Lam RW, Kennedy SH, Grigoriadis S, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. III. Pharmacotherapy. *J Affect Disord.* 2009;117(Suppl. 1):S26-S43
160. Conn DK, Gibson M, Feldman S, et al. National guidelines for seniors' mental health: The assessment and treatment of mental health issues in long-term care homes (focus on mood and behaviour symptoms). *Can J Geriatr.* 2006;9(Suppl. 2):S59-S64
161. R Mahendran, H L Yap. Clinical practice guidelines for depression. *Singapore Med J* 2005;46(11):610-5. 2005.
162. National Institute for Health and Clinical Excellence. Computerised cognitive behaviour therapy for depression and anxiety. 2006;97. 2006.
163. Nutt DJ, Davidson JR, Gelenberg AJ, et al. International consensus statement on major depressive disorder. *J Clin Psychiatry.* 2010;71(Suppl E1):e08.
164. National Institute for Health and Clinical Excellence. Depression in adults (update): Depression: The treatment and management of depression in adults. Final Version of guideline 90. London: NICE; 2009.
165. Harter M, Klesse C, Bermejo I, et al. Unipolar depression: Diagnostic and therapeutic recommendations from the current S3/National Clinical Practice Guideline. *Deutsches Arzteblatt International.* 2010;107(40):700-8. PMID:21031129
166. Gelenberg A, Freeman M, Markowitz J et al. Practice guideline for the treatment of patients with major depressive disorder. American Psychiatric Association; 2010.
167. Karasu B, Gelenberg A, Merriam A, et al. Practice guideline for treatment of patients with depression disorder second edition. APA Practice Guidelines. 2009;1-78.
168. Depression: Management of depression in primary and secondary care. 23. 2004.
169. National Institute for Health and Clinical Excellence. Depression: The treatment and management of depression in adults. 2009;1-585. 2009.
170. Pilling S, Anderson I, Goldberg D, et al. Guidelines: Depression in adults, including those with a chronic physical health problem: Summary of NICE guidance. *Br Med J.* 2009;339(7728):1025-7.
171. National Institute for Health and Clinical Excellence. Depression in adults with a chronic physical health problem: Treatment and management. NICE clinical guideline 91. London: NICE; 2009.
172. Zuckerbrot R, Cheung M.H, Jensen P, et al. Guidelines for adolescent Depression in primary care (GLAD-PC) I, Identification, assessment, and initial management. *Pediatr.* 2009;120(5):1299-312.
173. Hughes CW, Emslie GJ, Crismon ML, et al. Texas Children's Medication Algorithm Project: update from Texas Consensus Conference Panel on medication treatment of childhood major depressive disorder. *J Am Acad Child Adolesc Psychiatry.* 2007;46(6):667-86. PMID:17513980
174. Cheung AH, Zuckerbrot RA, Jensen PS, et al. Guidelines for adolescent depression in primary care (GLAD-PC): II. Treatment and ongoing management. *J Am Acad Pediatr.* 2007;120(5):e1313-e1326
175. Gallagher R. Evidence-based psychotherapies for depressed adolescents: A review and clinical guidelines. *Prim Psychiatry.* 2005;12(9):33-9.
176. National Institute for Clinical Excellence. Depression in Children and Young People : Identification and management in primary, community and secondary care. 2005;1-233. 2005.
177. Anderson IM, Ferrier IN, Baldwin RC, et al. Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2000 British Association for Psychopharmacology guidelines. *J Psychopharmacol (Oxf).* 2008;22(4):343-96. PMID:18413657
178. Corya SA, Williamson D, Sanger TM, et al. A randomized, double-blind comparison of olanzapine/fluoxetine combination, olanzapine, fluoxetine, and venlafaxine in treatment-resistant depression. *Depress Anxiety.* 2006;23(6):364-72. PMID:16710853

179. Shelton RC, Williamson DJ, Corya SA, et al. Olanzapine/fluoxetine combination for treatment-resistant depression: A controlled study of SSRI and nortriptyline resistance. *J Clin Psychiatry*. 2005;66(10):1289-97. PMID:16259543
180. Mazeh D, Shahal B, Aviv A, et al. A randomized, single-blind, comparison of venlafaxine with paroxetine in elderly patients suffering from resistant depression. *Int Clin Psychopharmacol*. 2007;22(6):371-5. PMID:17917556
181. McGrath PJ, Stewart JW, Fava M, et al. Tranylcypromine versus venlafaxine plus mirtazapine following three failed antidepressant medication trials for depression: A STAR*D report. *Am J Psychiatry*. 2006;163(9):1531-41. PMID:16946177
182. Fava M, Rush AJ, Wisniewski SR, et al. A comparison of mirtazapine and nortriptyline following two consecutive failed medication treatments for depressed outpatients: A STAR*D report. *Am J Psychiatry*. 2006;163(7):1161-72. PMID:16816220
183. Nierenberg AA, Fava M, Trivedi MH, et al. A comparison of lithium and T(3) augmentation following two failed medication treatments for depression: A STAR*D report. *Am J Psychiatry*. 2006;163(9):1519-30. PMID:16946176
184. Perlis RH, Moorjani P, Fagerness J, et al. Pharmacogenetic analysis of genes implicated in rodent models of antidepressant response: Association of TREK1 and treatment resistance in the STAR(*)D study. *Neuropsychopharmacol*. 2008;33(12):2810-9. PMID:18288090
185. Yates WR, Mitchell J, Rush AJ, et al. Clinical features of depressed outpatients with and without co-occurring general medical conditions in STAR*D. *Gen Hosp Psychiatry*. 2004;26(6):421-9. PMID:15567207
186. Lesser IM, Leuchter AF, Trivedi MH, et al. Characteristics of insured and noninsured outpatients with depression in STAR*D. *Psychiatr Serv*. 2005;56(8):995-1004.
187. Perlis RH, Patrick A, Smoller JW, et al. When is pharmacogenetic testing for antidepressant response ready for the clinic? A cost-effectiveness analysis based on data from the STAR*D study. *Neuropsychopharmacol*. 2009;34(10):2227-36. PMID:19494805
188. El-Khalili N, Joyce M, Atkinson S, et al. Extended-release quetiapine fumarate (quetiapine XR) as adjunctive therapy in major depressive disorder (MDD) in patients with an inadequate response to ongoing antidepressant treatment: A multicentre, randomized, double-blind, placebo-controlled study. *Int J Neuropsychopharmacol*. 2010;13(7):917-32. PMID:20175941
189. New Zealand Guidelines Group. Identification of common mental disorders and management of depression in primary care. 2008:1-190. 2008.
190. Ravindran AV, Lam RW, Filteau MJ, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. V. Complementary and alternative medicine treatments. *J Affect Disord*. 2009;117:S54-S64. ISI:000271042300007
191. Kennedy SH, Lam RW, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults Introduction. *J Affect Disord*. 2009;117:S1-S2. ISI:000271042300001
192. Anderson IM, Haddad PM. CANMAT Guidelines for depression: Clear and user-friendly. *J Affect Disord*. 2009;117:S3-S4. ISI:000271042300002
193. Horsley L. ACP guideline on second-generation antidepressants for depression treatment. *Am Fam Physician*. 2009;80(3):291-4.
194. Dudley M, Hadzi-Pavlovic D, Andrews D, et al. New-generation antidepressants, suicide and depressed adolescents: How should clinicians respond to changing evidence? *Aust NZ J Psychiatry*. 2008;42(6):456-66. PMID:18465372

195. Papakostas GI, Petersen TJ, Green C, et al. A description of next-step switching versus augmentation practices for outpatients with treatment-resistant major depressive disorder enrolled in an academic specialty clinic. *Ann Clin Psychiatry*. 2005;17(3):161-5. PMID:16433058
196. Blier P SST. Potential mechanisms of action of atypical antipsychotic medications in treatment-resistant depression and anxiety. *J Clin Psychiatry*. 2005;66(Suppl. 8):30-40.
197. McIntyre RS, Muzina DJ, Adams A, et al. Quetiapine XR efficacy and tolerability as monotherapy and as adjunctive treatment to conventional antidepressants in the acute and maintenance treatment of major depressive disorder: A review of registration trials. *Expert Opin Pharmacother*. 2009;10(18):3061-75. PM:19954275
198. Bauer M, El Khalili N, Datto C, et al. A pooled analysis of two randomised, placebo-controlled studies of extended release quetiapine fumarate adjunctive to antidepressant therapy in patients with major depressive disorder. *J Affect Disord*. 2010;127(1-3):19-30. PM:20884063
199. Nelson JC, Papakostas GI. Atypical antipsychotic augmentation in major depressive disorder: A meta-analysis of placebo-controlled randomized trials. *Am J Psychiatry*. 2009;166(9):980-91. PMID:19687129
200. Bauer M, Pretorius HW, Constant EL, et al. Extended-release quetiapine as adjunct to an antidepressant in patients with major depressive disorder: Results of a randomized, placebo-controlled, double-blind study. *J Clin Psychiatry*. 2009;70(4):540-9. PMID:19358791
201. Fredman SJ, Fava M, Kienke AS, et al. Partial response, nonresponse, and relapse with selective serotonin reuptake inhibitors in major depression: A survey of current "next-step" practices. *J Clin Psychiatry*. 2000;61(6):403-8. PMID:10901336
202. Baldessarini RJ, Tondo L, Hennen J. Treating the suicidal patient with bipolar disorder. Reducing suicide risk with lithium. *Ann N Y Acad Sci*. 2001;932:24-38. PM:11411189
203. Lyness JM, Heo M, Datto CJ, et al. Outcomes of minor and subsyndromal depression among elderly patients in primary care settings. *Ann Intern Med*. 2006;144(7):496-504. PM:16585663
204. Piaggio G, Elbourne DR, Altman DG, et al. Reporting of noninferiority and equivalence randomized trials: An extension of the CONSORT statement. *JAMA*. 2006;295(10):1152-60. PM:16522836
205. Kennard BD, Clarke GN, Weersing VR, et al. Effective components of TORDIA cognitive-behavioral therapy for adolescent depression: Preliminary findings. *J Consult Clin Psychol*. 2009;77(6):1033-41. PMID:19968380
206. Scott J, Paykel E, Morriss R, et al. Cognitive-behavioural therapy for severe and recurrent bipolar disorders: Randomised controlled trial. *BR J PSYCHIATR*. 2006;188:313-20. PM:16582056
207. Ioannidis JPA, Evans SJW, Gotzsche PC, et al. Better reporting of harms in randomized trials: An extension of the CONSORT statement. *Ann Intern Med*. 2004;141(10):781-8. ISI:000225206900005
208. Adli M, Bauer M, Rush AJ. Algorithms and collaborative-care systems for depression: are they effective and why? A systematic review. *Biol Psychiatry*. 2006;59(11):1029-38. PM:16769294
209. Turner EH, Matthews AM, Linardatos E, et al. Selective publication of antidepressant trials and its influence on apparent efficacy. *N Engl J Med*. 2008;358(3):252-60.

Abbreviations

ACP	American College of Physicians
AHRQ	Agency for Healthcare Research and Quality
ASEX	Arizona Sexual Experience Scale
BDI	Beck Depression Inventory
CAM	complementary and alternative medicine
CANMAT	Canadian Network for Mood and Anxiety Treatments
CBT	cognitive behavioral therapy
CCT	controlled clinical trial
CDRS-R	Children’s Depression Rating Scale–Revised
CER	comparative effectiveness review
CGI	clinical global impressions
CPG	clinical practice guidelines
CYP 2D6	enzyme CYP 2D6
DBT	dialectical behavior therapy
DSHS	Department of State Health Services
DSM-IV	Diagnostic and Statistical Manual – 4 th edition
ECT	electroconvulsive therapy
FDA	U.S. Food and Drug Administration
GLAD-PC	Guidelines for Adolescent Depression in Primary Care
HAMD	Hamilton Depression Rating Scale
HAMD-17/21/31	17 or 21 or 31 questions on the HAMD scale
HSRProj	Health Services Research Projects in Progress
IPT	interpersonal therapy
MADRS	Montgomery Asberg Depression Rating Scale
MDD	major depressive disorder
MDE	major depressive episode
mg/d	milligrams daily
NICE	National Institute of Clinical Excellence
PBO	placebo
PHQ-9	Patient Health Questionnaire 9 item
PICOT	Population, Intervention, Comparator, Outcome, Timeframe
QIDS-SR-16	Quick Inventory of Depressive Symptoms Self Report
QOL	quality of life
RCT	randomized controlled trial
rTMS	repetitive transcranial magnetic stimulation
SD	standard deviation
SNRI	Serotonin–norepinephrine reuptake inhibitors
SOE	strength of evidence
SSRI	selective serotonin reuptake inhibitors
STAR*D	Sequenced Treatment Alternatives to Relieve Depression
TADS	Treatment of Adolescents Study
TEP	technical expert panel
TORDIA	Treatment for Resistant Depression in Adolescents

UKU	Udvalg for Kliniske Undersøgelser (UKU) Side Effect Rating Scale
U.S.	United States
USPSTF	United States Preventive Services Task Force
VNS	vagal nerve stimulation
WHO	World Health Organization

Appendix A. Search Strategy

OVID-Medline

April 13 2011

1. dysthm*.tw.
2. (subclinical adj2 depressi*).tw.
3. (subsyndromal adj2 depressi*).tw.
4. (subthreshold adj2 depressi*).tw.
5. (subdiagnostic adj2 depressi*).tw.
6. Depression/
7. depressive disorder/ or depressive disorder, major/ or dysthymic disorder/
8. or/1-7
9. serotonin uptake inhibitors/ or citalopram/ or fluoxetine/ or fluvoxamine/ or paroxetine/ or sertraline/
10. (citalopram or celexa or cipramil or dalsan or recital or emocal or sepram or seropram).mp.
11. (escitalopram or es citalopram or lexapro or cipralext or esertia).mp.
12. (fluoxetine or prozac or fontex or seromex or seronil or sarafem or flutrin or fluox or lovan).mp.
13. (fluvoxamine or luvox or fevarin or faverin or dumyrox or favoxil or movox).mp.
14. (paroxetine or paxil or seroxat or sereupin or aropax or deroxat or rexetin or xetanor or paroxat).mp.
15. (sertraline or zoloft or lustral or serlain).mp.
16. ssri?.mp.
17. selective serotonin reuptake inhibit*.tw.
18. symbyax.mp.
19. or/9-18
20. Drug Resistance/
21. treatment failure/
22. Retreatment/
23. ((difficult or hard) adj3 treat).tw.
24. augment*.tw.
25. nonrespon*.tw.
26. non-respon*.tw.
27. switch*.tw.
28. ((insufficient or inadequate or incomplete) adj3 respon*).tw.
29. (ssri? adj3 (resist* or fail* or respon* or refractory)).tw.
30. (partial adj3 respon*).tw.
31. ((combination or adjunct*) adj3 (therap* or drug? or treat*)).tw.
32. ((treat* or therapy or drug) adj4 (resist* or fail*)).tw.
33. ((treatment resistant or refractory) adj3 depressi*).tw.
34. or/20-32
35. 8 and 34
36. 35 or 33
37. 8 and 19
38. 36 or 37

39. *depression/ or *depressive disorder/ or *depressive disorder, major/ or *dysthymic disorder/
 40. or/1-5
 41. 39 or 40
 42. 5-Hydroxytryptophan/
 43. phototherapy/
 44. light therapy.tw.
 45. exp Exercise/ae, th [Adverse Effects, Therapy]
 46. exp Exercise Therapy/
 47. exp Acupuncture Therapy/
 48. exp Massage/
 49. Relaxation Therapy/
 50. exp vitamins/
 51. Hypericum/
 52. john* wort.tw.
 53. deplin.tw.
 54. methylfolate.tw.
 55. Folic Acid/
 56. S-Adenosylmethionine/
 57. "SAM-e".tw.
 58. exp Fatty Acids, Omega-3/
 59. Cognitive Therapy/
 60. Crocus/
 61. Tryptophan/
 62. exp Inositol/
 63. or/42-62
 64. 41 and 63
 65. (harm? or adverse or "side effect?").tw.
 66. (adjunct* or augment*).tw.
 67. 65 or 66
 68. 41 and 67
 69. exp *antidepressive agents/ae, to [Adverse Drug Reaction, Drug Toxicity]
 70. 68 or 69
 71. 38 or 64 or 70
 72. animals/ not (animals/ and humans/)
 73. 71 not 72
 74. (comment or editorial).pt.
 75. 73 not 74
 76. review.pt,sh.
 77. 75 and 76
 78. meta-analysis.pt,ti,ab,sh.
 79. (meta anal\$ or metaanal\$).ti,ab,sh.
 80. ((methodol\$ or systematic\$ or quantitativ\$) adj3 (review\$ or overview\$ or survey\$)).ti.
 81. ((methodol\$ or systematic\$ or quantitativ\$) adj3 (review\$ or overview\$ or survey\$)).ab.
 82. ((pool\$ or combined or combining) adj (data or trials or studies or results)).ti,ab.
 83. (medline or embase or cochrane).ti,ab.
 84. or/81-83

85. review.pt,sh.
86. 84 and 85
87. 78 or 86 or 80 or 79
88. 75 and 87
89. 77 not 88
90. 75 not 89
91. limit 90 to yr="1980 -Current"
92. limit 91 to english language
93. 91 not 92

OVID-Embase

April 13 2011

1. depression/ or agitated depression/ or atypical depression/ or dysthymia/ or endogenous depression/ or involuntional depression/ or major depression/ or masked depression/ or melancholia/ or "mixed anxiety and depression"/ or "mixed depression and dementia"/ or organic depression/ or reactive depression/ or recurrent brief depression/
2. dysthm*.tw.
3. (subclinical adj2 depressi*).tw.
4. (subsyndromal adj2 depressi*).tw.
5. (subthreshold adj2 depressi*).tw.
6. (subdiagnostic adj2 depressi*).tw.
7. or/1-6
8. serotonin uptake inhibitor/ or citalopram/ or escitalopram/ or fluoxetine/ or fluoxetine plus olanzapine/ or fluvoxamine/ or paroxetine/ or sertraline/
9. ssri?.tw.
10. selective serotonin reuptake inhibit*.tw.
11. (citalopram or celexa or cipramil or dalsan or recital or emocal or sepram or seropram).mp.
12. (escitalopram or es citalopram or lexapro or ciprallex or esertia).mp.
13. (fluoxetine or prozac or fontex or seromex or seronil or sarafem or fluctin or fluox or lovan).mp.
14. (fluvoxamine or luvox or fevarin or faverin or dumyrox or favoxil or movox).mp.
15. (paroxetine or paxil or seroxat or sereupin or aropax or deroxat or rexetin or xetanor or paroxat).mp.
16. (sertraline or zoloft or lustral or serlain).mp.
17. symbyax.mp.
18. or/8-17
19. Drug Resistance/
20. exp treatment failure/
21. Retreatment/
22. ((difficult or hard) adj3 treat).tw.
23. augment*.tw.
24. non-respon*.tw.
25. nonrespon*.tw.
26. switch*.tw.
27. ((insufficient or inadequate or incomplete) adj3 response).tw.
28. (ssri? adj3 (resist* or fail* or response or refractory)).tw.

29. (partial adj3 respon*).tw.
30. ((combination or adjunct*) adj3 (therap* or drug? or treat*)).tw.
31. ((treat* or therapy or drug) adj4 (resist* or fail*)).tw.
32. ((treatment resistant or refractory) adj3 depressi*).tw.
33. or/19-31
34. 7 and 33
35. 32 or 34
36. 7 and 18
37. 35 or 36
38. *depression/ or *agitated depression/ or *atypical depression/ or *dysthymia/ or
*endogenous depression/ or *involutional depression/ or *major depression/ or *masked
depression/ or *melancholia/ or *"mixed anxiety and depression"/ or *"mixed depression and
dementia"/ or *organic depression/ or *reactive depression/ or *recurrent brief depression/
39. or/2-6
40. 38 or 39
41. exp *side effect/
42. (harm? or adverse or side effect?).tw.
43. 40 and 42
44. 41 or 42
45. 40 and 44
46. exp *antidepressant agent/ae, to [Adverse Drug Reaction, Drug Toxicity]
47. 45 or 46
48. 5 hydroxytryptophan/
49. exp vitamin/
50. exp Fatty Acids, Omega-3/
51. exp acupuncture/
52. exp exercise/
53. massage/
54. Relaxation Therapy/
55. phototherapy/
56. light therapy.tw.
57. Hypericum perforatum/
58. methylfolate.tw.
59. folic acid/
60. S-Adenosylmethionine/
61. SAM-e.tw.
62. (cbt or cognitive behavior?r therapy).tw.
63. cognitive behavior therapy/
64. inositol/
65. saffron/
66. crocus/
67. tryptophan/
68. exp diet therapy/
69. or/48-68
70. 40 and 69
71. (adjunct* or augment*).tw.

72. 40 and 71
73. 37 or 47 or 70 or 72
74. (editorial or note).pt.
75. 73 not 74
76. limit 75 to human
77. review.pt,sh.
78. 76 and 77
79. meta analysis/
80. meta-analysis.ti,ab.
81. (meta anal\$ or metaanal\$).ti,ab.
82. ((methodol\$ or systematic\$ or quantitativ\$) adj3 (review\$ or overview\$ or survey\$)).ti.
83. ((methodol\$ or systematic\$ or quantitativ\$) adj3 (review\$ or overview\$ or survey\$)).ab.
84. ((pool\$ or combined or combining) adj (data or trials or studies or results)).ti,ab.
85. (medline or embase or cochrane).ti,ab.
86. or/83-85
87. review.pt,sh.
88. 86 and 87
89. or/79-82
90. 89 or 88
91. 76 and 90
92. 78 not 91
93. 76 not 92
94. limit 93 to yr=1980-current
95. limit 94 to english language

Ovid-PsycINFO

April 13 2011

1. major depression/ or dysthymic disorder/ or endogenous depression/ or reactive depression/ or recurrent depression/ or atypical depression/ or "depression (emotion)"/
2. dysthm*.tw.
3. (subclinical adj2 depressi*).tw.
4. (subsyndromal adj2 depressi*).tw.
5. (subthreshold adj2 depressi*).tw.
6. (subdiagnostic adj2 depressi*).tw.
7. or/1-6
8. ((difficult or hard) adj3 treat).tw.
9. augmentation.tw.
10. nonrespon*.tw.
11. non-respon*.tw.
12. switch*.tw.
13. ((insufficient or inadequate or incomplete) adj3 response).tw.
14. (ssri? adj3 (resist* or fail* or response or refractory)).tw.
15. (partial adj3 response).tw.
16. ((combination or adjunct*) adj3 (therap* or drug? or treat*)).tw.
17. ((treat* or therapy or drug) adj4 (resist* or fail*)).tw.

18. or/8-17
19. 18 and 7
20. treatment resistant depression/
21. ((treatment resistant or refractory) adj3 depressi*).tw.
22. or/19-21
23. cognitive behavior therapy/ or cognitive therapy/
24. phototherapy/
25. "hydroxytryptophan (5-)" /
26. light therapy.tw.
27. exp exercise/
28. acupuncture/
29. massage/
30. exp relaxation therapy/
31. exp vitamins/ or vitamin therapy/
32. hypericum perforatum/
33. (S-Adenosylmethionine or SAM-e).tw.
34. folic acid/
35. fatty acids/
36. saffron.tw.
37. inositol.tw.
38. exp tryptophan/
39. or/23-38
40. serotonin reuptake inhibitors/ or citalopram/ or fluoxetine/ or fluvoxamine/ or paroxetine/
41. sertraline/
42. (citalopram or celexa or cipramil or dalsan or recital or emocal or sepram or seropram).mp.
43. (escitalopram or es citalopram or lexapro or cipralex or esertia).mp.
44. (fluvoxamine or luvox or fevarin or faverin or dumyrox or favoxil or movox).mp.
45. (fluoxetine or prozac or fontex or seromex or seronil or sarafem or fluctin or fluox or lovan).mp.
46. (paroxetine or paxil or seroxat or sereupin or aropax or deroxat or rexetin or xetanor or paroxat).mp.
47. (sertraline or zoloft or lustral or serlain).mp.
48. ssri?.mp.
49. selective serotonin reuptake inhibit*.mp.
50. symbyax.mp.
51. or/40-50
52. *major depression/ or *dysthymic disorder/ or *endogenous depression/ or *reactive depression/ or *recurrent depression/ or *treatment resistant depression/ or *"depression (emotion)" /
53. or/2-6
54. 52 or 53
55. (harm? or adverse or "side effect?").tw.
56. adverse effects.id.
57. exp "side effects (treatment)" /
58. drug interactions/
59. exp toxicity/

60. (adjunct* or augment*).tw.
61. or/55-60
62. 39 or 61
63. 54 and 62
64. 7 and 51
65. 22 or 63 or 64
66. limit 65 to human
67. limit 66 to ("comment/reply" or editorial or encyclopedia entry or obituary or review-book or review-media or review-software & other)
68. 66 not 67
69. limit 68 to yr="1980 -Current"
70. limit 69 to english language

OVID-Cochrane Central Register of Controlled Trials

April 13 2011

1. dysthm*.tw.
2. (subclinical adj2 depressi*).tw.
3. (subsyndromal adj2 depressi*).tw.
4. (subthreshold adj2 depressi*).tw.
5. (subdiagnostic adj2 depressi*).tw.
6. Depression/
7. depressive disorder/ or depressive disorder, major/ or dysthymic disorder/
8. or/1-7
9. serotonin uptake inhibitors/ or citalopram/ or fluoxetine/ or fluvoxamine/ or paroxetine/ or sertraline/
10. (citalopram or celexa or cipramil or dalsan or recital or emocal or sepram or seropram).mp.
11. (escitalopram or es citalopram or lexapro or cipralext or esertia).mp.
12. (fluoxetine or prozac or fontex or seromex or seronil or sarafem or fluctin or fluox or lovan).mp.
13. (fluvoxamine or luvox or fevarin or faverin or dumyrox or favoxil or movox).mp.
14. (paroxetine or paxil or seroxat or sereupin or aropax or deroxat or rexetin or xetanor or paroxat).mp.
15. (sertraline or zoloft or lustral or serlain).mp.
16. ssri?.mp.
17. selective serotonin reuptake inhibit*.tw.
18. symbyax.mp.
19. or/9-18
20. Drug Resistance/
21. treatment failure/
22. Retreatment/
23. ((difficult or hard) adj3 treat).tw.
24. augment*.tw.
25. nonrespon*.tw.
26. non-respon*.tw.
27. switch*.tw.
28. ((insufficient or inadequate or incomplete) adj3 respon*).tw.

29. (ssri? adj3 (resist* or fail* or respon* or refractory)).tw.
30. (partial adj3 respon*).tw.
31. ((combination or adjunct*) adj3 (therap* or drug? or treat*)).tw.
32. ((treat* or therapy or drug) adj4 (resist* or fail*)).tw.
33. ((treatment resistant or refractory) adj3 depressi*).tw.
34. or/20-32
35. 8 and 34
36. 35 or 33
37. 8 and 19
38. 36 or 37
39. *depression/ or *depressive disorder/ or *depressive disorder, major/ or *dysthymic disorder/
40. or/1-5
41. 39 or 40
42. 5-Hydroxytryptophan/
43. phototherapy/
44. light therapy.tw.
45. exp Exercise/ae, th [Adverse Effects, Therapy]
46. exp Exercise Therapy/
47. exp Acupuncture Therapy/
48. exp Massage/
49. Relaxation Therapy/
50. exp vitamins/
51. Hypericum/
52. john* wort.tw.
53. deplin.tw.
54. methylfolate.tw.
55. Folic Acid/
56. S-Adenosylmethionine/
57. "SAM-e".tw.
58. exp Fatty Acids, Omega-3/
59. Cognitive Therapy/
60. Crocus/
61. Tryptophan/
62. exp Inositol/
63. or/42-62
64. 41 and 63
65. (harm? or adverse or "side effect?").tw.
66. (adjunct* or augment*).tw.
67. 65 or 66
68. 41 and 67
69. exp *antidepressive agents/ae, to [Adverse Drug Reaction, Drug Toxicity]
70. 68 or 69
71. 38 or 64 or 70
72. limit 71 to yr="1980-Current"

OVID-AMED

April 13 2011

1. depression/
2. dysthm*.tw.
3. (subclinical adj2 depressi*).tw.
4. (subsyndromal adj2 depressi*).tw.
5. (subthreshold adj2 depressi*).tw.
6. (subdiagnostic adj2 depressi*).tw.
7. or/1-6
8. antidepressive agents/
9. (citalopram or celexa or cipramil or dalsan or recital or emocal or sepram or seropram).mp.
10. (escitalopram or es citalopram or lexapro or cipralext or esertia).mp.
11. (fluvoxamine or luvox or fevarin or faverin or dumyrox or favoxil or movox).mp.
12. (fluoxetine or prozac or fontex or seromex or seronil or sarafem or fluctin or fluox or lovan).mp.
13. (paroxetine or paxil or seroxat or sereupin or aropax or deroxat or rexetin or xetanor or paroxat).mp.
14. (sertraline or zoloft or lustral or serlain).mp.
15. ssri?.mp.
16. selective serotonin reuptake inhibit*.tw.
17. or/8-16
18. 7 and 17
19. ((difficult or hard) adj3 treat).tw.
20. (adjunct* or augment*).tw.
21. nonrespon*.tw.
22. non-respon*.tw.
23. switch*.tw.
24. ((insufficient or inadequate or incomplete) adj3 response).tw.
25. (ssri? adj3 (resist* or fail* or response or refractory)).tw.
26. (partial adj3 response).tw.
27. ((combination or adjunct*) adj3 (therap* or drug? or treat*)).tw.
28. ((treat* or therapy or drug) adj4 (resist* or fail*)).tw.
29. or/19-28
30. 7 and 29
31. ((treatment resistant or refractory) adj3 depressi*).tw.
32. 30 or 31
33. cognitive behavior therapy/ or cognitive therapy/
34. phototherapy/
35. hydroxytryptophan.tw.
36. light therapy.tw.
37. exp exercise therapy/
38. exp acupuncture therapy/
39. massage/
40. exp relaxation/
41. exp vitamins/
42. hypericum perforatum/
43. (S-Adenosylmethionine or SAM-e).tw.

44. exp complementary therapies/
45. folic acid/
46. exp fatty acids/
47. crocus/
48. saffron.tw.
49. inositol.tw.
50. tryptophan/
51. or/33-50
52. 7 and 51
53. (harm? or adverse or "side effect?").tw.
54. adverse effects/
55. or/53-54
56. 7 and 55
57. 18 or 32 or 52 or 56
58. limit 57 to (commentary or editorial or interview or news or notes)
59. 57 not 58
60. limit 59 to english
61. limit 60 to yr="1980 -Current"

EBSCO-CINAHL

- S2 TX Hydroxytryptophan
- S3 (MH "Therapeutic Exercise+")
- S4 (MH "Alternative Therapies+")
- S5 (MH "Massage+")
- S7 (MH "Simple Relaxation Therapy (Iowa NIC)")
- S8 (MH "St. John's Wort")
- S9 "methylfolate"
- S10 (MH "Folic Acid+")
- S11 (MH "S-Adenosylmethionine")
- S12 TX SAM-e
- S13 (MH "Fatty Acids, Omega 3+")
- S14 (MH "Cognitive Therapy")
- S15 "saffron"
- S16 (MH "Tryptophan")
- S17 (MH "Inositol")
- S18 S2 or S3 or S4 or S5 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17
- S19 (MM "Depression")
- S20 (MM "Depression, Reactive")
- S21 (MM "Dysthymic Disorder")
- S22 S19 or S20 or S21
- S23 (S19 or S20 or S21) and (S18 and S22)
- S24 Limiters - Publication Year from: 1980-2009
- S25 S23 and S24
- S26 Limiters - Publication Type: Accreditation, Advice and Referral Website, Anecdote, Audiovisual, Bibliography, Biography, Book, Book Chapter, Book Review, Cartoon, Code of

Ethics, Commentary, Computer Program, Consumer/Patient Teaching Materials, Directories, Editorial, Exam Questions, Games, Individual Testimonial Website, Interview, Listservs, Masters Thesis, Obituary, Pamphlet, Pamphlet Chapter, Poetry, Software, Teaching Materials, Tracings, Website

S27 S25 NOT S26

S28 S27 Limiters - Language: English

Grey Literature Search

The following sources were search using sensitive searches similar to the searches in bibliographic databases

Regulatory Information

FDA

Health Canada

Authorized Medicines for EU

Clinical Trial Registries

ClinicalTrials.gov

Current Controlled Trials

Clinical Study Results

WHO Clinical Trials

Abstracts and Conference Papers

Conference Papers Index

Scopus

Grants and Federally Funded Research

NIH RePORTER (a searchable database of federally funded biomedical research projects conducted at universities, hospitals, and other research institutions)

HSRPROJ (a database providing access to ongoing grants and contracts in health services research)

Other Miscellaneous Sources

Hayes, Inc. Health Technology Assessment

NY Academy of Medicine's Grey Literature Index

In addition, the following websites were searched specifically for guidelines on depression treatment

<http://www.guideline.gov/>

<http://guidance.nice.org.uk/>

<http://www.sign.ac.uk/>

<http://www.nhmrc.gov.au/publications/subjects/clinical.htm>

<http://www.nzgg.org.nz/>

<http://www.hc-sc.gc.ca/ahc-asc/legislation/guide-ld/index-eng.php>

Appendix B. Forms

Title and Abstract Level I

1. Is this report in English?

☐ No (stop)

2. Is this article a commentary/note, letter, editorial, case study, or narrative review (non-systematic review)?

☐ Yes (stop)

☐ No/can't tell

Instruction for Q2: If the citation is a commentary/note/letter, editorial or is a non-systematic review* (i.e. a review that is not systematic) you should answer "YES" and then go on to the next citation (don't forget to click "submit" or your answers won't be recorded). If the citation is for a PRIMARY study, a clinical practice guideline or a systematic review* (or any study type not listed above) you should answer "NO" and then continue screening. *Look carefully for words like "systematic review", "meta analysis", "Cochrane review" or "pooling", or some description of the methods used to assemble papers: Systematic reviews generally provide a detailed description of their methods that include searches that included more than 1 database (for example, MEDLINE, Embase, PsycInfo, etc.) and specify inclusion and exclusion criteria for eligible studies. - discusses inclusion and exclusion criteria.

- Do not exclude any guideline/recommendation on question2. We will include guidelines/recommendations where they are appropriate.

3. Does this article include subjects who are 12 years of age or older?

☐ Yes/can't tell)

☐ No (stop)

4. Does this article focus on the "treatment" of depression?

☐ Yes/can't tell)

☐ No (stop)

5. Does this article have a "primary focus" on "subjects" who have depression (including Dysthymia & Subsyndromal)?

Please answer "**no**" if the type of depression focused on is:

1. post-partum/puerperal Depression, **2.** bipolar depression, **3.** seasonal affective disorder **4.** post-operative depression **5.** premenstrual dysphoric disorder **6.** depressive psychosis **7.** dysphoria, mourning syndrome **8.** pseudodementia

☐ Yes/can't tell

☐ No (exclude)

6. Was this report published before 1980?

☐ Yes

7. Was this guideline published before 2004?

☐ Yes

☐ NO

8. This is a STAR*D publication:

- ☐ Yes-include
- ☐ Yes-exclude at level 3 : _____
- ☐ Yes- Honorable paper

Title & Abstract Level 2

1. What type of study is this citation?

- ☐ Primary study / Can't tell
- ☐ Systematic Review / Meta Analysis
- ☐ Guideline/ Recommendation (stop)
- ☐ None of the above (specify & stop) : _____

2. Is the population diagnosed as Major Depressive Disorder (MDD), Dysthymia, or Subsyndromal Depression?

- ☐ Yes
- ☐ No (stop)
- ☐ Can't tell

3. Does the study population include subjects who have failed to respond to treatment previously (if the only treatment they receive is rTMS, or ECT please answer No and go onto Q4)?

- ☐ Yes / Can't tell (stop-include)
- ☐ No (continue)

Instruction for Q3

We are interested in **ANY** articles with this group as the population or subpopulation—common terms to identify this population are:

· Treatment resistant, inadequate response, failed treatment, refractory depression

Sometimes they identify this population by the treatment commonly received after failure—common terms include:

· Augment/augmentation, switching, optimizing, changing dose,

Also respond “yes” to studies that focus on predictors of response rather than treatment efficacy / effectiveness

4. Does this study focus primarily on the following:

- ☐ Efficacy / effectiveness of an SSRI (monotherapy)
- ☐ Efficacy / effectiveness of a COMBINED treatment
- ☐ Efficacy / effectiveness of a NON-pharmacological treatment (monotherapy)
- ☐ Adverse events related to medications
- ☐ Other (specify in box intervention or population) : _____
- ☐ Efficacy / effectiveness of Non-SSRI drug intervention

This is a relevant guideline for this SR. Extract the data:

- ☐ Yes : _____
- ☐ No : _____

Investigators comments:

Full Text Screening, Level 3

1. What is the study design described in this study?

- ☐ RCT (randomized control trial) or CCT (clinical control trial)
- ☐ Cohort / Longitudinal
- ☐ Case-Control
- ☐ Cross-Sectional
- ☐ Interrupted time series with comparator group
- ☐ Systematic Review / Meta analysis (stop)
- ☐ Guideline / Recommendation (stop)
- ☐ Non-comparative design (before-after study, case series, or case report) (stop)
- ☐ Other (specify and can include qualitative studies, editorials, commentaries, etc) (stop)

2. Is the study population diagnosed primarily (>50%) with Dementia (Alzheimer's Disease, Vascular dementia, etc), Stroke (cerebrovascular accident), Parkinson's disease, Hypothyroidism, or Cushing's Syndrome?

- ☐ Yes (stop)
- ☐ No / Can't tell (continue)

3. Were the study subjects (diagnosed with MDD, Dysthymia, or Subsyndromal depression) recruited because they had failed to respond to an SSRI?

- ☐ YES – ALL (100%) of the subjects demonstrated an inadequate response to an SSRI as a part of this study
 - ☐ YES - ALL (100%) of the subjects, based on history, had an inadequate response to an SSRI prior to the start of the current study
 - ☐ YES - Some of the subjects had an inadequate response to an SSRI determined by history, and some by demonstration in this study
 - ☐ NO - All (100%) of the subjects had an inadequate response to a NON-SSRI anti-depressant determined by history, or by demonstration in this study (STOP)
 - ☐ NO - All (100%) of the subjects had an inadequate response to a SSRI combination therapy determined by history, or by demonstration in this study (STOP)
 - ☐ NO - All (100%) of the subjects had an inadequate response to a NON- SSRI combination therapy determined by history, or by demonstration in this study (STOP)
 - ☐ NO - All (100%) of the subjects had NOT failed to respond in this study (STOP)
- Can't tell if the subjects failed to respond to an SSRI or any other anti-depressant (STOP)

Q3: INSTRUCTION

Demonstrated an inadequate response to SSRI as a part of this study means that at the start/enrolment of the study patients are given/started on an SSRI and then followed forward in time to determine who did and did not respond adequately.

Those subjects who did **NOT** respond adequately continued on in the study and were then managed with

- 1) a NEW intervention / treatment OR
- 2) Switched to a different dose OR
- 3) Changed to a different duration of the SSRI OR
- 4) Combined the SSRI with another medication or supplement

Based on history had an inadequate response to SSRI prior to this study means:

- 1) that the subjects enter the study currently taking an SSRI and the investigators assess that their response is not adequate
- 2) subjects report their past history and indicate that they were on an SSRI previously and they did not have an adequate response, but they are currently not on the medication. The investigators must determine their past inadequate response from patient self-report or medical records.

4. Does the study include any of the following monotherapy interventions in the patients?
(check all that apply)

- ☐ Change the dose or duration of the same SSRI
- ☐ Change/switch to another SSRI
- ☐ Change/switch to an antidepressant medication of another class
- ☐ Change to a non-pharmacological intervention (only included list of interventions)
- ☐ NONE of the above (continue)

5. Does the study include any of the following combined therapy interventions in the patients?
(check all that apply)

- ☐ Adjunct therapy: addition of an augmenter (i.e. a drug that has no formal indication as monotherapy treatment for unipolar depression, or as a food supplement)
- ☐ Adjunct therapy: addition of a second SSRI or antidepressant from another class
- ☐ Adjunct therapy: addition of a non-pharmacological therapy (see list)
- ☐ Combinations of any of the interventions listed above or other interventions
- ☐ NONE of the above (continue)

6. Does this study focus on the outcomes (primary, secondary, and harm) of interest for our review?

- ☐ Yes
- ☐ No
- ☐ Other (specify) : _____

Q6: INSTRUCTION

Other outcomes could include measures of cardiovascular disease, or other biological markers.

Primary Outcomes: Partial or complete response, Remission (free of all symptoms or with few symptoms), Speed of response or remission, and Relapse

Secondary Outcomes: Quality of life, Adherence, Return to work, Global change, External service utilization

Harms: Treatment emergent symptoms as follows: Sexual dysfunction symptoms, Neuropsychiatric symptoms or sedation, Gastrointestinal disturbances, Weight gain or metabolic disturbance, Sleep, Cardiovascular system problems, Geriatric toxicity problems, Other common adverse effects (for example, headaches, orthostatic hypotension, hypertension)

7. Investigators comments:

8. STARD/TORDIA

- ☐ Yes (exclude) : _____
- ☐ Yes (include) : _____

9. If this study is a STARD/TORDIA study, is this one of the following (all excludes).

- ☐ An overview : _____
- ☐ A study with only phase 1 data : _____
- ☐ Other : _____

10. This is a guideline/recommendation before 2004:

- ☐ Yes

11. This is a guideline/recommendation that should be excluded because of:

- ☐ Focus on diagnosis or screening rather than treatment
- ☐ Not a population of interest
- ☐ Not a guideline
- ☐ Companion : _____
- ☐ Other : _____

12. The following options are the result of contact with author(s) on "Some" list OR a citation that did not have full text after 2 failed attempts to contact the author/s.:

- ☐ Responded and can't provide data
- ☐ Did not respond
- ☐ Unable to contact (wrong email address; can't find them)
- ☐ Responded but beyond our cut date
- ☐ Responded and provided data
- ☐ Need another FU
- ☐ Other : _____
- ☐ Exclude : _____

13. Note from the result of contact with author(s) on "Some" list:

1. Level 4 Data Extraction -Primary Studies (General Information)(Groupin)

- Group1 : _____
- Group2 : _____
- Group3 : _____
- Exclude

2. STUDY

- Companion paper : _____
- Honorable mention : _____
- Data included/extracted

3. Country(s) in which study was conducted:

4. Funding source (mark NR if not reported)

METHODOLOGY

5. Study type (If it is a multicentral study, please provide the number of centers in the box)

- ☐ RCT : _____
- ☐ Non-RCT : _____
- ☐ Cohort/longitudinal : _____
- ☐ Case-Control : _____
- ☐ Cross-Sectional : _____
- ☐ Other (specify) : _____

6. Setting

- ☐ Outpatient Psychiatric
- ☐ Inpatient Psychiatric
- ☐ Outpatient Primary Care
- ☐ Inpatient Primary Care
- ☐ Other (specify) : _____

Table No 1: Type of Intervention/treatment (List all that apply) (specify for each arm/group)

Type	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Intervention								

Table No 2: Sample characteristics

	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Total Recruited								
Total Eligible Screened								
Total Run-in Phase								
Sample of non-responders								

RANDOMIZED or GROUPED								
For each time point that has results provided (labeled as T1, T2, T3)								
Total who withdrew or were lost to follow-up when study outcomes are measured								
Withdrawal because of Adverse Effects								
Withdrawal because of Loss to Follow-up								
Total number of subjects analyzed								

POPULATION CHARACTERISTICS

Table No 3: Age

Age	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Min								
Max								
Mean								
SD								
SEM								
Median								
IQR								
Other (e.g. age group)								

Table No 4: Gender

Gender	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Male (No)								
Male (%)								
Female (No)								
Female (%)								

Table No 5: Ethnicity

Ethnicity	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
White (No)								
Hispanic (No)								
African-American (No)								
Oriental (No)								
Asian (No)								
Other (specify) (No)								

231. List all Inclusion criteria

- ☐ 1 : _____
- ☐ 2 : _____
- ☐ 3 : _____
- ☐ 4 : _____
- ☐ 5 : _____
- ☐ 6 : _____
- ☐ 7 : _____
- ☐ 8 : _____

232. List all Exclusion criteria

- ☐ 1 : _____
- ☐ 2 : _____
- ☐ 3 : _____
- ☐ 4 : _____
- ☐ 5 : _____
- ☐ 6 : _____
- ☐ 7 : _____
- ☐ 8 : _____

DISEASE

233. Diagnosis (list all that apply)

- ☐ Major Depressive Disorder (MDD)
- ☐ Dysthymia
- ☐ Subsyndromal
- ☐ Other (specify) : _____

234. Method(s) used to diagnose Depression:

- ☐ 1 : _____
- ☐ 2 : _____
- ☐ 3 : _____
- ☐ 4 : _____
- ☐ 5 : _____
- ☐ 6 : _____
- ☐ 7 : _____
- ☐ 8 : _____

235. Method of determining inadequate response (click all that apply and provide as much detail as possible. e.g. proportion).

- ☐ Prospective (Screening or Run-in Phase) : _____
- ☐ Retrospective: Medical chart : _____
- ☐ Retrospective: Patient self report of history of failure : _____
- ☐ Retrospective: Patient self report of history of adverse event response : _____
- ☐ Retrospective: Currently on medication to which they have not responded : _____
- ☐ Retrospective: Confirmation by clinician : _____
- ☐ Other (specify) : _____

236. Who determined previous treatment failure?

Table No 6: Length of current Episode

Length	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Min								
Max								
Mean								
SD								
SEM								
Median								
IQR								
Other								

301. Specify units in the mean for table 6 (above table).

- ☐ Week : _____
- ☐ Day : _____
- ☐ Month : _____
- ☐ Year : _____

Table No 7: Past Mental Health History (episodes of Depression over lifetime)

No of past episode	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Min								
Max								
Mean								
SD								

SEM								
Median								
IQR								
Other e.g. % (specify)								

Table No 8: Type and number of SSRI(s) that had previously failed to respond to (List all that apply) (specify for each arm/group)

Type/No	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Type								
No of drugs								
Type not specified								

INTERVENTION

390. Were patients tapered off existing medications prior to start of the study?

- ☐ Yes : _____
☐ No : _____
☐ Unclear : _____

391. Was a run-in phase employed?

- ☐ Yes (specify time in weeks) : _____
☐ No : _____

392. Was there a washout period following the run-in phase? (If yes, specify the time-interval)

- ☐ Yes : _____
☐ No : _____
☐ Unclear : _____

393. PURPOSE OF TREATMENT

394. What type of patients are excluded from proceeding to the next phase of treatment (List all criteria)?

- ☐ 1 : _____
☐ 2 : _____
☐ 3 : _____
☐ 4 : _____
☐ 5 : _____
☐ 6 : _____
☐ 7 : _____
☐ 8 : _____

Table No 9: Dose of treatment/intervention

Dose	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Initial (minimum)								
Initial (maximum)								
Final (minimum)								
Final (maximum)								
Other								

Table No 10: Treatment interval (week) of treatment/intervention for arm1/group1

SSRI	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Min								
Max								
Mean								
SD								
SEM								
Median								
IQR								
Other								

499. Specify units in the mean for table 10 (above table).

- ☐ Week : _____
☐ Day : _____
☐ Month : _____
☐ Year : _____

500. Type of treatment provider (describe in brief):

- ☐ Psychiatrist : _____
☐ Family Physician : _____
☐ Allied Health : _____
☐ Other : _____

RESULTS

Table No 11: Time points at which treatment discontinued (specify when outcomes were collected and the length of follow up in week(s))

Time Points	Week(s)	Note
First		
Intermediate		
Other		
Final		
Follow Up		

511. Patient Compliance (Detail definition if provided) (list all methods):

- ☐ 1: _____
- ☐ 2: _____
- ☐ 3: _____
- ☐ 4: _____
- ☐ 5: _____
- ☐ 6: _____
- ☐ 7: _____
- ☐ 8: _____

Table No 12: Compliance with treatment (End Point) (indicate compliance or non-compliance in the last box)

Comply	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Min								
Max								
Mean								
SD								
SEM								
Median								
IQR								

Other (e.g. number)								
Note (compliance or non-compliance)								

584. Percent (%) or number of subjects declaring use of Complementary and Alternative Medicine (CAM) interventions

- ☐ Baseline (No) : _____
- ☐ Baseline (%): _____
- ☐ Concurrent (No) : _____
- ☐ Concurrent (%): _____

585. Are there stratified ANALYSES for the following variables/factors (check all that apply):

- ☐ Depressive diagnosis (MDD vs Other) : _____
- ☐ Disease severity : _____
- ☐ Age : _____
- ☐ Gender : _____
- ☐ Race : _____
- ☐ Socioeconomic status : _____
- ☐ Medical comorbidities : _____
- ☐ Psychiatric comorbidities : _____
- ☐ other : _____
- ☐ other : _____
- ☐ other : _____

586. List all relevant outcomes/instruments used in this study. Place a (P) after the outcomes indicating that they are the primary outcomes.

- ☐ 1 : _____
- ☐ 2 : _____
- ☐ 3 : _____
- ☐ 4 : _____
- ☐ 5 : _____
- ☐ 6 : _____
- ☐ 7 : _____
- ☐ 8 : _____

587. Overall conclusions on efficacy from an abstract if no/short results reported :

588. Additional comments or important notes about this study :

589. Go to Data Extraction form for Harm

- ☐ Yes
- ☐ No

590. Investigator 1 Comments:

591. Investigator 2 Comments:

592. Investigator 3 Comments:

593. **Group**

- ☐ MoCo : _____
- ☐ MoMo : _____
- ☐ CoCo : _____
- ☐ STARD : _____
- ☐ Other : _____

1. Data Extraction, Primary Study-Harm (Grouping)

- ☐ Group1 : _____
- ☐ Group2 : _____
- ☐ Group3 : _____
- ☐ Exclude

2. Did the authors specify if the harms reported encompass ALL the events collected or a selected SAMPLE?

- ☐ Yes : _____
- ☐ No : _____
- ☐ Unclear : _____

3. Were the harms PRE-DEFINED using standardized or precise definitions?

- ☐ Yes : _____
- ☐ No : _____
- ☐ Unclear : _____

4. Were SEVERE events precisely defined?

- ☐ Yes : _____
- ☐ No : _____
- ☐ Unclear : _____

5. Were SERIOUS events precisely defined?

- ☐ Yes : _____
- ☐ No : _____
- ☐ Unclear : _____

6. Did the author(s) use STANDARD scale(s) or checklist(s) for harms collection?

- ☐ Yes : _____
- ☐ No : _____
- ☐ Unclear : _____

7. Was the mode of harms collection specified as:

- ☐ Active : _____
- ☐ Passive : _____
- ☐ Not Reported : _____
- ☐ Unclear : _____

8. Did the study specify WHO collected the harms?

- ☐ Yes : _____
- ☐ No : _____
- ☐ Unclear : _____

9. Did the study specify the TRAINING or BACKGROUND of who ascertained the harms (specify)?

- ☐ Yes : _____
- ☐ No : _____
- ☐ Unclear : _____

10. Did the study specify the TIMING and FREQUENCY of collection of the harms (specify)?

- Yes : _____
 ○ No : _____
 ○ Unclear : _____

11. Did the author(s) specify the type of analyses undertaken for harms data (specify)?

- Yes : _____
 ○ No : _____
 ○ Unclear : _____

Table No 1: Type of Intervention/treatment, sample size , Adverse Events (AE), and Withdrawals per group

Type	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Type of intervention								
No of Pts assigned								
No of Pts who have AE								
Percent of Pts who have AE								
No of Pts who withdrew due to AE								
Percent of Pts who withdrew								

Table No 2: Identify number (%) of patients who had severe or serious adverse events (AE) per group

Severe AD	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Suicidality								
Bleeding								
Low Sodium								
Death								
Other 1 _____								
Other 2 _____								
Other 3 _____								
Other 4 _____								
Other 5 _____								

Table No 3: Identify number (%) of patients who had adverse events (AE) per group

Adverse Events	Total	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Sexual Dysfunction								
Anxiety								
Sedation								
Gastrointestinal Disturbance (nausea, vomiting, diarrhea)								
Weight Loss								
Weight Gain								
Change in triglycerides								
Change in glucose								
Sleep disorder (insomnia or hypersomnia)								
Cardiovascular Problems (hypotension, tachycardia, bradycardia)								
Toxicity problems								
Headaches								
Other 1 _____								
Other 2 _____								
Other 3 _____								
Other 4 _____								
Other 5 _____								

278. Data Extractor/Reviewer:

279. Comments:

280. First Reviewer:

281. First Reviewer comments:

282. Second Reviewer:

283. Second Reviewer Comments:

284. Investigators Comments:

285. Go to outcome form

☐ Yes

☐ NO

286. New Question

287. Group

☐ MoCo

☐ MoMo

☐ CoCo

☐ STARD

☐ Other : _____

1. Quality Assessment for Primary Studies Rater #1 (Grouping)

- ☐ Group1 : _____
- ☐ Group2 : _____
- ☐ Group3 : _____
- ☐ Exclude

Instruction: Please read the instructions that were sent to you by email before completing this form.

2. Was the method of randomization adequate?

- ☐ Yes ☐ No ☐ Unsure : _____

3. Was the treatment allocation concealed?

- ☐ Yes ☐ No ☐ Unsure : _____

Was knowledge of the allocated interventions adequately prevented during the study?

4. Was the patient blinded to the intervention?

- ☐ Yes ☐ No ☐ Unsure : _____

5. Was the care provider blinded to the intervention?

- ☐ Yes ☐ No ☐ Unsure : _____

6. Was the outcome assessor blinded to the intervention?

- ☐ Yes ☐ No ☐ Unsure : _____

Were incomplete outcome data adequately addressed?

7. Was the drop-out rate described and acceptable?

- ☐ Yes ☐ No ☐ Unsure : _____

8. Were all randomized participants analyzed in the group to which they were allocated?

- ☐ Yes ☐ No ☐ Unsure : _____

9. Are reports of the study free of suggestion of selective outcome reporting?

- ☐ Yes ☐ No ☐ Unsure : _____

Other sources of potential bias:

10. Were the groups similar at baseline regarding the most important prognostic indicators?

- ☐ Yes ☐ No ☐ Unsure : _____

11. Were co-interventions avoided or similar?

- ☐ Yes ☐ No ☐ Unsure : _____

12. Was the compliance acceptable in all groups?

- ☐ Yes ☐ No ☐ Unsure : _____

13. Was the timing of the outcome assessment similar in all groups?

- ☐ Yes ☐ No ☐ Unsure : _____

14. Is the role of the study sponsor/ funder (i.e. manufacturer of the device) appropriate?

☐ Yes ☐ No ☐ Unsure : _____

15. Go to level 5

☐ Yes

16. Other:

1. Quality Assessment for Primary Studies Rater #2 (Grouping)

- ☐ Group1 : _____
- ☐ Group2 : _____
- ☐ Group3 : _____
- ☐ Exclude : _____

Instruction: Please read the instructions that were sent to you by email before completing this form.

2. Was the method of randomization adequate?

- ☐ Yes ☐ No ☐ Unsure : _____

3. Was the treatment allocation concealed?

- ☐ Yes ☐ No ☐ Unsure : _____

Was knowledge of the allocated interventions adequately prevented during the study?

4. Was the patient blinded to the intervention?

- ☐ Yes ☐ No ☐ Unsure : _____

5. Was the care provider blinded to the intervention?

- ☐ Yes ☐ No ☐ Unsure : _____

6. Was the outcome assessor blinded to the intervention?

- ☐ Yes ☐ No ☐ Unsure : _____

Were incomplete outcome data adequately addressed?

7. Was the drop-out rate described and acceptable?

- ☐ Yes ☐ No ☐ Unsure : _____

8. Were all randomized participants analyzed in the group to which they were allocated?

- ☐ Yes ☐ No ☐ Unsure : _____

9. Are reports of the study free of suggestion of selective outcome reporting?

- ☐ Yes ☐ No ☐ Unsure : _____

Other sources of potential bias:

10. Were the groups similar at baseline regarding the most important prognostic indicators?

- ☐ Yes ☐ No ☐ Unsure : _____

11. Were co-interventions avoided or similar?

- ☐ Yes ☐ No ☐ Unsure : _____

12. Was the compliance acceptable in all groups?

- ☐ Yes ☐ No ☐ Unsure : _____

13. Was the timing of the outcome assessment similar in all groups?

- ☐ Yes ☐ No ☐ Unsure : _____

14. Is the role of the study sponsor/ funder (i.e. manufacturer of the device) appropriate?

☐ Yes ☐ No ☐ Unsure : _____

15. Other:

16. Group

☐ MoCo

☐ MoMo

☐ CoCo

☐ STARD

☐ Other : _____

Data Extraction - Primary Study - outcome (Grouping)

- Group1 : _____
- Group2 : _____
- Group3 : _____
- Exclude

Table 1: List the time interval (wks) where study outcomes were collected

Study Outcome	Time Intervals (wks)
For prospective studies ONLY, identify the time interval from the start of the prospective evaluation of treatment response (baseline0) to the point of evaluation for non-response.	
For prospective and retrospective studies, identify the time interval from the start of the study with subjects who are non-responders (baseline1) to the following time points: Intermediate time point #1.	
Intermediate time point #1.	
Intermediate time point #2.	
Intermediate time point #3.	
End point or final time point	
Other #1:	
Other #2:	

Table 1, Remark/Note:

Table 2: List all outcomes (Response and/or Remission) and place a Y in the Time cell to indicate when these were collected. Please read helpfile carefully.

List all reported outcomes	Measurement Tool (e.g. HAMD)	Primary (P) Secondary (S)	Time 0 (Base-line)	Time 1 (Inter-mediate)	Time 2 (Inter-mediate)	Time 3 (Inter-mediate)	Time Final (End point)

Table 2,Remark/Note:

Table 3: List Study definitions of the following:

Outcome	Measurement Tool (e.g. HAMD)	Score threshold (e.g. >12)	Definitions	Note
Adequate Response (responders)				
Inadequate Response (non-responders)				
Partial Response (partial responders)				
None Response				
Remission (remitters)				
Non-remission				
Others				

Table 3,Remark/Note:

Table 4 : Endpoint Dichotomous Outcome 1 with Measurement Tool 1

Outcome 1/ Tool 1	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
N = _____								

% = _____								
Groups compared								
Reference Group								
Statistical Test								
Statistical Value								
OR								
RR								
CI _{lower}								
CI _{upper}								
P-value								
Significant level (e.g. 90%, 95%, 99%)								

Table 4--Remark/Note:

Table 5 : Endpoint Dichotomous Outcome 1 with Measurement Tool 2

Outcome 1/ Tool 2	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
N = _____								
% = _____								
Groups compared								
Reference Group								
Statistical Test								
Statistical Value								

OR								
RR								
CI _{lower}								
CI _{upper}								
P-value								
Significant level (e.g. 90%, 95%, 99%)								

Table 5--Remark/Note:

Table 6 : Endpoint Dichotomous Outcome 2 with Measurement Tool 1

Outcome 2/ Tool 1	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
N = _____								
% = _____								
Groups compared								
Reference Group								
Statistical Test								
Statistical Value								
OR								
RR								
CI _{lower}								
CI _{upper}								

P-value								
Significant level (e.g. 90%, 95%, 99%)								

Table 6--Remark/Note:

Table 7 : Endpoint Dichotomous Outcome 2 with Measurement Tool 2

Outcome 2/ Tool 2	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
N = _____								
% = _____								
Groups compared								
Reference Group								
Statistical Test								
Statistical Value								
OR								
RR								
CI _{lower}								
CI _{upper}								
P-value								
Significant level (e.g. 90%, 95%, 99%)								

Table 7--Remark/Note:

Specify type of outcome measure in table 8:

- ☐ Change score : _____
- ☐ Mean score : _____
- ☐ Adjusted mean score : _____
- ☐ Least square mean change : _____

Table 8 : Endpoint Continuous Outcome 1 with Measurement Tool 1

Outcome 1/ Tool 1	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
Minimum								
Maximum								
Mean								
SD								
SEM								
Groups compared								
Statistical Test								
Statistical Value								
P-value								
Significant level (e.g. 90%, 95%, 99%)								
Other : _____								

Table 8--Remark/Note:

Specify type of outcome measure in table 9:

- ☐ Change score : _____
- ☐ Mean score : _____
- ☐ Adjusted mean score : _____
- ☐ Least square mean change : _____

Table 9 : Endpoint Continuous Outcome 1 with Measurement Tool 2

Outcome 1/ Tool 2	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
Minimum								
Maximum								
Mean								
SD								
SEM								
Groups compared								
Statistical Test								
Statistical Value								
P-value								
Significant level (e.g. 90%, 95%, 99%)								
Other : _____								

Table 9--Remark/Note:

Specify type of outcome measure in table 10:

- ☐ Change score : _____
- ☐ Mean score : _____
- ☐ Adjusted mean score : _____
- ☐ Least square mean change : _____

Table 10 : Endpoint Continuous Outcome 2 with Measurement Tool 1

Outcome 2/ Tool 1	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								

N = total								
Minimum								
Maximum								
Mean								
SD								
SEM								
Groups compared								
Statistical Test								
Statistical Value								
P-value								
Significant level (e.g. 90%, 95%, 99%)								
Other : _____								

Table 10--Remark/Note:

Specify type of outcome measure in table 11:

- ☐ Change score : _____
- ☐ Mean score : _____
- ☐ Adjusted mean score : _____
- ☐ Least square mean change : _____

Table 11 : Endpoint Continuous Outcome 2 with Measurement Tool 2

Outcome 2/ Tool 2	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
Minimum								
Maximum								

Mean								
SD								
SEM								
Groups compared								
Statistical Test								
Statistical Value								
P-value								
Significant level (e.g. 90%, 95%, 99%)								
Other : _____								

Table 11--Remark/Note:

Table 12 : Baseline Measurement 1

Baseline Measurement 1	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
Minimum								
Maximum								
Mean								
SD								
SEM								
Median								
IQR								

Other #1 : _____								
Other #2 : _____								

Table 12--Remark/Note:

Table 13 : Baseline Measurement 2

Baseline Measurement 2	Entire Population	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Measurement Tool								
N = total								
Minimum								
Maximum								
Mean								
SD								
SEM								
Median								
IQR								
Other #1 : _____								
Other #2 : _____								

Table 13--Remark/Note:

Screener's note/remark:

1192. New Question

1193. New Question

1194. New Question

Go to Quality Assessment for Primary Studies

☐ Yes

☐ No

Investigator's Comments:

1197. Group

☐ MoCo

☐ MoMo

☐ CoCo

☐ STARD

☐ Other : _____

Level 4 - Data Extraction Guidelines & Recommendations

1. Is publication date of this guideline 2004 and forward?

- ☐ Yes (continue)
- ☐ No (stop)

2. What organization sponsored this Guideline?

3. In which country is this guideline applied?

4. What is the scope and purpose of this Guideline/Recommendation? (List all that apply)

- ☐ Treatment
- ☐ Diagnosis
- ☐ Prognosis
- ☐ Others (specify) : _____

5. Who are the Intended Users (check all that apply)

- ☐ Primary Care Physicians (e.g. General practitioners)
- ☐ Mental Health Specialist (Psychiatrists)
- ☐ Allied Mental Health Professionals (Social Workers, Mental Health Nurses, Occupational Therapists)
- ☐ Patients
- ☐ Others (specify)

6. What is the setting for use of this Guideline? (check all that apply)

- ☐ Primary Care
- ☐ Mental Health Out Patient Setting
- ☐ Mental Health Inpatient Setting
- ☐ Others (specify) : _____

7. What is the target population on this Guideline? (check all that apply)

- ☐ Adult MDD
- ☐ Adult Dysthymia
- ☐ Adult Subsyndromal
- ☐ Adolescent MDD
- ☐ Adolescent Dysthymia
- ☐ Adolescent Subsyndromal
- ☐ None of the above (stop)

8. Does this guideline have a specific recommendation (course of action) for patients who do not respond to the intervention(s)?

- ☐ Yes
- ☐ No
- ☐ Not sure

9. What is the definition of AND method of establishing "inadequate/ unsatisfactory" response?

Recommendation #1 for populations who failed to respond to previous antidepressants:

10. Specify Recommendation #1 for populations who failed to respond to previous antidepressants. (Please type in the exact wording)

11. Does the recommendation identify or stratify actions or suggestions based on the specific TYPE of antidepressant medication that subjects had not respond to adequately?

- ☐ NO: they do NOT specify previous type of antidepressant (go to Q13)
- ☐ YES: they specify the type of antidepressant

12. Specify the type/class of DRUG intervention (check all that apply)

- ☐ SSRI (specify) : _____
- ☐ SNRI (specify) : _____
- ☐ SSNRI (specify) : _____
- ☐ Other second generation antidepressants (specify) : _____
- ☐ None Pharmacological (specify) : _____

13. What type of system was used to grade or evaluate the strength of evidence (i.e. GRADE, or some association specific system?)

14. Grading of the recommendation #1: (i.e. strong recommendation)

15. Rating of quality of evidence for Recommendation #1 : (i.e. evidence at high risk of bias, or level I (indicating RCT design)

16. For the evidence that is cited to support the recommendation, please list the number and type of studies included: (i.e. 4 RCTs, and 2 Observational studies)

17. Does the recommendation ONLY specify actions / suggestions to switch to the use of MONTHERAPY that are generic (not specific to drug or intervention? (Please type in the exact wording)

18. Does the recommendation specify any of the following for MONTHERAPY treatment changes? (specify exact wording)

☐ ONLY specify actions / suggestions to switch but is non-specific (Specify exact wording) : _____

☐ Indicates to change the DOSE of the current SSRI or antidepressant : _____

☐ Indicates to change the DURATION of the current SSRI or antidepressant : _____

☐ Indicates a switch from one SSRI to another SSRI OR from one Non-SSRI antidepressant to another within the SAME drug class : _____

☐ Indicates a switch from an SSRI to another non-SSRI antidepressant of a different class : _____

☐ Indicates a switch from an SSRI or non-SSRI anti-depressant to a non-pharmacological treatment : _____

19. Does the recommendation specify any of the following for COMBINED THERAPY treatment changes: (specify exact wording)

☐ ONLY specify actions / suggestions to combine therapies but is non-specific : _____

☐ Indicates to combine therapies with Augmenters (drugs or food supplements) : _____

☐ Indicates to combine one SSRI or non-SSRI antidepressant with another SSRI or non-SSRI antidepressant of the SAME class : _____

☐ Indicates to combine one SSRI with another non-SSRI antidepressant : _____

☐ Indicates to combine an SSRI or antidepressant with a non-pharmacological intervention : _____

☐ Indicates to combine an SSRI or antidepressant with multiple combinations (any intervention previously listed) : _____

Recommendation #2 for populations who failed to respond to previous antidepressants:

10. Specify Recommendation #2 for populations who failed to respond to previous antidepressants. (Please type in the exact wording)

11. Does the recommendation identify or stratify actions or suggestions based on the specific TYPE of antidepressant medication that subjects had not respond to adequately?

☐ NO: they do NOT specify previous type of antidepressant (go to Q13)

☐ YES: they specify the type of antidepressant

12. Specify the type/class of DRUG intervention (check all that apply)

☐ SSRI (specify) : _____

☐ SNRI (specify) : _____

☐ SSNRI (specify) : _____

☐ Other second generation antidepressants (specify) : _____

☐ None Pharmacological (specify) : _____

13. What type of system was used to grade or evaluate the strength of evidence (i.e. GRADE, or some association specific system?)

14. Grading of the recommendation #2: (i.e. strong recommendation)

15. Rating of quality of evidence for Recommendation #2 : (i.e. evidence at high risk of bias, or level I (indicating RCT design)

16. For the evidence that is cited to support the recommendation, please list the number and type of studies included: (i.e. 4 RCTs, and 2 Observational studies)

17. Does the recommendation ONLY specify actions / suggestions to switch to the use of MONOTHERAPY that are generic (not specific to drug or intervention? (Please type in the exact wording)

18. Does the recommendation specify any of the following for MONTHERAPY treatment changes? (specify exact wording)

☐ ONLY specify actions / suggestions to switch but is non-specific (Specify exact wording) :

☐ Indicates to change the DOSE of the current SSRI or antidepressant : _____

☐ Indicates to change the DURATION of the current SSRI or antidepressant : _____

☐ Indicates a switch from one SSRI to another SSRI OR from one Non-SSRI antidepressant to another within the SAME drug class : _____

☐ Indicates a switch from an SSRI to another non-SSRI antidepressant of a different class :

☐ Indicates a switch from an SSRI or non-SSRI anti-depressant to a non-pharmacological treatment :

19. Does the recommendation specify any of the following for COMBINED THERAPY treatment changes: (specify exact wording)

☐ ONLY specify actions / suggestions to combine therapies but is non-specific :

☐ Indicates to combine therapies with Augmenters (drugs or food supplements) :

☐ Indicates to combine one SSRI or non-SSRI antidepressant with another SSRI or non-SSRI antidepressant of the SAME class : _____

☐ Indicates to combine one SSRI with another non-SSRI antidepressant : _____

☐ Indicates to combine an SSRI or antidepressant with a non-pharmacological intervention :

☐ Indicates to combine an SSRI or antidepressant with multiple combinations (any intervention previously listed) :

Recommendation #3 for populations who failed to respond to previous antidepressants:

10. Specify Recommendation #3 for populations who failed to respond to previous antidepressants. (Please type in the exact wording)

11. Does the recommendation identify or stratify actions or suggestions based on the specific TYPE of antidepressant medication that subjects had not respond to adequately?

☐ NO: they do NOT specify previous type of antidepressant (go to Q13)

☐ YES: they specify the type of antidepressant

12. Specify the type/class of DRUG intervention (check all that apply)

☐ SSRI (specify) : _____

☐ SNRI (specify) : _____

☐ SSNRI (specify) : _____

☐ Other second generation antidepressants (specify) : _____

☐ None Pharmacological (specify) : _____

13. What type of system was used to grade or evaluate the strength of evidence (i.e. GRADE, or some association specific system?)

14. Grading of the recommendation #3: (i.e. strong recommendation)

15. Rating of quality of evidence for Recommendation #3 : (i.e. evidence at high risk of bias, or level I (indicating RCT design)

16. For the evidence that is cited to support the recommendation, please list the number and type of studies included: (i.e. 4 RCTs, and 2 Observational studies)

17. Does the recommendation ONLY specify actions / suggestions to switch to the use of MONOTHERAPY that are generic (not specific to drug or intervention? (Please type in the exact wording)

18. Does the recommendation specify any of the following for MONOTHERAPY treatment changes? (specify exact wording)

☐ ONLY specify actions / suggestions to switch but is non-specific (Specify exact wording) :

☐ Indicates to change the DOSE of the current SSRI or antidepressant : _____

☐ Indicates to change the DURATION of the current SSRI or antidepressant : _____

☐ Indicates a switch from one SSRI to another SSRI OR from one Non-SSRI antidepressant to another within the SAME drug class : _____

☐ Indicates a switch from an SSRI to another non-SSRI antidepressant of a different class : _____

☐ Indicates a switch from an SSRI or non-SSRI anti-depressant to a non-pharmacological treatment : _____

19. Does the recommendation specify any of the following for COMBINED THERAPY treatment changes: (specify exact wording)

☐ ONLY specify actions / suggestions to combine therapies but is non-specific :

☐ Indicates to combine therapies with Augmenters (drugs or food supplements) :

☐ Indicates to combine one SSRI or non-SSRI antidepressant with another SSRI or non-SSRI antidepressant of the SAME class : _____

☐ Indicates to combine one SSRI with another non-SSRI antidepressant : _____

☐ Indicates to combine an SSRI or antidepressant with a non-pharmacological intervention : _____

☐ Indicates to combine an SSRI or antidepressant with multiple combinations (any intervention previously listed) : _____

Recommendation #4 for populations who failed to respond to previous antidepressants:

10. Specify Recommendation #4 for populations who failed to respond to previous antidepressants. (Please type in the exact wording)

11. Does the recommendation identify or stratify actions or suggestions based on the specific TYPE of antidepressant medication that subjects had not respond to adequately?

☐ NO: they do NOT specify previous type of antidepressant (go to Q13)

☐ YES: they specify the type of antidepressant

12. Specify the type/class of DRUG intervention (check all that apply)

- ☐ SSRI (specify) : _____
- ☐ SNRI (specify) : _____
- ☐ SSNRI (specify) : _____
- ☐ Other second generation antidepressants (specify) : _____
- ☐ None Pharmacological (specify) : _____

13. What type of system was used to grade or evaluate the strength of evidence (i.e. GRADE, or some association specific system)?

14. Grading of the recommendation #4: (i.e. strong recommendation)

15. Rating of quality of evidence for Recommendation #4 : (i.e. evidence at high risk of bias, or level I (indicating RCT design)

16. For the evidence that is cited to support the recommendation, please list the number and type of studies included: (i.e. 4 RCTs, and 2 Observational studies)

17. Does the recommendation ONLY specify actions / suggestions to switch to the use of MONOTHERAPY that are generic (not specific to drug or intervention? (Please type in the exact wording)

18. Does the recommendation specify any of the following for MONOTHERAPY treatment changes? (specify exact wording)

☐ ONLY specify actions / suggestions to switch but is non-specific (Specify exact wording) :

☐ Indicates to change the DOSE of the current SSRI or antidepressant : _____

☐ Indicates to change the DURATION of the current SSRI or antidepressant : _____

☐ Indicates a switch from one SSRI to another SSRI OR from one Non-SSRI antidepressant to another within the SAME drug class : _____

☐ Indicates a switch from an SSRI to another non-SSRI antidepressant of a different class :

☐ Indicates a switch from an SSRI or non-SSRI anti-depressant to a non-pharmacological treatment :

19. Does the recommendation specify any of the following for COMBINED THERAPY treatment changes: (specify exact wording)

☐ ONLY specify actions / suggestions to combine therapies but is non-specific :

☐ Indicates to combine therapies with Augmenters (drugs or food supplements) :

☐ Indicates to combine one SSRI or non-SSRI antidepressant with another SSRI or non-SSRI antidepressant of the SAME class : _____

☐ Indicates to combine one SSRI with another non-SSRI antidepressant : _____

☐ Indicates to combine an SSRI or antidepressant with a non-pharmacological intervention :

☐ Indicates to combine an SSRI or antidepressant with multiple combinations (any intervention previously listed) :

50. Data Extractor/Reviewer:

51. Second Reviewer:

52. This is a companion guideline to :

Level 5: Quality Assessment Tools for Guidelines and Recommendations: AGREE II instrument for Guidelines:

General Instruction, Rating Scale:

All AGREE II items are rated on the following 7-point scale:

Score of 1 (Strongly Disagree). A score of 1 should be given when there is no information that is relevant to the AGREE II item or if the concept is very poorly reported.

Score of 7 (Strongly Agree). A score of 7 should be given if the quality of reporting is exceptional and where the full criteria and considerations articulated in the User's Manual have been met.

Scores Between 2 and 6. A score between 2 and 6 is assigned when the reporting of the AGREE II item does not meet the full criteria or considerations. A score is assigned depending on the completeness and quality of reporting. Scores increase as more criteria are met and considerations addressed. The "How to Rate" section for each item includes details about assessment criteria and considerations specific to the item. (see instruction)

1. The overall objective(s) of the guideline is (are) specifically described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

2. The health question(s) covered by the guideline is (are) specifically described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

4. The guideline development group includes individuals from all the relevant professional groups.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

5. The views and preferences of the target population (patients, public, etc.) have been sought.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

6. The target users of the guideline are clearly defined.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

7. Systematic methods were used to search for evidence.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

8. The criteria for selecting the evidence are clearly described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

9. The strengths and limitations of the body of evidence are clearly described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

10. The methods used for formulating the recommendations are clearly described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

12. There is an explicit link between the recommendations and the supporting evidence.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

13. The guideline has been externally reviewed by experts prior to its publication.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

14. A procedure for updating the guideline is provided.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

15. The recommendations are specific and unambiguous.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

16. The different options for management of the condition or health issue are clearly presented.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

17. Key recommendations are easily identifiable.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

18. The guideline describes facilitators and barriers to its application.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

19. The guideline provides advice and / or tools on how the recommendations can be put into practice.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

20. The potential resource implications of applying the recommendations have been considered.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

21. The guideline presents monitoring and / or auditing criteria.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

22. The views of the funding body have not influenced the content of the guideline.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

23. Competing interests of guideline development group members have been recorded and addressed.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

24. Overall Assessment:

Would you recommend these guidelines for use in practice?

- ☐ Strongly recommend
- ☐ Recommend (with provisos alteration)
- ☐ Would not recommend
- ☐ Unsure

25. Comments:

26. Appraiser 1:

- ☐ Catherine
- ☐ Sara
- ☐ Homa
- ☐ Lina
- ☐ Other (specify) : _____

Level 5: Quality Assessment Tools for Guidelines and Recommendations: AGREE II instrument for Guidelines:

General Instruction, Rating Scale:

All AGREE II items are rated on the following 7-point scale:

Score of 1 (Strongly Disagree). A score of 1 should be given when there is no information that is relevant to the AGREE II item or if the concept is very poorly reported.

Score of 7 (Strongly Agree). A score of 7 should be given if the quality of reporting is exceptional and where the full criteria and considerations articulated in the User's Manual have been met.

Scores Between 2 and 6. A score between 2 and 6 is assigned when the reporting of the AGREE II item does not meet the full criteria or considerations. A score is assigned depending on the completeness and quality of reporting. Scores increase as more criteria are met and considerations addressed. The "How to Rate" section for each item includes details about assessment criteria and considerations specific to the item. (see instruction)

1. The overall objective(s) of the guideline is (are) specifically described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

2. The health question(s) covered by the guideline is (are) specifically described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

4. The guideline development group includes individuals from all the relevant professional groups.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

5. The views and preferences of the target population (patients, public, etc.) have been sought.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

6. The target users of the guideline are clearly defined.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

7. Systematic methods were used to search for evidence.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

8. The criteria for selecting the evidence are clearly described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

9. The strengths and limitations of the body of evidence are clearly described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

10. The methods used for formulating the recommendations are clearly described.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

12. There is an explicit link between the recommendations and the supporting evidence.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

13. The guideline has been externally reviewed by experts prior to its publication.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

14. A procedure for updating the guideline is provided.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

15. The recommendations are specific and unambiguous.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

16. The different options for management of the condition or health issue are clearly presented.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

17. Key recommendations are easily identifiable.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

18. The guideline describes facilitators and barriers to its application.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

19. The guideline provides advice and / or tools on how the recommendations can be put into practice.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

20. The potential resource implications of applying the recommendations have been considered.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

21. The guideline presents monitoring and / or auditing criteria.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

22. The views of the funding body have not influenced the content of the guideline.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

23. Competing interests of guideline development group members have been recorded and addressed.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

24. Overall Assessment:

Would you recommend these guidelines for use in practice?

- ☐ Strongly recommend
- ☐ Recommend (with provisos alteration)
- ☐ Would not recommend
- ☐ Unsure

25. Data Extractor/Reviewer:

26. Appraiser 2:

- ☐ Catherine
- ☐ Sara
- ☐ Other (specify) : _____

Appendix C. Excluded Studies

Electroconvulsive therapy. JAMA. 1985;254(15):2103-8. OVID-Embase

OVID-Embase.

Exclude: Not an eligible guideline

Separate and combined anxiolytic and anti-depressant treatment of mixed anxiety/depression: A double-blind, placebo controlled comparison. Sussex Clinical Trials Group. Acta Psychiatr Scand. 1985;72(1):81-8. PMID:2863922 OVID-Medline.

Exclude: Not an eligible population treatment

APA issues practice guideline for major depressive disorder in adults. Am Fam Physician. 1993;48(7):1312-3. OVID-Embase.

Exclude: Not an eligible guideline

Guidelines for treating depressive illness with antidepressants: A statement from the British Association for Psychopharmacology. J Psychopharmacol. 1993;7(1):19-23. OVID-PsycINFO.

Exclude: Not an eligible guideline

Practice guideline for major depressive disorder in adults. American Psychiatric Association. Am J Psychiatry. 1993;150(4:Suppl):1-26. PMID:8465906 OVID-Medline.

Exclude: Not an eligible guideline

The effect of sequential antidepressant treatment on geriatric depression: Erratum. J Affect Disord. 1996;41(1):77 OVID-PsycINFO.

Exclude: Not an eligible study design

Effect of Hypericum perforatum (St John's wort) in major depressive disorder: A randomized controlled trial. JAMA. 2002;287(14):1807-14. PM:11939866

Exclude: Not an eligible population treatment

St John's wort = SSRI for moderate-severe depression. S Afr Fam Pract. 2005;47(4):18. OVID-Embase.

Exclude: Not an eligible study design

Adjunctive aripiprazole effective for treatment-resistant depression. Prim Psychiatr. 2005;12(1):19 OVID-PsycINFO.

Exclude: Not an eligible study design

Botox treatment of depression. Prim Psychiatr. 2006;13(7):26-7. OVID-PsycINFO.

Exclude: Not an eligible study design

Augmenting standard antidepressant treatment may help recovery in elderly. Brown Univ Geriatr Psychopharmacol Update. 2007;11(8):1-7. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Do omega-3 fatty acids help in depression? Drug Ther Bull. 2007;45(2):9-12. EBSCO-CINAHL.

Exclude: Not an eligible study design

TADS results show fluoxetine plus CBT safer and more effective for teen depression. (Treatment for Adolescents with Depression Study)(cognitive-behavioral therapy). Brown Univ Child Adolesc Psychopharmacol Update. 2007;9(1):1-4. EBSCO-CINAHL.

Exclude: Not an eligible study design

Cognitive therapy equal to medication in augmentation for citalopram-resistant depression. Brown Univ Psychopharmacol Update. 2007;18(7):1-8. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Cognitive behavioral therapy + alternative selective serotonin reuptake inhibitor better than alternative SSRI alone in adolescent depression. J Natl Med Assoc. 2008;100(6):762-3. OVID-Embase.

Exclude: Not an eligible study design

Omissions in acknowledgments in: "The treatment for adolescents with depression study (TADS): Long-term effectiveness and safety outcomes". Arch Gen Psychiatr. 2008;65(1):101. OVID-PsycINFO.

Exclude: Not an eligible study design

POEMs. CBT plus alternative SSRI is better than alternative SSRI alone in adolescent depression. JAAPA. 2008;21(5):58 EBSCO-CINAHL.

Exclude: Not an eligible study design

Switching antidepressants plus CBT best for treatment-resistant depression in teens. (cognitive behavioral therapy). Brown Univ Child Adolesc Psychopharmacol Update. 2008;10(5):1-3. EBSCO-CINAHL.

Exclude: Not an eligible study design

Treating depression with comorbid personality disorder: meds, CT or both?... Cognitive therapy. Brown Univ Psychopharmacol Update. 2008;19(4):1-3. EBSCO-CINAHL.

Exclude: Not an eligible study design

Getting fitter, improving depression. *J Sport Exerc Psychol.* 2008;30(3):435 OVID-PsycINFO.
Exclude: Not an eligible population treatment

Cognitive behavioral therapy effective for depressed elderly. *J Natl Med Assoc.* 2010;102(4):358 OVID-Embase.
Exclude: Not an eligible study design

Omega-3 fatty acids not effective for depression in patients with coronary heart disease. *J Natl Med Assoc.* 2010;102(2):151 OVID-Embase.
Exclude: Not an eligible study design

Aan Het Rot MCD, Mathew S. Intravenous ketamine for treatment-resistant major depressive disorder. *Prim Psychiatr.* 2008;15(4):39-47. Wiley-CCTR.
Exclude: Not an eligible study design

aan het RM, Collins KA, Murrough JW, et al. Safety and efficacy of repeated-dose intravenous ketamine for treatment-resistant depression. *Biol Psychiatr.* 2010;67(2):139-45. PMID:19897179 OVID-Medline.
Exclude: Not an eligible study design

Aarnell G, Borjesson A, Eder DN, et al. Treatment resistant major depression - a comparison of fluoxetine/olanzapine combination therapy with venlafaxine. *Int J Neuropsychopharmacol.* 2002;5(Suppl 1):141. Wiley-CCTR.
Exclude: Not an eligible study design

Aarsland D, Larsen JP, Lim NG, et al. Citalopram plus mianserin in patients with Parkinson's disease and depression: An open-label study. *Nord J Psychiatr.* 1998;52(2):115-6. OVID-Embase.
Exclude: Not an eligible population design

Abbass AA. Intensive short-term dynamic psychotherapy of treatment-resistant depression: A pilot study. *Depress Anxiety.* 2006;23(7):449-52. OVID-Embase.
Exclude: Not an eligible study design

Abbass AA, Hancock JT, Henderson J, et al. Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database Syst Rev.* 2006;(4):CD004687. Wiley-CDSR.
Excluded - Systematic review - relevant topic, citations cross-matched

Aberg-Wistedt A. Comparison between zimelidine and desipramine in endogenous depression. A cross-over study. *Acta Psychiatr Scand.* 1982;66(2):129-38. PMID:6215831 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Aberg A. Controlled cross-over study of a 5-HT uptake inhibiting and an NA uptake inhibiting antidepressant. *Acta Psychiatr Scand Suppl.* 1981;63(Suppl. 290):244-55. PMID:6452794 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Abraham G, Milev R, Lawson SJ. T3 augmentation of SSRI resistant depression. *J Affect Disord.* 2006;91(2-3):211-5. OVID-PsycINFO.
Exclude: Not an eligible study design

Abraham IL, Neundorfer MM, Currie LJ. Effects of group interventions on cognition and depression in nursing home residents. *Nurs Res.* 1992;41(4):196-202. PMID:1383947 OVID-Medline.
Exclude: Not an eligible population treatment

Abraham, IL., Onega, LL., Reel, SJ. et al. Effects of cognitive group interventions on depressed frail nursing home residents. 1997:154-68. 1997. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Abt, KL. The effects of a group exercise intervention in the adjunctive treatment of depression Abt. 2006. OVID-PsycINFO.
Exclude: Not an eligible study design

Adlersberg S, Toren P, Mester R, et al. Verapamil is not an antidepressant in patients resistant to tricyclic antidepressants. *Clin Neuropharmacol.* 1994;17(3):294-7. PMID:9316675 OVID-Medline.
Exclude: Not an eligible study design

Adli M, Berghofer A, Linden M, et al. Effectiveness and feasibility of a standardized stepwise drug treatment regimen algorithm for inpatients with depressive disorders: results of a 2-year observational algorithm study. *J Clin Psychiatry.* 2002;63(9):782-90. PMID:12363118 OVID-Medline.
Exclude: Not an eligible study design

Adli M, Baethge C, Heinz A, et al. Is dose escalation of antidepressants a rational strategy after a medium-dose treatment has failed? A systematic review. *Eur Arch Psychiatry Clin Neurosci.* 2005;255(6):387-400. PMID:15868067 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Adli M, Pilhatsch M, Bauer M, et al. Safety of high-intensity treatment with the irreversible monoamine oxidase inhibitor tranylcypromine in patients with treatment-resistant depression. *Pharmacopsychiatr.* 2008;41(6):252-7. PMID:19067263 OVID-Medline.
Exclude: Not an eligible study design

Adli M, Bschor T, Bauer M, et al. Long-term outcome after lithium augmentation in unipolar depression: Focus on HPA system activity. *Neuropsychobiol.* 2009;60(1):23-30. OVID-Embase.

Exclude: Not an eligible study design

Adson DE, Kushner MG, Eiben KM, et al. Preliminary experience with adjunctive quetiapine in patients receiving selective serotonin reuptake inhibitors. *Depress Anxiety.* 2004;19(2):121-6. OVID-Embase.

Exclude: Not an eligible study design

Adson DE, Kushner MG, Fahnhorst TA. Treatment of residual anxiety symptoms with adjunctive aripiprazole in depressed patients taking selective serotonin reuptake inhibitors. *J Affect Disord.* 2005;86(1):99-104. PMID:15820277 OVID-Medline.

Exclude: Not an eligible study design

Aekwarangkoon S, Oakley LD, Suttharangsee W, et al. Effectiveness of brief cognitive-support treatment in mild to moderate depressed Thai adolescent students. *Thai J Nurs.* 2006;10(4):288-300. EBSCO-CINAHL.

Exclude: Not an eligible study design

Afuwape SA, Craig TK, Harris T, et al. The Cares of Life Project (CoLP): an exploratory randomised controlled trial of a community-based intervention for black people with common mental disorder. *J Affect Disord.* 2010;127(1-3):370-4. PMID:20547421 OVID-Medline.

Exclude: Not an eligible population treatment

Agid O, Lerer B. Algorithm-based treatment of major depression in an outpatient clinic: Clinical correlates of response to a specific serotonin reuptake inhibitor and to triiodothyronine augmentation. *Int J Neuropsychopharmacol.* 2003;6(1):41-9. PMID:12899735 OVID-Medline.

Exclude: Not an eligible study design

Agnoli A, Martucci N, Manna V. On the antidepressant effect of SAME: Clinical and pharmac-EEG study with SAME alone and in association with a beta-2 stimulant drug, phenoterole. *J Psychiatr Biol Therapeut.* 1984;7(Suppl. 1):104-5. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Agosti V, Ocepek-Welikson K. The efficacy of imipramine and psychotherapy in early-onset chronic depression: A reanalysis of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *J Affect Disord.* 1997;43(3):181-6. OVID-Embase.

Exclude: Not an eligible population treatment

Agosti V. One year clinical and psychosocial outcomes of early-onset chronic depression. *J Affect Disord.* 1999;54(1-2):171-5. PMID:10403160 OVID-Medline.

Exclude: Not an eligible study design

Agrawal A, Dixit SP, Dubey GP, et al. Clinical evaluation of anti-depressant properties of Basant (*Hypericum perforatum*). *Pharmacopsychocol.* 1994;7(3):253-6. OVID-PsycINFO.

Exclude: Mixed antidepressants:some failed on SSRI

Agricola R, Dalla VG, Urani R, et al. S-adenosyl-L-methionine in the treatment of major depression complicating chronic alcoholism. *Curr Ther Res Clin Exp.* 1994;55(1):83-92. OVID-Embase.

Exclude: Not an eligible study design

Aguilera A, Garza MJ, Munoz RF. Group cognitive-behavioral therapy for depression in Spanish: culture-sensitive manualized treatment in practice. *J Clin Psychol.* 2010;66(8):857-67. PMID:20549680 OVID-Medline.

Exclude: Not an eligible study design

Ahmed SH, Zaheeruddin. Early experience with fluoxetine. *JPMa.* 1991;41(11):275-7. PMID:1766070 OVID-Medline.

Exclude: Not an eligible study design

Aiken CB. Pramipexole in psychiatry: A systematic review of the literature. *ÿ.* 2007;68(8):1230-6. PM:17854248 Excluded - Systematic review - relevant topic, citations cross-matched

Aikens JE, Kroenke K, Swindle RW, et al. Nine-month predictors and outcomes of SSRI antidepressant continuation in primary care. *Gen Hosp Psychiatry.* 2005;27(4):229-36. PMID:15993253 OVID-Medline.

Exclude: Not an eligible population treatment

Ajel K, Bhogal K, Baldwin D. Prescribing of the antidepressant duloxetine: Can local clinical audit findings facilitate medicines management decisions? *Int J Psychiatr Clin Pract.* 2008;12(2):156-9. OVID-Embase.

Exclude: Not an eligible study design

Akechi T, Okuyama T, Onishi J, et al. Psychotherapy for depression among incurable cancer patients. *Cochrane Database of Systematic Reviews*. 2008;(2):CD005537. Wiley-CDSR. Excluded - Systematic review - relevant topic, citations cross-matched

Akhondzadeh BA, Moshiri E, Noorbala AA, et al. Comparison of petal of *Crocus sativus* L. and fluoxetine in the treatment of depressed outpatients: a pilot double-blind randomized trial. *Prog Neuropsychopharmacol Biol Psychiatry*. 2007;31(2):439-42. PMID:17174460 OVID-Medline.

Exclude: Not an eligible population treatment

Akhondzadeh S, Kashani L, Fotouhi A, et al. Comparison of *Lavandula angustifolia* Mill. tincture and imipramine in the treatment of mild to moderate depression: A double-blind, randomized trial. *Prog Neuropsychopharmacol Biol Psychiatry*. 2003;27(1):123-7. OVID-Embase.

Exclude: Not an eligible population treatment

Akhondzadeh S, Fallah-Pour H, Afkham K, et al. Comparison of *Crocus sativus* L. and imipramine in the treatment of mild to moderate depression: a pilot double-blind randomized trial. *BMC Compl Alternative Med*. 2004;4:12 PMID:15341662 OVID-Medline.

Exclude: Not an eligible population treatment

Akhondzadeh S, Fallah-Pour H, Afkham K, et al. A comparative trial of *Crocus sativus* L. (saffron) and imipramine in mild to moderate depression. *Focus Alternative Compl Ther*. 2005;10(1):22-3. OVID-Embase.

Exclude: Not an eligible population treatment

Akhondzadeh S, Tahmacebi-Pour N, Noorbala AA, et al. *Crocus sativus* L. in the treatment of mild to moderate depression: a double-blind, randomized and placebo-controlled trial. *Phytother Res*. 2005;19(2):148-51. PMID:15852492 OVID-Medline.

Exclude: Not an eligible population treatment

Akhondzadeh S, Jafari S, Raisi F, et al. Clinical trial of adjunctive celecoxib treatment in patients with major depression: A double blind and placebo controlled trial. *Depress Anxiety*. 2009;26(7):607-11. OVID-Embase.

Exclude: Not an eligible population treatment

Akizuki N, Okamura H, Akechi T, et al. Clinical experience of the pharmacological treatment algorithm for major depression in advanced cancer patients: Preliminary study. *Int J Psychiatr Clin Pract*. 2002;6(2):83-9. Exclude: Not an eligible study design

Alamo C, Lopez-Munoz F, Rubio G, et al. Combined treatment with reboxetine in depressed patients with no response to venlafaxine: A 6-week follow-up study. *Acta Neuropsychiatr*. 2007;19(5):291-6. OVID-Embase. Exclude: Not an eligible study design

Albanese MJ, Clodfelter RC, Jr., Khantzian EJ. Divalproex sodium in substance abusers with mood disorder. *J Clin Psychiatry*. 2000;61(12):916-21. PMID:11206596 OVID-Medline. Exclude: Not an eligible study design

Albin, J.I. A study measuring the effectiveness of cognitive/psychosocial intervention with a life-threatening illness: My thoughts, my illness, my life 1998. OVID-PsycINFO.

Exclude: Not an eligible study design

Alexopoulos GS, Raue P, Arean P. Problem-solving therapy versus supportive therapy in geriatric major depression with executive dysfunction. *Am J Geriatr Psychiatr*. 2003;11(1):46-52. PMID:12527539 OVID-Medline.

Exclude: Not an eligible population treatment

Alexopoulos GS, Sirey JA, Raue PJ, et al. Outcomes of depressed patients undergoing inpatient pulmonary rehabilitation. *Am J Geriatr Psychiatr*. 2006;14(5):466-75. PMID:16670251 OVID-Medline.

Exclude: Not an eligible study design

Alexopoulos GS, Raue PJ, Kiosses DN, et al. Problem-solving therapy and supportive therapy in older adults with major depression and executive dysfunction: Effect on disability. *Arch Gen Psychiatr*. 2011;68(1):33-41. PMID:21199963 OVID-Medline.

Exclude: Not an eligible population treatment

Alladin A, Alibhai A. Cognitive hypnotherapy for depression: an empirical investigation. *Int J Clin Exp Hypnosis*. 2007;55(2):147-66. PMID:17365072 OVID-Medline.

Exclude: Not an eligible population treatment

Allart-van Dam E, Hosman CM, Hoogduin CA, et al. Prevention of depression in subclinically depressed adults: follow-up effects on the 'Coping with Depression' course. *J Affect Disord*. 2007;97(1-3):219-28. PMID:16860874 OVID-Medline. Exclude: Not an eligible population treatment

Allart-van Dam E, Hosman CMH, Hoogduin CAL, et al. The Coping With Depression course: Short-term outcomes and mediating effects of a randomized controlled trial in the treatment of subclinical depression. *Behav Ther.* 2003;34(3):381-96. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Allen JJB. Depression and acupuncture: A controlled clinical trial. *Psychiatr Times.* 2000;17(3):-6p EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Allen JJB, Schnyer RN, Chambers AS, et al. Acupuncture for depression: A randomized controlled trial. *J Clin Psychiatr.* 2006;67(11):1665-73. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Allen JJB, Schnyer RN, Hitt SK. The efficacy of acupuncture in the treatment of major depression in women. *Psychol Sci.* 1998;9(5):397-401. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Almeida OP, Marsh K, Alfonso H, et al. B-vitamins reduce the long-term risk of depression after stroke: The VITATOPS-DEP trial. *Ann Neurol.* 2010;68(4):503-10. PMID:20976769 OVID-Medline.

Exclude: Not an eligible population/treatment

Alpert JE, Mischoulon D, Rubenstein GE, et al. Folinic acid (Leucovorin) as an adjunctive treatment for SSRI-refractory depression. *Ann Clin Psychiatr.* 2002;14(1):33-8. PMID:12046638 OVID-Medline.

Exclude: Not an eligible study design

Alpert JE, Papakostas G, Mischoulon D, et al. S-adenosyl-L-methionine (S-AMe) as an adjunct for resistant major depressive disorder: An open trial following partial or nonresponse to selective serotonin reuptake inhibitors or venlafaxine. *J Clin Psychopharmacol.* 2004;24(6):661-4. PMID:15538131 OVID-Medline.

Exclude: Not an eligible study design

Altshuler LL, Cohen LS, Moline ML, et al. Expert consensus guidelines for the treatment of depression in women: A new treatment tool. *Econom Neurosci.* 2001;3(6):48-61. OVID-Embase.

Exclude: Not an eligible guideline

Altshuler LL, Cohen LS, Moline ML, et al. Treatment of depression in women: A summary of the expert consensus guidelines. *J Psychiatr Pract.* 2001;7(3):185-208. OVID-PsycINFO.

Exclude: Not an eligible guideline

Alvarez E, Perez-Sola V, Perez-Blanco J, et al. Predicting outcome of lithium added to antidepressants in resistant depression. *J Affect Disord.* 1997;42(2-3):179-86. PMID:9105959 OVID-Medline.

Exclude: Not an eligible study design

Amsterdam J, Garcia-Espana F, Fawcett J, et al. Fluoxetine efficacy in menopausal women with and without estrogen replacement. *J Affect Disord.* 1999;55(1):11-7. PMID:10512601 OVID-Medline.

Exclude: Not an eligible population treatment

Amsterdam JD, Berwisch N. Treatment of refractory depression with combination reserpine and tricyclic antidepressant therapy. *J Clin Psychopharmacol.* 1987;7(4):238-42. Wiley-CCTR.

Exclude: Not an eligible population treatment

Amsterdam JD, Berwisch NJ. High dose tranylcypromine therapy for refractory depression. *Pharmacopsychiatr.* 1989;22(1):21-5. PMID:2710808 OVID-Medline.

Exclude: Not an eligible study design

Amsterdam JD, Garcia-Espana F, Rosenzweig M. Clomipramine augmentation in treatment-resistant depression. *Depress Anxiety.* 1997;5(2):84-90. PMID:9262938 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Amsterdam JD, Shults J. MAOI efficacy and safety in advanced stage treatment-resistant depression: A retrospective study. *J Affect Disord.* 2005;89(1-3):183-8. PMID:16213594 OVID-Medline.

Exclude: Not an eligible study design

Ancarani E, Biondi B, Bolletta A, et al. Major depression complicating hemodialysis in patients with chronic renal failure: A multicenter, double-blind, controlled clinical trial of S-adenosyl-L-methionine versus placebo. *Curr Ther Res Clin Exp.* 1993;54(6):680-6. Exclude: Not an eligible population treatment

Anderson IM, Nutt DJ, Deakin JFW. Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 1993 British Association for Psychopharmacology guidelines. *J Psychopharmacol.* 2000;14(1):3-20. OVID-Embase.

Exclude: Not an eligible guideline

Anderson IM, Sarsfield A, Haddad PM. Efficacy, safety and tolerability of quetiapine augmentation in treatment resistant depression: An open-label, pilot study. *J Affect Disord.* 2009;117(1-2):116-9. OVID-Embase.

Exclude: Not an eligible study design

Anderson L, Lewis G, Araya R, et al. Self-help books for depression: How can practitioners and patients make the right choice? *Br J Gen Pract.* 2005;55(514):387-92. PMID:15904559 OVID-Medline.

Exclude - Systematic review - relevant topic, citations cross-matched

Anderson T, Watson M, Davidson R. The use of cognitive behavioural therapy techniques for anxiety and depression in hospice patients: A feasibility study. *Palliat Med.* 2008;22(7):814-21. PMID:18755828 OVID-Medline.

Exclude: Not an eligible study design

Andersson G, Bergstrom J, Hollandare F, et al. Internet-based self-help for depression: Randomised controlled trial. *Br J Psychiatr.* 2005;187:456-61. PM:16260822 Exclude: Not an eligible population treatment

Ando M, Morita T, Akechi T, et al. The efficacy of mindfulness-based meditation therapy on anxiety, depression, and spirituality in Japanese patients with cancer. *J Palliat Med.* 2009;12(12):1091-4. OVID-Embase.

Exclude: Not an eligible study design

Ando M, Morita T, Miyashita M, et al. Effects of bereavement life review on spiritual well-being and depression. *J Pain Symptom Manage.* 2010;40(3):453-9. EBSCO-CINAHL.

Exclude: Not an eligible study design

Andrade C, Aswath A, Chaturvedi SK, et al. GS-02 for dysthymic disorder: Results of a preliminary, open study. *J Herb Pharmacother.* 2002;2(1):49-55. EBSCO-CINAHL.

Exclude: Not an eligible study design

Andruskevicius S. Parameters of the spectral analysis of the heart rate variability in treating depression. *Medicina.* 2009;45(3):214-20. PMID:19357451 OVID-Medline.

Exclude: Not an eligible population treatment

Anghelescu IG, Kohnen R, Szegedi A, et al. Comparison of Hypericum extract WS 5570 and paroxetine in ongoing treatment after recovery from an episode of moderate to severe depression: Results from a randomized multicenter study. *Pharmacopsychiatr.* 2006;39(6):213-9. PMID:17124643 OVID-Medline.

Exclude: Not an eligible population treatment

Annesi JJ. Changes in depressed mood associated with 10 weeks of moderate cardiovascular exercise in formerly sedentary adults. *Psychol Rep.* 2005;96(3):855-62. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Ansseau M, Pitchot W, Gonzalez MA, et al. Pilot study of flesinoxan, a 5-HT1A agonist, in major depression: Effects on sleep REM latency and body temperature. *Hum Psychopharmacol.* 1993;8(4):279-83. OVID-Embase.

Exclude: Not an eligible population treatment

Antikainen R, Lehtonen J, Koponen HJ, et al. The effect of hospital treatment on depression and anxiety in patients with borderline personality organization. *Nord J Psychiatr.* 1992;46(6):399-405. OVID-PsycINFO.

Exclude: Not an eligible study design

Antonuccio DO, Akins WT, Chatham PM, et al. An exploratory study: The psychoeducational group treatment of drug-refractory unipolar depression. *J Behav Ther Exp Psychiatr.* 1984;15(4):309-13. PMID:6396319 OVID-Medline.

Exclude: Not an eligible study design

Antonuccio DO, Thomas M, Danton WG. A cost-effectiveness analysis of cognitive behavior therapy and fluoxetine (Prozac) in the treatment of depression. *Behav Ther.* 1997;28(2):187-210. OVID-Embase.

Exclude: Not an eligible study design

Antunes HKM, Stella SG, Santos RF, et al. Depression, anxiety and quality of life scores in seniors after an endurance exercise program. *Revista Brasileira de Psiquiatria.* 2005;27(4):266-71. OVID-Embase.

Exclude: Not an eligible population treatment

Apóstolo JLA, Kolcaba K. The effects of guided imagery on comfort, depression, anxiety, and stress of psychiatric inpatients with depressive disorders. *Arch Psychiatr Nurs.* 2009;23(6):403-11. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Appelhof BC, Brouwer JP, van Dyck R, et al. Triiodothyronine addition to paroxetine in the treatment of major depressive disorder. *J Clin Endocrinol Metab.* 2004;89(12):6271-6. PMID:15579788 OVID-Medline.

Exclude: Not an eligible population treatment

Appleton KM, Hayward RC, Gunnell D, et al. Effects of n-3 long-chain polyunsaturated fatty acids on depressed mood: Systematic review of published trials. *Am J Clin Nutr.* 2006;84(6):1308-16. PMID:17158410 OVID-Medline.

Exclude - Systematic review - relevant topic, citations cross-matched

Appleton KM, Rogers PJ, Ness AR. Updated systematic review and meta-analysis of the effects of n-3 long-chain polyunsaturated fatty acids on depressed mood. *Am J Clin Nutr.* 2010;91(3):757-70. PMID:20130098 OVID-Medline.

Exclude: Systematic review - relevant topic, citations cross-matched

Araya R, Rojas G, Fritsch R, et al. Treating depression in primary care in low-income women in Santiago, Chile: A randomised controlled trial. *Lancet.* 2003;361(9362):995-1000. PM:12660056

Exclude: Not an eligible population treatment

Araya R, Flynn T, Rojas G, et al. Cost-effectiveness of a primary care treatment program for depression in low-income women in Santiago, Chile. *Am J Psychiatry.* 2006;163(8):1379-87. OVID-Embase.

Exclude: Not an eligible population treatment

Arean PA, Perri MG, Nezu AM, et al. Comparative effectiveness of social problem-solving therapy and reminiscence therapy as treatments for depression in older adults. *J Consult Clin Psychol.* 1993;61(6):1003-10. PM:8113478

Exclude: Not an eligible population treatment

Arean PA, Gum A, McCulloch CE, et al. Treatment of depression in low-income older adults. *Psychol Aging.* 2005;20(4):601-9. PMID:16420135 OVID-Medline.

Exclude: Not an eligible population treatment

Arean P, Miranda J. The treatment of depression in elderly primary care patients: A naturalistic study. *J Clin Geropsychol.* 1996;2(3):153-60. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Arean PA, Gum A, McCulloch CE, et al. Treatment of depression in low-income older adults. *Psychol Aging.* 2005;20(4):601-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Arnold LM, Meyers AL, Sunderajan P, et al. The effect of pain on outcomes in a trial of duloxetine treatment of major depressive disorder. *Ann Clin Psychiatr.* 2008;20(4):187-93. Wiley-CCTR.

Exclude: Not an eligible study design

Arsland D, Larsen JP, Neh GL, et al. Alpha₂-adrenoreceptor antagonism and serotonin reuptake inhibition in patients with Parkinson disease and depression. *Nord J Psychiatr.* 2000;54(6):411-5. OVID-Embase.

Exclude: Not an eligible study design

Artigas F, Pérez V, Alvarez E, et al. Neurobiological differences between responders and non-responders to SSRI treatments: Evidence from pindolol augmentation. *J Eur College Neuropsychopharmacol.* 1999;9(Suppl 5):S177 Wiley-CCTR.

Exclude: Not an eligible study design

Artigas F, Perez V, Alvarez E. Pindolol induces a rapid improvement of depressed patients treated with serotonin reuptake inhibitors. *Arch Gen Psychiatr.* 1994;51(3):248-51. OVID-PsycINFO.

Exclude: Not an eligible study design

Artigas F, Romero L, de Montigny C, et al. Acceleration of the effect of selected antidepressant drugs in major depression by 5-HT_{1A} antagonists. *Trends Neurosci.* 1996;19(9):378-83. OVID-PsycINFO.

Exclude: Not an eligible study design

Asarnow JR, Scott CV, Mintz J. A combined cognitive-behavioral family education intervention for depression in children: A treatment development study. *Cognit Ther Res.* 2002;26(2):221-9. OVID-Embase.

Exclude: Not an eligible population treatment

Asarnow JR, Jaycox LH, Tang L, et al. Long-term benefits of short-term quality improvement interventions for depressed youths in primary care. *Am J Psychiatry.* 2009;166(9):1002-10. PMID:19651711 OVID-Medline.

Exclude: Not an eligible population treatment

Asarnow JR, Jaycox LH, Duan N, et al. Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized controlled trial. *JAMA.* 2005;293(3):311-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Asheyckik R, Jackson T, Baker H, et al. The efficacy of L-tryptophan in the reduction of sleep disturbance and depressive state in alcoholic patients. *J Stud Alcohol.* 1989;50(6):525-32. PMID:2685471 OVID-Medline.

Exclude: Not an eligible population treatment

Aslan A, Balaceanu C, Manoiu A, et al. A double-blind study on the antidepressive effects of Gerovital H₃ and Aslavital in the elderly. *Rom J Gerontol Geriatr.* 1986;7(2):79-88. OVID-Embase

OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

AstraZeneca. A multicenter, double-blind, randomized, parallel-group, placebo-controlled phase III study of the efficacy and safety of quetiapine fumarate extended-release (SEROQUEL XR) in combination with an antidepressant in the treatment of patients with major depressive disorder with inadequate response to an antidepressant treatment (Onyx Study). CSR Study D1448C00007-Synopsis. 2007. Exclude: Not an eligible study design

Atlantis E, Chow C-M, Kirby A, et al. An effective exercise-based intervention for improving mental health and quality of life measures: A randomized controlled trial. *Prev Med.* 2004;39(2):424-34. OVID-Embase. Exclude: Not an eligible population treatment

Atmaca M, Kuloglu M, Tezcan E, et al. Switching to tianeptine in patients with antidepressant-induced sexual dysfunction. *Hum Psychopharmacol Clin Exp.* 2003;18(4):277-80. OVID-PsycINFO. Exclude: Not an eligible study design

Ayd FJ. Psychostimulant therapy for depressed medically ill patients. *Psychiatr Ann.* 1985;15(7):462-5. OVID-PsycINFO. Exclude: Not an eligible study design

Aydemir O, Deveci A, Taskin EO. Mirtazapine combination in treatment-resistant major depressive disorder: A retrospective evaluation of six weeks. *Klinik Psikofarmakoloji Bulteni.* 2009;19(4):347-52. OVID-Embase. Exclude: Not an eligible study design

Azhar MZ, Varma SL. Religious psychotherapy in depressive patients. *Psychother Psychosom.* 1995;63(3-4):165-8. PMID:7624461 OVID-Medline. Exclude: Not an eligible population treatment

Babyak M, Blumenthal JA, Herman S, et al. Exercise treatment for major depression: Maintenance of therapeutic benefit at 10 months. *Psychosom Med.* 2000;62(5):633-8. PMID:11020092 OVID-Medline. Exclude: Not an eligible population treatment

Baca BE, Giner UJ, Leal CC, et al. Venlafaxine extended release versus conventional antidepressants in the remission of depressive disorders after previous antidepressant failure: ARGOS study. *Depress Anxiety.* 2005;22(2):68-76. OVID-Embase. Exclude: Mixed antidepressants:some failed on SSRI

Baert S, De RR, Schacht R, et al. Attentional bias training in depression: Therapeutic effects depend on depression severity. *J Behav Ther Exp Psychiatr.* 2010;41(3):265-74. PMID:20227062 OVID-Medline. Exclude: Not an eligible population treatment

Baghai TC, Marcuse A, Brosch M, et al. The influence of concomitant antidepressant medication on safety, tolerability and clinical effectiveness of electroconvulsive therapy. *World J Biol Psychiatr.* 2006;7(2):82-90. PMID:16684680 OVID-Medline. Exclude: Not an eligible population treatment

Bailey,H.A. Coue revisited: An internet-based investigation of repetition and positive self-statements on depression, self-esteem, and automatic thoughts 2004. OVID-PsycINFO. Exclude: Not an eligible study design

Baker AL, Wilson PH. Cognitive-behavior therapy for depression: The effects of booster sessions on relapse. *Behav Ther.* 1985;16(4):335-44. OVID-Embase

OVID-Embase. Exclude: Not an eligible population treatment

Baker AL, Kavanagh DJ, Kay-Lambkin FJ, et al. Randomized controlled trial of cognitive-behavioural therapy for coexisting depression and alcohol problems: Short-term outcome. *Addiction.* 2010;105(1):87-99. OVID-Embase. Exclude: Not an eligible population treatment

Bakish D, Hooper CL, West DL, et al. Moclobemide and specific serotonin re-uptake inhibitor combination treatment of resistant anxiety and depressive disorders. *Hum Psychopharmacol.* 1995;10(2):105-9. OVID-Embase. Exclude: Not an eligible study design

Bakish D, Hooper CL, Thornton MD, et al. Fast onset: An open study of the treatment of major depressive disorder with nefazodone and pindolol combination therapy. *Int Clin Psychopharmacol.* 1997;12(2):91-7. PMID:9219044 OVID-Medline. Exclude: Not an eligible study design

Balaceanu-Stolnici C, Covic M, Manoiu A, et al. Double blind study concerning the antidepressive effects and the clinical tolerance of Gero vital H₃ without potassium metabisulphate. *Rom J Gerontol Geriatr.* 1996;17(1-2):46-61. OVID-Embase. Exclude: Not an eligible study design

Baldree,B.F. The self-statement: Cognitive mediation in affective disorder intervention strategies 1996. OVID-PsycINFO. Exclude: Not an eligible study design

Baldwin D, Hawley C, Szabadi E, et al. Reboxetine in the treatment of depression: Early clinical experience in the UK. *Int J Psychiatr Clin Pract.* 1998;2(3):195-201. OVID-Embase.

Exclude: Not an eligible study design

Baldwin RC, Jeffries S, Jackson A, et al. Treatment response in late-onset depression: Relationship to neuropsychological, neuroradiological and vascular risk factors. *Psychol Med.* 2004;34(1):125-36. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Ball C, Rice F, Thapar A. Childhood depression. *Curr Paediatr.* 2000;10(4):259-63. OVID-Embase.

Exclude: Not an eligible study design

Ball J, Kearney B, Wilhelm K, et al. Cognitive behaviour therapy and assertion training groups for patients with depression and comorbid personality disorders. *Behav Cognit Psychother.* 2000;28(1):71-85. OVID-Embase.

Exclude: Not an eligible population treatment

Ballon JS, Feifel D. A systematic review of modafinil: Potential clinical uses and mechanisms of action. *J Clin Psychiatr.* 2006;67(4):554-66. PMID:16669720 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Balyk,E.D. An analysis of rational emotive hypnotherapy in the treatment of depression: A pilot study 2004. OVID-PsycINFO.

Exclude: Not an eligible study design

Bano M, Iqbal F, Irshad E. Treatment of depression: Different approaches. *J Pers Clin Stud.* 2003;19(1):63-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Bar-Sela G, Atid L, Danos S, et al. Art therapy improved depression and influenced fatigue levels in cancer patients on chemotherapy. *Psychooncol.* 2007;16(11):980-4. EBSCO-CINAHL.

Exclude: Not an eligible study design

Barak Y, Stein D, Levine J, et al. Thyroxine augmentation of fluoxetine treatment for resistant depression in the elderly: An open trial. *Hum Psychopharmacol.* 1996;11(6):463-7. OVID-Embase.

Exclude: Not an eligible study design

Barak Y, Olmer A, Aizenberg D. Antidepressants reduce the risk of suicide among elderly depressed patients. *Neuropsychopharmacol.* 2006;31(1):178-81. PMID:16123751 OVID-Medline.

Exclude: Not an eligible population treatment

Baraniak A, Sheffield D. The efficacy of psychologically based interventions to improve anxiety, depression and quality of life in COPD: A systematic review and meta-analysis. *Patient Educ Couns.* 2011;83(1):29-36. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Barbato A, D'Avanzo Barbara BD. Marital therapy for depression. *Cochrane Database Syst Rev.* 2006;(2):Art. No.: CD004188 Wiley-CDSR.

Excluded - Systematic review - relevant topic, citations cross-matched

Barbee JG, Jamhour NJ. Lamotrigine as an augmentation agent in treatment-resistant depression. *J Clin Psychiatry.* 2002;63(8):737-41. PMID:12197456 OVID-Medline.

Exclude: Not an eligible study design

Barbee JG, Conrad EJ, Jamhour NJ. Aripiprazole augmentation in treatment-resistant depression. *Ann Clin Psychiatr.* 2004;16(4):189-94. PMID:15702566 OVID-Medline.

Exclude: Not an eligible study design

Barbee JG, Conrad EJ, Jamhour NJ. The effectiveness of olanzapine, risperidone, quetiapine, and ziprasidone as augmentation agents in treatment-resistant major depressive disorder. *J Clin Psychiatry.* 2004;65(7):975-81. PMID:15291687 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Barbee J, Jamhour N, Stewart J. Lamotrigine as an antidepressant augmentation agent in treatment refractory unipolar depression. In 2007. Exclude: Mixed antidepressants:some failed on SSRI

Barbisoni P, Bertozzi B, Franzoni S, et al. Mood improvement in elderly women after in-hospital physical rehabilitation. *Arch Phys Med Rehabil.* 1996;77(4):346-9. OVID-Embase.

Exclude: Not an eligible study design

Barbosa L, Berk M, Vorster M. A double-blind, randomized, placebo-controlled trial of augmentation with lamotrigine or placebo in patients concomitantly treated with fluoxetine for resistant major depressive episodes. *J Clin Psychiatry.* 2003;64(4):403-7. PMID:12716240 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Barbui C, Tansella M. Identification and management of depression in primary care settings: A meta-review of evidence. *Epidemiol Psichiatri Soc.* 2006;15(4):276-83. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Barbui C, Ostuzzi G, Cipriani A. SSRI plus supportive care more effective than supportive care alone for mild to moderate depression. *Evid Based Ment Health*. 2009;12(4):109 EBSCO-CINAHL. Exclude: Not an eligible study design

Bares M, Brunovsky M, Kopecek M, et al. Changes in QEEG prefrontal cordance as a predictor of response to antidepressants in patients with treatment resistant depressive disorder: a pilot study. *J Psychiatr Res*. 2007;41(3-4):319-25. PMID:16889798 OVID-Medline. Exclude: Not an eligible population treatment

Bares M, Brunovsky M, Kopecek M, et al. Early reduction in prefrontal theta QEEG cordance value predicts response to venlafaxine treatment in patients with resistant depressive disorder. *Eur Psychiatr*. 2008;23(5):350-5. PMID:18450430 OVID-Medline. Exclude: Not an eligible population treatment

Bares M, Novak T, Kopecek M, et al. Is combined treatment more effective than switching to monotherapy in patients with resistant depression? A retrospective study. *Neuroendocrinol Lett*. 2009;30(6):723-8. PMID:20038931 OVID-Medline. Exclude: Not an eligible population treatment

Bares M, Kopecek M, Novak T, et al. Low frequency (1-Hz), right prefrontal repetitive transcranial magnetic stimulation (rTMS) compared with venlafaxine ER in the treatment of resistant depression: A double-blind, single-centre, randomized study. *J Affect Disord*. 2009;118(1-3):94-100. OVID-Embase. Exclude: Not an eligible population treatment

Bares M, Novak T, Kopecek M, et al. Antidepressant monotherapy and combination of antidepressants in the treatment of resistant depression in current clinical practice: A retrospective study. *Int J Psychiatr Clin Pract*. 2010;14(4):303-8. OVID-Embase. Exclude: Mixed antidepressants; some failed on SSRI

Bares M, Brunovsky M, Novak T, et al. The change of prefrontal QEEG theta cordance as a predictor of response to bupropion treatment in patients who had failed to respond to previous antidepressant treatments. *Eur Neuropsychopharmacol*. 2010;20(7):459-66. OVID-PsycINFO. Exclude: Not an eligible study design

Barker WA, Scott J, Eccleston D. The Newcastle chronic depression study: Results of a treatment regime. *Int Clin Psychopharmacol*. 1987;2(3):261-72. PMID:3121718 OVID-Medline. Exclude: Not an eligible study design

Barkham M, Moorey J, Davis G. Cognitive-behavioural therapy in two-plus-one sessions: A pilot field trial. *Behav Psychother*. 1992;20(2):147-54. OVID-AMED. Exclude: Not an eligible population treatment

Barkham M, Shapiro DA, Hardy GE, et al. Psychotherapy in two-plus-one sessions: Outcomes of a randomized controlled trial of cognitive-behavioral and psychodynamic-interpersonal therapy for subsyndromal depression. *J Consult Clin Psychol*. 1999;67(2):201-11. PMID:10224730 OVID-Medline. Exclude: Not an eligible population treatment

Barkham M, Stiles WB, Connell J, et al. Effects of psychological therapies in randomized trials and practice-based studies. *Br J Clin Psychol*. 2008;47(4):397-415. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Barkham M, Shapiro DA. Brief psychotherapeutic interventions for job-related distress: A pilot study of prescriptive and exploratory therapy. *Counsell Psychol Q*. 1990;3(2):133-47. OVID-PsycINFO. Exclude: Not an eligible study design

Barkham M, Rees A, Shapiro DA, et al. Outcomes of time-limited psychotherapy in applied settings: Replicating the Second Sheffield Psychotherapy Project. *J Consult Clin Psychol*. 1996;64(5):1079-85. OVID-PsycINFO. Exclude: Not an eligible population treatment

Barnhofer T, Crane C, Hargus E, et al. Mindfulness-based cognitive therapy as a treatment for chronic depression: A preliminary study. *Behav Res Ther*. 2009;47(5):366-73. OVID-Embase. Exclude: Not an eligible population treatment

Barrera MJ. Reaffirmation of behavioral approaches to depression treatment. *Clin Psychol Sci Pract*. 2009;16(4):416-9. OVID-PsycINFO. Exclude: Not an eligible study design

Barrett JE, Williams J, Oxman TE, et al. The treatment effectiveness project. A comparison of the effectiveness of paroxetine, problem-solving therapy, and placebo in the treatment of minor depression and dysthymia in primary care patients: Background and research plan. *Gen Hosp Psychiatry*. 1999;21(4):260-73. OVID-Embase. Exclude: Not an eligible study design

Barrett JE, Williams JW, Oxman TE, et al. Treatment of dysthymia and minor depression in primary care: A randomized trial in patients aged 18 to 59 years. *J Fam ily Pract.* 2001;50(5):405-12. Wiley-CCTR.

Exclude: Not an eligible population treatment

Barrett PM, Farrell LJ, Ollendick TH, et al. Long-term outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: An evaluation of the friends program. *J Clin Child Adolesc Psychol.* 2006;35(3):403-11. PMID:16836477 OVID-Medline.

Exclude: Not an eligible population treatment

Bartholomew JB, Morrison D, Ciccolo JT. Effects of acute exercise on mood and well-being in patients with major depressive disorder. *Med Sci Sports Exerc.* 2005;37(12):2032-7. OVID-Embase.

Exclude: Not an eligible population treatment

Basoglu C, Ates MA, Algul A, et al. Adjuvant folate with escitalopram treatment and homocystein, folate, vitamin B-12 levels in patients with major depressive disorder. *Klinik Psikofarmakoloji Bulteni.* 2009;19(2):135-42. OVID-Embase.

Exclude: Not an eligible population treatment

Bastiaens L. Response to antidepressant treatment in a community mental health center. *Community Ment Health J.* 2004;40(6):561-7. PMID:15672694 OVID-Medline.

Exclude: Not an eligible study design

Bastiaens L. Adolescents' response to antidepressant treatment in a community mental health center. *Community Ment Health J.* 2005;41(1):77-84. PMID:15932054 OVID-Medline.

Exclude: Not an eligible study design

Bauer M, Zaninelli R, Muller-Oerlinghausen B, et al. Paroxetine and amitriptyline augmentation of lithium in the treatment of major depression: A double-blind study. *J Clin Psychopharmacol.* 1999;19(2):164-71. PMID:10211918 OVID-Medline.

Exclude: Not an eligible population treatment

Bauer M, Baur H, Berghofer A, et al. Effects of supraphysiological thyroxine administration in healthy controls and patients with depressive disorders. *J Affect Disord.* 2002;68(2-3):285-94. PMID:12063156 OVID-Medline.

Exclude: Not an eligible study design

Bauer M, Berghofer A, Bschor T, et al. Supraphysiological doses of L-Thyroxine in the maintenance treatment of prophylaxis-resistant affective disorders. *Neuropsychopharmacol.* 2002;27(4):620-8. Exclude: Not an eligible study design

Bauer M, Whybrow PC, Angst J, et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for biological treatment of unipolar depressive disorders, Part 1: Acute and continuation treatment of major depressive disorder. *World J Biol Psychiatr.* 2002;3(1):5-43. PMID:12479086 OVID-Medline.

Exclude: Not an eligible guideline

Bauer M, Pfennig A, Linden M, et al. Efficacy of an algorithm-guided treatment compared with treatment as usual: A randomized, controlled study of inpatients with depression. *J Clin Psychopharmacol.* 2009;29(4):327-33. PMID:19593170 OVID-Medline.

Exclude: Not an eligible population treatment

Bauer M, Pretorius HW, Constant EL, et al. Extended-release quetiapine as adjunct to an antidepressant in patients with major depressive disorder: Results of a randomized, placebo-controlled, double-blind study. *J Clin Psychiatry.* 2009;70(4):540-9. PMID:19358791 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Bauer M, Tharmanathan P, Volz HP, et al. The effect of venlafaxine compared with other antidepressants and placebo in the treatment of major depression: A meta-analysis. *Eur Arch Psychiatry Clin Neurosci.* 2009;259(3):172-85. PMID:19165525 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Bauer M, Hellweg R, Graf KJ, et al. 3rd International Conference on Refractory Depression (1995, October 18-21, Napa, CA, US) & 149th Annual Meeting of the American Psychiatric Association (1996, May 4-9, New York, NY, US). *Neuropsychopharmacol.* 1998;18(6):444-55. OVID-PsycINFO.

Exclude: Not an eligible study design

Bauer M, Bschor T, Kunz D, et al. Double-blind, placebo-controlled trial of the use of lithium to augment antidepressant medication in continuation treatment of unipolar major depression. *Am J Psychiatry.* 2000;157(9):1429-35. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Baune BT, Caliskan S, Todder D. Effects of adjunctive antidepressant therapy with quetiapine on clinical outcome, quality of sleep and daytime motor activity in patients with treatment-resistant depression. *Hum Psychopharmacol.* 2007;22(1):1-9. PMID:17191266 OVID-Medline.

Exclude: Not an eligible study design

Baxter J, Liston EH, Schwartz JM. Prolongation of the antidepressant response to partial sleep deprivation by lithium. *Psychiatry Res.* 1986;19(1):17-23. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Beach SRH, O'Leary KD. Treating depression in the context of marital discord: Outcome and predictors of response of marital therapy versus cognitive therapy. *Behav Ther.* 1992;23(4):507-28. OVID-Embase.

Exclude: Not an eligible population treatment

Beach SR, O'Leary KD. The treatment of depression occurring in the context of marital discord. *Behav Ther.* 1986;17(1):43-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Beardslee WR, Salt P, Versage EM, et al. Sustained change in parents receiving preventive interventions for families with depression. *Am J Psychiatry.* 1997;154(4):510-5. OVID-Embase.

Exclude: Not an eligible population treatment

Bearn J, Franey C, Arendt J, et al. A study of the effects of desipramine treatment alone and in combination with L-triiodothyronine on 6-sulphatoxymelatonin excretion in depressed patients. *Br J Psychiatr.* 1989;155:341-7. PMID:2611544 OVID-Medline.

Exclude: Not an eligible study design

Beasley CM, Jr., Sayler ME, Cunningham GE, et al. Fluoxetine in tricyclic refractory major depressive disorder. *J Affect Disord.* 1990;20(3):193-200. PMID:2148340 OVID-Medline.

Exclude: Not an eligible study design

Beauchemin KM, Hays P. Sunny hospital rooms expedite recovery from severe and refractory depressions. *J Affect Disord.* 1996;40(1-2):49-51. PMID:8882914 OVID-Medline.

Exclude: Not an eligible population treatment

Beauchemin KM, Hays P. Phototherapy is a useful adjunct in the treatment of depressed in-patients. *Acta Psychiatr Scand.* 1997;95(5):424-7. PMID:9197908 OVID-Medline.

Exclude: Not an eligible population treatment

Beck AT, Hollon SD, Young JE. Treatment of depression with cognitive therapy and amitriptyline. *Arch Gen Psychiatr.* 1985;42(2):142-8. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Beckman SE, Sommi RW, Switzer J. Consumer use of St. John's wort: A survey on effectiveness, safety, and tolerability. *Pharmacother.* 2000;20(5):568-74. PMID:10809344 OVID-Medline.

Exclude: Not an eligible population treatment

Beckner V, Howard I, Vella L, et al. Telephone-administered psychotherapy for depression in MS patients: Moderating role of social support. *J Behav Med.* 2010;33(1):47-59. PMID:19941048 OVID-Medline.

Exclude: Not an eligible population treatment

Bedi N, Chilvers C, Churchill R, et al. Assessing effectiveness of treatment of depression in primary care. *Br J Psychiatr.* 2000;177(4):312-8. OVID-AMED.

Exclude: Not an eligible population treatment

Bee PE, Bower P, Gilbody S, et al. Improving health and productivity of depressed workers: A pilot randomized controlled trial of telephone cognitive behavioral therapy delivery in workplace settings. *Gen Hosp Psychiatry.* 2010;32(3):337-40. OVID-Embase.

Exclude: Not an eligible population treatment

Beets MW, Mitchell E. Effects of yoga on stress, depression, and health-related quality of life in a nonclinical, bi-ethnic sample of adolescents: A pilot study. *Hispanic Health Care Int.* 2010;8(1):47-53. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Behnke K, Jensen GS, Graubaum HJ, et al. Hypericum perforatum versus fluoxetine in the treatment of mild to moderate depression. *Adv Ther.* 2002;19(1):43-52. PMID:12008860 OVID-Medline.

Exclude: Not an eligible study design

Bell AC, D'Zurilla TJ. Problem-solving therapy for depression: A meta-analysis. *Clin Psychol Rev.* 2009;29(4):348-53. PMID:19299058 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Bell IR, Edman JS, Morrow FD, et al. Brief communication. Vitamin B1, B2, and B6 augmentation of tricyclic antidepressant treatment in geriatric depression with cognitive dysfunction. *J Am Coll Nutr.* 1992;11(2):159-63. PMID:1578091 OVID-Medline.

Exclude: Not an eligible population treatment

Bell KM, Plon L, Bunney WE, Jr., et al. S-adenosylmethionine treatment of depression: A controlled clinical trial. *Am J Psychiatry*. 1988;145(9):1110-4. PMID:3046382 OVID-Medline.

Exclude: Not an eligible population treatment

Bell KM, Potkin SG, Carreon D, et al. S-adenosylmethionine blood levels in major depression: Changes with drug treatment. *Acta Neurol Scand*. 1994;Suppl.:154-8. PMID:7941961 OVID-Medline.

Exclude: Not an eligible population treatment

Bella R, Biondi R, Raffaele R, et al. Effect of acetyl-L-carnitine on geriatric patients suffering from dysthymic disorders. *Int J Clin Pharmacol Res*. 1990;10(6):355-60. PMID:2099360 OVID-Medline.

Exclude: Not an eligible population design

Bellino S, Zizza M, Rinaldi C, et al. Combined treatment of major depression in patients with borderline personality disorder: A comparison with pharmacotherapy. *Can J Psychiatr*. 2006;51(7):453-60. PMID:16838827 OVID-Medline.

Exclude: Not an eligible population treatment

Bellino S, Zizza M, Rinaldi C, et al. Combined therapy of major depression with concomitant borderline personality disorder: Comparison of interpersonal and cognitive psychotherapy. *Can J Psychiatr*. 2007;52(11):718-25. PMID:18399039 OVID-Medline.

Exclude: Not an eligible population treatment

Belsher G, Wilkes TCR, Rush AJ. An open, multisite pilot study of cognitive therapy for depressed adolescents. *J Psychother Pract Res*. 1995;4(1):52-66. OVID-Embase.

Exclude: Not an eligible study design

Beltman MW, Voshaar RC, Speckens AE. Cognitive-behavioural therapy for depression in people with a somatic disease: Meta-analysis of randomised controlled trials. *Br J Psychiatr*. 2010;197(1):11-9. PMID:20592427 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Benedetti F, Colombo C, Pontiggia A, et al. Morning light treatment hastens the antidepressant effect of citalopram: A placebo-controlled trial. *J Clin Psychiatry*. 2003;64(6):648-53. PMID:12823078 OVID-Medline.

Exclude: Not an eligible population treatment

Benkert O, Szegedi A, Wetzel H, et al. Dose escalation vs continued doses of paroxetine and maprotiline: A prospective study in depressed outpatients with inadequate treatment response. *Acta Psychiatr Scand*. 1997;95(4):288-96. OVID-PsycINFO.

Exclude: Mixed antidepressants:some failed on SSRI

Bennett, C.F. Treatment effects of acupuncture on anxiety and depression in working women University of South Carolina. 1997. EBSCO-CINAHL.

Exclude: Not an eligible study design

Bennett JA. Combined thioridazine and desipramine: Early antidepressant response. *Psychopharmacol*. 1984;82(3):263-5. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Benton T, Staab J, Evans DL. Medical co-morbidity in depressive disorders. *Ann Clin Psychiatr*. 2007;19(4):289-303. PMID:18058286 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Berger S, Schad T, Von W, V, et al. Effects of cognitive behavioral stress management on HIV-1 RNA, CD4 cell counts and psychosocial parameters of HIV-infected persons. *AIDS*. 2008;22(6):767-75. OVID-Embase.

Exclude: Not an eligible population treatment

Bergman J, Miodownik C, Palatnik A, et al. Efficacy of bupropion XR in treatment-resistant elderly patients: A case series study. *Clin Neuropharmacol*. 2011;34(1):17-20. OVID-Embase.

Exclude: Not an eligible study design

Berkman LF, Blumenthal J, Burg M, et al. Effects of treating depression and low perceived social support on clinical events after myocardial infarction: The Enhancing Recovery in Coronary Heart Disease Patients (ENRICH) Randomized Trial. *JAMA*. 2003;289(23):3106-16. PMID:12813116 OVID-Medline.

Exclude: Not an eligible population treatment

Berlanga C, Ortega-Soto HA, Ontiveros M, et al. Efficacy of S-adenosyl-L-methionine in speeding the onset of action of imipramine. *Psychiatry Res*. 1992;44(3):257-62. PMID:1289923 OVID-Medline.

Exclude: Not an eligible population treatment

Berlanga C, Ortega-Soto HA. A 3-year follow-up of a group of treatment-resistant depressed patients with a MAOI/tricyclic combination. *J Affect Disord*. 1995;34(3):187-92. PMID:7560546 OVID-Medline.

Exclude: Not an eligible study design

Berlanga C, Mendieta D, Alva G, et al. Failure of tibolone to potentiate the pharmacological effect of fluoxetine in postmenopausal major depression. *J Womens Health*. 2003;12(1):33-9. PMID:12639367 OVID-Medline.

Exclude: Not an eligible population treatment

Berlim MT, Pargendler J, Brenner J, et al. Significant improvement in the quality of life of Brazilian depressed outpatients 12 weeks following the start of antidepressants. *Psychiatry Res*. 2007;153(3):253-9. OVID-Embase.

Exclude: Not an eligible study design

Berlim MT, Turecki G. Definition, assessment, and staging of treatment-resistant refractory major depression: A review of current concepts and methods. *Can J Psychiatr*. 2007;52(1):46-54. PMID:17444078 Excluded - Systematic review - relevant topic, citations cross-matched

Berlim MT, Turecki G. What is the meaning of treatment resistant/refractory major depression (TRD)? A systematic review of current randomized trials. *Eur Neuropsychopharmacol*. 2007;17(11):696-707. PMID:17521891 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Berman RB, Fava M, Thase ME, et al. The third consecutive, positive, double-blind, placebo controlled trial of aripiprazole augmentation in the treatment of major depression. [Abstract] *Am Coll Neuropsychopharmacol Ann Meeting Abst* 2008;

Berman RM, Darnell AM, Miller HL, et al. Effect of pindolol in hastening response to fluoxetine in the treatment of major depression: A double-blind, placebo-controlled trial. *Am J Psychiatry*. 1997;154(1):37-43. PMID:8988956 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Berman RM, Anand A, Capiello A, et al. The use of pindolol with fluoxetine in the treatment of major depression: Final results from a double-blind, placebo-controlled trial. *Biol Psychiatr*. 1999;45(9):1170-7. PMID:10331109 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Bernardo CG, Singh V, Thompson PM. Safety and efficacy of psychopharmacological agents used to treat the psychiatric sequelae of common neurological disorders. *Expert Opinion on Drug Safety*. 2008;7(4):435-45. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Bernstein GA, Borchardt CM, Perwien AR, et al. Imipramine plus cognitive-behavioral therapy in the treatment of school refusal. *J Am Acad Child Adolesc Psychiatry*. 2000;39(3):276-83. Wiley-CCTR.

Exclude: Not an eligible population treatment

Berstrom J, Hollandare F, Carlbring P, et al. Treatment of depression via the Internet: A randomized trial of a self-help programme. *J Telemed Telecare*. 2003;9(Suppl2):85 OVID-PsycINFO.

Exclude: Not an eligible study design

Bertschy G, Ragama-Pardos E, Ait-Ameur A, et al. Lithium augmentation in venlafaxine non-responders: An open study. *Eur Psychiatr*. 2003;18(6):314-7. PMID:14611927 OVID-Medline.

Exclude: Not an eligible study design

Beusterien KM, Buesching DP, Robison RN, et al. Evaluation of an information exchange program for primary care patients with depression. *Dis Manage*. 2000;3(1):1-9. OVID-Embase.

Exclude: Not an eligible study design

Beutler LE, Scogin F, Kirkish P, et al. Group cognitive therapy and alprazolam in the treatment of depression in older adults. *J Consult Clin Psychol*. 1987;55(4):550-6. OVID-Embase.

Exclude: Not an eligible population treatment

Beutler LE, Machado PP, Engle D, et al. Differential patient treatment maintenance among cognitive, experiential, and self-directed psychotherapies. *J Psychother Integrat*. 1993;3(1):15-31. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Bhar SS, Gelfand LA, Schmid SP, et al. Sequence of improvement in depressive symptoms across cognitive therapy and pharmacotherapy. *J Affect Disord*. 2008;110(1-2):161-6. PMID:18276017 OVID-Medline.

Exclude: Not an eligible population treatment

Bharucha AJ, Dew MA, Miller MD, et al. Psychotherapy in long-term care: A review. *J Am Med Dir Assoc*. 2006;7(9):568-80. PMID: 17095422 EBSCO-CINAHL.

Excluded - Systematic review - relevant topic, citations cross-matched

Bichescu D, Neuner F, Schauer M, et al. Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. *Behav Res Ther*. 2007;45(9):2212-20. PMID:17288990 OVID-Medline.

Exclude: Not an eligible population treatment

Bidzinski A, Swiecicki L, Tonderska A, et al. Effects of phototherapy on the activities of MAO, DBH, pseudocholinesterase and upon choline transport in erythrocytes of patients with seasonal and non-seasonal depression. *New Trends Exp Clin Psychiatr.* 1996;12(3):175-8. OVID-Embase.
Exclude: Not an eligible study design

Biegel GM, Brown KW, Shapiro SL, et al. Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: A randomized clinical trial. *J Consult Clin Psychol.* 2009;77(5):855-66. OVID-Embase.
Exclude: Not an eligible population treatment

Bijl MJ, Visser LE, Hofman A, et al. Influence of the CYP2D6*4 polymorphism on dose, switching and discontinuation of antidepressants. *Br J Clin Pharmacol.* 2008;65(4):558-64. PMID:18070221 OVID-Medline.
Exclude: Not an eligible population treatment

Bilich LL, Deane FP, Phipps AB, et al. Effectiveness of bibliotherapy self-help for depression with varying levels of telephone helpline support. *Clin Psychol Psychother.* 2008;15(2):61-74. PMID:19115429 OVID-Medline.
Exclude: Not an eligible population treatment

Bindemann S, Soukop M, Kaye SB. Randomised controlled study of relaxation training. *Eur J Canc.* 1991;27(2):170-4. Wiley-CCTR.
Exclude: Not an eligible population treatment

Binder EB, Owens MJ, Liu W, et al. Association of polymorphisms in genes regulating the corticotropin-releasing factor system with antidepressant treatment response. *Arch Gen Psychiatr.* 2010;67(4):369-79. PMID:20368512 OVID-Medline.
Exclude: Not an eligible population treatment

Birkenhager TK, Vegt M, Nolen WA. An open study of triiodothyronine augmentation of tricyclic antidepressants in inpatients with refractory depression. *Pharmacopsychiatr.* 1997;30(1):23-6. PMID:9065966 OVID-Medline.
Exclude: Not an eligible study design

Birkenhager TK, van den Broek WW, Mulder PG, et al. Comparison of two-phase treatment with imipramine or fluvoxamine, both followed by lithium addition, in inpatients with major depressive disorder. *Am J Psychiatry.* 2004;161(11):2060-5. PMID:15514407 OVID-Medline.
Exclude: Not an eligible study design

Birkenhager TK, van den Broek WW, Moleman P, et al. Outcome of a 4-step treatment algorithm for depressed inpatients. *J Clin Psychiatry.* 2006;67(8):1266-71. PMID:16965206 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Birmaher B, Waterman GS, Ryan ND, et al. Randomized, controlled trial of amitriptyline versus placebo for adolescents with "treatment-resistant" major depression. *J Am Acad Child Adolesc Psychiatry.* 1998;37(5):527-35. PMID:9585655 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Birmaher B, Brent DA, Kolko D, et al. Clinical outcome after short-term psychotherapy for adolescents with major depressive disorder. *Arch Gen Psychiatr.* 2000;57(1):29-36. PMID:10632230 OVID-Medline.

Exclude: Not an eligible population treatment

Birnie K, Garland SN, Carlson LE. Psychological benefits for cancer patients and their partners participating in mindfulness-based stress reduction (MBSR). *Psychooncol.* 2010;19(9):1004-9. EBSCO-CINAHL.

Exclude: Not an eligible study design

Bjerksten L, Edman GV, Alken RG, et al. Hypericum extract LI 160 and fluoxetine in mild to moderate depression: A randomized, placebo-controlled multi-center study in outpatients. *Eur Arch Psychiatry Clin Neurosci.* 2005;255(1):40-7. PMID:15538592 OVID-Medline.

Exclude: Not an eligible population treatment

Blackburn IM, Bishop S, Glen AI, et al. The efficacy of cognitive therapy in depression: A treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. *Br J Psychiatry.* 1981;139:181-9. PMID:7317698 OVID-Medline.
Exclude: Not an eligible population treatment

Blackburn IM, Bishop S. Changes in cognition with pharmacotherapy and cognitive therapy. *Br J Psychiatr.* 1983;143:609-17. PMID:6661604 OVID-Medline.

Exclude: Not an eligible population treatment

Blackburn IM, Eunson KM, Bishop S. A two-year naturalistic follow-up of depressed patients treated with cognitive therapy, pharmacotherapy and a combination of both. *J Affect Disord.* 1986;10(1):67-75. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Blackburn IM, Moore RG. Controlled acute and follow-up trial of cognitive therapy and pharmacotherapy in out-patients with recurrent depression. *Br J Psychiatr.* 1997;171:328-34. PMID:9373420 OVID-Medline.

Exclude: Not an eligible population treatment

Blake H, Mo P, Malik S, et al. How effective are physical activity interventions for alleviating depressive symptoms in older people? A systematic review. *Clin Rehabil.* 2009;23(10):873-87. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Blanch J, Rousaud A, Hautzinger M, et al. Assessment of the efficacy of a cognitive-behavioural group psychotherapy programme for HIV-infected patients referred to a consultation-liaison psychiatry department. *Psychother Psychosom.* 2002;71(2):77-84. PMID:11844943 OVID-Medline.

Exclude: Not an eligible study design

Blenkiron P. Coping with depression: A pilot study to assess the efficacy of a self-help audio cassette. *Br J Gen Pract.* 2001;51(466):366-70. OVID-Embase.

Exclude: Not an eligible study design

Blier P, Bergeron R. Effectiveness of pindolol with selected antidepressant drugs in the treatment of major depression. *J Clin Psychopharmacol.* 1995;15(3):217-22. PMID:7636000 OVID-Medline.

Exclude: Not an eligible study design

Blier P, Szabo ST. Potential mechanisms of action of atypical antipsychotic medications in treatment-resistant depression and anxiety. *J Clin Psychiatry.* 2005;66(Suppl. 8):30-40. Exclude: Not an eligible study design

Blier P, Gobbi G, Turcotte JE, et al. Mirtazapine and paroxetine in major depression: A comparison of monotherapy versus their combination from treatment initiation. *Eur Neuropsychopharmacol.* 2009;19(7):457-65. PMID:19345072 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Blier P, Ward HE, Tremblay P, et al. Combination of antidepressant medications from treatment initiation for major depressive disorder: A double-blind randomized study. *Am J Psychiatry.* 2010;167(3):281-8. PMID:20008946 OVID-Medline.

Exclude: Not an eligible population treatment

Blier P, Bergeron R, de Montigny C. Selective activation of postsynaptic 5-HT_{1A} receptors induces rapid antidepressant response. *Neuropsychopharmacol.* 1997;16(5):333-8. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Blitzer LE, Atchison-Nevel DJ, Kenny MC. Using acupuncture to treat major depressive disorder: A pilot investigation. *Clin Acupunc Oriental Med.* 2003;4(4):144-7. OVID-Embase.

Exclude: Not an eligible study design

Bloch M, Schwartzman Y, Bonne O, et al. Concurrent treatment of nonresistant major depression with desipramine and lithium: A double-blind, placebo-controlled study. *J Clin Psychopharmacol.* 1997;17(1):44-8. PMID:9004056 OVID-Medline.

Exclude: Not an eligible population treatment

Blom MB, Jonker K, Dusseldorp E, et al. Combination treatment for acute depression is superior only when psychotherapy is added to medication. *Psychother Psychosom.* 2007;76(5):289-97. PMID:17700049 OVID-Medline.

Exclude: Not an eligible population treatment

Blumenthal JA, Emery CF, Rejeski WJ. The effects of exercise training on psychosocial functioning after myocardial infarction. *J Cardpulm Rehabil.* 1988;8(5):183-93. OVID-Embase.

Exclude: Not an eligible population treatment

Blumenthal JA, Babyak MA, Moore KA, et al. Effects of exercise training on older patients with major depression. *Arch Intern Med.* 1999;159(19):2349-56. PMID:10547175 OVID-Medline.

Exclude: Not an eligible population treatment

Blumenthal JA, Babyak MA, Doraiswamy PM, et al. Exercise and pharmacotherapy in the treatment of major depressive disorder. *Psychosom Med.* 2007;69(7):587-96. PMID:17846259 OVID-Medline.

Exclude: Not an eligible population treatment

Blumer D. Antidepressant and double antidepressant treatment for the affective disorder of epilepsy. *J Clin Psychiatr.* 1997;58(1):3-11. OVID-PsycINFO.

Exclude: Not an eligible study design

Bockting CL, Schene AH, Spinhoven P, et al. Preventing relapse/recurrence in recurrent depression with cognitive therapy: A randomized controlled trial. *J Consult Clin Psychol.* 2005;73(4):647-57. PMID:16173852 OVID-Medline.

Exclude: Not an eligible population treatment

Bockting CL, Spinhoven P, Wouters LF, et al. Long-term effects of preventive cognitive therapy in recurrent depression: A 5.5-year follow-up study. *J Clin Psychiatr.* 2009;70(12):1621-8. PMID:20141705 OVID-Medline.

Exclude: Not an eligible population treatment

Bodenmann G, Plancherel B, Beach SRH, et al. Effects of coping-oriented couples therapy on depression: A randomized clinical trial. *J Consult Clin Psychol.* 2008;76(6):944-54. OVID-Embase.

Exclude: Not an eligible population treatment

Bodin T, Martinsen EW. Mood and self-efficacy during acute exercise in clinical depression: A randomized, controlled study. *J Sport Exerc Psychol.* 2004;26(4):623-33. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Bodkin JA, Zornberg GL, Lukas SE, et al. Buprenorphine treatment of refractory depression. *J Clin Psychopharmacol.* 1995;15(1):49-57. PMID:7714228 OVID-Medline.

Exclude: Not an eligible study design

Bodkin JA, Lasser RA, Wines JD, Jr., et al. Combining serotonin reuptake inhibitors and bupropion in partial responders to antidepressant monotherapy. *J Clin Psychiatry.* 1997;58(4):137-45. PMID:9164423 OVID-Medline.

Exclude: Not an eligible study design

Boer Peter CAM, Wiersma D, Russo S, et al. Paraprofessionals for anxiety and depressive disorders. *Cochrane Database Syst Rev.* 2005;(2):Art No.:CD004688. Wiley-CDSR.

Excluded - Systematic review - relevant topic, citations cross-matched

Bogner HR, Morales KH, Post EP, et al. Diabetes, depression, and death: A randomized controlled trial of a depression treatment program for older adults based in primary care (PROSPECT). *Diabet Care.* 2007;30(12):3005-10. OVID-Embase.

Exclude: Not an eligible population treatment

Bohlmeijer E, Prenger R, Taal E, et al. The effects of mindfulness-based stress reduction therapy on mental health of adults with a chronic medical disease: A meta-analysis. *J Psychosom Res.* 2010;68(6):539-44. PMID:20488270 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Bolton P, Bass J, Neugebauer R, et al. Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial. *JAMA.* 2003;289(23):3117-24. PM:12813117 Exclude: Not an eligible population treatment

Bond M, Perry JC. Psychotropic medication use, personality disorder and improvement in long-term dynamic psychotherapy. *J Nerv Ment Dis.* 2006;194(1):21-6. PMID:16462551 OVID-Medline.

Exclude: Not an eligible population treatment

Bondolfi G, Lissner C, Kosel M, et al. Fluoxetine augmentation in citalopram non-responders: Pharmacokinetic and clinical consequences. *Int J Neuropsychopharmacol.* 2000;3(1):55-60. OVID-Embase.

Exclude: Not an eligible study design

Bondolfi G, Jermann F, der Linden MV, et al. Depression relapse prophylaxis with mindfulness-based cognitive therapy: Replication and extension in the Swiss health care system. *J Affect Disord.* 2010;122(3):224-31. OVID-Embase.

Exclude: Not an eligible population treatment

Bonnet, L.H. Effects of aerobic exercise in combination with Cognitive Therapy on self-reported depression 2006. OVID-PsycINFO.

Exclude: Not an eligible study design

Bordet R, Thomas P, Dupuis B. Effect of pindolol on onset of action of paroxetine in the treatment of major depression: Intermediate analysis of a double-blind, placebo-controlled trial. *Recherche et d'Experimentation Psychopharmacologique. Am J Psychiatry.* 1998;155(10):1346-51. PMID:9766765 OVID-Medline.

Exclude: Not an eligible population treatment

Boren JJ, Leventhal AM, Edmund PH. Just how effective are antidepressant medications? Results of a major new study. *J Contemp Psychother.* 2009;39(2):93-100. OVID-Embase.

Exclude: Mixed antidepressants: some failed on SSRI

Borgherini G, Conforti D, Cognolato S, et al. Efficacy and tolerability of venlafaxine in patients hospitalized with moderate to severe depression: An open-label pilot study. *Curr Ther Res Clin Exp.* 1999;60(12):672-80. OVID-Embase.

Exclude: Not an eligible study design

Bornstein S. Cross-over trial comparing the antidepressant effects of amineptine and maprotiline. *Curr Med Res Opin.* 1979;6(2):107-10. Wiley-CCTR.

Exclude: Not an eligible population treatment

Bortolotti B, Menchetti M, Bellini F, et al. Psychological interventions for major depression in primary care: A meta-analytic review of randomized controlled trials. *Gen Hosp Psychiatry*. 2008;30(4):293-302. PMID:18585531 OVID-Medline.

Exclude: Systematic review - relevant topic, citations cross-matched

Borup C, Uden M. Combined fluoxetine and disulfiram treatment of alcoholism with comorbid affective disorders: A naturalistic outcome study, including quality of life measurements. *Eur Psychiatr*. 1994;9(2):83-9. OVID-Embase.

Exclude: Not an eligible study design

Bosmans JE, Hermens MLM, de Bruijne MC, et al. Cost-effectiveness of usual general practitioner care with or without antidepressant medication for patients with minor or mild-major depression. *J Affect Disord*. 2008;111(1):106-12. OVID-Embase.

Exclude: Not an eligible population treatment

Bosmans JE, van Schaik DJF, de Bruijne MC, et al. Are psychological treatments for depression in primary care cost-effective? *J Ment Health Policy Econom*. 2008;11(1):3-15. OVID-Embase.

Exclude: Systematic review - relevant topic, citations cross-matched

Bosscher RJ. Running and mixed physical exercises with depressed psychiatric patients. *Int J Sport Psychol*. 1993;24(2):170-84. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Bosworth HB, Hays JC, George LK, et al. Psychosocial and clinical predictors of unipolar depression outcome in older adults. *Int J Geriatr Psychiatry*. 2002;17(3):238-46. Exclude: Not an eligible study design

Bottlender R, Rudolf D, Jager M, et al. Are bipolar I depressive patients less responsive to treatment with antidepressants than unipolar depressive patients? Results from a case control study. *Eur Psychiatr*. 2002;17(4):200-5. Exclude: Not an eligible study design

Bouckoms A, Mangini L. Pergolide: An antidepressant adjuvant for mood disorders? *Psychopharmacol Bull*. 1993;29(2):207-11. OVID-PsycINFO.

Exclude: Not an eligible study design

Boulos C, Kutcher S, Gardner D, et al. An open naturalistic trial of fluoxetine in adolescents and young adults with treatment-resistant major depression. *J Child Adolesc Psychopharmacol*. 1992;2(2):103-11. OVID-PsycINFO.

Exclude: Not an eligible study design

Boulton DW, Balch AH, Royzman K, et al. The pharmacokinetics of standard antidepressants with aripiprazole as adjunctive therapy: Studies in healthy subjects and in patients with major depressive disorder. *J Psychopharmacol*. 2010;24(4):537-46. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Boury M, Treadwell T, Kumar VK. Integrating psychodrama and cognitive therapy: An exploratory study. *Int J Action Meth*. 2001;54(1):13-37. OVID-PsycINFO.

Exclude: Not an eligible study design

Bouwer C, Stein DJ. Buspirone is an effective augmenting agent of serotonin selective re-uptake inhibitors in severe treatment-refractory depression. *S Afr Med J*. 1997;(4 Suppl):534-7. PMID:9180827 OVID-Medline.

Exclude: Not an eligible study design

Bower P, Byford S, Sibbald B, et al. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. II: Cost effectiveness. *Br Med J*. 2000;321(7273):1389-92. PMID:11099285 OVID-Medline.

Exclude: Not an eligible population treatment

Bowers WA. Treatment of depressed in-patients: Cognitive therapy plus medication, relaxation plus medication, and medication alone. *Br J Psychiatr*. 1990;156:73-8. PMID:2404539 OVID-Medline.

Exclude: Not an eligible population treatment

Bowman D, Scogin F, Lyrene B. The efficacy of self-examination therapy and cognitive bibliotherapy in the treatment of mild to moderate depression. *Psychother Res*. 1995;5(2):131-40. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Bowman V, Ward LC, Bowman D, et al. Self-examination therapy as an adjunct treatment for depressive symptoms in substance abusing patients. *Addict Behav*. 1996;21(1):129-33. PMID:8729714 OVID-Medline.

Exclude: Not an eligible population treatment

Boyd G.M. Effects of group therapy on levels of depression of family caregivers of patients with dementia residing in nursing homes 2006. OVID-PsycINFO.

Exclude: Not an eligible study design

Bradley RH, Barkin RL, Jerome J, et al. Efficacy of venlafaxine for the long term treatment of chronic pain with associated major depressive disorder. *Am J Ther.* 2003;10(5):318-23. PMID:12975715 OVID-Medline.

Exclude: Not an eligible study design

Bradjkovic L, Jevtovic S, Bilic V, et al. The efficacy of a brief supportive psychodynamic therapy in treating anxious-depressive disorder in Daily Hospital. *Coll Antropol.* 2009;33(1):245-51. PMID:19408633 OVID-Medline.

Exclude: Not an eligible study design

Bramesfeld A, Adler G, Brassen S, et al. Day-clinic treatment of late-life depression. *Int J Geriatr Psychiatry.* 2001;16(1):82-7. PMID:11180490 OVID-Medline.

Exclude: Not an eligible study design

Bransfield RC. Potential uses of modafinil in psychiatric disorders. *J Appl Res.* 2004;4(2):198-207. OVID-Embase.

Exclude: Not an eligible study design

Brattstrom A. Long-term effects of St. John's wort (*Hypericum perforatum*) treatment: A 1-year safety study in mild to moderate depression. *Phytomed.* 2009;16(4):277-83. PMID:19299116 OVID-Medline.

Exclude: Not an eligible study design

Brenes GA, Williamson JD, Messier SP, et al. Treatment of minor depression in older adults: A pilot study comparing sertraline and exercise. *Aging Ment Health.* 2007;11(1):61-8. PMID:17164159 OVID-Medline.

Exclude: Not an eligible population treatment

Brenner R, Azbel V, Madhusoodanan S, et al. Comparison of an extract of hypericum (LI 160) and sertraline in the treatment of depression: A double-blind, randomized pilot study. *Clin Ther.* 2000;22(4):411-9. PMID:10823363 OVID-Medline.

Exclude: Not an eligible population treatment

Brent D, Onorato M, Enrile A and others. Treatment of resistant depression in adolescents (TORDIA). In 2004. Wiley-CCTR.

Exclude: Not an eligible guideline

Brent DA, Holder D, Kolko D, et al. A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Arch Gen Psychiatr.* 1997;54(9):877-85. PMID:9294380 OVID-Medline.

Exclude: Not an eligible population treatment

Brent DA, Birmaher B. Adolescent depression. *N Engl J Med.* 2002;347(9):667-71. Exclude: Not an eligible guideline

Brent DA. The treatment of SSRI-resistant depression in adolescents (TORDIA): In search of the best next step. *Depress Anxiety.* 2009;26(10):871-4. PMID:19798756 OVID-Medline.

Exclude: Not an eligible population treatment

Brent, David A., Roth, Claudia M., Holder, Diane P. et al. Psychosocial interventions for treating adolescent suicidal depression: A comparison of three psychosocial interventions. 1996:187-206. 1996. OVID-PsycINFO.

Exclude: Not an eligible study design

Bressi C, Porcellana M, Marinaccio PM, et al. Short-term psychodynamic psychotherapy versus treatment as usual for depressive and anxiety disorders: A randomized clinical trial of efficacy. *J Nerv Ment Dis.* 2010;198(9):647-52. OVID-Embase.

Exclude: Not an eligible population/treatment

Bricker JB, Russo J, Stein MB, et al. Does occasional cannabis use impact anxiety and depression treatment outcomes? Results from a randomized effectiveness trial. *Depress Anxiety.* 2007;24(6):392-8. PMID:17096386 OVID-Medline.

Exclude: Not an eligible population treatment

Bridge LR, Benson P, Pietroni PC, et al. Relaxation and imagery in the treatment of breast cancer. *Br Med J.* 1988;297(6657):1169-72. Wiley-CCTR.

Exclude: Not an eligible population treatment

Bristow M, Bright J. Group cognitive therapy in chronic depression: Results from two intervention studies. *Behav Cognit Psychother.* 1995;23(4):373-80. OVID-Embase.

Exclude: Not an eligible study design

Brittle N, Patel S, Wright C, et al. An exploratory cluster randomized controlled trial of group exercise on mobility and depression in care home residents. *Clin Rehabil.* 2009;23(2):146-54. PMID:19164402 OVID-Medline.

Exclude: Not an eligible population treatment

Britton WB, Haynes PL, Fridel KW, et al. Polysomnographic and subjective profiles of sleep continuity before and after mindfulness-based cognitive therapy in partially remitted depression. *Psychosom Med.* 2010;72(6):539-48. PMID:20467003 OVID-Medline.

Exclude: Not an eligible population treatment

Brockman B, Poynton A, Ryle A, et al. Effectiveness of time-limited therapy carried out by trainees: Comparison of two methods. *Br J Psychiatr*. 1987;151:602-10. OVID-PsycINFO.
Exclude: Not an eligible study design

Brodie NH, McGhie RL, O'Hara H, et al. Once daily administration of a fluphenazine/nortriptyline preparation in the treatment of mixed anxiety/depressive states. *Curr Med Res Opin*. 1976;4(5):346-52. Wiley-CCTR.
Exclude: Not an eligible population treatment

Brody BL, Roch-Levecq AC, Kaplan RM, et al. Age-related macular degeneration: Self-management and reduction of depressive symptoms in a randomized, controlled study. *J Am Geriatr Soc*. 2006;54(10):1557-62. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Brolhier C, Hamrick N, Jacobson B. Aerobic exercise: A potential occupational therapy modality for adolescents with depression. *Occup Ther Ment Health*. 1993;12(4):19-29. OVID-Embase.
Exclude: Not an eligible study design

Broota A, Dhir R. Efficacy of two relaxation techniques in depression. *J Pers Clin Stud*. 1990;6(1):83-90. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Brothers BM, Yang HC, Strunk DR, et al. Cancer patients with major depressive disorder: Testing a biobehavioral/cognitive behavior intervention. *J Consult Clin Psychol*. 2011;79(2):253-60. OVID-PsycINFO.
Exclude: Not an eligible study design

Brown C, Schulberg HC, Madonia MJ, et al. Treatment outcomes for primary care patients with major depression and lifetime anxiety disorders. *Am J Psychiatry*. 1996;153:1293-300. Exclude: Not an eligible population treatment

Brown C, Schulberg HC, Sacco D, et al. Effectiveness of treatments for major depression in primary medical care practice: A post hoc analysis of outcomes for African American and white patients. *J Affect Disord*. 1999;53(2):185-92. PM:10360414
Exclude: Not an eligible population treatment

Brown ES, Gan V, Jeffress J, et al. Antidepressant treatment of caregivers of children with asthma. *Psychosom*. 2008;49(5):420-5. PMID:18794511 OVID-Medline.
Exclude: Not an eligible study design

Brown JSL, Elliott SA, Boardman J, et al. Meeting the unmet need for depression services with psycho-educational self-confidence workshops: Preliminary report. *Br J Psychiatr*. 2004;185(6):511-5. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Brown JSL, Elliott SA, Boardman J, et al. Can the effects of a 1-day CBT psychoeducational workshop on self-confidence be maintained after 2 years? A naturalistic study. *Depress Anxiety*. 2008;25(7):632-40. OVID-PsycINFO.
Excluded - Systematic review - relevant topic, citations cross-matched

Brown MA, Goldstein-Shirley J, Robinson J, et al. The effects of a multi-modal intervention trial of light, exercise, and vitamins on women's mood. *Women Health*. 2001;34(3):93-112. PMID:11708689 OVID-Medline.
Exclude: Not an eligible population treatment

Brown MA, Shirley JL. Enhancing women's mood and energy: A research-based program for subthreshold depression using light, exercise, and vitamins. *Holist Nurs Pract*. 2005;19(6):278-84. PMID:16269947 OVID-Medline.
Exclude: Not an eligible study design

Brown MA, Munford A. Rehabilitation of post MI depression and psychological invalidism: A pilot study. *Int J Psychiatry Med*. 1983;13(4):291-8. OVID-PsycINFO.
Exclude: Not an eligible study design

Brown RA, Evans DM, Miller IW, et al. Cognitive-behavioral treatment for depression in alcoholism. *J Consult Clin Psychol*. 1997;65(5):715-26. PMID:9337490 OVID-Medline.
Exclude: Not an eligible population treatment

Brown RP, Frances A, Kocsis JH, et al. Psychotic vs. nonpsychotic depression: Comparison of treatment response. *J Nerv Ment Dis*. 1982;170(10):635-7. PMID:6125562 OVID-Medline.
Exclude: Not an eligible population treatment

Brown RA, Lewinsohn PM. A psychoeducational approach to the treatment of depression: Comparison of group, individual, and minimal contact procedures. *J Consult Clin Psychol*. 1984;52(5):774-83. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Brown RA, Evans DM, Miller IW, et al. Cognitive-behavioral treatment for depression in alcoholism. *J Consult Clin Psychol*. 1997;65(5):715-26. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Brown SA, Glasner-Edwards SV, Tate SR, et al. Integrated cognitive behavioral therapy versus twelve-step facilitation therapy for substance-dependent adults with depressive disorders. *J Psychoactive Drugs*. 2006;38(4):449-60. OVID-Embase.

Exclude: Not an eligible population treatment

Brown, W.H.Jr. A cognitive-behavioral intervention to decrease symptoms of depression, anxiety and somatic complaints in adults diagnosed with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Brown. 2003. OVID-PsycINFO.

Exclude: Not an eligible study design

Browne G, Steiner M, Roberts J, et al. Sertraline and/or interpersonal psychotherapy for patients with dysthymic disorder in primary care: 6-month comparison with longitudinal 2-year follow-up of effectiveness and costs. *J Affect Disord*. 2002;68(2-3):317-30. PMID:12063159 OVID-Medline.

Exclude: Not an eligible population treatment

Browne M, Lapierre YD, Hrdina PD, et al. Lithium as an adjunct in the treatment of major depression. *Int Clin Psychopharmacol*. 1990;5(2):103-10. PMID:2116474 OVID-Medline.

Exclude: Not an eligible population treatment

Bruce ML, Ten Have TR, Reynolds CF, III, et al. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: A randomized controlled trial. *JAMA*. 2004;291(9):1081-91. PMID:14996777 OVID-Medline.

Exclude: Not an eligible population treatment

Bruijn JA, Moleman P, Mulder PG, et al. Comparison of 2 treatment strategies for depressed inpatients: Imipramine and lithium addition or mirtazapine and lithium addition. *J Clin Psychiatry*. 1998;59(12):657-63. PMID:9921699 OVID-Medline.

Exclude: Not an eligible population treatment

Brunoni AR, Fraguas J, Fregni F. Pharmacological and combined interventions for the acute depressive episode: Focus on efficacy and tolerability. *Therapeut Clin Risk Manag*. 2009;5(1):897-910. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Brunstein-Klomek A, Zalsman G, Mufson L. Interpersonal psychotherapy for depressed adolescents (IPT-A). *Isr J Psychiatry Relat Sci*. 2007;44(1):40-6. PMID:17665810 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Brunwasser SM, Gillham JE, Kim ES. A meta-analytic review of the Penn Resiliency Program's effect on depressive symptoms. *J Consult Clin Psychol*. 2009;77(6):1042-54. PMID:19968381 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Bryan C, Songer T, Brooks MM, et al. The impact of diabetes on depression treatment outcomes. *Gen Hosp Psychiatry*. 2010;32(1):33-41. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Bschor T, Berghöfer A, Ströhle A, et al. How long should the lithium augmentation strategy be maintained? A 1-year follow-up of a placebo-controlled study in unipolar refractory major depression. *J Clin Psychopharmacol*. 2002;22(4):427-30. Wiley-CCTR.

Exclude: Not an eligible population treatment

Bschor T, Baethge C. No evidence for switching the antidepressant: Systematic review and meta-analysis of RCTs of a common therapeutic strategy: Review. *Acta Psychiatr Scand*. 2010;121(3):174-9. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Bschor T, Adli M, Baethge C, et al. Lithium augmentation increases the ACTH and cortisol response in the combined DEX/CRH test in unipolar major depression. *Neuropsychopharmacol*. 2002;27(3):470-8. OVID-PsycINFO.

Exclude: Not an eligible study design

Bschor T, Baethge C, Adli M, et al. Association between responses to lithium augmentation and the combined DEX/CRH test in major depressive disorder. *J Psychiatr Res*. 2003;37(2):135-43. OVID-PsycINFO.

Exclude: Not an eligible study design

Bschor T, Baethge C, Adli M, et al. Lithium augmentation increases post-dexamethasone cortisol in the dexamethasone suppression test in unipolar major depression. *Depress Anxiety*. 2003;17(1):43-8. OVID-PsycINFO.

Exclude: Not an eligible study design

Bulloch AG, Patten SB. Non-remission of depression in the general population as assessed by the HAMD-7 scale. *Depress Anxiety*. 2008;25(5):393-7. PMID:17948276 OVID-Medline.

Exclude: Not an eligible population treatment

Bump GM, Reynolds CF, III, Smith G, et al. Accelerating response in geriatric depression: A pilot study combining sleep deprivation and paroxetine. *Depress Anxiety*. 1997;6(3):113-8. PMID:9442985 OVID-Medline.

Exclude: Not an eligible study design

Bump GM, Mulsant BH, Pollock BG, et al. Paroxetine versus nortriptyline in the continuation and maintenance treatment of depression in the elderly. *Depress Anxiety*. 2001;13(1):38-44. PMID:11233459 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Burnand Y, Andreoli A, Kolatte E, et al. Psychodynamic psychotherapy and clomipramine in the treatment of major depression. *Psychiatr Serv*. 2002;53(5):585-90. PMID:11986508 OVID-Medline.

Exclude: Not an eligible population treatment

Burton E, Stice E, Bearman SK, et al. Experimental test of the affect-regulation theory of bulimic symptoms and substance use: A randomized trial. *Int J Eat Disord*. 2007;40(1):27-36. PMID:16958129 OVID-Medline.

Exclude: Not an eligible population treatment

Butler LD, Waelde LC, Hastings TA, et al. Mediation with Yoga, group therapy with hypnosis, and psychoeducation for long-term depressed mood: A randomized pilot trial. *J Clin Psychiatry*. 2008;64(7):806-20. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Butler S, Agius M, Holt C, et al. An audit to identify factors that are more commonly associated with depressed patients on augmentation therapy under the Bedfordshire East Community Mental Health Team (BECMHT). *Psychiatria Danubina*. 2010;22:Suppl-9 PMID:21057417 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Buyssse DJ, Reynolds CF, III, Houck PR, et al. Does lorazepam impair the antidepressant response to nortriptyline and psychotherapy? *J Clin Psychiatry*. 1997;58(10):426-32. PMID:9375592 OVID-Medline.

Exclude: Not an eligible population treatment

Byford S, Barrett B, Roberts C, et al. Cost-effectiveness of selective serotonin reuptake inhibitors and routine specialist care with and without cognitive behavioural therapy in adolescents with major depression. *Br J Psychiatry*. 2007;191:521-7. PMID:18055956 OVID-Medline.

Exclude: Not an eligible population treatment

Cabanero M, Laje G, Detera-Wadleigh S, et al. Association study of phosphodiesterase genes in the sequenced treatment alternatives to relieve depression sample. *Pharmacogenetics Genom*. 2009;19(3):235-8. OVID-Embase.

Exclude: Not an eligible population treatment

Cabiya JJ, Padilla-Cotto L, Gonzalez K, et al. Effectiveness of a cognitive-behavioral intervention for Puerto Rican children. *Revista Interamericana de Psicologia*. 2008;42(2):195-202. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Cahill J, Barkham M, Hardy G, et al. Outcomes of patients completing and not completing cognitive therapy for depression. *Br J Clin Psychol*. 2003;42(Pt:2):2-43. PMID:12828803 OVID-Medline.

Exclude: Not an eligible population treatment

Cain JW. Poor response to fluoxetine: Underlying depression, serotonergic overstimulation, or a "therapeutic window"? *J Clin Psychiatry*. 1992;53(8):272-7. PMID:1500403 OVID-Medline.

Exclude: Not an eligible study design

Calabrese C, Londeborg P.D., Shelton MD, et al. Citalopram treatment of paroxetine-intolerant depressed patients. *J Clin Psychiatry*. 2003;64:564-7. Exclude: Not an eligible study design

Calabrese C, Gregory WL, Leo M, et al. Effects of a standardized Bacopa monnieri extract on cognitive performance, anxiety, and depression in the elderly: A randomized, double-blind, placebo-controlled trial. *J Altern Complement Med*. 2008;14(6):707-13. PMID:18611150 OVID-Medline.

Exclude: Not an eligible population treatment

Calabrese JR, Londeborg PD, Shelton MD, et al. Citalopram treatment of fluoxetine-intolerant depressed patients. *J Clin Psychiatry*. 2003;64(5):562-7. PMID:12755660 OVID-Medline.

Exclude: Not an eligible population treatment

Calcedo Ordonez A, Arosamene X, Otero Perez FJ, et al. Clomipramine/benzazepam combination in the treatment of major depressive disorders. *Hum Psychopharmacol Clin Exp*. 1992;7(2):115-22. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Calear AL, Christensen H, Mackinnon A, et al. The YouthMood Project: A cluster randomized controlled trial of an online cognitive behavioral program with adolescents. *J Consult Clin Psychol*. 2009;77(6):1021-32. PMID:19968379 OVID-Medline.

Exclude: Not an eligible population treatment

Calear AL, Christensen H. Review of internet-based prevention and treatment programs for anxiety and depression in children and adolescents. *Med J Aust*. 2010;192(11 Suppl):S12-4. PMID:20528700 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Calear AL, Christensen H. Systematic review of school-based prevention and early intervention programs for depression. *J Adolesc*. 2010;33(3):429-38. PMID:19647310 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Caliyurt O, Guducu F. Partial sleep deprivation therapy combined with sertraline induces more rapid improvements in quality of life items in major depressive disorder. *J Affect Disord*. 2005;88(1):75-8. PMID:15967511 OVID-Medline.

Exclude: Not an eligible population treatment

Campbell JM. Treating depression in well older adults: Use of diaries in cognitive therapy. *Issues Ment Health Nurs*. 1992;13(1):19-29. PMID:1737700 OVID-Medline.

Exclude: Not an eligible population treatment

Candy B, Jones L, Williams R, et al. Psychostimulants for depression. *Cochrane Database Syst Rev*. 2008;(2):Art No.:CD006722 Wiley-CDSR.

Excluded - Systematic review - relevant topic, citations cross-matched

Canna, M.A. Controlled evaluation of the effects of expressive writing on subsequent cognitive behavioral group treatment with an anxious/depressed sample 2006. OVID-PsycINFO. Exclude: Not an eligible study design

Cantor DS, Stevens E. QEEG correlates of auditory-visual entrainment treatment efficacy of refractory depression. *J Neurother*. 2009;13(2):100-8. OVID-Embase.

Exclude: Not an eligible population treatment

Cao Y, Song L, Wang Z. Controlled study of venlafaxine combined with quetiapine in refractory depression. *J Clin Psychosom Dis*. 2005;11(2):129-30. Wiley-CCTR.

Exclude: Not an eligible study design

Cape J, Whittington C, Buszewicz M, et al. Brief psychological therapies for anxiety and depression in primary care: Meta-analysis and meta-regression. *BMC Med*. 2010;8(Art No.:38). OVID-Embase. Exclude - Systematic review - relevant topic, citations cross-matched

Cappeliez P. Presentation of depression and response to group cognitive therapy with older adults. *J Clin Gerontology*. 2000;(6):165-74. Exclude: Not an eligible study design

Cappiello A, McDougale CJ, Malison RT, et al. Yohimbine augmentation of fluvoxamine in refractory depression: A single-blind study. *Biol Psychiatr*. 1995;38(11):765-7. Wiley-CCTR. Exclude: Not an eligible study design

Cappiello A, McDougale CJ, Delgado PL, et al. Lithium and desipramine versus desipramine alone in the treatment of severe major depression: A preliminary study. *Int Clin Psychopharmacol*. 1998;13(5):191-8. PMID:9817623 OVID-Medline. Exclude: Mixed antidepressants: some failed on SSRI

Carney CE, Segal ZV, Edinger JD, et al. A comparison of rates of residual insomnia symptoms following pharmacotherapy or cognitive-behavioral therapy for major depressive disorder. *J Clin Psychiatry*. 2007;68(2):254-60. PMID:17335324 OVID-Medline.

Exclude: Not an eligible population treatment

Carney MW, Edeh J, Bottiglieri T, et al. Affective illness and S-adenosyl methionine: A preliminary report. *Clin Neuropharmacol*. 1986;9(4):379-85. PMID:2425961 OVID-Medline.

Exclude: Not an eligible population treatment

Carney MW, Chary TK, Bottiglieri T, et al. Switch and S-adenosylmethionine. *Ala J Med Sci*. 1988;25(3):316-9. PMID:3052141 OVID-Medline. Exclude: Not an eligible study design

Carney RM, McKeivitt PM, Goldberg AP. Psychological effects of exercise training in hemodialysis patients. *Nephron*. 1983;33(3):179-81. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Carney RM, Templeton B, Hong BA, et al. Exercise training reduces depression and increases the performance of pleasant activities in hemodialysis patients. *Nephron*. 1987;47(3):194-8. PMID:3317091 OVID-Medline.

Exclude: Not an eligible population treatment

Carney RM, Freedland KE, Rubin EH, et al. Omega-3 augmentation of sertraline in treatment of depression in patients with coronary heart disease: A randomized controlled trial. *JAMA*. 2009;302(15):1651-7. PMID:19843899 OVID-Medline.

Exclude: Not an eligible population treatment

Carpenter KM, Aharonovich E, Smith JL, et al. Behavior therapy for depression in drug dependence (BTDD): Results of a stage Ia therapy development pilot. *Am J Drug Alcohol Abuse*. 2006;32(4):541-8. PMID:17127541 OVID-Medline.

Exclude: Not an eligible population treatment

Carpenter KM, Smith JL, Aharonovich E, et al. Developing therapies for depression in drug dependence: Results of a stage 1 therapy study. *Am J Drug Alcohol Abuse*. 2008;34(5):642-52. PMID:18821458 OVID-Medline.

Exclude: Not an eligible population treatment

Carpenter LL, Jocic Z, Hall JM, et al. Mirtazapine augmentation in the treatment of refractory depression. *J Clin Psychiatry*. 1999;60(1):45-9. OVID-Embase.

Exclude: Not an eligible study design

Carpenter L L, Yasmin S, Price L H. A double-blind, placebo-controlled study of mirtazapine augmentation for refractory depression. In 2000. Wiley-CCTR.

Exclude: Not an eligible study design

Carpenter L L, Yasmin S, Price L H. A double-blind, placebo-controlled study of mirtazapine augmentation for refractory major depression: Preliminary findings. In 2000. Wiley-CCTR.

Exclude: Not an eligible study design

Carpenter LL, Yasmin S, Price LH. A double-blind, placebo-controlled study of antidepressant augmentation with mirtazapine. *Biol Psychiatry*. 2002;51(2):183-8. PMID:11822997 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Carpenter LL, Leon Z, Yasmin S, et al. Do obese depressed patients respond to topiramate? A retrospective chart review. *J Affect Disord*. 2002;69(1-3):251-5. PMID:12103474 OVID-Medline.

Exclude: Not an eligible study design

Carpenter LL, Milosavljevic N, Schecter JM, et al. Augmentation with open-label atomoxetine for partial or nonresponse to antidepressants. *J Clin Psychiatry*. 2005;66(10):1234-8. PMID:16259536 OVID-Medline.

Exclude: Not an eligible study design

Carpenter LL, Bayat L, Moreno F, et al. Decreased cerebrospinal fluid concentrations of substance P in treatment-resistant depression and lack of alteration after acute adjunct vagus nerve stimulation therapy. *Psychiatry Res*. 2008;157(1-3):123-9.

PMID:17976740 OVID-Medline.

Exclude: Not an eligible population treatment

Carr A. Depression in young people: Description, assessment and evidence-based treatment. *Dev Neurorehabil*. 2008;11(1):3-15. PMID:17943506 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Carrico AW, Antoni MH, Weaver KE, et al. Cognitive-behavioural stress management with HIV-positive homosexual men: Mechanisms of sustained reductions in depressive symptoms. *Chronic Illn*. 2005;1(3):207-15. PMID:17152183 OVID-Medline.

Exclude: Not an eligible population treatment

Carrico AW, Antoni MH, Duran RE, et al. Reductions in depressed mood and denial coping during cognitive behavioral stress management with HIV-positive gay men treated with HAART. *Ann Behav Med*. 2006;31(2):155-64. OVID-Embase.

Exclude: Not an eligible population treatment

Carrieri PB, Indaco A, Gentile S, et al. S-Adenosylmethionine treatment of depression in patients with Parkinson's disease. A double-blind, crossover study versus placebo. *Curr Ther Res Clin Exp*. 1990;48(1):154-60. OVID-Embase.

Exclude: Not an eligible population design

Carroll BJ, Mowbray RM, Davies B. Sequential comparison of L-tryptophan with E.C.T. in severe depression. *Lancet*. 1970;1(7654):967-9. Wiley-CCTR.

Exclude: Not an eligible study design

Carroll KM, Nich C, Rounsaville BJ. Differential symptom reduction in depressed cocaine abusers treated with psychotherapy and pharmacotherapy. *J Nerv Ment Dis*. 1995;183(4):251-9. PMID:7714514 OVID-Medline.

Exclude: Not an eligible population treatment

Carroll S, Hides L, Catania L, et al. Integrated cognitive behaviour therapy for co-occurring substance misuse and major depression: Lessons from a youth mental health service. *Australas Psychiatry*. 2009;17(5):365-70. PMID:20455796 OVID-Medline.

Exclude: Not an eligible study design

Carta MG, Zairo F, Mellino G, et al. Add-on quetiapine in the treatment of major depressive disorder in elderly patients with cerebrovascular damage. *Clin Pract Epidemiol Ment Health*. 2007;Article Number: 28.: OVID-Embase. Exclude: Not an eligible study design

Caruso I, Fumagalli M, Boccassini L, et al. Treatment of depression in rheumatoid arthritic patients: A comparison of S-adenosylmethionine (Samyr) and placebo in a double-blind study. *Clin Trials J*. 1987;24(4):305-10. OVID-Embase. Exclude: Not an eligible study design

Carvalho AF, Cavalcante JL, Castelo MS, et al. Augmentation strategies for treatment-resistant depression: A literature review. *J Clin Pharm Ther*. 2007;32(5):415-28. ISI:000249450400001 Excluded - Systematic review - relevant topic, citations cross-matched

Casamassima F, Huang J, Fava M, et al. Phenotypic effects of a bipolar liability gene among individuals with major depressive disorder. *Am J Med Genet*. 2010;(1):303-9. PMID:19388002 OVID-Medline. Exclude: Not an eligible population treatment

Casciano R, Arikian SR, Tarride J-E, et al. Antidepressant selection for major depressive disorder: The budgetary impact on managed care. *Drug Benefit Trends*. 2000;12(5):6BH-17BH. OVID-Embase. Exclude: Not an eligible study design

Case,S.C. The effects of group therapy and exercise on depression and self-esteem in college students 2003. OVID-PsycINFO. Exclude: Not an eligible study design

Cassano P, Lattanzi L, Soldani F, et al. Pramipexole in treatment-resistant depression: An extended follow-up. *Depress Anxiety*. 2004;20(3):131-8. PMID:15549689 OVID-Medline. Exclude: Not an eligible study design

Cassano P, Lattanzi L, Fava M, et al. Ropinirole in treatment-resistant depression: A 16-week pilot study. *Can J Psychiatr*. 2005;50(6):357-60. PMID:15999953 OVID-Medline. Exclude: Not an eligible study design

Castle D, Schweitzer I, Tiller J. STAR*D: Has it taught us anything about the management of depression? *Australas Psychiatr*. 2009;17(5):360-4. PMID:20455795 OVID-Medline. Exclude: Systematic Review before 2005

Castonguay LG, Schut AJ, Aikens DE, et al. Integrative cognitive therapy for depression: A preliminary investigation. *J Psychother Integrat*. 2004;14(1):4-20. OVID-PsycINFO. Exclude: Not an eligible study design

Castro M. The treatment of depression with homeopathy. *Alternative Compl Ther*. 1997;3(4):300-5. EBSCO-CINAHL. Exclude: Not an eligible study design

Cavanagh K, Shapiro DA, Van Den BS, et al. The effectiveness of computerized cognitive behavioural therapy in routine care. *Br J Clin Psychol*. 2006;45(Pt:4):4-514. PMID:17076960 OVID-Medline. Exclude: Not an eligible study design

Cayiroglu S, Holub U, Zapotoczky HG. The scientific dialogue: From basic research to clinical intervention., Lisse, Netherlands:Swets & Zeitlinger Publishers;1990. The combination of cognitive behaviour therapy and antidepressants in the treatment of depressed patients: Does it share the additional or dependent model of interaction? OVID-PsycINFO. Exclude: Not an eligible study design.

Ceskova E, Nahunek K, Rysanek R, et al. Clinical experience with parenteral clomipramine and desipramine in the treatment of drug-resistant endogenous depression. *Act Nerv Super*. 1981;23(3):212-4. OVID-PsycINFO. Exclude: Not an eligible population treatment

Cevasco AM, Kennedy R, Generally NR. Comparison of movement-to-music, rhythm activities, and competitive games on depression, stress, anxiety, and anger of females in substance abuse rehabilitation. *J Music Ther*. 2005;42(1):64-80. PMID:15839734 OVID-Medline. Exclude: Not an eligible population treatment

Chan,E.K.H. Efficacy of cognitive-behavioral, pharmacological, and combined treatments of depression: A meta-analysis 2006. OVID-PsycINFO. Exclude: Not an eligible study design

Chan I, Kong P, Leung P, et al. Cognitive-behavioral group program for Chinese heterosexual HIV-infected men in Hong Kong. *Patient Educ Couns*. 2005;56(1):78-84. PMID:15590226 OVID-Medline. Exclude: Not an eligible population treatment

Chan MF, Chan EA, Mok E, et al. Effect of music on depression levels and physiological responses in community-based older adults. *Int J Ment Health Nurs*. 2009;18(4):285-94. EBSCO-CINAHL. Exclude: Not an eligible population treatment

Chan MF, Chan EA, Mok E. Effects of music on depression and sleep quality in elderly people: A randomised controlled trial. *Complement Ther Med*. 2010;18(3-4):150-9. EBSCO-CINAHL.

Exclude: Not an eligible population/treatment

Chang M, Chen C, Huang K. Effects of music therapy on psychological health of women during pregnancy. *J Clin Nurs*. 2008;17(19):2580-7. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Chang SH, Fang MC, Yang YS. Effectiveness of transcutaneous electrical acupoint stimulation for improving depressive mood status among nursing home elders in Taiwan: A pilot study. *Geriatr Nurs*. 2010;31(5):324-30. PMID:20933145 OVID-Medline.

Exclude: Not an eligible population treatment

Chaput Y, Magnan A, Gendron A. The co-administration of quetiapine or placebo to cognitive-behavior therapy in treatment refractory depression: A preliminary trial. *BMC Psychiatr*. 2008;8:73 Wiley-CCTR.

Exclude: Mixed antidepressants:some failed on SSRI

Charney DS, Price LH, Heninger GR. Desipramine-yohimbine combination treatment of refractory depression: Implications for the beta-adrenergic receptor hypothesis of antidepressant action. *Arch Gen Psychiatr*. 1986;43(12):1155-61. PMID:3022664 OVID-Medline.

Exclude: Not an eligible population treatment

Chaudhry HR, Najam N, Naqvi A. The value of amineptine in depressed patients treated with cognitive behavioural psychotherapy. *Hum Psychopharmacol*. 1998;13(6):419-24. OVID-Embase.

Exclude: Not an eligible population treatment

Chen J, Gao K, Kemp DE. Second-generation antipsychotics in major depressive disorder: Update and clinical perspective. *Curr Opin Psychiatry*. 2011;24(1):10-7. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Chen K, Chen M, Chao H, et al. Sleep quality, depression state, and health status of older adults after silver yoga exercises: Cluster randomized trial. *Int J Nurs Stud*. 2009;46(2):154-63. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Chen K, Chen M, Lin M, et al. Effects of yoga on sleep quality and depression in elders in assisted living facilities. *J Nurs Res*. 2010;18(1):53-61. EBSCO-CINAHL.

Exclude: Not an eligible study design

Chen TH, Lu RB, Chang AJ, et al. The evaluation of cognitive-behavioral group therapy on patient depression and self-esteem. *Arch Psychiatr Nurs*. 2006;20(1):3-11. PMID:16442469 OVID-Medline.

Exclude: Not an eligible population treatment

Chen Y, Guo JJ, Zhan S, et al. Treatment effects of antidepressants in patients with post-stroke depression: A meta-analysis. *Ann Pharmacother*. 2006;40(12):2115-22. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Cherkezova M, Toteva S. Acupuncture in the treatment of alcoholics with a depressive syndrome. *J Russ East Eur Psychol*. 1993;26(1):28-30. OVID-PsycINFO.

Exclude: Not an eligible study design

Cheung AH, Emslie GJ, Mayes TL. Review of the efficacy and safety of antidepressants in youth depression. *J Child Psychol Psychiatr Allied Discipl*. 2005;46(7):735-54. PMID:15972068 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Child A, Sanders J, Sigel P, et al. Meeting the psychological needs of cardiac patients: An integrated stepped-care approach within a cardiac rehabilitation setting. *Br J Cardiol*. 2010;17(4):175-9. EBSCO-CINAHL.

Exclude: Not an eligible population/treatment

Chilvers C, Dewey M, Fielding K, et al. Antidepressant drugs and generic counselling for treatment of major depression in primary care: Randomised trial with patient preference arms. *Br Med J*. 2001;322(7289):772-5. PM:11282864

Exclude: Not an eligible population treatment

Cho YC, Tsay SL. The effect of acupressure with massage on fatigue and depression in patients with end-stage renal disease. *J Nurs Res*. 2004;12(1):51-9. PMID:15136963 OVID-Medline.

Exclude: Not an eligible population treatment

Choi AN, Lee MS, Lim HJ. Effects of group music intervention on depression, anxiety, and relationships in psychiatric patients: A pilot study. *J Altern Complement Med*. 2008;14(5):567-70. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Chou KL, Lee PW, Yu EC, et al. Effect of Tai Chi on depressive symptoms amongst Chinese older patients with depressive disorders: A randomized clinical trial. *Int J Geriatr Psychiatry*. 2004;19(11):1105-7. PM:15497192 Exclude: Not an eligible population treatment

Chouinard G, Young SN, Annable L, et al. Tryptophan-nicotinamide, imipramine and their combination in depression: A controlled study. *Acta Psychiatr Scand*. 1979;59(4):395-414. Wiley-CCTR. Exclude: Not an eligible population treatment

Christensen H, Griffiths KM, Korten A. Web-based cognitive behavior therapy: Analysis of site usage and changes in depression and anxiety scores. *J Med Internet Res*. 2002;4(1):e3. PMID:11956035 OVID-Medline. Exclude: Not an eligible study design

Christensen H, Griffiths KM, Korten AE, et al. A comparison of changes in anxiety and depression symptoms of spontaneous users and trial participants of a cognitive behavior therapy website. *J Med Internet Res*. 2004;6(4):e46 PMID:15631970 OVID-Medline. Exclude: Not an eligible study design

Christensen H, Griffiths KM, Jorm AF. Delivering interventions for depression by using the internet: Randomised controlled trial. *Br Med J*. 2004;328(7434):265 PMID:14742346 OVID-Medline. Exclude: Not an eligible population treatment

Christensen H, Griffiths KM, Mackinnon AJ, et al. Online randomized controlled trial of brief and full cognitive behaviour therapy for depression. *Psychol Med*. 2006;36(12):1737-46. PMID:16938144 OVID-Medline. Exclude: Not an eligible population treatment

Chronis AM, Gamble SA, Roberts JE, et al. Cognitive-behavioral depression treatment for mothers of children with attention-deficit/hyperactivity disorder. *Behav Ther*. 2006;37(2):143-58. PMID:16942968 OVID-Medline. Exclude: Not an eligible population treatment

Chu BC, Harrison TL. Disorder-specific effects of CBT for anxious and depressed youth: A meta-analysis of candidate mediators of change. *Clin Child Fam Psychol Rev*. 2007;10(4):352-72. PMID:17985239 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Chu I-H, Buckworth J, Kirby TE, et al. Effect of exercise intensity on depressive symptoms in women. *Ment Health Phys Activ*. 2009;2(1):37-43. OVID-Embase. Exclude: Not an eligible population treatment

Chu, I.H. Effect of exercise intensity during aerobic training on depressive symptoms in initially sedentary depressed women 2008. OVID-PsycINFO. Exclude: Not an eligible study design

Chun, D.S. An assessment of support group participation on depression and adherence in veterans with hepatitis C 2002. OVID-PsycINFO. Exclude: Not an eligible study design

Chung L, Tsai P, Liu B, et al. Home-based deep breathing for depression in patients with coronary heart disease: A randomised controlled trial. *Int J Nurs Stud*. 2010;47(11):1346-53. EBSCO-CINAHL. Exclude: Not an eligible population/treatment

Church J. The application of cognitive-behavioural therapy for depression to people with human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). *Psychooncol*. 1998;7(2):78-88. EBSCO-CINAHL. Exclude: Not an eligible study design

Ciarambino T, Ferrara N, Castellino P, et al. Effects of a 6-days-a-week low protein diet regimen on depressive symptoms in young-old type 2 diabetic patients. *Nutr*. 2011;27(1):46-9. OVID-Embase. Exclude: Not an eligible population/treatment

Ciechanowski P, Wagner E, Schmalig K, et al. Community-integrated home-based depression treatment in older adults: A randomized controlled trial. *JAMA*. 2004;291(13):1569-77. PM:15069044 Exclude: Not an eligible population treatment

Cipher DJ, Clifford PA, Roper KD. The effectiveness of geropsychological treatment in improving pain, depression, behavioral disturbances, functional disability, and health care utilization in long-term care. *Clin Gerontol*. 2007;30(3):23-40. OVID-Embase. Exclude: Not an eligible population design

Clarke DM, Currie KC. Depression, anxiety and their relationship with chronic diseases: A review of the epidemiology, risk and treatment evidence. *Med J Aust*. 2009;190(7 Suppl):S54-S60 OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Clarke G, Reid E, Eubanks D, et al. Overcoming depression on the Internet (ODIN): A randomized controlled trial of an Internet depression skills intervention program. *J Med Internet Res*. 2002;4(3):E14 PMID:12554545 OVID-Medline. Exclude: Not an eligible population treatment

Clarke G, DeBar L, Lynch F, et al. A randomized effectiveness trial of brief cognitive-behavioral therapy for depressed adolescents receiving antidepressant medication. *J Am Acad Child Adolesc Psychiatry*. 2005;44(9):888-98. PMID:16113617 OVID-Medline. Exclude: Not an eligible population treatment

Clarke G, Eubanks D, Reid E, et al. Overcoming Depression on the Internet (ODIN) (2): A randomized trial of a self-help depression skills program with reminders. *J Med Internet Res*. 2005;7(2):e16 PMID:15998607 OVID-Medline. Exclude: Not an eligible population treatment

Clarke GN, Hawkins W, Murphy M, et al. Targeted prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: A randomized trial of a group cognitive intervention. *J Am Acad Child Adolesc Psychiatry*. 1995;34(3):312-21. PMID:7896672 OVID-Medline. Exclude: Not an eligible population treatment

Clarke GN, Rohde P, Lewinsohn PM, et al. Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *J Am Acad Child Adolesc Psychiatry*. 1999;38(3):272-9. PMID:10087688 OVID-Medline. Exclude: Not an eligible population treatment

Clarke GN, Hornbrook M, Lynch F, et al. A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Arch Gen Psychiatr*. 2001;58(12):1127-34. PMID:11735841 OVID-Medline. Exclude: Not an eligible population treatment

Clarke GN, Hornbrook M, Lynch F, et al. Group cognitive-behavioral treatment for depressed adolescent offspring of depressed parents in a health maintenance organization. *J Am Acad Child Adolesc Psychiatry*. 2002;41(3):305-13. PMID:11886025 OVID-Medline. Exclude: Not an eligible population treatment

Clayton A, Guico-Pabia C. Recognition of depression among women presenting with menopausal symptoms. *Menopause*. 2008;15(4):758-67. OVID-Embase.

Exclude: - Systematic review - relevant topic, citations cross-matched

Clement K, Covertson CR, Johnson MJ, et al. St. John's wort and the treatment of mild to moderate depression: A systematic review. *Holist Nurs Pract*. 2006;20(4):197-203. PMID:16825922 OVID-Medline.

Exclude: - Systematic review - relevant topic, citations cross-matched

Clunie F. Double blind randomised controlled trial comparing moclobemide and phenelzine in treatment resistant depression. In 2001. Wiley-CCTR. Exclude: Not an eligible study design

Cocker KI, Bell DR, Kidman AD. Cognitive behaviour therapy with advanced breast cancer patients: A brief report of a pilot study. *Psychooncol*. 1994;3(3):233-7. OVID-Embase. Exclude: Not an eligible study design

Cockram A, McCall L, Judd F, et al. The development and pilot testing of a Focused Education and Psychotherapy Program (FEPP) for treatment of depression in general practice. *Australas Psychiatr*. 2002;10(3):268-74. Exclude: Not an eligible study design

Coelho HF, Boddy K, Ernst E. Massage therapy for the treatment of depression: A systematic review. *Int J Clin Pract*. 2008;62(2):325-33. PMID:18081800 OVID-Medline.

Exclude: - Systematic review - relevant topic, citations cross-matched

Cohen AJ. Treatment of anergic depression in Hashimoto's thyroiditis with fluoxetine and d-amphetamine. *Depression*. 1993;1(2):110-4. OVID-PsycINFO.

Exclude: Not an eligible study design

Cohen LS, Altshuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA*. 2006;295(5):499-507. OVID-Embase. Exclude: Not an eligible population treatment

Cohen S, O'Leary KD, Foran H. A randomized clinical trial of a brief, problem-focused couple therapy for depression. *Behav Ther*. 2010;41(4):433-46. PMID:21035609 OVID-Medline. Exclude: Not an eligible population treatment

Cole BS. Spiritually-focused psychotherapy for people diagnosed with cancer: A pilot outcome study. *Ment Health Relig Cult*. 2005;8(3):217-26. OVID-Embase.

Exclude: Not an eligible population treatment

Cole JO, Schatzberg AF, Sniffen C. Trazodone in treatment resistant depression: An open study. *J Clin Psychopharmacol*. 1981;1(Suppl 6):49S-54S.

Exclude: Not an eligible study design

Cole MG, McCusker J, Elie M, et al. Systematic detection and multidisciplinary care of depression in older medical inpatients: A randomized trial. *CMAJ*. 2006;174(1):38-44. PMID:16330624 OVID-Medline.

Exclude: Not an eligible population treatment

Coleman E, Cesnik J, Moore AM, et al. An exploratory study of the role of psychotropic medications in the treatment of sex offenders. *J Offender Rehabil*. 1992;18(3-4):75-88. OVID-PsycINFO.

Exclude: Not an eligible study design

Colle LM, Belair J-F, DiFeo M, et al. Extended open-label fluoxetine treatment of adolescents with major depression. *J Child Adolesc Psychopharmacol*. 1994;4(4):225-32. OVID-Embase.

Exclude: Not an eligible study design

Collet L, Cottraux J, Ladouceur R. Cognitive therapy of depression and counterdemand effects: A pilot study. *Psychol Rep*. 1987;60(2):555-60. OVID-PsycINFO.

Exclude: Not an eligible study design

Collins J, Abou SMT. Rolipram: A new concept for the treatment of tricyclic resistant depression. *J DRUG DEV*. 1992;5(2):65-70. Wiley-CCTR.

Exclude: Not an eligible population treatment

Collins, R.W. The treatment of depression: An integrative psychotherapy model 1997. OVID-PsycINFO.

Exclude: Not an eligible study design

Comas DL. Effects of cognitive and behavioral group treatment on the depressive symptomatology of Puerto Rican women. *J Consult Clin Psychol*. 1981;49(5):627-32. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Comer EW. Integrating the health and mental health needs of the chronically ill: A group for individuals with depression and sickle cell disease. *Soc Work Health Care*. 2004;38(4):57-76. PMID:15149906 OVID-Medline.

Exclude: Not an eligible study design

Compas BE, Forehand R, Keller G, et al. Randomized controlled trial of a family cognitive-behavioral preventive intervention for children of depressed parents. *J Consult Clin Psychol*. 2009;77(6):1007-20. PMID:19968378 OVID-Medline.

Exclude: Not an eligible population treatment

Compas BE, Champion JE, Forehand R, et al. Coping and parenting: Mediators of 12-month outcomes of a family group cognitive-behavioral preventive intervention with families of depressed parents. *J Consult Clin Psychol*. 2010;78(5):623-34. PMID:20873898 OVID-Medline.

Exclude: Not an eligible population treatment

Congleton, A.B. The effect of a cognitive-behavioral group intervention on the locus of control, attributional style, and depressive symptoms of middle school students 1996. OVID-PsycINFO.

Exclude: Not an eligible study design

Conn DK, Clarke D, van Reekum R. Depression in Holocaust survivors: Profile and treatment outcome in a geriatric day hospital program. *Int J Geriatr Psychiatry*. 2000;15(4):331-7. OVID-Embase.

Exclude: Not an eligible population treatment

Conn DK, Steingart AB. Diagnosis and management of late life depression: A guide for the primary care physician. *Int J Psychiatry Med*. 1997;27(3):269-81. OVID-PsycINFO.

Exclude: Not an eligible guideline

Conn VS. Depressive symptom outcomes of physical activity interventions: Meta-analysis findings. *Ann Behav Med*. 2010;39(2):128-38. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Connerley, R.C. Distant intercessory prayer as an adjunct to psychotherapy with depressed outpatients: A small-scale investigation 2003. OVID-PsycINFO.

Exclude: Not an eligible study design

Conradi HJ, de Jonge P, Kluiters H, et al. Enhanced treatment for depression in primary care: Long-term outcomes of a psycho-educational prevention program alone and enriched with psychiatric consultation or cognitive behavioral therapy. *Psychol Med*. 2007;37(6):849-62. PMID:17376257 OVID-Medline.

Exclude: Not an eligible population treatment

Conradi HJ, de Jonge P, Ormel J. Cognitive-behavioural therapy v. usual care in recurrent depression. *Br J Psychiatr.* 2008;193(6):505-6. PMID:19043158 OVID-Medline.

Exclude: Not an eligible population treatment

Conradsson M, Littbrand H, Lindelof N, et al. Effects of a high-intensity functional exercise programme on depressive symptoms and psychological well-being among older people living in residential care facilities: A cluster-randomized controlled trial. *Aging Ment Health.* 2010;14(5):565-76. PMID:20496181 OVID-Medline.

Exclude: Not an eligible population treatment

Constantino MJ, Marnell ME, Haile AJ, et al. Integrative cognitive therapy for depression: A randomized pilot comparison. *Psychother.* 2008;45(2):122-34. OVID-Embase.

Exclude: Not an eligible population treatment

Cook JW, Spring B, McChargue DE, et al. Influence of fluoxetine on positive and negative affect in a clinic-based smoking cessation trial. *Psychopharmacol.* 2004;173(1-2):153-9. PMID:14727000 OVID-Medline.

Exclude: Not an eligible population treatment

Cooke M, Moyle W, Shum D, et al. A randomized controlled trial exploring the effect of music on quality of life and depression in older people with dementia. *J Health Psychol.* 2010;15(5):765-76. EBSCO-CINAHL.

Exclude: Not an eligible population/treatment

Cooke RG, Joffe RT, Levitt AJ. T3 augmentation of antidepressant treatment in T4-replaced thyroid patients. *J Clin Psychiatry.* 1992;53(1):16-8. PMID:1737734 OVID-Medline.

Exclude: Not an eligible study design

Coon DW, Thompson L, Steffen A, et al. Anger and depression management: Psychoeducational skill training interventions for women caregivers of a relative with dementia. *Gerontologist.* 2003;43(5):678-89. PMID:14570964 OVID-Medline.

Exclude: Not an eligible population treatment

Cooper-Kazaz R, Apter JT, Cohen R, et al. Combined treatment with sertraline and liothyronine in major depression: A randomized, double-blind, placebo-controlled trial. *Arch Gen Psychiatr.* 2007;64(6):679-88. PMID:17548749 OVID-Medline.

Exclude: Not an eligible population treatment

Cooper-Kazaz R, Lerer B. Efficacy and safety of triiodothyronine supplementation in patients with major depressive disorder treated with specific serotonin reuptake inhibitors. *Int J Neuropsychopharmacol.* 2008;11(5):685-99. PMID:18047754 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cooper AJ, Datta SR. A placebo controlled evaluation of L-tryptophan in depression in the elderly. *Can J Psychiatr.* 1980;25(5):386-90. PMID:7407745 OVID-Medline.

Exclude: Not an eligible population treatment

Coppen A, Whybrow PC, Noguera R, et al. The comparative antidepressant value of L-tryptophan and imipramine with and without attempted potentiation by liothyronine. *Arch Gen Psychiatr.* 1972;26(3):234-41. Wiley-CCTR.

Exclude: Not an eligible population treatment

Coppen A, Abou-Saleh MT. Lithium therapy: From clinical trials to practical management. *Acta Psychiatr Scand.* 1988;78(6):754-62. PMID:3146892 OVID-Medline.

Exclude: Not an eligible population treatment

Coppen A, Bailey J. Enhancement of the antidepressant action of fluoxetine by folic acid: A randomised, placebo controlled trial. *J Affect Disord.* 2000;60(2):121-30. PMID:10967371 OVID-Medline.

Exclude: Not an eligible population treatment

Corey-Lisle PK, Birnbaum H, Greenberg P, et al. Economic impact of olanzapine plus fluoxetine combination therapy among patients treated for depression: A pilot study. *Psychopharmacol Bull.* 2003;37(3):90-8. PMID:14608242 OVID-Medline.

Exclude: Not an eligible study design

Corey-Lisle PK, Nash R, Stang P, et al. Response, partial response, and nonresponse in primary care treatment of depression. *Arch Intern Med.* 2004;164(11):1197-204. PMID:15197045 OVID-Medline.

Exclude: Not an eligible population treatment

Corrado P, Gottlieb H. Alternative medicine. The effect of biofeedback and relaxation training on depression in chronic pain patients. *Am J Pain Manage.* 1999;9(1):18-21. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Corya SA, Andersen SW, Detke HC, et al. Long-term antidepressant efficacy and safety of olanzapine/fluoxetine combination: A 76-week open-label study. *J Clin Psychiatry*. 2003;64(11):1349-56. PMID:14658950 OVID-Medline.
Exclude: Not an eligible study design

Costa e Silva. Randomized, double-blind comparison of venlafaxine and fluoxetine in outpatients with major depression. *J Clin Psychiatry*. 1998;59(7):352-7. PMID:9714263 OVID-Medline.
Exclude: Not an eligible population treatment

Costa Miranda V, Trufelli DC, Santos J, et al. Effectiveness of guarana (*Paullinia cupana*) for postradiation fatigue and depression: Results of a pilot double-blind randomized study. *J Altern Compl Med*. 2009;15(4):431-3. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Courbasson CM, de Sorkin AA, Dullerud B, et al. Acupuncture treatment for women with concurrent substance use and anxiety/depression: An effective alternative therapy? *Fam Community Health*. 2007;30(2):112-20. PMID:19241647 OVID-Medline.
Exclude: Not an eligible population treatment

Coventry PA, Gellatly JL. Improving outcomes for COPD patients with mild-to-moderate anxiety and depression: A systematic review of cognitive behavioural therapy. *Br J Health Psychol*. 2008;13(Pt:3):381-400. PMID:17535503 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Covi L, Lipman RS. Cognitive behavioral group psychotherapy combined with imipramine in major depression. *Psychopharmacol Bull*. 1987;23(1):173-6. PM:3602315 Exclude: Not an eligible population treatment

Covi L, Roth D, Lipman RS. Cognitive group psychotherapy of depression: The close-ended group. *Am J Psychother*. 1982;36(4):459-69. OVID-PsycINFO.
Exclude: Not an eligible study design

Cowen PJ, McCance SL, Cohen PR, et al. Lithium increases 5-HT-mediated neuroendocrine responses in tricyclic resistant depression. *Psychopharmacol*. 1989;99(2):230-2. PMID:2508159 OVID-Medline.
Exclude: Not an eligible study design

Cox AA. A description of a behavioral group treatment for depression. *J Specialists Group Work*. 1984;9(2):85-92. OVID-PsycINFO.
Exclude: Not an eligible study design

Cox, J.G. Is exercise an evidence-based intervention for clinical depression in older adults: A meta-analysis of randomized studies 2000-2006 2008. OVID-PsycINFO.
Exclude: Not an eligible study design

Coyle C, Denault V, Miller R, et al. Understanding systematic reviews and their implications for evidence-based practice by examining aerobic exercise as a recreational therapy intervention for individuals with major depressive disorders. *Am J Rec Ther*. 2008;7(3):13-22. EBSCO-CINAHL.
Excluded - Systematic review - relevant topic, citations cross-matched

Craft LL, Freund KM, Culpepper L, et al. Intervention study of exercise for depressive symptoms in women. *J Womens Health*. 2007;16(10):1499-509. OVID-Embase.
Exclude: Not an eligible population treatment

Craft LL. Exercise and clinical depression: Examining two psychological mechanisms. *Psychol Sport Exerc*. 2005;6(2):151-71. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Craig AR, Hancock K, Chang E, et al. Immunizing against depression and anxiety after spinal cord injury. *Arch Phys Med Rehabil*. 1998;79(4):375-7. OVID-Embase.
Exclude: Not an eligible population treatment

Craigie MA, Nathan P. A nonrandomized effectiveness comparison of broad-spectrum group CBT to individual CBT for depressed outpatients in a community mental health setting. *Behav Ther*. 2009;40(3):302-14. PMID:19647531 OVID-Medline.
Exclude: Not an eligible population treatment

Crail-Melendez D, Herrera A, Ramfrez-Bermudez J, et al. Cognitive behavioral therapy for treatment of depression in patients with temporal lobe epilepsy. *Clin Neuropsychiatr*. 2010;7(1):22-7. OVID-Embase.
Exclude: Not an eligible study design

Creed F, Guthrie E, Ratcliffe J, et al. Does psychological treatment help only those patients with severe irritable bowel syndrome who also have a concurrent psychiatric disorder? *Aust NZ J Psychiatr*. 2005;39(9):807-15. PMID:16168039 OVID-Medline.
Exclude: Not an eligible population treatment

Criconia AM, Araquistain JM, Daffina N, et al. Results of treatment with s-adenosyl-l-methionine in patients with major depression and internal illnesses. *Curr Ther Res Clin Exp.* 1994;55(6):666-74. OVID-Embase.

Exclude: Not an eligible study design

Crismon ML, Trivedi M, Pigott TA, et al. The Texas medication algorithm project: Report of the Texas consensus conference panel on medication treatment of major depressive disorder. *J Clin Psychiatry.* 1999;60(3):142-56. OVID-Embase.

Exclude: Not an eligible guideline

Crits-Christoph P, Gibbons MBC, Temes CM, et al. Interpersonal accuracy of interventions and the outcome of cognitive and interpersonal therapies for depression. *J Consult Clin Psychol.* 2010;78(3):420-8. OVID-Embase.

Exclude: Not an eligible study design

Crossley NA, Bauer M. Acceleration and augmentation of antidepressants with lithium for depressive disorders: Two meta-analyses of randomized, placebo-controlled trials. *J Clin Psychiatr.* 2007;68(6):935-40. PMID:17592920 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Crowley JJ, Lipsky RH, Lucki I, et al. Variation in the genes encoding vesicular monoamine transporter 2 and beta-1 adrenergic receptor and antidepressant treatment outcome. *Psychiatr Genet.* 2008;18(5):248-51. PMID:18797399 OVID-Medline.

Exclude: For guideline, not a population of interest

Cruciani RA, Dvorkin E, Homel P, et al. L-carnitine supplementation for the treatment of fatigue and depressed mood in cancer patients with carnitine deficiency: A preliminary analysis. *Ann NY Acad Sci.* 2004;1033:168-76. PMID:15591014 OVID-Medline.

Exclude: Not an eligible study design

Cruess S, Antoni MH, Hayes A, et al. Changes in mood and depressive symptoms and related change processes during cognitive-behavioral stress management in HIV-infected men. *Cognit Ther Res.* 2002;26(3):373-92. OVID-Embase.

Exclude: Not an eligible population treatment

Cuijpers P. Prevention of depression in chronic general medical disorders: A pilot study. *Psychol Rep.* 1998;82(3:Pt 1):t-8 PMID:9676483 OVID-Medline.

Exclude: Not an eligible population treatment

Cuijpers P, van Lier PA, van Straten A, et al. Examining differential effects of psychological treatment of depressive disorder: An application of trajectory analyses. *J Affect Disord.* 2005;89(1-3):137-46. PMID:16274750 OVID-Medline.

Exclude: Not an eligible population treatment

Cuijpers P, Smit F, Voordouw I, et al. Outcome of cognitive behaviour therapy for minor depression in routine practice. *Psychol Psychother.* 2005;78(Pt:2):2-88. PMID:16004697 OVID-Medline.

Exclude: Not an eligible study design

Cuijpers P, van Straten A, Smit F. Psychological treatment of late-life depression: A meta-analysis of randomized controlled trials. *Int J Geriatr Psychiatry.* 2006;21(12):1139-49. PMID:16955421 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Smits N, et al. Screening and early psychological intervention for depression in schools: Systematic review and meta-analysis. *Eur Child Adolesc Psychiatry.* 2006;15(5):300-7. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Warmerdam L. Behavioral activation treatments of depression: A meta-analysis. *Clin Psychol Rev.* 2007;27(3):318-26. PMID:17184887 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Warmerdam L. Problem solving therapies for depression: A meta-analysis. *Eur Psychiatr.* 2007;22(1):9-15. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, Smit F, van Straten A. Psychological treatments of subthreshold depression: A meta-analytic review. *Acta Psychiatr Scand.* 2007;115(6):434-41. PMID:17498154 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Warmerdam L. Are individual and group treatments equally effective in the treatment of depression in adults? A meta-analysis. *Eur J Psychiatr.* 2008;22(1):38-51. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, van Oppen P, et al. Are psychological and pharmacologic interventions equally effective in the treatment of adult depressive disorders? A meta-analysis of comparative studies. *ÿ*. 2008;69(11):1675-85. PMID:18945396 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Warmerdam L, et al. Characteristics of effective psychological treatments of depression: A metaregression analysis. *Psychother Res*. 2008;18(2):225-36. PMID:18815968 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Warmerdam L, et al. Psychological treatment of depression: A meta-analytic database of randomized studies. *BMC Psychiatr*. 2008;8:Art No.:36 OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Andersson G, et al. Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *J Consult Clin Psychol*. 2008;76(6):909-22. PMID:19045960 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P. Review: Relaxation better than wait-list, minimal or no treatment for depression but not as good as psychological treatments. *Evid Based Ment Health*. 2009;12(3):76-7. EBSCO-CINAHL.

Exclude: Not an eligible study design

Cuijpers P, Dekker J, Hollon SD, et al. Adding psychotherapy to pharmacotherapy in the treatment of depressive disorders in adults: A meta-analysis. *ÿ*. 2009;70(9):1219-29. PMID:19818243 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, Munoz RF, Clarke GN, et al. Psychoeducational treatment and prevention of depression: The "Coping with Depression" course thirty years later. *Clin Psychol Rev*. 2009;29(5):449-58. PMID:19450912 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, van Schaik A, et al. Psychological treatment of depression in primary care: A meta-analysis. *Br J Gen Pract*. 2009;59(559):e51-e60 PMID:19192368 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Warmerdam L, et al. Psychotherapy versus the combination of psychotherapy and pharmacotherapy in the treatment of depression: A meta-analysis. *Depress Anxiety*. 2009;26(3):279-88. PMID:19031487 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, Smit F, Bohlmeijer E, et al. Efficacy of cognitive-behavioural therapy and other psychological treatments for adult depression: Meta-analytic study of publication bias. *Br J Psychiatr*. 2010;196:173-8. PMID:20194536 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Schuurmans J, et al. Psychotherapy for chronic major depression and dysthymia: A meta-analysis. *Clin Psychol Rev*. 2010;30(1):51-62. PMID:19781837 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Cuijpers P, van Straten A, Hollon SD, et al. The contribution of active medication to combined treatments of psychotherapy and pharmacotherapy for adult depression: A meta-analysis. *Acta Psychiatr Scand*. 2010;121(6):415-23. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Cukrowicz KC, Joiner J. Computer-based intervention for anxious and depressive symptoms in a non-clinical population. *Cognit Ther Res*. 2007;31(5):677-93. OVID-Embase.

Exclude: Not an eligible population treatment

Cukrowicz, K.C. Prevention of anxiety and depression 2008. OVID-PsycINFO.

Exclude: Not an eligible study design

Cullen, J.M. Testing the effectiveness of behavioral activation therapy in the treatment of acute unipolar depression 2003. OVID-PsycINFO.

Exclude: Not an eligible study design

Cullen M, Mitchell P, Brodaty H, et al. Carbamazepine for treatment-resistant melancholia. *J Clin Psychiatry*. 1991;52(11):472-6. PMID:1744065 OVID-Medline.

Exclude: Not an eligible study design

Cully JA, Stanley MA, Deswal A, et al. Cognitive-behavioral therapy for chronic cardiopulmonary conditions: Preliminary outcomes from an open trial. *Prim Care Comp J Clin Psychiatr*. 2010;12(4):e1-e6 OVID-Embase.

Exclude: Not an eligible study design

Cunningham J. The effects of exercise and relaxation training upon psychological variables in coronary heart patients 1980. OVID-PsycINFO.

Exclude: Not an eligible study design

Cunningham LA. Once-daily venlafaxine extended release (XR) and venlafaxine immediate release (IR) in outpatients with major depression. Venlafaxine XR 208 Study Group. *Ann Clin Psychiatr*.

1997;9(3):157-64. PMID:9339881 OVID-Medline.

Exclude: Not an eligible population treatment

Curry JF, Wells KC, Lochman JE, et al. Cognitive-behavioral intervention for depressed, substance-abusing adolescents: Development and pilot testing. *J Am Acad Child Adolesc Psychiatry*.

2003;42(6):656-65. PMID:12921473 OVID-Medline.

Exclude: Not an eligible study design

Exclude: Not an eligible study design

Cyranowski JM, Frank E, Shear MK, et al. Interpersonal psychotherapy for depression with panic spectrum symptoms: A pilot study. *Depress Anxiety*. 2005;21(3):140-2. PMID:15965998 OVID-Medline.

Exclude: Not an eligible study design

d'Elia G, Hallstrom T, Nystrom C, et al. Zimelidine vs maprotiline in depressed outpatients: A preliminary report. *Acta Psychiatr Scand Suppl*. 1981;290:225-35. PMID:6452793 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

da Silva TL, Ravindran LN, Ravindran AV. Yoga in the treatment of mood and anxiety disorders: A review. *Asian J Psychiatry*. 2009;2(1):6-16. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

da Silva TM, Munhoz RP, Alvarez C, et al. Depression in Parkinson's disease: A double-blind, randomized, placebo-controlled pilot study of omega-3 fatty-acid supplementation. *J Affect Disord*. 2008;111(2-3):351-9. PMID:18485485 OVID-Medline.

Exclude: Not an eligible population design

Dadkhah A, Raoufi MG. A Japanese treatment used in major depressive disorder in adolescence. *Percept Motor Skills*. 2007;105(2):531-8. EBSCO-CINAHL.

Exclude: Not an eligible study design

Dai Y, Zhang S, Yamamoto J, et al. Cognitive behavioral therapy of minor depressive symptoms in elderly Chinese Americans: A pilot study.

Community Ment Health J. 1999;35(6):537-42.

PMID:10863990 OVID-Medline.

Exclude: Not an eligible population treatment

Dalen J, Smith BW, Shelley BM, et al. Pilot study: Mindful Eating and Living (MEAL): Weight, eating behavior, and psychological outcomes associated with a mindfulness-based intervention for people with obesity. *Complement Ther Med*.

2010;18(6):260-4. EBSCO-CINAHL.

Exclude: Not an eligible study design

Daley A. Exercise and depression: A review of reviews. *J Clin Psychol Med Settings*.

2008;15(2):140-7. PMID:19104978 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Dallal A, Fontaine R, Ontiveros A, et al. Lithium carbonate augmentation of desipramine in refractory depression. *Can J Psychiatr*. 1990;35(7):608-11.

PMID:2125237 OVID-Medline.

Exclude: Not an eligible study design

Dalton EJ, Rotondi D, Levitan RD, et al. Use of slow-release melatonin in treatment-resistant depression. *J Psychiatr Neurosci*. 2000;25(1):48-52. PMID:10721684 OVID-Medline.

Exclude: Not an eligible study design

Dam J, Ryde L, Svejso J, et al. Morning fluoxetine plus evening mianserin versus morning fluoxetine plus evening placebo in the acute treatment of major depression. *Pharmacopsychiatr*. 1998;31(2):48-54. PMID:9562208 OVID-Medline.

Exclude: Not an eligible population treatment

Dana E.C. A cognitive-behavioral intervention for conduct-disordered and concurrently conduct-disordered and depressed children 1998. OVID-PsycINFO.

Exclude: Not an eligible study design

Dang MT. Walking away the blues: Exercise for depression in older adults. *Nurs*. 2010;40(11):33-6. EBSCO-CINAHL.

Exclude: Not an eligible population/treatment

Dannowski U, Baune BT, Bockermann I, et al. Adjunctive antidepressant treatment with quetiapine in agitated depression: Positive effects on symptom reduction, psychopathology and remission rates. *Hum Psychopharmacol*. 2008;23(7):587-93.

PMID:18663773 OVID-Medline.

Exclude: Not an eligible population treatment

Darbinyan V, Aslanyan G, Amroyan E, et al. Clinical trial of Rhodiola rosea L. extract SHR-5 in the treatment of mild to moderate depression. *Nord J Psychiatr.* 2007;61(5):343-8. PMID:17990195 OVID-Medline.

Exclude: Not an eligible population treatment

Darewych O. The effectiveness of art psychotherapy on self-esteem, self-concept, and depression in children with glaucoma. *Can Art Ther Assoc J.* 2009;22(2):2-17. EBSCO-CINAHL.

Exclude: Not an eligible study design

Daughters SB, Braun AR, Sargeant MN, et al. Effectiveness of a brief behavioral treatment for inner-city illicit drug users with elevated depressive symptoms: The life enhancement treatment for substance use (LETS Act!). *J Clin Psychiatry.* 2008;69(1):122-9. PMID:18312046 OVID-Medline.

Exclude: Not an eligible population treatment

David-Ferdon C, Kaslow NJ. Evidence-based psychosocial treatments for child and adolescent depression. *J Clin Child Adolesc Psychol.* 2008;37(1):62-104. OVID-PsycINFO.

Excluded - Systematic review - relevant topic, citations cross-matched

David D, Szentagotai A, Lupu V, et al. Rational emotive behavior therapy, cognitive therapy, and medication in the treatment of major depressive disorder: A randomized clinical trial, posttreatment outcomes, and six-month follow-up. *J Clin Psychiatry.* 2008;64(6):728-46. PMID:18473339 OVID-Medline.

Exclude: Not an eligible population treatment

Davidson JR, Morrison RM, Shore J, et al. Homeopathic treatment of depression and anxiety. *Altern Ther Health Med.* 1997;3(1):46-9. PMID:8997804 OVID-Medline.

Exclude: Not an eligible study design

Davidson JR, Abraham K, Connor KM, et al. Effectiveness of chromium in atypical depression: A placebo-controlled trial. *Biol Psychiatry.* 2003;53(3):261-4. Wiley-CCTR.

Exclude: Not an eligible population treatment

Davidson KW, Rieckmann N, Clemow L, et al. Enhanced depression care for patients with acute coronary syndrome and persistent depressive symptoms: Coronary psychosocial evaluation studies randomized controlled trial. *Arch Intern Med.* 2010;170(7):600-8. PMID:20386003 OVID-Medline.

Exclude: Not an eligible population treatment

Davidson O, King M, Sharpe D, et al. A pilot randomized trial evaluating GP registrar management of major depression following brief training in cognitive behaviour therapy. *Educ Gen Pract.* 1999;10(4):485-8. OVID-Embase.

Exclude: Not an eligible study design

Davis GR, Armstrong HE, Donovan DM, et al. Cognitive-behavioral treatment of depressed affect among epileptics: Preliminary findings. *J Clin Psychiatry.* 1984;40(4):930-5. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Davis LL, Wisniewski SR, Howland RH, et al. Does comorbid substance use disorder impair recovery from major depression with SSRI treatment? An analysis of the STAR*D level one treatment outcomes. *Drug Alcohol Dependence.* 2010;107(2-3):161-70. PMID:19945804 OVID-Medline.

Exclude: Not an eligible population treatment

Davis L, Barlow DH, Smith L. Comorbidity and the treatment of principal anxiety disorders in a naturalistic sample. *Behav Ther.* 2010;41(3):296-305. OVID-PsycINFO.

Exclude: Not an eligible study design

de Carvalho MR, Sato EI, Tebexreni AS, et al. Effects of supervised cardiovascular training program on exercise tolerance, aerobic capacity, and quality of life in patients with systemic lupus erythematosus. *ÿÿ.* 2005;53(6):838-44. OVID-PsycINFO.

Exclude: Not an eligible population treatment

De Cuyper S, Timbremont B, Braet C, et al. Treating depressive symptoms in schoolchildren: A pilot study. *Eur Child Adolesc Psychiatry.* 2004;13(2):105-14. PMID:15103536 OVID-Medline.

Exclude: Not an eligible population treatment

de Godoy DV, de Godoy RF. A randomized controlled trial of the effect of psychotherapy on anxiety and depression in chronic obstructive pulmonary disease. *Arch Phys Med Rehab.* 2003;84(8):1154-7. PMID:12917854 OVID-Medline.

Exclude: Not an eligible population treatment

de Graaf LE, Gerhards SA, Evers SM, et al. Clinical and cost-effectiveness of computerised cognitive behavioural therapy for depression in primary care: Design of a randomised trial. *BMC Pub Health.* 2008;8:224 PMID:18590518 OVID-Medline.

Exclude: Not an eligible study design

de Graaf LE, Gerhards SA, Arntz A, et al. Clinical effectiveness of online computerised cognitive-behavioural therapy without support for depression in primary care: Randomised trial. *Br J Psychiatr*. 2009;195(1):73-80. PMID:19567900 OVID-Medline.

Exclude: Not an eligible population treatment

de Graaf LE, Huibers MJ, Riper H, et al. Use and acceptability of unsupported online computerized cognitive behavioral therapy for depression and associations with clinical outcome. *J Affect Disord*. 2009;116(3):227-31. PMID:19167094 OVID-Medline.

Exclude: Not an eligible population treatment

de Graaf LE, Gerhards SA, Arntz A, et al. One-year follow-up results of unsupported online computerized cognitive behavioural therapy for depression in primary care: A randomized trial. *J Behav Ther Exp Psychiatr*. 2011;42(1):89-95. PMID:20723885 OVID-Medline.

Exclude: Not an eligible population treatment

De Groot M, Kushnick M, Doyle T, et al. A model of community-based behavioral intervention for depression in diabetes: Program ACTIVE. *Diabetes Spectrum*. 2010;23(1):18-25. OVID-Embase.

Exclude: Not an eligible study design

De Groot M, Kushnick M, Doyle T, et al. From research to practice/diabetes and depression: Challenges and some opportunities. A model of community-based behavioral intervention for depression in diabetes: Program ACTIVE. *Appalachians Coming Together to Increase Vital Exercise*. *Diabetes Spectrum*. 2010;23(1):18-25. EBSCO-CINAHL.

Exclude: Not an eligible study design

de Jong R, Treiber R, Henrich G. Effectiveness of two psychological treatments for inpatients with severe and chronic depression. *Cognit Ther Res*. 1986;(10):645-63. Exclude: Not an eligible population treatment

de Jonghe F, Kool S, van Aalst G, et al. Combining psychotherapy and antidepressants in the treatment of depression. *J Affect Disord*. 2001;64(2-3):217-29. PMID:11313088 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

de Jonghe F, Hendricksen M, van Aalst G, et al. Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *Br J Psychiatr*. 2004;185:37-45. PMID:15231554 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

De Leo D. S-adenosyl-L-methionine (SAMe) in clinical practice: Preliminary report on 75 minor depressives. *Curr Ther Res Clin Exp*. 1985;37(4):658-61. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

De Leo D. S-Adenosylmethionine as an antidepressant: A double-blind trial versus placebo. *Curr Ther Res Clin Exp*. 1987;41(6):865-70. OVID-Embase.

Exclude: Not an eligible population treatment

de Maat S, Dekker J, Schoevers R, et al. Relative efficacy of psychotherapy and pharmacotherapy in the treatment of depression: A meta-analysis. *Psychother Res*. 2006;16(5):566-78. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

de Maat S, Dekker J, Schoevers R, et al. Short psychodynamic supportive psychotherapy, antidepressants, and their combination in the treatment of major depression: A mega-analysis based on three randomized clinical trials. *Depress Anxiety*. 2008;25(7):565-74. PMID:17557313 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

de Man-van Ginkel JM, Gooskens F, Schuurmans MJ, et al. A systematic review of therapeutic interventions for poststroke depression and the role of nurses. *J Clin Nurs*. 2010;19(23-24):3274-90. PMID:21083778 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

De Mello MF, Myczcowisk LM, Menezes PR. A randomized controlled trial comparing moclobemide and moclobemide plus interpersonal psychotherapy in the treatment of dysthymic disorder. *J Psychother Pract Res*. 2001;(10):117-23. Exclude: Not an eligible population treatment

De Mello MF, de Jesus MJ, Bacaltchuk J, et al. A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. *Eur Arch Psychiatry Clin Neurosci*. 2005;255(2):75-82. PMID:15812600 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

de Montigny C, Grunberg F, Mayer A, et al. Lithium induces rapid relief of depression in tricyclic antidepressant drug non-responders. *Br J Psychiatr*. 1981;138:252-6. PMID:7272619 OVID-Medline. Exclude: Not an eligible study design

de Montigny C, Cournoyer G, Morissette R, et al. Lithium carbonate addition in tricyclic antidepressant-resistant unipolar depression: Correlations with the neurobiologic actions of tricyclic antidepressant drugs and lithium ion on the serotonin system. *Arch Gen Psychiatr*. 1983;40(12):1327-34. Wiley-CCTR.

Exclude: Not an eligible study design

de Montigny C, Elie R, Caille G. Rapid response to the addition of lithium in iprindole-resistant unipolar depression: A pilot study. *Am J Psychiatry*. 1985;142(2):220-3. PMID:3918468 OVID-Medline.

Exclude: Not an eligible study design

de Montigny C, Silverstone PH, Debonnel G, et al. Venlafaxine in treatment-resistant major depression: A Canadian multicenter, open-label trial. *J Clin Psychopharmacol*. 1999;19(5):401-6. PMID:10505581 OVID-Medline.

Exclude: Not an eligible study design

de Piano FA, de Piano LC, Carter W, et al. Physical fitness training: Adjunctive treatment for the depressed, low self esteem and muscular tense patient. *Psychother Private Pract*. 1984;2(3):75-83. OVID-PsycINFO.

Exclude: Not an eligible population treatment

De Vanna M, Rigamonti R. Oral S-adenosyl-L-methionine in depression. *Curr Ther Res Clin Exp*. 1992;52(3):478-85. OVID-Embase.

Exclude: Not an eligible population treatment

De Zeeuw ELEJ, Tak ECPM, Dusseldorp E, et al. Workplace exercise intervention to prevent depression: A pilot randomized controlled trial. *Ment Health Phys Activ*. 2010;3(2):72-7. OVID-Embase.

Exclude: Not an eligible population/treatment

de Zwaan M, Schonbeck G, Nutzinger D, et al. Fluvoxamine and behavior therapy in the treatment of depressed obese. *Pharmacopsychiatr*. 1989;22(5):223 OVID-Embase.

Exclude: Not an eligible study design

de Zwaan M, Nutzinger DO, Schoback G, et al. The scientific dialogue: From basic research to clinical intervention., Lisse, Netherlands:Swets & Zeitlinger Publishers;1990. Pharmacotherapy in behavioral treatment for depressed obese. OVID-PsycINFO.

Exclude: Not an eligible study design.

Dean-Clower E, Doherty-Gilman AM, Keshaviah A, et al. Acupuncture as palliative therapy for physical symptoms and quality of life for advanced cancer patients. *Integr Canc Ther*. 2010;9(2):158-67. OVID-Embase.

Exclude: Not an eligible study design

Deas D, Randall CL, Roberts JS, et al. A double-blind, placebo-controlled trial of sertraline in depressed adolescent alcoholics: A pilot study. *Hum Psychopharmacol*. 2000;15(6):461-9. OVID-Embase.

Exclude: Not an eligible population treatment

DeBattista C, Lembke A, Solvason HB, et al. A prospective trial of modafinil as an adjunctive treatment of major depression. *J Clin Psychopharmacol*. 2004;24(1):87-90. PMID:14709953 OVID-Medline.

Exclude: Not an eligible study design

DeBattista C, Solomon A, Arnow B, et al. The efficacy of divalproex sodium in the treatment of agitation associated with major depression. *J Clin Psychopharmacol*. 2005;25(5):476-9. PMID:16160625 OVID-Medline.

Exclude: Not an eligible study design

DeBattista C, Kinrys G, Hoffman D et al. Referenced-EEG (rEEG) efficacy compared to STAR*D for patients with depression treatment failure: A first look at final results. *CNS Response, Inc.*; 2009. Excluded

DeBattista C, Kinrys G, Hoffman D, et al. The use of referenced-EEG (rEEG) in assisting medication selection for the treatment of depression. *J Psychiatr Res*. 2011;45(1):64-75. OVID-Embase.

Exclude: Mixed antidepressants; some failed on SSRI

DeBattista C, Solvason HB, Poirier J, et al. A prospective trial of bupropion SR augmentation of partial and non-responders to serotonergic antidepressants. *J Clin Psychopharmacol*. 2003;23(1):27-30. OVID-PsycINFO.

Exclude: Not an eligible study design

Deberry S, Davis S, Reinhard KE. A comparison of meditation-relaxation and cognitive/behavioral techniques for reducing anxiety and depression in a geriatric population. *J Geriatr Psychiatry*. 1989;22(2):231-47. PMID:2701175 OVID-Medline.

Exclude: Not an eligible population treatment

DeBerry S. The effects of meditation-relaxation on anxiety and depression in a geriatric population. *Psychother Theory Res Pract*. 1982;19(4):512-21. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Dekker J, Molenaar PJ, Kool S, et al. Dose-effect relations in time-limited combined psychopharmacological treatment for depression. *Psychol Med*. 2005;35(1):47-58. PMID:15842028 OVID-Medline.

Exclude: Not an eligible population treatment

Dekker JJ, Koelen JA, Van HL, et al. Speed of action: the relative efficacy of short psychodynamic supportive psychotherapy and pharmacotherapy in the first 8 weeks of a treatment algorithm for depression. *J Affect Disord.* 2008;109(1-2):183-8. PMID:18061276 Exclude: Not an eligible population treatment

Del Vecchio M, Amati A, Vacca L, et al. Monitoring S-adenosyl-methionine blood levels and antidepressant effect. *Acta Neurol.* 1980;2(6):488-95. PMID:7027755 OVID-Medline. Exclude: Not an eligible study design

DelBello MP, Adler CM, Whitsel RM, et al. A 12-week single-blind trial of quetiapine for the treatment of mood symptoms in adolescents at high risk for developing bipolar I disorder. *J Clin Psychiatry.* 2007;68(5):789-95. OVID-Embase. Exclude: Not an eligible study design

Delgado PL, Price LH, Charney DS, et al. Efficacy of fluvoxamine in treatment-refractory depression. *J Affect Disord.* 1988;15(1):55-60. PMID:2970493 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Delle CR, Pancheri P, Scapicchio P. Efficacy and tolerability of oral and intramuscular S-adenosyl-L-methionine 1,4-butanedisulfonate (SAME) in the treatment of major depression: Comparison with imipramine in 2 multicenter studies. *Am J Clin Nutr.* 2002;76(5):1172S-6S. PMID:12418499 OVID-Medline. Excluded

Deltito JA, Moline M, Pollak C, et al. Effects of phototherapy on non-seasonal unipolar and bipolar depressive spectrum disorders. *J Affect Disord.* 1991;23(4):231-7. PMID:1791269 OVID-Medline. Exclude: Not an eligible population treatment

den Boer PC, Wiersma D, Ten V, I, et al. Cognitive self-therapy for chronic depression and anxiety: A multi-centre randomized controlled study. *Psychol Med.* 2007;37(3):329-39. PMID:17076917 OVID-Medline. Exclude: Not an eligible population treatment

Denko TC, Friedman ES. Augmentation strategies in Star*D: A review. *Prim Psychiatry.* 2007;14(1):46-50. OVID-PsycINFO. Exclude: Not an eligible population treatment

DeRubeis RJ, Hollon SD, Evans MD, et al. Can psychotherapies for depression be discriminated? A systematic investigation of cognitive therapy and interpersonal therapy. *J Consult Clin Psychol.* 1982;50(5):744-56. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

DeRubeis RJ, Hollon SD, Amsterdam JD, et al. Cognitive therapy vs medications in the treatment of moderate to severe depression. *Arch Gen Psychiatry.* 2005;62(4):409-16. PMID:15809408 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Descilo T, Vedamurtachar A, Gerbarg PL, et al. Effects of a yoga breath intervention alone and in combination with an exposure therapy for post-traumatic stress disorder and depression in survivors of the 2004 South-East Asia tsunami. *Acta Psychiatrica Scand.* 2010;121(4):289-300. OVID-Embase. Exclude: Not an eligible population treatment

Deshmukh AD, Sarvaiya AA, Nayak AS. Effect of Indian classical music on quality of sleep in depressed patients: a randomized controlled trial. *Nord J Music Ther.* 2009;18(1):70-8. EBSCO-CINAHL. Exclude: Not an eligible population treatment

Deslandes AC, Moraes H, Alves H, et al. Effect of aerobic training on EEG alpha asymmetry and depressive symptoms in the elderly: A 1-year follow-up study. *Braz J Med Biol Res.* 2010;43(6):585-92. PMID:20464340 OVID-Medline. Exclude: Not an eligible population treatment

Dessauer M, Goetze U, Tolle R. Periodic sleep deprivation in drug-refractory depression. *Neuropsychobiology.* 1985;13(3):111-6. PMID:3900797 OVID-Medline. Exclude: Not an eligible population treatment

Dessaules A, Johnson SM, Denton WH. Emotion-focused therapy for couples in the treatment of depression: A pilot study. *Am J Fam Ther.* 2003;31(5):345-53. OVID-Embase. Exclude: Not an eligible population treatment

Dew MA, Reynolds CF, III, Mulsant B, et al. Initial recovery patterns may predict which maintenance therapies for depression will keep older adults well. *J Affect Disord.* 2001;65(2):155-66. PMID:11356239 OVID-Medline. Exclude: Not an eligible population treatment

Dew MA, Whyte EM, Lenze EJ, et al. Recovery from major depression in older adults receiving augmentation of antidepressant pharmacotherapy. *Am J Psychiatry*. 2007;164(6):892-9. PMID:17541048 OVID-Medline.

Exclude: Not an eligible population treatment

Dhooper SS, Green SM, Huff MB, et al. Efficacy of a group approach to reducing depression in nursing home elderly residents. *J Gerontol Soc Work*. 1993;(20):87-100. Exclude: Not an eligible population treatment

Di Giulio G. Therapist, client factors, and efficacy in cognitive behavioural therapy: A meta-analytic exploration of factors that contribute to positive outcome 2010. OVID-PsycINFO.

Excluded - Systematic review - relevant topic, citations cross-matched

Di Palma C, Urani R, Agricola R, et al. Is methylfolate effective in relieving major depression in chronic alcoholics? A hypothesis of treatment. *Curr Ther Res Clin Exp*. 1994;55(5):559-68. OVID-Embase.

Exclude: Not an eligible study design

Di Rocco A, Rogers JD, Brown R, et al. S-Adenosyl-Methionine improves depression in patients with Parkinson's disease in an open-label clinical trial. *Mov Disord*. 2000;15(6):1225-9. PMID:11104210 OVID-Medline.

Exclude: Not an eligible study design

Diamond G, Josephson A. Family-based treatment research: A 10-year update. *J Am Acad Child Adolesc Psychiatry*. 2005;44(9):872-87. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Diamond GS, Reis BF, Diamond GM, et al. Attachment-based family therapy for depressed adolescents: A treatment development study. *J Am Acad Child Adolesc Psychiatry*. 2002;41(10):1190-6. PMID:12364840 Exclude: Not an eligible population treatment

Diamond S, Baltes BJ. The office treatment of mixed anxiety and depression with combination therapy. *Psychosom*. 1969;10(6):360-5. Wiley-CCTR. Exclude: Not an eligible population treatment

Dias RS, Kerr-Correa F, Moreno RA, et al. Efficacy of hormone therapy with and without methyltestosterone augmentation of venlafaxine in the treatment of postmenopausal depression: A double-blind controlled pilot study. *Menopause*. 2006;13(2):202-11. PMID:16645534 OVID-Medline.

Exclude: Not an eligible population treatment

Diaz A, Fouilloux C, Ortiz S. Open trial study of a combined antidepressant (amitriptyline, perphenazine, diazepam) versus fluoxetine or imipramine in ambulatory depressed patients. *Proc West Pharmacol Soc*. 2002;45:154-5. PMID:12434564 OVID-Medline.

Exclude: Not an eligible population treatment

Diazgranados N, Ibrahim LA, Brutsche NE, et al. Rapid resolution of suicidal ideation after a single infusion of an N-methyl-D-aspartate antagonist in patients with treatment-resistant major depressive disorder. *J Clin Psychiatr*. 2010;71(12):1605-11. PMID:20673547 OVID-Medline.

Exclude: Not an eligible study design

Dichter GS, Felder JN, Smoski MJ. The effects of Brief Behavioral Activation Therapy for Depression on cognitive control in affective contexts: An fMRI investigation. *J Affect Disord*. 2010;126(1-2):236-44. PMID:20421135 OVID-Medline.

Exclude: Not an eligible population treatment

Diego MA, Field T, Hernandez-Reif M, et al. HIV adolescents show improved immune function following massage therapy. *Int J Neurosci*. 2001;106(1-2):35-45. Wiley-CCTR.

Exclude: Not an eligible population treatment

Dierick M, Ravizza L, Realini R, et al. A double-blind comparison of venlafaxine and fluoxetine for treatment of major depression in outpatients. *Prog Neuropsychopharmacol Biol Psychiatry*. 1996;20(1):57-71. PMID:8861177 OVID-Medline.

Exclude: Not an eligible population treatment

Dietrich DE, Bode L, Spannhuth CW, et al. Amantadine in depressive patients with Borna disease virus (BDV) infection: An open trial. *Bipolar Disorders*. 2000;2(1):65-70. PMID:11254023 OVID-Medline.

Exclude: Not an eligible study design

Dietz LJ, Mufson L, Irvine H, et al. Family-based interpersonal psychotherapy for depressed preadolescents: An open-treatment trial. *Early Interv Psychiatr*. 2008;2(3):154-61. OVID-Embase. Exclude: Not an eligible population treatment

DiMascio A, Weissman MM, Prusoff BA, et al. Differential symptom reduction by drugs and psychotherapy in acute depression. *Arch Gen Psychiatr*. 1979;36(13):1450-6. Wiley-CCTR. Exclude: Not an eligible population treatment

Dimeo F, Bauer M, Varahram I, et al. Benefits from aerobic exercise in patients with major depression: A pilot study. *Br J Sports Med*. 2001;35(2):114-7. PMID:11273973 OVID-Medline. Exclude: Not an eligible study design

Dimidjian S. Behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of major depression 2005. OVID-PsycINFO. Exclude: Not an eligible study design

Dimidjian S, Hollon SD, Dobson KS, et al. Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *J Consult Clin Psychol*. 2006;74(4):658-70. PMID:16881773 OVID-Medline. Exclude: Not an eligible population treatment

Dimitriou EC, Logothetis JA, Paschalidou M. A double blind comparative study of mianserin and a fixed combination of amitriptyline plus clordiazepoxide. *Adv Biochem Psychopharmacol*. 1982;32:213-22. PMID:7046365 OVID-Medline. Exclude: Not an eligible population treatment

Dimitriou EC, Dimitriou CE. Buspirone augmentation of antidepressant therapy. *J Clin Psychopharmacol*. 1998;18(6):465-9. PMID:9864079 OVID-Medline. Exclude: Not an eligible study design

Dinan TG, Barry S. A comparison of electroconvulsive therapy with a combined lithium and tricyclic combination among depressed tricyclic nonresponders. *Acta Psychiatr Scand*. 1989;80(1):97-100. PMID:2504034 OVID-Medline. Exclude: Not an eligible population treatment

Dinan TG, Scott LV. Does pindolol induce a rapid improvement in depressed patients resistant to serotonin reuptake inhibitors? *J Serotonin Res*. 1996;3(3):119-21. OVID-Embase. Exclude: Not an eligible study design

Dinan TG, Lavelle E, Cooney J, et al. Dexamethasone augmentation in treatment-resistant depression. *Acta Psychiatr Scand*. 1997;95(1):58-61. PMID:9051162 OVID-Medline. Exclude: Not an eligible study design

Ditzler K, Gessner B, Schatton WFH, et al. Clinical trial on Neurapas versus placebo in patients with mild to moderate depressive symptoms: A placebo-controlled, randomised double-blind study. Phase IV: Clinical trial. *Complement Ther Med*. 1994;2(1):5-13. OVID-Embase. Exclude: Not an eligible population treatment

Dixon M. Does 'healing' benefit patients with chronic symptoms? A quasi-randomized trial in general practice. *J R Soc Med*. 1998;91(4):183-8. PMID:9659302 OVID-Medline. Exclude: Not an eligible population treatment

Dixon R, Cohen J. Steady state plasma concentration profiles and therapeutic response in anxious-depressed outpatients after administration of a clordiazepoxide-amitriptyline combination. *J Clin Psychopharmacol*. 1983;3(2):107-9. OVID-Embase.

OVID-Embase. Exclude: Not an eligible study design

Dobbin A, Maxwell M, Elton R. A benchmarked feasibility study of a self-hypnosis treatment for depression in primary care. *Int J Clin Exp Hypnosis*. 2009;57(3):293-318. PMID:19459090 OVID-Medline. Exclude: Not an eligible population treatment

Dobia B, McMurray NE. Applicability of learned helplessness to depressed women undergoing assertion training. *Aust J Psychol*. 1985;37(1):71-80. OVID-PsycINFO. Exclude: Not an eligible population treatment

Dobkin RD, Menza M, Marin H, et al. Bupropion improves sexual functioning in depressed minority women: An open-label switch study. *J Clin Psychopharmacol*. 2006;26(1):21-6. PMID:16415700 OVID-Medline. Exclude: Not an eligible study design

Dobkin RD, Allen LA, Alloy LB, et al. Adaptive inferential feedback partner training for depression: A pilot study. *Cognit Behav Pract*. 2007;14(4):350-63. OVID-Embase. Exclude: Not an eligible study design

Dobkin RD, Allen LA, Menza M. Cognitive-behavioral therapy for depression in Parkinson's disease: A pilot study. *Mov Disord*. 2007;22(7):946-52. OVID-Embase. Exclude: Not an eligible study design

Dobson KS, Hollon SD, Dimidjian S, et al. Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the prevention of relapse and recurrence in major depression. *J Consult Clin Psychol*. 2008;76(3):468-77. PMID:18540740 OVID-Medline.

Exclude: Not an eligible population treatment

Dobson KS, Hopkins JA, Fata L, et al. The prevention of depression and anxiety in a sample of high-risk adolescents: A randomized controlled trial. *Can J School Psychol*. 2010;25(4):291-310. OVID-PsycINFO.

Exclude: Not an eligible population/treatment

Docherty JP, Sack DA, Roffman M, et al. A double-blind, placebo-controlled, exploratory trial of chromium picolinate in atypical depression: Effect on carbohydrate craving. *J Psychiatr Pract*. 2005;11(5):302-14. Wiley-CCTR.

Exclude: Not an eligible population treatment

Dodd S HDMGeal. To combine or not to combine? A literature review of antidepressant combination therapy. *J Affect Disord*. 2005;(89):1-11. Excluded - Systematic review - relevant topic, citations cross-matched

Doggrell SA. Fluoxetine - Do the benefits outweigh the risks in adolescent major depression? *Expert Opin Pharmacother*. 2005;6(1):147-50. OVID-Embase.

Exclude: Not an eligible study design

Dolezal-Wood S, Belar CD, Snibbe J. A comparison of computer-assisted psychotherapy and cognitive-behavioral therapy in groups. *J Clin Psychol Med Settings*. 1998;5(1):103-15. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Dombrovski AY, Blakesley-Ball RE, Mulsant BH, et al. Speed of improvement in sleep disturbance and anxiety compared with core mood symptoms during acute treatment of depression in old age. *Am J Geriatr Psychiatry*. 2006;14(6):550-4. PMID:16731725 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Dombrovski AY, Lenze EJ, Dew MA, et al. Maintenance treatment for old-age depression preserves health-related quality of life: A randomized, controlled trial of paroxetine and interpersonal psychotherapy. *J Am Geriatr Soc*. 2007;55(9):1325-32. PMID:17767673 OVID-Medline.

Exclude: Not an eligible population treatment

Dominguez RA, Jacobson AF, Goldstein BJ, et al. Comparison of triazolam and placebo in the treatment of insomnia in depressed patients. *Curr Ther Res Clin Exp*. 1984;36(5 I):856-65. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Domino ME, Burns BJ, Silva SG, et al. Cost-effectiveness of treatments for adolescent depression: Results from TADS. *Am J Psychiatry*. 2008;165(5):588-96. PMID:18413703 OVID-Medline.

Exclude: Not an eligible population treatment

Domino ME, Foster EM, Vitiello B, et al. Relative cost-effectiveness of treatments for adolescent depression: 36-week results from the TADS randomized trial. *J Am Acad Child Adolesc Psychiatry*. 2009;48(7):711-20. PMID:19465880 OVID-Medline.

Exclude: Not an eligible population treatment

Domschke K, Lawford B, Laje G, et al. Brain-derived neurotrophic factor (BDNF) gene: No major impact on antidepressant treatment response. *Int J Neuropsychopharmacol*. 2010;13(1):93-101. PMID:19236730 OVID-Medline.

Exclude: Not an eligible population treatment

Dong JT. Research on the reduction of anxiety and depression with acupuncture. *Am J Acupunc*. 1993;21(4):327-30. OVID-Embase.

Exclude: Not an eligible study design

Doree J P, Tourjman S V, Kunicki S and others. Comparison of quetiapine versus lithium treatment of resistant depression. In 2004. Wiley-CCTR.

Exclude: Not an eligible study design

Dorée JP, Des RJ, Lew V, et al. Quetiapine augmentation of treatment-resistant depression: A comparison with lithium. *Curr Med Res Opin*. 2007;23(2):333-41. Wiley-CCTR.

Exclude: Mixed antidepressants:some failed on SSRI

Dornseif BE, Dunlop SR, Potvin JH, et al. Effect of dose escalation after low-dose fluoxetine therapy. *Psychopharmacol Bull*. 1989;25(1):71-9. PMID:2672072 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Dowrick C, Dunn G, Ayuso-Mateos JL, et al. Problem solving treatment and group psychoeducation for depression: Multicentre randomised controlled trial. Outcomes of Depression International Network (ODIN) Group. *Br Med J*. 2000;321(7274):1450-4. PM:11110739 Exclude: Not an eligible population treatment

Doyme EJ, Ossip-Klein DJ, Bowman ED, et al. Running versus weight lifting in the treatment of depression. *J Consult Clin Psychol.* 1987;55(5):748-54. PMID:3454786 OVID-Medline.

Exclude: Not an eligible population treatment

Dozois DJ, Bieling PJ, Patelis-Siotis I, et al. Changes in self-schema structure in cognitive therapy for major depressive disorder: A randomized clinical trial. *J Consult Clin Psychol.* 2009;77(6):1078-88. PMID:19968384 OVID-Medline.

Exclude: Not an eligible population treatment

Drago F, Motta A, Grossi E. Intravenous maprotiline in severe and resistant primary depression: A double-blind comparison with clomipramine. *J Int Med Res.* 1983;11(2):78-84. Wiley-CCTR.

Exclude: Not an eligible population treatment

Driessen E, Van HL, Schoevers RA, et al. Cognitive Behavioral Therapy versus Short Psychodynamic Supportive Psychotherapy in the outpatient treatment of depression: A randomized controlled trial. *BMC Psychiatr.* 2007;7:58 PMID:17963493 OVID-Medline.

Exclude: Not an eligible study design

Driessen E, Cuijpers P, Hollon SD, et al. Does pretreatment severity moderate the efficacy of psychological treatment of adult outpatient depression? A meta-analysis. *J Consult Clin Psychol.* 2010;78(5):668-80. PMID:20873902 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Driessen E, Cuijpers P, de Maat SCM, et al. The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clin Psychol Rev.* 2010;30(1):25-36. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Driscoll HC, Basinski J, Mulsant BH, et al. Late-onset major depression: Clinical and treatment-response variability. *Int J Geriatr Psychiatry.* 2005;20(7):661-7. PMID:16021664 OVID-Medline.

Exclude: Not an eligible study design

Driver S, Ede A. Impact of physical activity on mood after TBI. *Brain Inj.* 2009;23(3):203-12. OVID-Embase.

Exclude: Not an eligible population treatment

Duan D-M, Tu Y, Jiao S, et al. The relevance between symptoms and magnetic resonance imaging analysis of the hippocampus of depressed patients given electro-acupuncture combined with fluoxetine intervention - A randomized, controlled trial. *Chin J Integrat Med.* 2011;17(3):190-9. OVID-Embase.

Exclude: Not an eligible population/treatment

Duan DM, Tu Y, Chen LP, et al. Efficacy evaluation for depression with somatic symptoms treated by electroacupuncture combined with Fluoxetine. *J Tradit Chin Med.* 2009;29(3):167-73. PMID:19894377 OVID-Medline.

Exclude: Not an eligible population treatment

Duarte PS, Miyazaki MC, Blay SL, et al. Cognitive-behavioral group therapy is an effective treatment for major depression in hemodialysis patients. *Kidney Int.* 2009;76(4):414-21. OVID-Embase.

Exclude: Not an eligible population treatment

Dube S, Dube S, Andersen S W and others. Olanzapine-fluoxetine for treatment-resistant depression. In 2002. Wiley-CCTR.

Exclude: Not an eligible study design

Dube S, Andersen S W, Paul S and others. Meta-analysis of olanzapine-fluoxetine in treatment-resistant depression. In 2002. Wiley-CCTR.

Exclude: Not an eligible study design

Dubicka B, Elvins R, Roberts C, et al. Combined treatment with cognitive-behavioural therapy in adolescent depression: Meta-analysis. *Br J Psychiatr.* 2010;197(6):433-40. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Dubovsky SL, Buzan R, Thomas M, et al. Nicardipine improves the antidepressant action of ECT but does not improve cognition. *J ECT.* 2001;17(1):3-10. PMID:11281512 OVID-Medline.

Exclude: Not an eligible population treatment

Dudley DL, Volberding N, Loebel P. Intravenous chlorimipramine and refractory depression. *Gen Hosp Psychiatry.* 1980;2(1):61-4. PMID:7380252 OVID-Medline.

Exclude: Not an eligible study design

Dudley M, Hadzi-Pavlovic D, Andrews D, et al. New-generation antidepressants, suicide and depressed adolescents: How should clinicians respond to changing evidence? *Aust NZ J Psychiatr.* 2008;42(6):456-66. PMID:18465372 OVID-Medline.

Exclude: Not an eligible study design

Duffy SA, Ronis DL, Valenstein M, et al. A tailored smoking, alcohol, and depression intervention for head and neck cancer patients. *Cancer Epidemiol Biomarkers Prev.* 2006;15(11):2203-8.

PMID:17119047 OVID-Medline.

Exclude: Not an eligible population treatment

Dufresne RL, Kass DJ, Becker RE. Bupropion and thiothixene versus placebo and thiothixene in the treatment of depression in schizophrenia. *Drug Dev Res.* 1988;12(3-4):259-66. OVID-Embase.

Exclude: Not an eligible population treatment

Dujovne, V.F. Comparison of cognitive-behavioral to pharmacological treatment of depression in prepubertal children 1994. OVID-PsycINFO.

Exclude: Not an eligible study design

Dunlop BW, Crits-Christoph P, Evans DL, et al. Coadministration of modafinil and a selective serotonin reuptake inhibitor from the initiation of treatment of major depressive disorder with fatigue and sleepiness: a double-blind, placebo-controlled study. *J Clin Psychopharmacol.* 2007;27(6):614-9. PMID:18004129 OVID-Medline.

Exclude: Not an eligible population treatment

Dunn AL, Trivedi MH, Kampert JB, et al. The DOSE study: A clinical trial to examine efficacy and dose response of exercise as treatment for depression. *Control Clin Trials.* 2002;23(5):584-603. Exclude: Not an eligible study design

Dunn AL, Trivedi MH, Kampert JB, et al. Exercise treatment for depression: Efficacy and dose response. *Am J Prev Med.* 2005;28(1):1-8. PMID:15626549 OVID-Medline.

Exclude: Not an eligible population treatment

Dunn NJ, Rehm LP, Schillaci J, et al. A randomized trial of self-management and psychoeducational group therapies for comorbid chronic posttraumatic stress disorder and depressive disorder. *J Trauma Stress.* 2007;20(3):221-37. OVID-Embase.

Exclude: Not an eligible population treatment

Dunner DL, Schmalting KB, Hendrickson H, et al. Cognitive therapy versus fluoxetine in the treatment of dysthymic disorder. *Depression.* 1996;4(1):34-41. PMID:9160652 OVID-Medline.

Exclude: Not an eligible population treatment

Dunner DL, Rush AJ, Russell JM, et al. Prospective, long-term, multicenter study of the naturalistic outcomes of patients with treatment-resistant depression. *J Clin Psychiatry.* 2006;67(5):688-95. PMID:16841617 OVID-Medline.

Exclude: Not an eligible study design

Dunner DL, Blier P, Keller MB, et al. Preventing recurrent depression: Long-term treatment for major depressive disorder. *Prim Care Comp J Clin Psychiatr.* 2007;9(3):214-23. OVID-Embase.

Exclude: Not an eligible study design

Dunner DL. Venlafaxine in the treatment of unresolved symptoms of depression following antidepressant therapy. *Prim Psychiatr.* 2007;14(3):39-49. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Dursun SM, Devarajan S, Kutcher S. The 'dalhousie serotonin cocktail' for treatment-resistant major depressive disorder. *J Psychopharmacol.* 2001;15(2):136-8. PMID:11448087 OVID-Medline.

Exclude: Not an eligible study design

Earley W, McIntyre A, Bauer M, et al. Efficacy and tolerability of extended release quetiapine fumarate (quetiapine extended release) as add-on to antidepressants in patients with major depressive disorder (MDD): Results from a double-blind, randomized phase III study. [Abstract] *Am Coll Neuropsychopharmacol Ann Meeting Abstr* 2007;

Ebert D, Albert R, May A, et al. Combined SSRI-RIMA treatment in refractory depression. Safety data and efficacy. *Psychopharmacol.* 1995;119(3):342-4. Wiley-CCTR.

Exclude: Mixed antidepressants: some failed on SSRI

Echeburua E, Salaberria K, De Corral P, et al. Treatment of mixed anxiety-depression disorder: Long-term outcome. *Behav Cognit Psychother.* 2006;34(1):95-101. OVID-Embase.

Exclude: Not an eligible population treatment

Eckstain, D. Combined cognitive behavioral treatment plus caregiver sessions for childhood depression 2009. OVID-PsycINFO.

Exclude: Not an eligible study design

Edwards D R. A double-blind, placebo-controlled trial of lithium augmentation of antidepressants in treatment-resistant depression in elderly patients. In 1998. Wiley-CCTR.

Exclude: Not an eligible study design

Edwards N, Gardiner M, Ritchie DM, et al. Effect of exercise on negative affect in residents in special care units with moderate to severe dementia. *Alzheimer Dis Assoc Disord.* 2008;22(4):362-8. PMID:18978600 OVID-Medline.

Exclude: Not an eligible study design

Ehrensing RH, Kastin AJ, Wurzlows GF, et al. Improvement in major depression after low subcutaneous doses of MIF-1. *J Affect Disord*. 1994;31(4):227-33. OVID-PsycINFO.

Exclude: Mixed antidepressants:some failed on SSRI

Eidelson JI. Cognitive group therapy for depression: 'Why and what'. *Int J Ment Health*. 1985;13(3-4):54-66. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Ekers D, Lovell K. Self-help for anxiety and depression in primary care: An audit of a pilot clinic. *Clin Effect Nurs*. 2002;6(3-4):129-33. EBSCO-CINAHL.

Exclude: Not an eligible study design

Ekers D, Richards D, Gilbody S. A meta-analysis of randomized trials of behavioural treatment of depression. *Psychol Med*. 2008;38(5):611-23. PMID:17903337 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Ekers D, Richards D, McMillan D, et al. Behavioural activation delivered by the non-specialist: Phase II randomised controlled trial. *Br J Psychiatr*. 2011;198(1):66-72. OVID-Embase.

Exclude: Not an eligible population/treatment

Eksi A, Braun KL. Over-time changes in PTSD and depression among children surviving the 1999 Istanbul earthquake. *Eur Child Adolesc Psychiatry*. 2009;18(6):384-91. OVID-Embase.

Exclude: Not an eligible population treatment

El-Khalili N, Joyce M, Atkinson S, et al. Adjunctive extended-release quetiapine fumarate (quetiapine extended release) in patients with major depressive disorder and inadequate antidepressant response. *Int J Neuropsychopharmacol*. 2010; Exclude: Mixed antidepressants:some failed on SSRI

El-Khalili N, Joyce M, Atkinson S, et al. Extended-release quetiapine fumarate (quetiapine XR) as adjunctive therapy in major depressive disorder (MDD) in patients with an inadequate response to ongoing antidepressant treatment: a multicentre, randomized, double-blind, placebo-controlled study. *Int J Neuropsychopharmacol*. 2010;13(7):917-32. PMID:20175941 OVID-Medline.

Exclude: Mixed antidepressants; some failed on SSRI

Elkin I, Shea MT, Watkins JT, et al. National Institute of Mental Health Treatment of Depression Collaborative Research Program. General effectiveness of treatments. *Arch Gen Psychiatr*. 1989;46(11):971-82. PMID:2684085 OVID-Medline.

Exclude: Not an eligible population treatment

Eller T, Vasar V, Shlik J, et al. Effects of bupropion augmentation on pro-inflammatory cytokines in escitalopram-resistant patients with major depressive disorder. *J Psychopharmacol*. 2009;23(7):854-8. PMID:18562403 OVID-Medline.

Exclude: Not an eligible population treatment

Ellis PM, Smith DAR. Treating depression: The beyondblue guidelines for treating depression in primary care: "Not so much what you do but that you keep doing it". *Med J Aust*. 2002;176(Suppl.):S77-S83 Exclude: Not an eligible guideline

Ellis PM, Hickie IB, Smith DAR. Summary of guideline for the treatment of depression. *Australas Psychiatr*. 2003;11(1):34-8. OVID-PsycINFO.

Exclude: Not an eligible guideline

Elmqvist JM, Melton TK, Croarkin P, et al. A systematic overview of measurement-based care in the treatment of childhood and adolescent depression. *J Psychiatr Pract*. 2010;16(4):217-34. PMID:20644357 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Elsenga S, van den Hoofdakker RH. Clinical effects of sleep deprivation and clomipramine in endogenous depression. *J Psychiatr Res*. 1982;17(4):361-74. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Emanuels-Zuurveen L, Emmelkamp PM. Individual behavioural-cognitive therapy v. marital therapy for depression in maritally distressed couples. *Br J Psychiatr*. 1996;169(2):181-8. PMID:8871794 OVID-Medline.

Exclude: Not an eligible population treatment

Emanuels-Zuurveen L, Emmelkamp PM. Spouse-aided therapy with depressed patients. *Behav Modif*. 1997;21(1):62-77. PMID:8995042 OVID-Medline.

Exclude: Not an eligible population treatment

Embling S. The effectiveness of cognitive behavioural therapy in depression. *Nurs Stand*. 2002;17(14-15):33-41. PMID:12567797 OVID-Medline.

Exclude: Not an eligible population treatment

Emrich HM, Berger M, Riemann D, et al. Serotonin reuptake inhibition vs. norepinephrine reuptake inhibition: A double-blind differential-therapeutic study with fluvoxamine and oxaprotiline in endogenous and neurotic depressives. *Pharmacopsychiatr.* 1987;20(2):60-3. PMID:3108909 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Emslie G, Clarke G, Wagner K, et al. The treatment of ssri-resistant depression in adolescents (tordia). *World Psychiatr.* 2009;8(Suppl 1):37 Wiley-CCTR. Exclude: Not an eligible study design

Engelhardt W, Carl G, Hartung E. Intra-individual open comparison of burst-suppression-isoflurane-anaesthesia versus electroconvulsive therapy in the treatment of severe depression. *Eur J Anaesthesiol.* 1993;10(2):113-8. PMID:8462536 OVID-Medline. Exclude: Not an eligible population treatment

Enns MW, Cox BJ, Pidlubny SR. Group cognitive behaviour therapy for residual depression: Effectiveness and predictors of response. *Cognit Behav Ther.* 2002;31(1):31-40. OVID-Embase. Exclude: Not an eligible study design

Erfurth A, Ackenheil M, Moller HJ. Effects of pindolol in hastening response to serotonergic antidepressants: An open study in severely depressed in-patients. *Clin Neuropsychiatr.* 2004;1(3):196-201. OVID-PsycINFO. Exclude: Not an eligible study design

Erlen JA, Mellors MP, Sereika SM, et al. The use of life review to enhance quality of life of people living with AIDS: A feasibility study. *Qual Life Res.* 2001;10(5):453-64. Wiley-CCTR. Exclude: Not an eligible population treatment

Ernst E. Herbal remedies for depression and anxiety. *Adv Psychiatr Treatment.* 2007;13(4):312-6. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Ernst E. Review: St John's wort superior to placebo and similar to antidepressants for major depression but with fewer side effects. *Evid Based Ment Health.* 2009;12(3):78 EBSCO-CINAHL. Exclude: Not an eligible study design

Eskin M, Ertekin K, Demir H. Efficacy of a problem-solving therapy for depression and suicide potential in adolescents and young adults. *Cognit Ther Res.* 2008;32(2):227-45. OVID-Embase. Exclude: Not an eligible population treatment

Ettelson,R.G. The treatment of adolescent depression 2003. OVID-PsycINFO.

Exclude: Not an eligible study design

Evaluation of Genomic Applications in Practice and Prevention (EGAPP) Working Group. Recommendations from the EGAPP Working Group: Testing for cytochrome P450 polymorphisms in adults with nonpsychotic depression treated with selective serotonin reuptake inhibitors. *Genet Med.* 2007;9(12):819-25. PMID:18091431 OVID-Medline.

Exclude: Not an eligible guideline

Evans MD, Hollon SD, DeRubeis RJ, et al. Differential relapse following cognitive therapy and pharmacotherapy for depression. *Arch Gen Psychiatr.* 1992;49(10):802-8. PMID:1417433 OVID-Medline.

Exclude: Not an eligible population treatment

Evans ME. Depression in elderly physically ill in-patients: A 12-month prospective study. *Int Clin Psychopharmacol.* 1993;8(4):333-6. PMID:8277159 OVID-Medline.

Exclude: Not an eligible study design

Evans R, Connis R. Comparison of brief group therapies for depressed cancer patients receiving radiation treatment. *Public Health Rep.* 1995;(110):306-11. Exclude: Not an eligible population treatment

Even C, Schroder CM, Friedman S, et al. Efficacy of light therapy in nonseasonal depression: A systematic review. *J Affect Disord.* 2008;108(1-2):11-23. PMID:17950467 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Evins AE, Culhane MA, Alpert JE, et al. A controlled trial of bupropion added to nicotine patch and behavioral therapy for smoking cessation in adults with unipolar depressive disorders. *J Clin Psychopharmacol.* 2008;28(6):660-6. PMID:19011435 OVID-Medline.

Exclude: Not an eligible population treatment

Fabbri S, Fava GA, Rafanelli C, et al. Family intervention approach to loss of clinical effect during long-term antidepressant treatment: A pilot study. *J Clin Psychiatry.* 2007;68(9):1348-51. PMID:17915972 OVID-Medline.

Exclude: Not an eligible population treatment

Fahlen T, Agren H, Edstrom A and others. Buspiron augmentation of SSRI therapy in treatment-refractory depression. In 1996. Wiley-CCTR. Exclude: Not an eligible study design

Fahlén T, Agren H, Edström A and others. Buspirone in SSRI-refractory depression. In 1996. Wiley-CCTR.

Exclude: Not an eligible study design

Fahndrich E. Effects of sleep deprivation on depressed patients of different nosological groups. *Psychiatry Res.* 1981;5(3):277-85. PMID:6948310 OVID-Medline.

Exclude: Not an eligible study design

Fahy TJ. Side effects of moclobemide in depressed patients refractory to other treatments. *Ir J Psychol Med.* 1993;10(1):24-7. OVID-Embase.

Exclude: Not an eligible study design

Fakhoury TA, Miller JM, Hammer AE, et al. Effects of lamotrigine on mood in older adults with epilepsy and co-morbid depressive symptoms: An open-label, multicentre, prospective study. *Drugs Aging.* 2008;25(11):955-62. PMID:18947263 OVID-Medline.

Exclude: Not an eligible study design

Falconnier L. Socioeconomic status in the treatment of depression. *Am J Orthopsychiatry.* 2009;79(2):148-58. PMID:19485632 OVID-Medline.

Exclude: Not an eligible population treatment

Fan L, Fu W, Xu N, et al. Meta-analysis of 20 clinical, randomized, controlled trials of acupuncture for depression. *Neural Regen Res.* 2010;5(24):1862-9. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Fang Y, Yuan C, Xu Y, et al. Comparisons of the efficacy and tolerability of extended-release venlafaxine, mirtazapine, and paroxetine in treatment-resistant depression: A double-blind, randomized pilot study in a Chinese population. *J Clin Psychopharmacol.* 2010;30(4):357-64. PMID:20571433 OVID-Medline.

Exclude: Mixed antidepressants; some failed on SSRI

Farabaugh A, Locascio JJ, Yap L, et al. Cognitive-behavioral therapy for patients with Parkinson's disease and comorbid major depressive disorder. *Psychosom.* 2010;51(2):124-9. OVID-Embase.

Exclude: Not an eligible study design

Faramarzi M, Kheirkhah F, Esmaelzadeh S, et al. Is psychotherapy a reliable alternative to pharmacotherapy to promote the mental health of infertile women? A randomized clinical trial. *Eur J Obstet Gynecol Reprod Biol.* 2008;141(1):49-53. PMID:18848381 OVID-Medline.

Exclude: Not an eligible population treatment

Faramarzi M, Alipor A, Esmaelzadeh S, et al. Treatment of depression and anxiety in infertile women: Cognitive behavioral therapy versus fluoxetine. *J Affect Disord.* 2008;108(1-2):159-64. PMID:17936366 OVID-Medline.

Exclude: Not an eligible population treatment

Faravelli C, Albanesi G, Sessarego A. Viquiline in resistant depression: A double-blind, placebo-controlled trial. *Neuropsychobiol.* 1988;20(2):78-81. PMID:3075725 OVID-Medline.

Exclude: Not an eligible population treatment

Farid FF, Wenger TL, Tsai SY, et al. Use of bupropion in patients who exhibit orthostatic hypotension on tricyclic antidepressants. *J Clin Psychiatry.* 1983;44(5:Pt 2):t-3 PMID:6406451 OVID-Medline.

Exclude: Not an eligible study design

Fasullo S, Vinci GG. Treatment of resistant depression with TRH. *Psichiatria e Psicoterapia Analitica.* 1991;10(3):241-6. Wiley-CCTR.

Exclude: Not an eligible population treatment

Fava GA, Savron G, Grandi S, et al. Cognitive-behavioral management of drug-resistant major depressive disorder. *J Clin Psychiatry.* 283;58(6):278-82. PMID:9228899 OVID-Medline.

Exclude: Not an eligible study design

Fava GA, Grandi S, Zielezny M, et al. Cognitive behavioral treatment of residual symptoms in primary major depressive disorder. *Am J Psychiatry.* 1994;151(9):1295-9. PMID:8067483 OVID-Medline.

Exclude: Not an eligible population treatment

Fava GA, Grandi S, Zielezny M, et al. Four-year outcome for cognitive behavioral treatment of residual symptoms in major depression. *Am J Psychiatry.* 1996;153(7):945-7. PMID:8659620 OVID-Medline.

Exclude: Not an eligible population treatment

Fava GA, Rafanelli C, Grandi S, et al. Prevention of recurrent depression with cognitive behavioral therapy: Preliminary findings. *Arch Gen Psychiatr.* 1998;55(9):816-20. PMID:9736008 OVID-Medline.

Exclude: Not an eligible population treatment

Fava GA, Rafanelli C, Grandi S, et al. Six-year outcome for cognitive behavioral treatment of residual symptoms in major depression. *Am J Psychiatry.* 1998;155(10):1443-5. PMID:9766780 OVID-Medline.

Exclude: Not an eligible population treatment

Fava GA, Rafanelli C, Cazzaro M, et al. Well-being therapy. A novel psychotherapeutic approach for residual symptoms of affective disorders. *Psychol Med*. 1998;28(2):475-80. PMID:9572104 OVID-Medline.

Exclude: Not an eligible population treatment

Fava GA, Ruini C, Rafanelli C, et al. Cognitive behavior approach to loss of clinical effect during long-term antidepressant treatment: A pilot study. *Am J Psychiatry*. 2002;159(12):2094-5. PMID:12450962 OVID-Medline.

Exclude: Not an eligible population treatment

Fava GA, Ruini C, Rafanelli C, et al. Six-year outcome of cognitive behavior therapy for prevention of recurrent depression. *Am J Psychiatry*. 2004;161(10):1872-6. Wiley-CCTR.

Exclude: Not an eligible population treatment

Fava GA, Ruini C, Rafanelli C. Sequential treatment of mood and anxiety disorders. *J Clin Psychiatr*. 2005;66(11):1392-400. PMID:16420076 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Fava M, Rosenbaum JF, Cohen L, et al. High-dose fluoxetine in the treatment of depressed patients not responsive to a standard dose of fluoxetine. *J Affect Disord*. 1992;25(4):229-34. PMID:1430659 OVID-Medline.

Exclude: Not an eligible study design

Fava M, Giannelli A, Rapisarda V, et al. Rapidity of onset of the antidepressant effect of parenteral S-adenosyl-L-methionine. *Psychiatry Res*. 1995;56(3):295-7. PMID:7568552 OVID-Medline.

Exclude: Not an eligible study design

Fava M, Rappe SM, Pava JA, et al. Relapse in patients on long-term fluoxetine treatment: Response to increased fluoxetine dose. *J Clin Psychiatry*. 1995;56(2):52-5. PMID:7852252 OVID-Medline.

Exclude: Not an eligible population treatment

Fava M, Papakostas GI, Petersen T, et al. Switching to bupropion in fluoxetine-resistant major depressive disorder. *Ann Clin Psychiatr*. 2003;15(1):17-22. PMID:12839429 OVID-Medline.

Exclude: Not an eligible study design

Fava M, McGrath PJ, Sheu WP, et al. Switching to reboxetine: An efficacy and safety study in patients with major depressive disorder unresponsive to fluoxetine. *J Clin Psychopharmacol*. 2003;23(4):365-9. PMID:12920412 OVID-Medline.

Exclude: Not an eligible study design

Fava M, Alpert J, Nierenberg AA, et al. A double-blind, randomized trial of St John's wort, fluoxetine, and placebo in major depressive disorder. *J Clin Psychopharmacol*. 2005;25(5):441-7.

PMID:16160619 OVID-Medline.

Exclude: Not an eligible population treatment

Fava M, McCall WV, Krystal A, et al. Eszopiclone co-administered with fluoxetine in patients with insomnia coexisting with major depressive disorder. *Biol Psychiatr*. 2006;59(11):1052-60.

PMID:16581036 OVID-Medline.

Exclude: Not an eligible population treatment

Fava M, Thase ME, DeBattista C, et al. Modafinil augmentation of selective serotonin reuptake inhibitor therapy in MDD partial responders with persistent fatigue and sleepiness. *Ann Clin Psychiatr*. 2007;19(3):153-9. PMID:17729016 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Fava M, Wisniewski SR, Thase ME, et al. Metabolic assessment of aripiprazole as adjunctive therapy in major depressive disorder: A pooled analysis of 2 studies. *J Clin Psychopharmacol*. 2009;29(4):362-7. PMID:19593176 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Fawcett J, Edwards JH, Kravitz HM, et al. Alprazolam: an antidepressant? Alprazolam, desipramine, and an alprazolam-desipramine combination in the treatment of adult depressed outpatients. *J Clin Psychopharmacol*. 1987;7(5):295-310. PMID:3316312 OVID-Medline.

Exclude: Not an eligible population treatment

Fawcett J, Kravitz HM, Zajecka JM, et al. CNS stimulant potentiation of monoamine oxidase inhibitors in treatment-refractory depression. *J Clin Psychopharmacol*. 1991;11(2):127-32. PMID:2056139 OVID-Medline.

Exclude: Not an eligible study design

Feet PO, Larsen S, Robak OH. A double blind study in out-patients with primary non-agitated depression treated with imipramine in combination with placebo, diazepam or dixyrazine. *Acta Psychiatr Scand*. 1985;72(4):334-40. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Feighner JP, Brauzer B, Gelenberg AJ, et al. A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacol*. 1979;61(2):217-25. Wiley-CCTR.

Exclude: Not an eligible population treatment

Feighner JP, Boyer WF, Tyler DL, et al. Adverse consequences of fluoxetine-MAOI combination therapy. *J Clin Psychiatry*. 1990;51(6):222-5. PMID:2347858 OVID-Medline.

Exclude: Not an eligible study design

Feighner JP, Sverdllov L, Nicolau G, et al. Clinical effectiveness of nemifitide, a novel pentapeptide antidepressant, in depressed outpatients: Comparison of follow-up re-treatment with initial treatment. *Int J Neuropsychopharmacol*. 2003;6(3):207-13. PMID:12974986 OVID-Medline.

Exclude: Not an eligible population treatment

Feighner JP, Sverdllov L, Hlavka J, et al. Clinical effect of nemifitide, a novel pentapeptide antidepressant, in the treatment of severely depressed refractory patients. *Int Clin Psychopharmacol*. 2008;23(1):29-35. PMID:18090505 OVID-Medline.

Exclude: Not an eligible study design

Feijo DM, de Jesus MJ, Bacaltchuk J, et al. A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. *Eur Arch Psychiatry Clin Neurosci*. 2005;255(2):75-82. OVID-Embase.

Exclude: Systematic review - relevant topic, citations cross-matched

Fekadu A, Wooderson SC, Markopoulou K, et al. What happens to patients with treatment-resistant depression? A systematic review of medium to long term outcome studies. *J Affect Disord*. 2009;116(1-2):4-11. PMID:19007996 OVID-Medline.

Exclude: Systematic review - relevant topic, citations cross-matched

Feldman G, Harley R, Kerrigan M, et al. Change in emotional processing during a dialectical behavior therapy-based skills group for major depressive disorder. *Behav Res Ther*. 2009;47(4):316-21. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Fenton L, Fasula M, Ostroff R, et al. Can cognitive behavioral therapy reduce relapse rates of depression after ECT? A preliminary study. *J ECT*. 2006;22(3):196-8. PMID:16957536 OVID-Medline.

Exclude: Not an eligible study design

Ferguson J, Cunningham L, Merideth C, et al. Bupropion in tricyclic antidepressant nonresponders with unipolar major depressive disorder. *Ann Clin Psychiatr*. 1994;6(3):153-60. PMID:7881495 OVID-Medline.

Exclude: Not an eligible study design

Ferguson JM, Shingleton RN. An open-label, flexible-dose study of memantine in major depressive disorder. *Clin Neuropharmacol*. 2007;30(3):136-44. PMID:17545748 OVID-Medline.

Exclude: Not an eligible study design

Ferrando SJ, Freyberg Z. Treatment of depression in HIV positive individuals: A critical review. *Int Rev Psychiatry*. 2008;20(1):61-71. OVID-PsycINFO. Excluded - Systematic review - relevant topic, citations cross-matched

Ferrucci R, Bortolomasi M, Vergari M, et al. Transcranial direct current stimulation in severe, drug-resistant major depression. *J Affect Disord*. 2009;118(1-3):215-9. OVID-Embase.

Exclude: Not an eligible study design

Fetsch RJ, Sprinkle RL. Effects of running on depressed adults. *Am Ment Health Couns Assoc J*. 1983;5(2):75-84. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Field T, Hernandez-Reif M, Hart S, et al. Effects of sexual abuse are lessened by massage therapy. *J Bodywork Movement Ther*. 1997;1(2):65-9. OVID-AMED.

Exclude: Not an eligible population treatment

Finch EJJ, Katona CLE. Lithium augmentation in the treatment of refractory depression in old age. *Int J Geriatr Psychiatry*. 1989;4(1):41-6. OVID-Embase.

Exclude: Not an eligible study design

Findling RL, McNamara NK, O'Riordan MA, et al. An open-label pilot study of St. John's wort in juvenile depression. *J Am Acad Child Adolesc Psychiatry*. 2003;42(8):908-14. PMID:12874492 OVID-Medline.

Exclude: Not an eligible population treatment

Findling RL, Lingler J, Rowles BM, et al. A pilot pharmacotherapy trial for depressed youths at high genetic risk for bipolarity. *J Child Adolesc Psychopharmacol*. 2008;18(6):615-21. PMID:19108666 OVID-Medline.

Exclude: Not an eligible population treatment

Finkelstein FO, Watnick S, Finkelstein SH, et al. The treatment of depression in patients maintained on dialysis. *J Psychosom Res*. 2002;53(4):957-60. OVID-Embase.

Exclude: Not an eligible study design

Finucane A, Mercer SW. An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatr.* 2006;6:14 PMID:16603060 OVID-Medline.

Exclude: Not an eligible study design

Firth-Cozens J, Brewin CR. Attributional change during psychotherapy. *Br J Clin Psychol.* 1988;27(1):47-54. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Fischer P, Tauscher J, Kufferle B, et al. Weak antidepressant response after buspirone augmentation of serotonin reuptake inhibitors in refractory severe depression. *Int Clin Psychopharmacol.* 1998;13(2):83-6. PMID:9669189 OVID-Medline.

Exclude: Not an eligible study design

Flaughner, M. The intervention of music on perceptions of chronic pain, depression, and anxiety in ambulatory individuals with cancer University of Alabama at Birmingham. 2002. EBSCO-CINAHL.

Exclude: Not an eligible study design

Fleck MP, Horwath E. Pharmacologic management of difficult-to-treat depression in clinical practice. *Psychiatr Serv.* 2005;56(8):1005-11. PMID:16088019 OVID-Medline.

Excluded - Systematic review - relevant topic,

citations cross-matched

Fleck MP, Moreno R, Andrade AG, et al. Efficacy of milnacipran in outpatients experiencing major depression non respondent to SSRIs: A 12-week open study. *Revista de Psiquiatria Clinica.* 2010;37(6):241-50. OVID-Embase.

Exclude: Not an eligible study design

Fleischhauer J, Glauser G, Hofstetter P. The influence of light therapy in depressive patients. *Pharmacopsychiatr.* 1988;21(6):414-5. PMID:3244780 OVID-Medline.

Exclude: Not an eligible study design

Fleurence R, Williamson R, Jing Y, et al. A systematic review of augmentation strategies for patients with major depressive disorder. *Psychopharmacol Bull.* 2009;42(3):57-90. OVID-Embase.

Exclude: Mixed antidepressants: some failed on SSRI

Excluded - Systematic review - relevant topic, citations cross-matched

Flint AJ, Rifat SL. A prospective study of lithium augmentation in antidepressant-resistant geriatric depression. *J Clin Psychopharmacol.* 1994;14(5):353-6. PMID:7806693 OVID-Medline.

Exclude: Not an eligible study design

Flint AJ, Rifat SL. The effect of sequential antidepressant treatment on geriatric depression. *J Affect Disord.* 1996;36(3-4):95-105. PMID:8821312 OVID-Medline.

Exclude: Not an eligible study design

Flint AJ, Rifat SL. Anxious depression in elderly patients. Response to antidepressant treatment. *Am J Geriatr Psychiatry.* 1997;5(2):107-15. PMID:9106374 OVID-Medline.

Exclude: Not an eligible study design

Flint AJ, Rifat SL. The effect of treatment on the two-year course of late-life depression. *Br J Psychiatr.* 1997;170(MAR.):268-72. OVID-Embase.

Exclude: Not an eligible study design

Flint AJ, Rifat SL. Maintenance treatment for recurrent depression in late life. A four-year outcome study. *Am J Geriatr Psychiatry.* 2000;8(2):112-6. PMID:10804071 OVID-Medline.

Exclude: Not an eligible study design

Floyd M, Scogin F, McKendree-Smith NL, et al. Cognitive therapy for depression: a comparison of individual psychotherapy and bibliotherapy for depressed older adults. *Behav Modif.* 2004;28(2):297-318. PMID:14997954 OVID-Medline.

Exclude: Not an eligible population treatment

Floyd M, Rohen N, Shackelford JA, et al. Two-year follow-up of bibliotherapy and individual cognitive therapy for depressed older adults. *Behav Modif.* 2006;30(3):281-94. PMID:16574815 OVID-Medline.

Exclude: Not an eligible population treatment

Fombonne E, Zinck S. Handbook of depression in children and adolescents., New York, NY, US: Guilford Press; 2008. Psychopharmacological treatment of depression in children and adolescents. OVID-PsycINFO.

Exclude: Systematic review - relevant topic, citations cross-matched.

Fontaine R, Ontiveros A, Elie R, et al. Lithium carbonate augmentation of desipramine and fluoxetine in refractory depression. *Biol Psychiatry.* 1991;29(9):946-8. PMID:1904782 OVID-Medline.

Exclude: Mixed antidepressants: some failed on SSRI

Fontaine R, Ontiveros A, Elie R, et al. "Lithium carbonate augmentation of desipramine and fluoxetine in refractory depression": Correction. *Biol Psychiatry.* 1992;31(3):322 OVID-PsycINFO.

Exclude: Not an eligible study design

Fontaine R, Ontiveros A, Elie R, et al. "Lithium carbonate augmentation of desipramine and fluoxetine in refractory depression": Correction. *Biol Psychiatry.* 1992;31(3):322 OVID-PsycINFO.

Exclude: Not an eligible study design

Forman EM, Herbert JD, Moitra E, et al. A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behav Modif.* 2007;31(6):772-99. PMID:17932235 OVID-Medline.

Exclude: Not an eligible population treatment

Fornaro P, Giberti F, Albano C, et al. Lamotrigine in the treatment of major depression. Preliminary results from an open study on outpatients. *Ital J Psychiatr Behav Sci.* 1998;8(3):114-8. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Forstmeier S, Rueddel H. Improving volitional competence is crucial for the efficacy of psychosomatic therapy: A controlled clinical trial. *Psychother Psychosom.* 2007;76(2):89-96. Wiley-CCTR.

Exclude: Not an eligible population treatment

Foster MA, Ragsdale K, Dunne B, et al. Detection and treatment of depression in a VA primary care clinic. *Psychiatr Serv.* 1999;50(11):1494-5. OVID-Embase.

Exclude: Not an eligible study design

Foster RP. Treating depression in vulnerable urban women: A feasibility study of clinical outcomes in community service settings. *Am J Orthopsychiatry.* 2007;77(3):443-53. PMID:17696673 OVID-Medline.

Exclude: Not an eligible population treatment

Fournier JC, DeRubeis RJ, Shelton RC, et al. Antidepressant medications v. cognitive therapy in people with depression with or without personality disorder. *Br J Psychiatr.* 2008;192(2):124-9. PMID:18245030 OVID-Medline.

Exclude: Not an eligible population treatment

Fowler JC, Ackerman SJ, Spearburg S, et al. Personality and symptom change in treatment-refractory inpatients: Evaluation of the phase model of change using Rorschach,TAT, and DSM-IV Axis V. *J Pers Assess.* 2004;83(3):306-22. PMID:15548467 OVID-Medline.

Exclude: Not an eligible study design

Franchini L, Bongiorno F, Spagnolo C, et al. Psychoeducational group intervention in addition to antidepressant therapy as relapse preventive strategy in unipolar patients. *Clin Neuropsychiatr.* 2006;3(4):282-5. OVID-Embase.

Exclude: Not an eligible population treatment

Franco C, Manas I, Cangas AJ, et al. Reducing teachers' psychological distress through a mindfulness training program. *Spanish J Psychol.* 2010;13(2):655-66. OVID-Embase.

Exclude: Not an eligible population/treatment

Frank E, Kupfer DJ, Perel JM, et al. Three-year outcomes for maintenance therapies in recurrent depression. *Arch Gen Psychiatr.* 1990;47(12):1093-9. Wiley-CCTR.

Exclude: Not an eligible population treatment

Frank E, Kupfer DJ, Levenson J. Combined pharmacotherapy and psychotherapy for depression., Washington, DC, US:American Psychiatric Association;1990. Continuation therapy for unipolar depression: The case for combined treatment. OVID-PsycINFO.

Exclude: Not an eligible study design.

Frank E, Grochocinski VJ, Spanier CA, et al. Interpersonal psychotherapy and antidepressant medication: Evaluation of a sequential treatment strategy in women with recurrent major depression. *J Clin Psychiatry.* 2000;61(1):51-7. PMID:10695647 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Frank E, Kupfer DJ, Buysse DJ, et al. Randomized trial of weekly, twice-monthly, and monthly interpersonal psychotherapy as maintenance treatment for women with recurrent depression. *Am J Psychiatry.* 2007;164(5):761-7. PMID:17475735 OVID-Medline.

Exclude: Not an eligible population treatment

Frank E, Stewart BD. Treating depression in victims of rape. *Clin Psychol.* 1983;36(4):95-8. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Frankenburg,J.B. The effects of three experimental phenomenological techniques in treating dysthymic depression 1996. OVID-PsycINFO.

Exclude: Not an eligible study design

Franzblau SH, Echevarria S, Smith M, et al. A preliminary investigation of the effects of giving testimony and learning yogic breathing techniques on battered women's feelings of depression. *J Interpersonal Violence.* 2008;23(12):1800-8. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Frazer CJ, Christensen H, Griffiths KM. Effectiveness of treatments for depression in older people. *Med J Aust.* 2005;182(12):627-32. PMID:15963019 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Frederick C. Pools and wellings: The resolution of refractory intermittent depressive symptoms with ego-state therapy. *Hypnos*. 1993;20(4):221-7. OVID-AMED.

Exclude: Not an eligible study design

Frederick JT, Steinman LE, Prohaska T, et al. Community-based treatment of late life depression: An expert panel-informed literature review. *Am J Prev Med*. 2007;33(3):222-49. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Free ML, Oei TP, Sanders MR. Treatment outcome of a group cognitive therapy program for depression. *Int J Group Psychother*. 1991;41(4):533-47. PMID:1938020 OVID-Medline. Exclude: Not an eligible study design

Freedland KE, Skala JA, Carney RM, et al. Treatment of depression after coronary artery bypass surgery: A randomized controlled trial. *Arch Gen Psychiatr*. 2009;66(4):387-96. PMID:19349308 OVID-Medline. Exclude: Not an eligible population design

Freeman MP, Hibbeln JR, Wisner KL, et al. An open trial of Omega-3 fatty acids for depression in pregnancy. *Acta Neuropsychiatr*. 2006;18(1):21-4. OVID-Embase. Exclude: Not an eligible study design

Freeman MP, Hibbeln JR, Silver M, et al. Omega-3 fatty acids for major depressive disorder associated with the menopausal transition: A preliminary open trial. *Menopause*. 2011;18(3):279-84. OVID-Embase. Exclude: Not an eligible study design

Fremont J, Wilcoxon CL. Aerobic exercise and cognitive therapy in the treatment of dysphoric moods. *Cognit Ther Res*. 1987;11(2):241-51. OVID-Embase. Exclude: Not an eligible population treatment

Friedberg F, Krupp LB. A comparison of cognitive behavioral treatment for chronic fatigue syndrome and primary depression. *Clin Infect Dis*. 1994;18(Suppl 1):S105-10. PMID:8148435 OVID-Medline. Exclude: Not an eligible population treatment

Friedberg RD, McClure JM, Wilding L, et al. A cognitive-behavioral skills training group for children experiencing anxious and depressive symptoms: A clinical report with accompanying descriptive data. *J Contemp Psychother*. 2003;33(3):157-75. OVID-Embase. Exclude: Not an eligible study design

Friede M, Henneicke von Zepelin HH, Freudenstein J. Differential therapy of mild to moderate depressive episodes (ICD-10 F 32.0; F 32.1) with St. John's wort. *Pharmacopsychiatr*. 2001;34:Suppl-41 PMID:11518073 OVID-Medline.

Exclude: Not an eligible population treatment

Friedman AS. Interaction of drug therapy with marital therapy in depressive patients. *Arch Gen Psychiatr*. 1975;32(5):619-37. Wiley-CCTR. Exclude: Not an eligible population treatment

Friedman ES, Wisniewski SR, Gilmer W, et al. Sociodemographic, clinical, and treatment characteristics associated with worsened depression during treatment with citalopram: Results of the NIMH star*D trial. *Depress Anxiety*. 2009;26(7):612-21. OVID-Embase. Exclude: Mixed antidepressants:some failed on SSRI

Friedman ES, Thase ME, Wisniewski SR, et al. Cognitive therapy augmentation versus CT switch treatment: A STAR*D report. *Int J Cognit Ther*. 2009;2(1):66-87. OVID-PsycINFO. Exclude: Mixed antidepressants:some failed on SSRI

Friedman MA, Cardemil EV, Uebelacker LA, et al. The GIFT program for major depression: Integrating group, individual, and family treatment. *J Psychother Integrat*. 2005;15(2):147-68. OVID-Embase. Exclude: Not an eligible study design

Fristad MA, Verducci JS, Walters K, et al. Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. *Arch Gen Psychiatr*. 2009;66(9):1013-21. OVID-Embase. Exclude: Not an eligible population treatment

Frothingham, S.S. The effects of an optimism-based cognitive behavioral intervention on mood and functioning in cardiac patients 2006. OVID-PsycINFO. Exclude: Not an eligible study design

Frye MA, Ketter TA, Kimbrell TA, et al. A placebo-controlled study of lamotrigine and gabapentin monotherapy in refractory mood disorders. *J Clin Psychopharmacol*. 2000;20(6):607-14. OVID-Embase. Exclude: Not an eligible population treatment

Frye MA, Ketter TA, Leverich GS, et al. The increasing use of polypharmacotherapy for refractory mood disorders: 22 years of study. *J Clin Psychiatry*. 2000;(61):9-15. Exclude: Not an eligible population treatment

Fu Keung WD. Cognitive and health-related outcomes of group cognitive behavioural treatment for people with depressive symptoms in Hong Kong: Randomized wait-list control study. *Aust NZ J Psychiatr.* 2008;42(8):702-11. OVID-Embase. Exclude: Not an eligible population treatment

Fu WB, Fan L, Zhu XP, et al. Depressive neurosis treated by acupuncture for regulating the liver: A report of 176 cases. *J Tradit Chin Med.* 2009;29(2):83-6. PMID:19663089 OVID-Medline. Exclude: Not an eligible population treatment

Fukunishi I, Hosaka T, Matsumoto T, et al. Liaison psychiatry and HIV infection (II): Application of relaxation in HIV positive patients. *Psychiatry Clin Neurosci.* 1997;51(1):5-8. OVID-Embase. Exclude: Not an eligible population treatment

Furtado CP, Maller JJ, Fitzgerald PB. A magnetic resonance imaging study of the entorhinal cortex in treatment-resistant depression. *Psychiatry Res.* 2008;163(2):133-42. PMID:18511243 OVID-Medline. Exclude: Not an eligible population treatment

Furtado VA, Srihari V, Kumar A. Atypical antipsychotics for people with both schizophrenia and depression. *Cochrane Database Syst Rev.* 2008;(1):Art No.:CD005377. Wiley-CDSR. Excluded - Systematic review - relevant topic, citations cross-matched

Furukawa TA, Cipriani A, Barbui C, et al. Long-term treatment of depression with antidepressants: A systematic narrative review. *Can J Psychiatry.* 2007;52(9):545-52. PMID:17953158 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Furze G, Dumville JC, Miles JN, et al. "Prehabilitation" prior to CABG surgery improves physical functioning and depression. *Int J Cardiol.* 2009;132(1):51-8. PMID:18703241 OVID-Medline. Exclude: Not an eligible population treatment

Gabelic I, Moll E. Moclobemide (Ro 11-1163) versus desipramine in the treatment of endogenous depression. *Acta Psychiatr Scand Suppl.* 1990;360:44-5. PMID:2248068 OVID-Medline. Exclude: Not an eligible population treatment

Gabelic I, Kuhn B. Moclobemide (Ro 11-1163) versus tranylcypromine in the treatment of endogenous depression. *Acta Psychiatr Scand Suppl.* 1990;82(360):63 OVID-Embase. OVID-Embase. Exclude: Not an eligible population treatment

Gabriel A. Lamotrigine adjunctive treatment in resistant unipolar depression: An open, descriptive study. *Depress Anxiety.* 2006;23(8):485-8. PMID:16845646 OVID-Medline. Exclude: Not an eligible study design

Gagiano CA, Muller PG, Fourie J, et al. The therapeutic efficacy of paroxetine: (a) An open study in patients with major depression not responding to antidepressants; (b) A double-blind comparison with amitriptyline in depressed outpatients. *Acta Psychiatr Scand Suppl.* 1989;350:130-1. PMID:2530765 OVID-Medline. Exclude: Not an eligible study design

Gaik, F.V. Merging east and west: A preliminary study applying spring forest qigong to depression as an alternative and complementary treatment 2003. OVID-PsycINFO. Exclude: Not an eligible study design

Galecki P, Szemraj J, Bienkiewicz M, et al. Oxidative stress parameters after combined fluoxetine and acetylsalicylic acid therapy in depressive patients. *Hum Psychopharmacol.* 2009;24(4):277-86. PMID:19319921 OVID-Medline. Exclude: Not an eligible population treatment

Gallagher-Thompson D, Hanley-Peterson P, Thompson LW. Maintenance of gains versus relapse following brief psychotherapy for depression. *Journal of Consulting and Clinical Psychology.* 1990;58(3):371-4. OVID-Embase. OVID-Embase. Exclude: Not an eligible population treatment

Gallagher-Thompson D, Gray HL, Tang PC, et al. Impact of in-home behavioral management versus telephone support to reduce depressive symptoms and perceived stress in Chinese caregivers: Results of a pilot study. *Am J Geriatr Psychiatry.* 2007;15(5):425-34. PMID:17463192 OVID-Medline. Exclude: Not an eligible population treatment

Gallagher-Thompson D, Gray HL, Dupart T, et al. Effectiveness of cognitive/behavioral small group intervention for reduction of depression and stress in non-Hispanic White and Hispanic/Latino women dementia family caregivers: Outcomes and mediators of change. *J Rational-Emotive Cognit Behav Ther.* 2008;26(4):286-303. OVID-PsycINFO. Exclude: Not an eligible population treatment

Gallagher DE, Thompson LW. Treatment of major depressive disorder in older adult outpatients with brief psychotherapies. *Psychother Theory Res Pract*. 1982;19(4):482-90. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Gallagher DE, Thompson LW. Effectiveness of psychotherapy for both endogenous and nonendogenous depression in older adult outpatients. *J Gerontol*. 1983;38(6):707-12. OVID-PsycINFO.

Exclude: Not an eligible study design

Gallagher SM, Allen JJ, Hitt SK, et al. Six-month depression relapse rates among women treated with acupuncture. *Complement Ther Med*. 2001;9(4):216-8. PMID:12184348 OVID-Medline.

Exclude: Not an eligible population treatment

Ganster DC, Mayes BT, Sime WE, et al. Managing organizational stress: A field experiment. *J Appl Psychol*. 1982;67(5):533-42. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Garakani A, Martinez JM, Marcus S, et al. A randomized, double-blind, and placebo-controlled trial of quetiapine augmentation of fluoxetine in major depressive disorder. *Int Clin Psychopharmacol*. 2008;23(5):269-75. PMID:18703936 OVID-Medline.

Exclude: Not an eligible population treatment

Garcia-Lizana F, Munoz-Mayorga I. Telemedicine for depression: A systematic review. *Perspect Psychiatr Care*. 2010;46(2):119-26. EBSCO-CINAHL.

Excluded - Systematic review - relevant topic, citations cross-matched

Garcia-Toro M, Segura C, Gonzalez A, et al. Inefficacy of burst-suppression anesthesia in medication-resistant major depression: A controlled trial. *J ECT*. 2001;17(4):284-8. PMID:11731731 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Gardner EA. Long-term preventive care in depression: The use of bupropion in patients intolerant of other antidepressants. *J Clin Psychiatry*. 1983;44(5:Pt 2):t-62 PMID:6406449 OVID-Medline.

Exclude: Not an eligible study design

Gariballa S, Forster S. Effects of dietary supplements on depressive symptoms in older patients: A randomised double-blind placebo-controlled trial. *Clin Nutr*. 2007;26(5):545-51. PMID:17662509 OVID-Medline.

Exclude: Not an eligible population treatment

Garriock HA, Delgado P, Kling MA, et al. Number of risk genotypes is a risk factor for major depressive disorder: A case control study. *Behav Brain Func*. 2006;2, 2006. Article Number: 24. Date of Publication: 05 Jul 2006.: OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Garriock HA, Hamilton SP. Genetic studies of drug response and side effects in the STAR*D study, part 2. *J Clin Psychiatry*. 2009;70(9):1323-5. PMID:19818256 OVID-Medline.

Exclude: Not an eligible study design

Garriock HA, Hamilton SP. Genetic studies of drug response and side effects in the STAR*D study, part 1. *J Clin Psychiatr*. 2009;70(8):1186-7. OVID-Embase.

Exclude: Not an eligible population treatment

Garriock HA, Tanowitz M, Kraft JB, et al. Association of mu-opioid receptor variants and response to citalopram treatment in major depressive disorder. *Am J Psychiatry*. 2010;167(5):565-73. PMID:20194481 OVID-Medline.

Exclude: Not an eligible population treatment

Garriock HA, Kraft JB, Shyn SI, et al. A genomewide association study of citalopram response in major depressive disorder. *Biol Psychiatr*. 2010;67(2):133-8. PMID:19846067 OVID-Medline.

Exclude: Not an eligible population treatment

Comparative effectiveness of second-generation antidepressants in the pharmacologic treatment of adult depression. Gartlehner G, Hansen RA, Thieda P et al. 2007;

Garvey MJ, DeRubeis RJ, Hollon SD, et al. Response of depression to very high plasma levels of imipramine plus desipramine. *Biol Psychiatr*. 1991;30(1):57-62. OVID-PsycINFO.

Exclude: Not an eligible study design

Gary RA, Sueta CA, Dougherty M, et al. Home-based exercise improves functional performance and quality of life in women with diastolic heart failure. *Heart Lung*. 2004;33(4):210-8. Wiley-CCTR.

Exclude: Not an eligible population treatment

Garzya G, Corallo D, Fiore A, et al. Evaluation of the effects of L-acetylcarnitine on senile patients suffering from depression. *Drugs Under Exp Clin Res*. 1990;16(2):101-6. PMID:2205455 OVID-Medline.

Exclude: Not an eligible population design

Gastpar M, Singer A, Zeller K. Efficacy and tolerability of hypericum extract STW3 in long-term treatment with a once-daily dosage in comparison with sertraline. *Pharmacopsychiatr.* 2005;38(2):78-86. PMID:15744631 OVID-Medline.

Exclude: Not an eligible population treatment

Gastpar M, Singer A, Zeller K. Comparative efficacy and safety of a once-daily dosage of hypericum extract STW3-VI and citalopram in patients with moderate depression: A double-blind, randomised, multicentre, placebo-controlled study. *Pharmacopsychiatr.* 2006;39(2):66-75. PMID:16555167 OVID-Medline.

Exclude: Not an eligible population treatment

Gaszner P. About the menopausal depression. *Neuropsychopharmacol Hungarica.* 2005;7(4):208-14. PMID:16496486 OVID-Medline.

Exclude: Not an eligible population treatment

Gayle RC, Spitler DL, Karper WB, et al. Psychological changes in exercising COPD patients. *Int J Rehabil Res.* 1988;11(4):335-42. OVID-Embase.

Exclude: Not an eligible population treatment

Gaynes BN, Rush AJ, Trivedi MH, et al. Primary versus specialty care outcomes for depressed outpatients managed with measurement-based care: Results from STAR*D. *J Gen Intern Med.* 2008;23(5):551-60. PMID:18247097 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Gaynes BN, Warden D, Trivedi MH, et al. What did STAR*D teach us? Results from a large-scale, practical, clinical trial for patients with depression. *Psychiatr Serv.* 2009;60(11):1439-45. PMID:19880458 OVID-Medline.

Exclude: Not an eligible population treatment

Gaynor ST, Lawrence PS. Complementing CBT for depressed adolescents with Learning through In-Vivo Experience (LIVE): Conceptual analysis, treatment description, and feasibility study. *Behav Cognit Psychother.* 2002;30(1):79-101. OVID-Embase.

Exclude: Not an eligible study design

Gecele M, Francesetti G, Meluzzi A. Acetyl-L-carnitine in aged subjects with major depression: Clinical efficacy and effects on the circadian rhythm of cortisol. *Dement.* 1991;2(6):333-7. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Gelenberg AJ, Shelton RC, Crits-Christoph P, et al. The effectiveness of St. John's Wort in major depressive disorder: A naturalistic phase 2 follow-up in which nonresponders were provided alternate medication. *J Clin Psychiatry.* 2004;65(8):1114-9. PMID:15323598 OVID-Medline.

Exclude: Not an eligible population treatment

Gelhart RP, King HL. The influence of comorbid risk factors on the effectiveness of cognitive-behavioral treatment of depression. *Cognit Behav Pract.* 2001;8(1):18-28. OVID-Embase.

Exclude: Not an eligible study design

Gelhart RP, Hand-Ronga N, King HL. Group cognitive-behavioral treatment of depression and the interaction of demographic variables. *J Cognit Psychother.* 2002;16(4):469-86. OVID-Embase.

Exclude: Not an eligible study design

Geller B, Cooper TB, Graham DL, et al. Double-blind placebo-controlled study of nortriptyline in depressed adolescents using a "fixed plasma level" design. *Psychopharmacol Bull.* 1990;26(1):85-90. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Geller SE, Studee L. Botanical and dietary supplements for mood and anxiety in menopausal women. *Menopause.* 2007;14(3 Pt 1):541-9. PMID:17194961 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Gelman CR, Lopez M, Foster RP. Evaluating the impact of a cognitive-behavioral intervention with depressed Latinas: A preliminary report. *Soc Work Ment Health.* 2005;4(2):1-16. EBSCO-CINAHL.

Exclude: Not an eligible study design

Gendron A, McIntyre A. Quetiapine adjunct to selective serotonin reuptake inhibitors or venlafaxine in patients with major depression, comorbid anxiety, and residual depressive symptoms: A randomized, placebo-controlled pilot study. *Depress Anxiety.* 2007;24(7):487-94. OVID-Embase.

Exclude: Mixed antidepressants; some failed on SSRI

Gensichen J, Petersen JJ, Karroum T, et al. Positive impact of a family practice-based depression case management on patient's self-management. *Gen Hosp Psychiatry.* 2011;33(1):23-8. OVID-Embase.

Exclude: Not an eligible population/treatment

Genthner GC, Friedman HL, Studley CF. Improvement in depression following reduction of upper cervical vertebral subluxation using orthospinology technique. *J Vertebral Sublux Res.* 2005;1-4. EBSCO-CINAHL.
Exclude: Not an eligible study design

George T, Theodoros MT, Chiu E, et al. An open study of sertraline in patients with major depression who failed to respond to moclobemide. *Aust NZ J Psychiatr.* 1999;33(6):889-95. PMID:10619217 OVID-Medline.
Exclude: Not an eligible study design

Georgotas A, Friedman E, McCarthy M, et al. Resistant geriatric depressions and therapeutic response to monoamine oxidase inhibitors. *Biol Psychiatr.* 1983;18(2):195-205. PMID:6830930 OVID-Medline.
Exclude: Not an eligible study design

Geretsegger C, Bitterlich W, Stelzig R, et al. Paroxetine with pindolol augmentation: A double-blind, randomized, placebo-controlled study in depressed in-patients. *Eur Neuropsychopharmacol.* 2008;18(2):141-6. PMID:18054209 OVID-Medline.
Exclude: Not an eligible population treatment

Gerhards SA, de Graaf LE, Jacobs LE, et al. Economic evaluation of online computerised cognitive-behavioural therapy without support for depression in primary care: Randomised trial. *Br J Psychiatr.* 2010;196:310-8. PMID:20357309 OVID-Medline.
Exclude: Not an eligible population treatment

Gervasoni N, Aubry JM, Gex-Fabry M, et al. Is there a place for tricyclic antidepressants and subsequent augmentation strategies in obtaining remission for patients with treatment resistant depression? *Pharmacol Res.* 2009;59(3):202-6. PMID:19073260 OVID-Medline.
Exclude: Not an eligible study design

Gervasoni N, Legendre-Simon P, Aubry JM, et al. Early telephone intervention for psychiatric outpatients starting antidepressant treatment. *Nord J Psychiatr.* 2010;64(4):265-7. PMID:20166864 OVID-Medline.
Exclude: Not an eligible population treatment

Ghaemi SN, Katzow JJ, Desai SP, et al. Gabapentin treatment of mood disorders: A preliminary study. *J Clin Psychiatry.* 1998;59(8):426-9. PMID:9721823 OVID-Medline.
Exclude: Not an eligible study design

Ghaemi SN, Cherry EL, Katzow JA, et al. Does olanzapine have antidepressant properties? A retrospective preliminary study. *Bipolar Disorders.* 2000;2(3:Pt 1):t-9 PMID:11256687 OVID-Medline.
Exclude: Not an eligible study design

Gharabawi G, Canuso C, Pandina G. A double-blind placebo-controlled study of adjunctive risperidone for treatment-resistant major depressive disorder. [Abstract] *Int J Neuropsychopharmacol.* 2006;9:(Supplement 1):S236

Ghaziuddin N, Naylor MW, King CA. Fluoxetine in tricyclic refractory depression in adolescents. *Depression.* 1995;2(6):287-91. OVID-Embase.
Exclude: Not an eligible study design

Ghaziuddin N, Kutcher SP, Knapp P, et al. Summary of the practice parameter for the use of electroconvulsive therapy with adolescents. *J Am Acad Child Adolesc Psychiatry.* 2004;43(1):119-22. PMID:14691369 OVID-Medline.
Exclude: Not an eligible guideline

Giannelli A, Rabboni M, Zarattini F, et al. A combination of hypothalamic phospholipid liposomes with trazodone for treatment of depression. An open controlled study. *Acta Psychiatr Scand.* 1989;79(1):52-8. PMID:2648767 OVID-Medline.
Exclude: Not an eligible population treatment

Gibbons CJ, Fournier JC, Stirman SW, et al. The clinical effectiveness of cognitive therapy for depression in an outpatient clinic. *J Affect Disord.* 2010;125(1-3):169-76. PMID:20080305 OVID-Medline.
Exclude: Not an eligible study design

Gilbert G. Adults with both anxiety and depression respond poorly to treatment. *J Natl Med Assoc.* 2008;100(7):870-1. OVID-Embase.
Exclude: Not an eligible study design

Gilbert J, Strong J. Dysfunctional attitudes in patients with depression: A study of patients admitted to a private psychiatric hospital. *Br J Occup Ther.* 1994;57(1):15-9. OVID-PsycINFO.
Exclude: Not an eligible study design

Gilbody S, Bower P, Fletcher J, et al. Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med.* 2006;166(21):2314-21. PMID:17130383 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Gill A, Womack R, Safranek S. Clinical Inquiries: Does exercise alleviate symptoms of depression? *J Fam Pract.* 2010;59(9):530-1. PMID:20824231 OVID-Medline.

Exclude - Systematic review - relevant topic, citations cross-matched

Gillham JE, Hamilton J, Freres DR, et al. Preventing depression among early adolescents in the primary care setting: a randomized controlled study of the Penn Resiliency Program. *J Abnorm Child Psychol.* 2006;34(2):203-19. PMID:16741684 OVID-Medline.

Exclude: Not an eligible population treatment

Gilmer WS, Gollan JK, Wisniewski SR, et al. Does the duration of index episode affect the treatment outcome of major depressive disorder? A STAR*D report. *J Clin Psychiatry.* 2008;69(8):1246-56. PMID:18681756 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Ginsberg DL. Chromium picolinate treatment of atypical depression. *Prim Psychiatr.* 2003;10(4):23-4. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Ginsberg DL. Adjunctive ropinirole for treatment-resistant depression. *Prim Psychiatr.* 2005;12(8):26-7. OVID-PsycINFO.

Exclude: Not an eligible study design

Ginsberg DL. Atomoxetine augmentation of antidepressants. *Prim Psychiatr.* 2005;12(3):19 OVID-PsycINFO.

Exclude: Not an eligible study design

Gitlin MJ, Weiner H, Fairbanks L, et al. Failure of T3 to potentiate tricyclic antidepressant response. *J Affect Disord.* 1987;13(3):267-72. PMID:2960719 OVID-Medline.

Exclude: Not an eligible population treatment

Given C, Given B, Rahbar M, et al. Does a symptom management intervention affect depression among cancer patients: Results from a clinical trial. *Psychooncol.* 2004;13(11):818-30. PMID:15386790 OVID-Medline.

Exclude: Not an eligible population treatment

Glassman AH, Platman SR. Potentiation of a monoamine oxidase inhibitor by tryptophan. *J Psychiatr Res.* 1969;7(2):83-8. Wiley-CCTR.

Exclude: Not an eligible population treatment

Glueckauf RL, Davis WS, Allen K, et al. Integrative cognitive-behavioral and spiritual counseling for rural dementia caregivers with depression. *Rehabil Psychol.* 2009;54(4):449-61. PMID:19929127 OVID-Medline.

Exclude: Not an eligible study design

Godfrey PS, Toone BK, Carney MW, et al. Enhancement of recovery from psychiatric illness by methylfolate. *Lancet.* 1990;336(8712):392-5. PMID:1974941 OVID-Medline.

Exclude: Not an eligible population treatment

Godfrin KA, van HC. The effects of mindfulness-based cognitive therapy on recurrence of depressive episodes, mental health and quality of life: A randomized controlled study. *Behav Res Ther.* 2010;48(8):738-46. PMID:20462570 OVID-Medline.

Exclude: Not an eligible population treatment

Goel N, Terman M, Terman JS, et al. Controlled trial of bright light and negative air ions for chronic depression. *Psychol Med.* 2005;35(7):945-55. PMID:16045061 OVID-Medline.

Exclude: Not an eligible population treatment

Goel N, Etwaroo GR. Bright light, negative air ions and auditory stimuli produce rapid mood changes in a student population: A placebo-controlled study. *Psychol Med.* 2006;36(9):1253-63. PMID:16756690 OVID-Medline.

Exclude: Not an eligible population treatment

Gold C, Solli HP, Kruger V, et al. Dose-response relationship in music therapy for people with serious mental disorders: Systematic review and meta-analysis. *Clin Psychol Rev.* 2009;29(3):193-207. PMID:19269725 OVID-Medline.

Exclude - Systematic review - relevant topic, citations cross-matched

Goldberg B. Psychotropic drugs in children: A guide for the family physician. *Can Fam Physician.* 1989;35(DEC.):2459-63. OVID-Embase.

Exclude: Not an eligible guideline

Gonul AS, Oguz A, Yabanoglu I, et al. Buspiron and pindolol in augmentation therapy of treatment-resistant depression. *Eur Neuropsychopharmacol.* 1999;9(Suppl 5):215 Wiley-CCTR.

Exclude: Mixed antidepressants:some failed on SSRI

Gonul AS, Doksat K, Eker C, et al. Trends in serotonin uptake inhibitor research, Hauppauge, NY:Nova Biomedical Books;2005. Managing treatment-resistant depression: Focusing on increasing serotonergic transmission. OVID-PsycINFO.

Exclude: Not an eligible study design.

Gonzalez-Pinto A, Gutierrez M, Gonzalez N, et al. Efficacy and safety of venlafaxine-ECT combination in treatment-resistant depression. *J Neuropsychiatr Clin Neurosci*. 2002;14(2):206-9. PMID:11983797 OVID-Medline.

Exclude: Not an eligible study design

Gonzalez GM, Munoz RF, Perez-Arce P, et al. Depression and HIV disease in injection drug users: A Spanish language feasibility study. *Psychol Addict Behav*. 1993;7(3):149-54. OVID-PsycINFO.

Exclude: Not an eligible study design

Goodwin FK, Prange AJ, Jr., Post RM, et al. Potentiation of antidepressant effects by L-triiodothyronine in tricyclic nonresponders. *Am J Psychiatry*. 1982;139(1):34-8. PMID:7055275 OVID-Medline.

Exclude: Not an eligible study design

Goodwin GM. Evidence-based guidelines for treating bipolar disorder: Recommendations from the British Association for Psychopharmacology. *J Psychopharmacol*. 2003;17(2):149-73. OVID-Embase.

Exclude: Not an eligible guideline

Goodyer I, Dubicka B, Wilkinson P, et al. Selective serotonin reuptake inhibitors (SSRIs) and routine specialist care with and without cognitive behaviour therapy in adolescents with major depression: Randomised controlled trial. *Br Med J*. 2007;335(7611):142. PMID:17556431 OVID-Medline.

Exclude: Not an eligible population treatment

Goodyer IM, Dubicka B, Wilkinson P, et al. A randomised controlled trial of cognitive behaviour therapy in adolescents with major depression treated by selective serotonin reuptake inhibitors. The ADAPT trial. *Health Technol Assess*. 60 B.C.;12(14):iii-iv. PMID:18462573 OVID-Medline.

Exclude: Not an eligible population treatment

Gordijn MCM, Beersma DGM, Korte HJ, et al. Testing the hypothesis of a circadian phase disturbance underlying depressive mood in nonseasonal depression. *J Biol Rhythms*. 1998;13(2):132-47. OVID-PsycINFO.

Exclude: Not an eligible study design

Gordon VC, Matwychuk AC, Sachs EG, et al. A 3-yr follow-up of a cognitive-behavioral therapy intervention. *Arch Psychiatr Nurs*. 1988;2(4):218-26. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Gorgulu Y, Caliyurt O. Rapid antidepressant effects of sleep deprivation therapy correlates with serum BDNF changes in major depression. *Brain Res Bull*. 2009;80(3):158-62. PMID:19576267 OVID-Medline.

Exclude: Not an eligible population treatment

Gortner ET, Gollan JK, Dobson KS, et al. Cognitive-behavioral treatment for depression: Relapse prevention. *J Consult Clin Psychol*. 1998;66(2):377-84. PMID:9583341 OVID-Medline.

Exclude: Not an eligible population treatment

Gosney MA, Hammond MF, Shenkin A, et al. Effect of micronutrient supplementation on mood in nursing home residents. *Gerontology*. 2008;54(5):292-9. PMID:18463429 OVID-Medline.

Exclude: Not an eligible population treatment

Graf MC, Gaudiano BA, Geller PA. Written emotional disclosure: A controlled study of the benefits of expressive writing homework in outpatient psychotherapy. *Psychother Res*. 2008;18(4):389-99. PMID:18815991 OVID-Medline.

Exclude: Not an eligible population treatment

Gram LF, Rasmussen NA, Andersen PM, et al. Acute and continuation therapy in unipolar depression: Observations from the run-in phase of a maintenance trial. *Acta Psychiatr Scand*. 2008;118(2):123-9. OVID-Embase.

Exclude: Not an eligible study design

Grant GM, Salcedo V, Hynan LS, et al. Effectiveness of quality of life therapy for depression. *Psychol Rep*. 1995;76(3:Pt 2):t-8. PMID:7480486 OVID-Medline.

Exclude: Not an eligible study design

Gravem A, Amthor KF, Astrup C, et al. A double-blind comparison of citalopram (Lu 10-171) and amitriptyline in depressed patients. *Acta Psychiatr Scand*. 1987;75(5):478-86. PMID:3300171 OVID-Medline.

Exclude: Not an eligible population treatment

Gray N, Mays MZ, Wolf D, et al. Culturally focused wellness intervention for American Indian women of a small southwest community: Associations with alcohol use, abstinence self-efficacy, symptoms of depression, and self-esteem. *Am J Health Promot*. 2010;25(2):e1-10. PMID:21066905 OVID-Medline.

Exclude: Not an eligible population treatment

Greden JF, Pande AC. Treatment of resistant depression with 5-HT uptake inhibitors. *Clin Neuropharmacol*. 1992;15:Suppl-443A. PMID:1498908 OVID-Medline.

Exclude: Not an eligible study design

Greden JF, Valenstein M, Spinner J, et al. Buddy-to-Buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression, and suicide. *Ann NY Acad Sci.* 2010;1208:90-7. PMID:20955330 OVID-Medline.
Exclude: Not an eligible study design

Green BL, Krupnick JL, Chung J, et al. Impact of PTSD comorbidity on one-year outcomes in a depression trial. *J Clin Psychiatry.* 2006;62(7):815-35. PMID:16703602 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Green TD, Reynolds CF, III, Mulsant BH, et al. Accelerating antidepressant response in geriatric depression: A post hoc comparison of combined sleep deprivation and paroxetine versus monotherapy with paroxetine, nortriptyline, or placebo. *J Geriatr Psychiatry Neurol.* 1999;12(2):67-71. PMID:10483927 OVID-Medline.
Exclude: Not an eligible study design

Grenyer BF, Crowe T, Meyer B, et al. Fish oil supplementation in the treatment of major depression: A randomised double-blind placebo-controlled trial. *Prog Neuropsychopharmacol Biol Psychiatry.* 2007;31(7):1393-6. Wiley-CCTR.
Exclude: Not an eligible population treatment

Griffith PR. Is tryptophan useful in the treatment of depression? *Employee Assist Q.* 1986;2(1):23-30. OVID-Embase

OVID-Embase.
Exclude: Not an eligible study design

Griffiths KM, Christensen H. Internet-based mental health programs: A powerful tool in the rural medical kit. *Aust J Rural Health.* 2007;15(2):81-7. PMID:17441815 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Griffiths L, Blignault I, Yellowlees P. Telemedicine as a means of delivering cognitive-behavioural therapy to rural and remote mental health clients. *J Telemed Telecare.* 2006;12(3):136-40. PMID:16638234 OVID-Medline.
Exclude: Not an eligible study design

Grigoriadis S, Kennedy S H, Srinivasan J and others. SSRI augmentation with raloxifene for treatment-resistant depression. In 2001. Wiley-CCTR.
Exclude: Not an eligible study design

Grime PR. Computerized cognitive behavioural therapy at work: A randomized controlled trial in employees with recent stress-related absenteeism. *Occup Med.* 2004;54(5):353-9. Wiley-CCTR.
Exclude: Not an eligible population treatment

Grof P, Joffe R, Kennedy S, et al. An open study of oral flesinoxan, a 5-HT_{1A} receptor agonist, in treatment-resistant depression. *Int Clin Psychopharmacol.* 1993;8(3):167-72. PMID:8263314 OVID-Medline.
Exclude: Not an eligible study design

Grossman P, Kappos L, Gensicke H, et al. MS quality of life, depression, and fatigue improve after mindfulness training: A randomized trial. *Neurology.* 2010;75(13):1141-9. EBSCO-CINAHL.
Exclude: Not an eligible population/treatment

Grunhaus L, Hirschman S, Dolberg OT, et al. Coadministration of melatonin and fluoxetine does not improve the 3-month outcome following ECT. *J ECT.* 2001;17(2):124-8. PMID:11417923 OVID-Medline.
Exclude: Not an eligible population treatment

Grunhaus L J, Hirschmann S, Dolberg O T. Melatonin and fluoxetine in the prevention of depressive relapses after successful ECT treatment. In 1997. Wiley-CCTR.
Exclude: Not an eligible study design

Guaraldi GP, Fava M, Mazzi F, et al. An open trial of methyltetrahydrofolate in elderly depressed patients. *Ann Clin Psychiatr.* 1993;5(2):101-5. PMID:8348200 OVID-Medline.
Exclude: Not an eligible study design

Guelfi J D, Troy S. Sertraline in depressed patients resistant and/or intolerant to a previous treatment. In 1999 May 15; 1999. Wiley-CCTR.
Exclude: Not an eligible study design

Guétin S, Portet F, Picot MC, et al. Effect of music therapy on anxiety and depression in patients with Alzheimer's type dementia: Randomised, controlled study. *Dement Geriatr Cognit Disord.* 2009;28(1):36-46. EBSCO-CINAHL.
Exclude: Not an eligible population design

Guirguis-Younger M, Cappeliez P, Younger A. A community-based intervention for treating depression in seniors. *Can J Nurs Res.* 2008;40(1):61-79. PMID:18459272 OVID-Medline.
Exclude: Not an eligible study design

Gum AM, Arean PA, Bostrom A. Low-income depressed older adults with psychiatric comorbidity: Secondary analyses of response to psychotherapy and case management. *Int J Geriatr Psychiatry.* 2007;22(2):124-30. PMID:17096464 OVID-Medline.
Exclude: Not an eligible population treatment

Gupta PK, Kumar M, Kumari R, et al. Anuloma-Viloma Pranayama and anxiety and depression among the aged. *J Indian Acad Appl Psychol.* 2010;36(1):159-64. OVID-PsycINFO.

Exclude: Mixed antidepressants:some failed on SSRI

Gusi N, Reyes MC, Gonzalez-Guerrero JL, et al. Cost-utility of a walking programme for moderately depressed, obese, or overweight elderly women in primary care: A randomised controlled trial. *BMC Pub Health.* 2008;8:231 PMID:18611277 OVID-Medline.

Exclude: Not an eligible population treatment

Gutierrez RL, McKercher R, Galea J, et al. Lamotrigine augmentation strategy for patients with treatment-resistant depression. *CNS Spectrums.* 2005;10(10):800-5. OVID-Embase.

Exclude: Not an eligible study design

Gwirtsman HE, Szuba MP, Toren L, et al. The antidepressant response to tricyclics in major depressives is accelerated with adjunctive use of methylphenidate. *Psychopharmacol Bull.* 1994;30(2):157-64. PMID:7831449 OVID-Medline.

Exclude: Not an eligible study design

Gyulai L, Bauer M, Garcia-Espana F, et al. Bone mineral density in pre-and post-menopausal women with affective disorder treated with long-term L-thyroxine augmentation. *J Affect Disord.* 2001;66(2-3):185-91. PMID:11578671 OVID-Medline.

Exclude: Not an eligible population treatment

Ha EH, Oh KJ. Effects of cognitive-behavioral group therapy for depressive mothers of children with behavior problems. *Child Fam Behav Ther.* 2006;28(2):1-13. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Habib D, Seif ED. Effectiveness of cognitive behaviour therapy in schoolchildren with depressive symptoms in Alexandria, Egypt. *East Mediterranean Health J.* 2007;13(3):615-24. PMID:17687835 OVID-Medline.

Exclude: Not an eligible study design

Habukawa M, Uchimura N, Kakuma T, et al. Effect of CPAP treatment on residual depressive symptoms in patients with major depression and coexisting sleep apnea: Contribution of daytime sleepiness to residual depressive symptoms. *Sleep Med.* 2010;11(6):552-7. OVID-Embase.

Exclude: Not an eligible study design

Hackett ML, Anderson CS, House AO. Management of depression after stroke: A systematic review of pharmacological therapies. *Stroke.* 2005;36(5):1092-7. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Hackett ML, Anderson CS, House A, et al. Interventions for treating depression after stroke. *Cochrane Database Syst Rev.* 2008;(4):CD003437. PMID:18843644 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Hagen R, Nordahl HM, Kristiansen L, et al. A randomized trial of cognitive group therapy vs. waiting list for patients with co-morbid psychiatric disorders: Effect of cognitive group therapy after treatment and six and twelve months follow-up. *Behav Cognit Psychother.* 2005;33(1):33-44. OVID-Embase.

Exclude: Not an eligible population treatment

Hagen R, Nordahl HM, Grawe RW. Cognitive-behavioural group treatment of depression in patients with psychotic disorders. *Clin Psychol Psychother.* 2005;12(6):465-74. OVID-Embase.

Exclude: Not an eligible study design

Halford WK. Cognitive behavioural treatment of adjustment disorder with depressed mood following marital breakdown. *Behav Change.* 1987;4(1):28-33. OVID-Embase.

Exclude: Not an eligible study design

Hallert C, Astrom J, Walan A. Reversal of psychopathology in adult coeliac disease with the aid of pyridoxine (vitamin B6). *Scand J Gastroenterol.* 1983;18(2):299-304. PMID:6369511 OVID-Medline.

Exclude: Not an eligible population treatment

Hamamci Z. Integrating psychodrama and cognitive behavioral therapy to treat moderate depression. *Arts Psychother.* 2006;33(3):199-207. OVID-Embase.

Exclude: Not an eligible population treatment

Hambridge JA, Turner A, Baker AL. BraveHeart begins: pilot results of group cognitive behaviour therapy for depression and anxiety in cardiac patients. *Aust NZ J Psychiatr.* 2009;43(12):1171-7. PMID:20001417 OVID-Medline.

Exclude: Not an eligible study design

Hamdan-Mansour AM, Puskar K, Bandak AG. Effectiveness of cognitive-behavioral therapy on depressive symptomatology, stress and coping strategies among Jordanian university students. *Issues Ment Health Nurs*. 2009;30(3):188-96. PMID:19291496 OVID-Medline.
Exclude: Not an eligible population treatment

Hampel P, Graef T, Krohn-Grimberghe B, et al. Effects of gender and cognitive-behavioral management of depressive symptoms on rehabilitation outcome among inpatient orthopedic patients with chronic low back pain: A 1 year longitudinal study. *Eur Spine J*. 2009;18(12):1867-80. OVID-Embase.
Exclude: Not an eligible population treatment

Hamre HJ, Witt CM, Glockmann A, et al. Anthroposophic therapy for chronic depression: A four-year prospective cohort study. *BMC Psychiatr*. 2006;6:57 PMID:17173663 OVID-Medline.
Exclude: Not an eligible study design

Hamre HJ, Witt CM, Glockmann A, et al. Eurythmy therapy in chronic disease: A four-year prospective cohort study. *BMC Pub Health*. 2007;7, 2007. Article Number: 61. Date of Publication: 2007.: OVID-Embase.
Exclude: Not an eligible study design

Hamre HJ, Witt CM, Glockmann A, et al. Rhythmical massage therapy in chronic disease: A 4-year prospective cohort study. *J Altern Complement Med*. 2007;13(6):635-42. PMID:17718646 OVID-Medline.
Exclude: Not an eligible study design

Han C, Li X, Luo H, et al. Clinical study on electro-acupuncture treatment for 30 cases of mental depression. *J Tradit Chin Med*. 2004;24(3):172-6. PMID:15510791 OVID-Medline.
Exclude: Not an eligible population treatment

Han P, Kwan M, Chen D, et al. A controlled naturalistic study on a weekly music therapy and activity program on disruptive and depressive behaviors in dementia. *Dement Geriatr Cognit Disord*. 2011;30(6):540-6. EBSCO-CINAHL.
Exclude: Not an eligible population/treatment

Hangen KD, Vesper J, Ploch M. Multicenter double-blind study examining the antidepressant effectiveness of the hypericum extract LI 160. *J Geriatr Psychiatry Neurol*. 1994;7(Suppl):-8 PMID:7857501 OVID-Medline.
Excluded

Hannaford CP, Harrell EH, Cox K. Psychophysiological effects of a running program on depression and anxiety in a psychiatric population. *Psychol Record*. 1988;38(1):37-48. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Hannan N, Hamzah Z, Akinpeloye HO, et al. Venlafaxine-mirtazapine combination in the treatment of persistent depressive illness. *J Psychopharmacol*. 2007;21(2):161-4. PMID:17329295 OVID-Medline.
Exclude: Not an eligible study design

Hanser SB, Thompson LW. Effects of a music therapy strategy on depressed older adults. *J Gerontology*. 1994;49(6):265-9. PM:7963281
Exclude: Not an eligible population treatment

Hanson, L.M. The efficacy of three treatments for depression: Morita psychotherapy, dietary brain-chemistry treatment, and the combination of morita psychotherapy/brain-chemistry treatment as compared to no-treatment control 2002. OVID-PsycINFO.
Exclude: Not an eligible study design

Hansson M, Bodlund O, Chotai J. Patient education and group counselling to improve the treatment of depression in primary care: A randomized controlled trial. *J Affect Disord*. 2008;105(1-3):235-40. OVID-Embase.
Exclude: Not an eligible population treatment

Hantouche EG, Akiskal HS, Lancrenon S, et al. Mood stabilizer augmentation in apparently "unipolar" MDD: Predictors of response in the naturalistic French national EPIDEP study. *J Affect Disord*. 2005;84(2-3):243-9. PMID:15708422 OVID-Medline.
Exclude: Not an eligible population treatment

Harden, J.A.T. Effect of movement group therapy on depression, morale and self-esteem in aged women University of Texas at Austin. 1989. EBSCO-CINAHL.
Exclude: Not an eligible study design

Hardy GE, Cahill J, Stiles WB, et al. Sudden gains in cognitive therapy for depression: A replication and extension. *J Consult Clin Psychol*. 2005;73(1):59-67. PMID:15709832 OVID-Medline.
Exclude: Not an eligible study design

Hare HP. Comparison of chlorthalidoxepoxide-amitriptyline combination with amitriptyline alone in anxiety-depressive states. *J Clin Pharmacol New Drugs*. 1971;11(6):456-60. Wiley-CCTR.
Exclude: Not an eligible population treatment

Haringsma R, Engels GI, Cuijpers P, et al. Effectiveness of the Coping With Depression (CWD) course for older adults provided by the community-based mental health care system in the Netherlands: A randomized controlled field trial. *Int Psychogeriatr*. 2006;18(2):307-25. PMID:16255838
Exclude: Not an eligible population treatment

Harley R, Sprich S, Safren S, et al. Adaptation of dialectical behavior therapy skills training group for treatment-resistant depression. *J Nerv Ment Dis*. 2008;196(2):136-43. Wiley-CCTR.
Exclude: Not an eligible population treatment

Harner H, Hanlon AL, Garfinkel M. Effect of Iyengar yoga on mental health of incarcerated women: A feasibility study. *Nurs Res*. 2010;59(6):389-99. PMID:20842067 OVID-Medline.
Exclude: Not an eligible study design

Harrer G, Hubner WD, Podzuweit H. Effectiveness and tolerance of the hypericum extract LI 160 compared to maprotiline: A multicenter double-blind study. *J Geriatr Psychiatry Neurol*. 1994;7:Suppl-8 PMID:7857503 OVID-Medline.
Exclude: Not an eligible population treatment

Harrer G, Schmidt U, Kuhn U, et al. Comparison of equivalence between the St. John's wort extract LoHyp-57 and fluoxetine. *Arzneim-Forsch*. 1999;49(4):289-96. PMID:10337446 OVID-Medline.
Exclude: Not an eligible population treatment

Harris T, Brown GW, Robinson R. Befriending as an intervention for chronic depression among women in an inner city. 1: Randomised controlled trial. *Br J Psychiatr*. 1999;174:219-24. PMID:10448446 OVID-Medline.
Exclude: Not an eligible population treatment

Hart S, Fonareva I, Merluzzi N, et al. Treatment for depression and its relationship to improvement in quality of life and psychological well-being in multiple sclerosis patients. *Qual Life Res*. 2005;14(3):695-703. PMID:16022063 OVID-Medline.
Exclude: Not an eligible population treatment

Hartley DE, Elsabagh S, File SE. Gincosan (a combination of Ginkgo biloba and Panax ginseng): The effects on mood and cognition of 6 and 12 weeks' treatment in post-menopausal women. *Nutr Neurosci*. 2004;7(5-6):325-33. Wiley-CCTR.
Exclude: Not an eligible population treatment

Harvey AT, Silkey BS, Kornstein SG, et al. Acute worsening of chronic depression during a double-blind, randomized clinical trial of antidepressant efficacy: Differences by sex and menopausal status. *J Clin Psychiatry*. 2007;68(6):951-8. PMID:17592923 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Hauenstein EJ. Testing innovative nursing care: Home intervention with depressed rural women. *Issues Ment Health Nurs*. 1996;17(1):33-50. EBSCO-CINAHL.
Exclude: Not an eligible study design

Hautzinger, M., Jong-Meyer, R. Cognitive-behavioural therapy versus pharmacotherapy in depression. 1996:329-40. 1996. OVID-PsycINFO.
Exclude: Not an eligible study design

Hawkins WE, Latkin C, Green DL. Depression therapy with injection drug users: Results of a pilot study. *Am J Drug Alcohol Abuse*. 2005;31(2):243-51. PMID:15912714 OVID-Medline.
Exclude: Not an eligible study design

Hawley C, Sivakumaran T, Huber TJ, et al. Combination therapy with nefazodone and lithium: Safety and tolerability in fourteen patients. *Int J Psychiatr Clin Pract*. 1998;2(4):251-4. OVID-Embase.
Exclude: Not an eligible study design

Hawley CJ, Quick SJ, Ratnam S, et al. Safety and tolerability of combined treatment with moclobemide and SSRIs: a systematic study of 50 patients. *Int Clin Psychopharmacol*. 1996;11(3):187-91. PMID:8923097 OVID-Medline.
Exclude: Not an eligible study design

Hawley CJ, Pattinson HA, Quick SJ, et al. A protocol for the pharmacologic treatment of major depression. A field test of a potential prototype. *J Affect Disord*. 1998;47(1-3):87-96. PMID:9476748 OVID-Medline.
Exclude: Not an eligible guideline

Hayward LM, Sullivan AC, Libonati JR. Group exercise reduces depression in obese women without weight loss. *Percept Motor Skills*. 2000;90(1):204-8. PMID:10769900 OVID-Medline.
Exclude: Not an eligible study design

He Q, Zhang J, Tang Y. A controlled study on treatment of mental depression by acupuncture plus TCM medication. *J Tradit Chin Med*. 2007;27(3):166-9. PMID:17955648 OVID-Medline.
Exclude: Not an eligible population treatment

He Y, Wang X, Xiao C, et al. Paroxetine with psychotherapy on post-stroke depression patients, a random placebo-controlled study. *Neurol Ment Health*. 2005;(5):6-9. Exclude: Not an eligible population treatment

Hebenstreit GF, Fellerer K, Zochling R, et al. A pharmacokinetic dose titration study in adult and elderly depressed patients. *Acta Psychiatr Scand Suppl*. 1989;350:81-4. PMID:2530795 OVID-Medline.

Exclude: Not an eligible population treatment

Hejazi S, Ashayeri H, Mahmoodi M, et al. Effects of music on depression in students of Iran University of Medical Sciences, Tehran 2004. *SBMU Faculty Nurs Midwif Q*. 2005;14(47):56 EBSCO-CINAHL. Exclude: Not an eligible population treatment

Hellerstein D J, Little S, Batchelder S and others. Dysthymia: An outcome study of combined group therapy and medication treatment versus medication treatment alone. In 1997. Wiley-CCTR.

Exclude: Not an eligible study design

Hellerstein DJ, Little SA, Samstag LW, et al. Adding group psychotherapy to medication treatment in dysthymia: A randomized prospective pilot study. *J Psychother Pract Res*. 2001;10(2):93-103. PMID:11264333 OVID-Medline.

Exclude: Not an eligible population treatment

Hellerstein DJ, Batchelder S, Hyler S, et al. Aripiprazole as an adjunctive treatment for refractory unipolar depression. *Prog Neuropsychopharmacol Biol Psychiatry*. 2008;32(3):744-50. PMID:18164528 OVID-Medline.

Exclude: Not an eligible study design

Hemmeter U, Hatzinger M, Brand S, et al. Effect of flumazenil-augmentation on microsleep and mood in depressed patients during partial sleep deprivation. *J Psychiatr Res*. 2007;41(10):876-84. PMID:16978648 OVID-Medline.

Exclude: Not an eligible population treatment

Hendrickx B, Floris M. A controlled pilot study of the combination of fluvoxamine and lithium. *Curr Ther Res Clin Exp*. 1991;49(1):106-10. OVID-Embase.

Exclude: Not an eligible study design

Heninger GR, Charney DS, Sternberg DE. Lithium carbonate augmentation of antidepressant treatment. An effective prescription for treatment-refractory depression. *Arch Gen Psychiatr*. 1983;40(12):1335-42. Wiley-CCTR.

Exclude: Not an eligible population treatment

Henken T, Huibers Marcus JH, Churchill R, et al. Family therapy for depression. *Cochrane Database Syst Rev*. 2007;(3):CD006728 Wiley-CDSR. Excluded - Systematic review - relevant topic, citations cross-matched

Hennings JM, Owashi T, Binder EB, et al. Clinical characteristics and treatment outcome in a representative sample of depressed inpatients - findings from the Munich Antidepressant Response Signature (MARS) project. *J Psychiatr Res*. 2009;43(3):215-29. PMID:18586274 OVID-Medline.

Exclude: Not an eligible study design

Heresco-Levy U, Javitt DC, Gelfin Y, et al. Controlled trial of D-cycloserine adjuvant therapy for treatment-resistant major depressive disorder. *J Affect Disord*. 2006;93(1-3):239-43. PMID:16677714 OVID-Medline.

Exclude: Not an eligible population treatment

Hermens ML, van Hout HP, Terluin B, et al. Clinical effectiveness of usual care with or without antidepressant medication for primary care patients with minor or mild-major depression: A randomized equivalence trial. *BMC Med*. 2007;5:36 PMID:18067659 OVID-Medline.

Exclude: Not an eligible population treatment

Hernandez-Avila CA, Modesto-Lowe V, Feinn R, et al. Nefazodone treatment of comorbid alcohol dependence and major depression. *Alcoholism Clin Exp Res*. 2004;28(3):433-40. OVID-Embase.

Exclude: Not an eligible population treatment

Hernandez-Reif M, Ironson G, Field T, et al. Breast cancer patients have improved immune and neuroendocrine functions following massage therapy. *J Psychosom Res*. 2004;57(1):45-52. PMID:15256294 OVID-Medline.

Exclude: Not an eligible population treatment

Herrington RN, Bruce A, Johnstone EC, et al. Comparative trial of L-tryptophan and amitriptyline in depressive illness. *Psychol Med*. 1976;6(4):673-8. Wiley-CCTR.

Exclude: Not an eligible population treatment

Herwig U, Fallgatter AJ, Hoppner J, et al. Antidepressant effects of augmentative transcranial magnetic stimulation: Randomised multicentre trial. *Br J Psychiatr*. 2007;191:441-8. PMID:17978325 OVID-Medline.

Exclude: Not an eligible population treatment

Hesse M. Integrated psychological treatment for substance use and co-morbid anxiety or depression vs. treatment for substance use alone. A systematic review of the published literature. *BMC Psychiatr.* 2009;9(Art No.:6): OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Hewett K, Chrzanowski W, Schmitz M, et al. Eight-week, placebo-controlled, double-blind comparison of the antidepressant efficacy and tolerability of bupropion XR and venlafaxine XR. *J Psychopharmacol.* 2009;23(5):531-8. PMID:18635695 OVID-Medline.

Exclude: Not an eligible population treatment

Hickman SE, Barrick AL, Williams CS, et al. The effect of ambient bright light therapy on depressive symptoms in persons with dementia. *J Am Geriatr Soc.* 2007;55(11):1817-24. PMID:17944896 OVID-Medline.

Exclude: Not an eligible population design

Hides L, Carroll S, Catania L, et al. Outcomes of an integrated cognitive behaviour therapy (CBT) treatment program for co-occurring depression and substance misuse in young people. *J Affect Disord.* 2010;121(1-2):169-74. PMID:19604584 OVID-Medline.

Exclude: Not an eligible study design

Hides L, Samet S, Lubman DI. Cognitive behaviour therapy (CBT) for the treatment of co-occurring depression and substance use: Current evidence and directions for future research. *Drug Alcohol Rev.* 2010;29(5):508-17. PMID:20887574 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Hilsenroth MJ, Ackerman SJ, Blagys MD, et al. Short-term psychodynamic psychotherapy for depression: An examination of statistical, clinically significant, and technique-specific change. *J Nerv Ment Dis.* 2003;191(6):349-57. PMID:12826915 OVID-Medline.

Exclude: Not an eligible study design

Himelhoch S, Medoff DR. Efficacy of antidepressant medication among HIV-positive individuals with depression: A systematic review and meta-analysis. *Aids Patient Care STDS.* 2005;19(12):813-22. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Himelhoch S, Mohr D, Maxfield J, et al. Feasibility of telephone-based cognitive behavioral therapy targeting major depression among urban dwelling African-American people with co-occurring HIV. *Psychol Health Med.* 2011;16(2):156-65. OVID-PsycINFO.

Exclude: Not an eligible study design

Hirose S, Ashby CR, Jr. An open pilot study combining risperidone and a selective serotonin reuptake inhibitor as initial antidepressant therapy. *J Clin Psychiatry.* 2002;63(8):733-6. PMID:12197455 OVID-Medline.

Exclude: Not an eligible study design

Hirsch C, Jolley S, Williams R. A study of outcome in a clinical psychology service and preliminary evaluation of cognitive-behavioural therapy in real practice. *J Ment Health.* 2000;9(5):537-49. EBSCO-CINAHL.

Exclude: Not an eligible study design

Hirschfeld RM, Dunner DL, Keitner G, et al. Does psychosocial functioning improve independent of depressive symptoms? A comparison of nefazodone, psychotherapy, and their combination. *Biol Psychiatr.* 2002;51(2):123-33. PMID:11822991 OVID-Medline.

Exclude: Not an eligible population treatment

Hirschfeld RMA, Nemeroff CB, Dunner DL, et al. Guidelines for the long-term treatment of depression. *J Clin Psychiatr.* 1994;55(12 SUPPL.):61-9. OVID-Embase.

Exclude: Not an eligible guideline

Hitt, R.A. An evidence-based group treatment for depressed female adolescents and their mothers 2006. OVID-PsycINFO.

Exclude: Not an eligible study design

Hobi V, Gastpar M, Gastpar G, et al. Driving ability of depressive patients under antidepressants. *J Int Med Res.* 1982;10(2):65-81. PMID:6121737 OVID-Medline.

Exclude: Not an eligible population treatment

Hodgkiss AD, McCarthy PT, Sulke AN, et al. High dose tertiary amine tricyclic antidepressants in the treatment of severe refractory depression: The central role of plasma concentration estimations. *Hum Psychopharmacol.* 1995;10(5):407-15. OVID-Embase.

Exclude: Not an eligible study design

Hoencamp E, Haffmans PM, Dijken WA. Lithium addition versus brofaromine in refractory, depressed patients. *Clin Neuropharmacol.* 1992;15(1 Pt B):325 Wiley-CCTR.

Exclude: Not an eligible study design

Hoencamp E, Haffmans PM, Dijken WA, et al. Brofaromine versus lithium addition to maprotiline. A double-blind study in maprotiline refractory depressed outpatients. *J Affect Disord.* 1994;30(3):219-27. PMID:8006248 OVID-Medline. Excluded

Hoencamp E, Haffmans J, Dijken WA, et al. Lithium augmentation of venlafaxine: An open-label trial. *J Clin Psychopharmacol.* 2000;20(5):538-43. PMID:11001238 OVID-Medline. Exclude: Not an eligible study design

Hoffman BM, Babyak MA, Sherwood A, et al. Effects of aerobic exercise on sexual functioning in depressed adults. *Ment Health Phys Activ.* 2009;2(1):23-8. OVID-Embase. Exclude: Not an eligible population treatment

Hoffman BM, Babyak MA, Craighead WE, et al. Exercise and pharmacotherapy in patients with major depression: One-year Follow-Up of the SMILE study. *Psychosom Med.* 2011;73(2):127-33. OVID-Embase. Exclude: Not an eligible population/treatment

Hoffman JM, Bell KR, Powell JM, et al. A randomized controlled trial of exercise to improve mood after traumatic brain injury. *Pm & R.* 2010;2(10):911-9. PMID:20970760 OVID-Medline. Exclude: Not an eligible population treatment

Hofmann SG, Sawyer AT, Witt AA, et al. The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *J Consult Clin Psychol.* 2010;78(2):169-83. PMID:20350028 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Hogg JA, Deffenbacher JL. A comparison of cognitive and interpersonal-process group therapies in the treatment of depression among college students. *J Couns Psychol.* 1988;35(3):304-10. OVID-PsycINFO. Exclude: Not an eligible population treatment

Hojajj CR. Reconsidering antidepressants infusions for resistant depressions in out-patient service. *Neurol Psychiatr Brain Res.* 1995;3(2):129-32. OVID-Embase. Exclude: Not an eligible study design

Hollinghurst S, Peters TJ, Kaur S, et al. Cost-effectiveness of therapist-delivered online cognitive-behavioural therapy for depression: Randomised controlled trial. *Br J Psychiatr.* 2010;197(4):297-304. PMID:20884953 OVID-Medline. Exclude: Not an eligible population treatment

Hollister LE, Overall JE, Shelton J, et al. Drug therapy of depression. Amitriptyline, perphenazine, and their combination in different syndromes. *Arch Gen Psychiatr.* 1967;17(4):486-93. Wiley-CCTR. Exclude: Not an eligible population treatment

Hollon SD, DeRubeis RJ, Evans MD, et al. Cognitive therapy and pharmacotherapy for depression. Singly and in combination. *Arch Gen Psychiatr.* 1992;49(10):774-81. PMID:1417429 OVID-Medline. Exclude: Not an eligible population treatment

Hollon, S. D., DeRubeis, R. J., Evans, M. D. Cognitive therapy in the treatment and prevention of depression. 1996:293-317. 1996. OVID-PsycINFO. Exclude: Not an eligible study design

Hollon SD, DeRubeis RJ, Shelton RC, et al. Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. *Arch Gen Psychiatr.* 2005;62(4):417-22. PMID:15809409 OVID-Medline. Exclude: Not an eligible population treatment

Hollon SD, Jarrett RB, Nierenberg AA, et al. Psychotherapy and medication in the treatment of adult and geriatric depression: Which monotherapy or combined treatment? *J Clin Psychiatr.* 2005;66(4):455-68. PMID:15816788 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Hollon SD, Shelton RC. Treatment guidelines for major depressive disorder. *Behav Ther.* 2001;32(2):235-58. OVID-PsycINFO. Exclude: Not an eligible guideline

Holmgren E, Gosman-Hedstrom G, Lindstrom B, et al. What is the benefit of a high-intensive exercise program on health-related quality of life and depression after stroke? A randomized controlled trial. *Adv Physiother.* 2010;12(3):125-33. OVID-Embase. Exclude: Not an eligible population/treatment

Holroyd S, Durgee J. Venlafaxine in treatment refractory geriatric depression. *Clin Gerontol.* 1998;18(3):39-50. OVID-Embase. Exclude: Not an eligible study design

Holsboer-Trachsler E, Ernst K. Sustained antidepressive effect of repeated partial sleep deprivation. *Psychopathol.* 1986;19:Suppl-6 PMID:3575621 OVID-Medline. Exclude: Not an eligible population treatment

Holtzheimer PE, III, Meeks TW, Kelley ME, et al. A double-blind, placebo-controlled pilot study of galantamine augmentation of antidepressant treatment in older adults with major depression. *Int J Geriatr Psychiatry*. 2008;23(6):625-31. PMID:18058832 OVID-Medline.

Exclude: Not an eligible population treatment

Honore P, Moller SE, Jorgensen A. Lithium + L-tryptophan compared with amitriptyline in endogenous depression. *J Affect Disord*. 1982;4(1):79-82. PMID:6461690 OVID-Medline.

Exclude: Not an eligible population treatment

Hopko DR, Bell JL, Armento M, et al. Cognitive-behavior therapy for depressed cancer patients in a medical care setting. *Behav Ther*. 2008;39(2):126-36. PMID:18502246 OVID-Medline.

Exclude: Not an eligible study design

Hopwood SE, Bogle S, Wildgust HJ. The combination of fluoxetine and lithium in clinical practice. *Int Clin Psychopharmacol*. 1993;8(4):325-7. PMID:8277157 OVID-Medline.

Exclude: Not an eligible study design

Hornig-Rohan M, Amsterdam JD. Venlafaxine versus stimulant therapy in patients with dual diagnosis ADD and depression. *Prog Neuropsychopharmacol Biol Psychiatry*. 2002;26(3):585-9. PMID:11999912 OVID-Medline.

Exclude: Not an eligible population treatment

Horowitz A, Reinhardt JP, Boerner K. The effect of rehabilitation on depression among visually disabled older adults. *Aging Ment Health*. 2005;9(6):563-70. OVID-Embase.

Exclude: Not an eligible population treatment

Horstmann S, Lucae S, Menke A, et al. Polymorphisms in GRIK4, HTR2A, and FKBP5 show interactive effects in predicting remission to antidepressant treatment. *Neuropsychopharmacol*. 2010;35(3):727-40. OVID-Embase.

Exclude: Not an eligible population treatment

Hosaka T, Sugiyama Y. Structured intervention in family caregivers of the demented elderly and changes in their immune function. *Psychiatry Clin Neurosci*. 2003;57(2):147-51. OVID-Embase.

Exclude: Not an eligible study design

Hou WH, Chiang PT, Hsu TY, et al. Treatment effects of massage therapy in depressed people: A meta-analysis. *J Clin Psychiatr*. 2010;71(7):894-901. PMID:20361919 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Hou Y-M, Kang B, Lin J-D, et al. Combined cognitive therapy with fluoxetine hydrochloride on patients with senile depressive neurosis in open wards: A randomized controlled study. *Chin J Clin Rehab*. 2003;7(30):4105-7. OVID-Embase.

Exclude: Not an eligible population design

Houghton S, Curran J, Saxon D. An uncontrolled evaluation of group behavioural activation for depression. *Behav Cognit Psychother*. 2008;36(2):235-9. OVID-Embase.

Exclude: Not an eligible study design

Howell CA, Turnbull DA, Beilby JJ, et al. Preventing relapse of depression in primary care: A pilot study of the "Keeping the blues away" program. *Med J Aust*. 2008;188(12:Suppl):Suppl-41 PMID:18558915 OVID-Medline.

Exclude: Not an eligible population treatment

Howland RH. Sequenced treatment alternatives to relieve depression (STAR*D) - Part 2: Study outcomes. *J Psychosoc Nurs Ment Health Serv*. 2008;46(10):21-4. ISI:000259780300009 Exclude:

Not an eligible population treatment

Howland RH, Rush AJ, Wisniewski SR, et al. Concurrent anxiety and substance use disorders among outpatients with major depression: Clinical features and effect on treatment outcome. *Drug Alcohol Dependence*. 2009;99(1-3):248-60. PMID:18986774 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Høstmaelingen HJ, Asskilt O, Austad SG, et al. Primary care treatment of depression in the elderly: A double-blind, multi-centre study of flupenthixol ('Fluanxol') and sustained-release amitriptyline. *Curr Med Res Opin*. 1989;11(9):593-9. Wiley-CCTR.

Exclude: Not an eligible population treatment

Hsu W, Lai H. Effects of music on major depression in psychiatric inpatients. *Arch Psychiatr Nurs*. 2004;18(5):193-9. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Hu XZ, Rush AJ, Charney D, et al. Association between a functional serotonin transporter promoter polymorphism and citalopram treatment in adult outpatients with major depression. *Arch Gen Psychiatr*. 2007;64(7):783-92. PMID:17606812 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Huang Y, Chen J, Zou J. Effect of scalp electroacupuncture on post-stroke depression. *Chin J Clin Rehab*. 2005;9(40):172-3. OVID-Embase.

Exclude: Not an eligible population design

Hubner WD, Lande S, Podzuweit H. Hypericum treatment of mild depressions with somatic symptoms. *J Geriatr Psychiatry Neurol*. 1994;7:Suppl-4 PMID:7857500 OVID-Medline.
Exclude: Not an eligible population treatment

Hughes CW, Emslie GJ, Lynn CM, et al. The Texas children's medication algorithm project: Report of the Texas consensus conference panel on medication treatment of childhood major depressive disorder. *J Am Acad Child Adolesc Psychiatry*. 1999;38(11):1442-54. OVID-Embase.
Exclude: Not an eligible guideline

Hughes S, Cohen D. A systematic review of long-term studies of drug treated and non-drug treated depression. *J Affect Disord*. 2009;118(1-3):9-18. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Huibers Marcus JH, Beurskens A, Bleijenberg G, et al. Psychosocial interventions by general practitioners. *Cochrane Database Syst Rev*. 2007;(3):CD003494. Wiley-CDSR.
Excluded - Systematic review - relevant topic, citations cross-matched

Hunkeler EM, Meresman JF, Hargreaves WA, et al. Efficacy of nurse telehealth care and peer support in augmenting treatment of depression in primary care. *Arch Fam Med*. 2000;9(8):700-8. OVID-Embase.
Exclude: Not an eligible population treatment

Hunkeler EM, Katon W, Tang L, et al. Long term outcomes from the IMPACT randomised trial for depressed elderly patients in primary care. *Br Med J*. 2006;332(7536):259-63. PM:16428253
Exclude: Not an eligible population treatment

Husain MM, Rush JA, Wisniewski SR, et al. Family history of depression and therapeutic outcome: Findings from STAR*D. *J Clin Psychiatry*. 2009;70(2):185-95. PMID:19192454 OVID-Medline.
Exclude: Not an eligible population treatment

Huskamp HA, Azzone V, Frank RG. Carve-outs, women, and the treatment of depression. *Women's Health Issues*. 1998;8(5):267-82. OVID-Embase.
Exclude: Not an eligible population treatment

Huskamp HA, Busch AB, Domino ME, et al. Antidepressant reformulations: Who uses them, and what are the benefits? *Health Aff*. 2009;28(3):734-45. PMID:19414882 OVID-Medline.
Exclude: Not an eligible population treatment

Hvas AM, Juul S, Lauritzen L, et al. No effect of vitamin B-12 treatment on cognitive function and depression: A randomized placebo controlled study. *J Affect Disord*. 2004;81(3):269-73. PMID:15337331 OVID-Medline.
Exclude: Not an eligible population treatment

Hyer L, Yeager CA, Hilton N, et al. Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care. *Am J Alzheimer's Dis Other Dementias*. 2008;23(6):528-39. PMID:19001352 OVID-Medline.
Exclude: Not an eligible population treatment

Hynninen MJ, Bjerke N, Pallesen S, et al. A randomized controlled trial of cognitive behavioral therapy for anxiety and depression in COPD. *Respir Med*. 2010;104(7):986-94. PMID:20346640 OVID-Medline.
Exclude: Not an eligible population treatment

Hypericum Depression Trial Study Group. Effect of Hypericum perforatum (St John's wort) in major depressive disorder: A randomized controlled trial. *JAMA*. 2002;287(14):1807-14. PMID:11939866 OVID-Medline.
Exclude: Not an eligible population treatment

Hyun M, Chung HC, Lee Y. The effect of cognitive-behavioral group therapy on the self-esteem, depression, and self-efficacy of runaway adolescents in a shelter in South Korea. *Appl Nurs Res*. 2005;18(3):160-6. EBSCO-CINAHL.
Exclude: Not an eligible population treatment

Ianniello A, Ostuni PA, Sfriso P, et al. S-adenosyl-L-methionine in Sjogren's syndrome and fibromyalgia. *Curr Ther Res Clin Exp*. 1994;55(6):699-706. OVID-PsycINFO.
Exclude: Not an eligible study design

Ilhan YL, Corapcioglu A, Kocabasoglu N, et al. A prospective randomized single-blind, multicenter trial comparing the efficacy and safety of paroxetine with and without quetiapine therapy in depression associated with anxiety. *Int J Psychiatr Clin Pract*. 2004;8(4):205-11. OVID-Embase.
Exclude: Not an eligible population treatment

Ille R, Spona J, Zickl M, et al. "Add-On"-therapy with an individualized preparation consisting of free amino acids for patients with a major depression. *Eur Arch Psychiatry Clin Neurosci*. 2007;257(4):222-9. PMID:17401733 OVID-Medline.
Exclude: Not an eligible population treatment

Inoue T, Nakagawa S, Kitaichi Y, et al. Long-term outcome of antidepressant-refractory depression: the relevance of unrecognized bipolarity. *J Affect Disord.* 2006;95(1-3):61-7. PMID:16797078 OVID-Medline.

Exclude: Not an eligible study design

Inoue T, Kitaichi Y, Masui T, et al. Pramipexole for stage 2 treatment-resistant major depression: An open study. *Prog Neuropsychopharmacol Biol Psychiatry.* 2010;34(8):1446-9. OVID-Embase.

Exclude: Not an eligible study design

Inoue T, Abekawa T, Nakagawa S, et al. Long-term naturalistic follow-up of lithium augmentation: Relevance to bipolarity. *J Affect Disord.* 2011;129(1-3):64-7. OVID-Embase.

Exclude: Not an eligible study design

Inoue T, Tsuchiya K, Miura J, et al. Bromocriptine treatment of tricyclic and heterocyclic antidepressant-resistant depression. *Biol Psychiatry.* 1996;40(2):151-3. OVID-PsycINFO.

Exclude: Not an eligible study design

Insel TR, Wang PS. The STAR*D trial: Revealing the need for better treatments. *Psychiatr Serv.* 2009;60(11):1466-7. PMID:19880463 OVID-Medline.

Exclude: Not an eligible population treatment

Interian A, Allen LA, Gara MA, et al. A pilot study of culturally adapted cognitive behavior therapy for Hispanics with major depression. *Cognit Behav Pract.* 2008;15(1):67-75. OVID-Embase.

Exclude: Not an eligible study design

Ioannidis JPA, Evans SJW, Gotzsche PC, et al. Better reporting of harms in randomized trials: An extension of the CONSORT statement. *Ann Intern Med.* 2004;141(10):781-8. ISI:000225206900005

Exclude: Not an eligible guideline

Iosifescu DV, Nierenberg AA, Mischoulon D, et al. An open study of triiodothyronine augmentation of selective serotonin reuptake inhibitors in treatment-resistant major depressive disorder. *J Clin Psychiatry.* 2005;66(8):1038-42. PMID:16086620 OVID-Medline.

Exclude: Not an eligible study design

Iosifescu DV, Bolo NR, Nierenberg AA, et al. Brain bioenergetics and response to triiodothyronine augmentation in major depressive disorder. *Biol Psychiatry.* 2008;63(12):1127-34. PMID:18206856 OVID-Medline.

Exclude: Not an eligible study design

Iqbal S, Bassett M. Evaluation of perceived usefulness of activity scheduling in an inpatient depression group. *J Psychiatr Ment Health Nurs.* 2008;15(5):393-8. PMID:18454825 OVID-Medline.

Exclude: Not an eligible study design

Irene R, Luis MA, Helena D-C, et al. Switching to duloxetine from selective serotonin reuptake inhibitors in non- or partial responders: Results from a Spanish sample. *Int J Psychiatr Clin Pract.* 2009;13(2):100-8. OVID-Embase.

Exclude: Not an eligible study design

Isaac MT, Isaac MB, Gallo F, et al. Milnacipran and pindolol: A randomized trial of reduction of antidepressant latency. *Hum Psychopharmacol.* 2003;18(8):595-601. PMID:14696018 OVID-Medline.

Exclude: Not an eligible population treatment

Ising M, Lucae S, Binder EB, et al. A genomewide association study points to multiple loci that predict antidepressant drug treatment outcome in depression. *Arch Gen Psychiatr.* 2009;66(9):966-75. PMID:19736353 OVID-Medline.

Exclude: For Mixed antidepressants; some failed on SSRI

Itil TM, Michael ST, Baccari S. Antidepressant effects of fluoxetine, a long-acting potent thymoleptic (a double-blind controlled trial). *Curr Ther Res Clin Exp.* 1984;35(6):1014-32. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Ivkovic M, Damjanovic A, Jovanovic A, et al. Lamotrigine versus lithium augmentation of antidepressant therapy in treatment-resistant depression: Efficacy and tolerability. *Psychiatria Danubina.* 2009;21(2):187-93. PMID:19556947 OVID-Medline.

Exclude: Mixed antidepressants: some failed on SSRI

Izumi T, Inoue T, Kitagawa N, et al. Open pergolide treatment of tricyclic and heterocyclic antidepressant-resistant depression. *J Affect Disord.* 2000;61(1-2):127-32. PMID:11099751 OVID-Medline.

Exclude: Not an eligible study design

Jacobs MK, Christensen A, Snibbe JR, et al. A comparison of computer-based versus traditional individual psychotherapy. *Prof Psychol Res Pract.* 2001;32(1):92-6. Exclude: Not an eligible population treatment

Jacobsen FM. Possible augmentation of antidepressant response by buspirone. *J Clin Psychiatry*. 1991;52(5):217-20. PMID:2033029 OVID-Medline.

Exclude: Not an eligible study design

Jacobson AF. Doctor-patient concordance in a placebo-controlled trial of limbitrol versus its components. *Psychopharmacol Bull*. 1978;14(3):61-3. Wiley-CCTR.

Exclude: Not an eligible study design

Jacobson NS, Dobson K, Fruzzetti AE, et al. Marital therapy as a treatment for depression. *J Consult Clin Psychol*. 1991;59(4):547-57. PMID:1918559 OVID-Medline.

Exclude: Not an eligible population treatment

Jacobson NS, Fruzzetti AE, Dobson K, et al. Couple therapy as a treatment for depression: II. The effects of relationship quality and therapy on depressive relapse. *J Consult Clin Psychol*. 1993;61(3):516-9. PMID:8326054 OVID-Medline.

Exclude: Not an eligible population treatment

Jahn H, Schick M, Kiefer F, et al. Metyrapone as additive treatment in major depression: A double-blind and placebo-controlled trial. *Arch Gen Psychiatr*. 2004;61(12):1235-44. PMID:15583115 OVID-Medline.

Exclude: Not an eligible population treatment

James AC, Winmill L, Anderson C, et al. A preliminary study of an extension of a community dialectic behaviour therapy (DBT) programme to adolescents in the looked after care system. *Child Adolesc Ment Health*. 2011;16(1):9-13. OVID-Embase.

Exclude: Not an eligible study design

James RT, Dean BC. A comparison of a single night-time and a divided daily dosage regimen of a chlordiazepoxide/amitriptyline combination. *Curr Med Res Opin*. 1980;6(8):573-5. Wiley-CCTR.

Exclude: Not an eligible population treatment

James RT, Dean BC. Comparison of limbitrol (chlordiazepoxide/amitriptyline) and amitriptyline alone as a single night-time dose for the treatment of depression with anxiety. *J Int Med Res*. 1985;13(2):84-7. PMID:3888730 OVID-Medline.

Exclude: Not an eligible population treatment

Jamison C, Scogin F. The outcome of cognitive bibliotherapy with depressed adults. *J Consult Clin Psychol*. 1995;63(4):644-50. PMID:7673542 OVID-Medline.

Exclude: Not an eligible population treatment

Jamison, C.S.'. Outcome, process, and client variables in cognitive bibliotherapy with depressed adults 1994. OVID-PsycINFO.

Exclude: Not an eligible study design

Janakiramaiah N, Gangadhar BN, Murthy PJN, et al. Therapeutic efficacy of Sudarshan Kriya Yoga (SKY) in dysthymic disorder. *Nimhans J*. 1998;16(1):21-8. OVID-PsycINFO.

Exclude: Not an eligible study design

Janakiramaiah N, Gangadhar BN, Naga Venkatesha Murthy PJ, et al. Antidepressant efficacy of Sudarshan Kriya Yoga (SKY) in melancholia: A randomized comparison with electroconvulsive therapy (ECT) and imipramine. *J Affect Disord*. 2000;57(1-3):255-9. PMID:10708840 OVID-Medline.

Exclude: Not an eligible population treatment

Jansen IH, Olde Rikkert MG, Hulsbos HA, et al. Toward individualized evidence-based medicine: five "N of 1" trials of methylphenidate in geriatric patients. *J Am Geriatr Soc*. 2001;49(4):474-6. PMID:11347795 OVID-Medline.

Exclude: Not an eligible study design

Januel D, Galinowski A, Poirier MF, et al. Prospective study of antidepressants combined with lithium in unipolar depression: Preliminary results. *Lithium*. 1994;5(4):253-7. OVID-PsycINFO.

Exclude: Not an eligible study design

Januel D, Poirier MF, D'alche-Biree F, et al. Multicenter double-blind randomized parallel-group clinical trial of efficacy of the combination clomipramine (150 mg/day) plus lithium carbonate (750 mg/day) versus clomipramine (150 mg/day) plus placebo in the treatment of unipolar major depression. *J Affect Disord*. 2003;76(1-3):191-200. Wiley-CCTR.

Exclude: Not an eligible population treatment

Jarrett RB, Basco MR, Risser R, et al. Is there a role for continuation phase cognitive therapy for depressed outpatients? *J Consult Clin Psychol*. 1998;66(6):1036-40. PMID:9874918 OVID-Medline.

Exclude: Not an eligible population treatment

Jarrett RB, Schaffer M, McIntire D, et al. Treatment of atypical depression with cognitive therapy or phenelzine: A double-blind, placebo-controlled trial. *Arch Gen Psychiatr*. 1999;56(5):431-7. PMID:10232298 OVID-Medline.

Exclude: Not an eligible population treatment

Jarrett RB, Kraft D, Doyle J, et al. Preventing recurrent depression using cognitive therapy with and without a continuation phase: A randomized clinical trial. *Arch Gen Psychiatr*. 2001;58(4):381-8. PMID:11296099 OVID-Medline.

Exclude: Not an eligible population treatment

Javnbakht M, Kenari RH, Ghasemi M. Effects of yoga on depression and anxiety of women. *Complement Ther Clin Pract*. 2009;15(2):102-4. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Jazayeri S, Tehrani-Doost M, Keshavarz SA, et al. Comparison of therapeutic effects of omega-3 fatty acid eicosapentaenoic acid and fluoxetine, separately and in combination, in major depressive disorder. *Aust NZ J Psychiatr*. 2008;42(3):192-8. PMID:18247193 OVID-Medline.

Exclude: Not an eligible population treatment

Jefferson JW. Treating affective disorders in the presence of cardiovascular disease. *Psychiatr Clin North Am*. 1983;6(1):141-55. PMID:6889170 OVID-Medline.

Exclude: Not an eligible study design

Jensen C. Psychosocial treatment of depression in women: Nine single-subject evaluations. *Res Soc Work Pract*. 1994;4(3):267-82. OVID-PsycINFO.

Exclude: Not an eligible study design

Jensen HV, Olafsson K, Lykke-Olesen L, et al. Combining nortriptyline and lithium in elderly depressed patients: A double-blind, placebo-controlled study. *Lithium*. 1992;3(4):259-62. OVID-Embase.

Exclude: Not an eligible population treatment

Ji Y, Hebbiring S, Zhu H, et al. Glycine and a glycine dehydrogenase (GLDC) SNP as citalopram/escitalopram response biomarkers in depression: pharmacometabolomics-informed pharmacogenomics. *Clin Pharmacol Therapeut*. 2011;89(1):97-104. PMID:21107318 OVID-Medline.

Exclude: Systematic Review before 2005

Jiahui Z, Peng S. Clinical observation on acupuncture treatment of depressive neurosis in 30 cases. *J Tradit Chin Med*. 2006;26(3):191-2. PMID:17078447 OVID-Medline.

Exclude: Not an eligible population treatment

Joanne L, Jim M, Constance L, et al. Cognitive-behavioral and psychodynamic group psychotherapy in treatment of geriatric depression. *J Consult Clin Psychol*. 1984;52(2):180-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Joffe H, Groninger H, Soares C, et al. An open trial of mirtazapine in menopausal women with depression unresponsive to estrogen replacement therapy. *J Womens Health Gender Based Med*. 2001;10(10):999-1004. OVID-Embase.

Exclude: Not an eligible study design

Joffe H, Petrillo LF, Viguera AC, et al. Treatment of premenstrual worsening of depression with adjunctive oral contraceptive pills: A preliminary report. *J Clin Psychiatry*. 2007;68(12):1954-62. PMID:18162029 OVID-Medline.

Exclude: Not an eligible population treatment

Joffe RT, Singer W. A comparison of triiodothyronine and thyroxine in the potentiation of tricyclic antidepressants. *Psychiatry Res*. 1990;32(3):241-51. PMID:2201988 OVID-Medline.

Exclude: Not an eligible population treatment

Joffe RT, Singer W. Thyroid hormone use to enhance the effects of drugs. *Clin Neuropharmacol*. 1992;15 Suppl 1 Pt A:389A-90A. Wiley-CCTR.

Exclude: Not an eligible population treatment

Joffe RT, Singer W, Levitt AJ, et al. A placebo-controlled comparison of lithium and triiodothyronine augmentation of tricyclic antidepressants in unipolar refractory depression. *Arch Gen Psychiatr*. 1993;50(5):387-93. Wiley-CCTR.

Exclude: Not an eligible population treatment

Joffe RT, Schuller DR. An open study of buspirone augmentation of serotonin reuptake inhibitors in refractory depression. *J Clin Psychiatry*. 1993;54(7):269-71. PMID:8335654 OVID-Medline.

Exclude: Not an eligible study design

Joffe RT, Bakish D. Combined SSRI-moclobemide treatment of psychiatric illness. *J Clin Psychiatry*. 1994;55(1):24-5. PMID:8294388 OVID-Medline.

Exclude: Not an eligible study design

Joffe RT, Levitt AJ, Sokolov ST, et al. Response to an open trial of a second SSRI in major depression. *J Clin Psychiatry*. 1996;57(3):114-5. PMID:8617695 OVID-Medline.

Exclude: Not an eligible study design

Joffe RT, Levitt AJ. Relationship between antidepressant partial and nonresponse and subsequent response to antidepressant augmentation. *J Affect Disord*. 1999;52(1-3):257-9. PMID:10357043 OVID-Medline.

Exclude: Not an eligible population treatment

Joffe RT, Sawka AM, Marriott MJ, et al. Does substitution of T4 with T3 plus T4 for T4 replacement improve depressive symptoms in patients with hypothyroidism? *Ann NY Acad Sci.* 2004;1032:287-8. Wiley-CCTR.

Exclude: Not an eligible population design

Johnson JE, Zlotnick C. A pilot study of group interpersonal psychotherapy for depression in substance-abusing female prisoners. *J Subst Abuse Treat.* 2008;34(4):371-7. OVID-Embase.

Exclude: Not an eligible study design

Johnston GA. Megavitamins and psychotherapy: Effective, economical and time-saving treatment: A three year study. *J Orthomolecular Med.* 1993;8(2):104-20. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Johnston JA, Lineberry CG, Ascher JA, et al. A 102-center prospective study of seizure in association with bupropion. *J Clin Psychiatr.* 1991;52(11):450-6. OVID-PsycINFO.

Exclude: Not an eligible study design

Johnstone EC, Owens DG, Lambert MT, et al. Combination tricyclic antidepressant and lithium maintenance medication in unipolar and bipolar depressed patients. *J Affect Disord.* 1990;20(4):225-33. PMID:2149728 OVID-Medline.

Exclude: Not an eligible population treatment

Joliat MJ, Brown EB, Miner CM. Changes in energy after switching from daily citalopram, paroxetine, or sertraline to once-weekly fluoxetine. *J Clin Psychopharmacol.* 2004;24(4):464-7. OVID-PsycINFO.

Exclude: Not an eligible study design

Jones ID, Karapiperis V, Bowman L, et al. Does formal psychoeducational support influence anxiety and depression levels in cardiac patients and their relatives? A pilot study. *J Cardpulm Rehabil.* 2006;26(3):172-5. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Joo JH, Lenze EJ, Mulsant BH, et al. Risk factor for falls during treatment of late-life depression. *J Clin Psychiatry.* 2002;63(10):936-41. Exclude: Not an eligible study design

Jorde R, Sneve M, Figenschau Y, et al. Effects of vitamin D supplementation on symptoms of depression in overweight and obese subjects: Randomized double blind trial. *J Intern Med.* 2008;264(6):599-609. PMID:18793245 OVID-Medline.

Exclude: Not an eligible population treatment

Jorm AF, Allen NB, O'Donnell CP, et al. Effectiveness of complementary and self-help treatments for depression in children and adolescents. *Med J Aust.* 2006;185(7):368-72. PMID:17014404 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Jorm AF, Morgan AJ, Hetrick SE. Relaxation for depression. *Cochrane Database Syst Rev.* 2008;(4):CD007142. PMID:18843744 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Judd FK, Piterman L, Cockram AM, et al. A comparative study of venlafaxine with a focused education and psychotherapy program versus venlafaxine alone in the treatment of depression in general practice. *Hum Psychopharmacol.* 2001;16(5):423-8. OVID-Embase.

Exclude: Not an eligible population treatment

Jungkunz G, Nedopil N, Ruther E. Acute effects of the synthetic analogue of methionine enkephalin FK 33-824 on depressive symptoms. *Pharmacopsychiatry.* 1983;16(3):90-2. PMID:6351118 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Juruena MF, Pariante CM, Papadopoulos AS, et al. Prednisolone suppression test in depression: Prospective study of the role of HPA axis dysfunction in treatment resistance. *Br J Psychiatr.* 2009;194(4):342-9. PMID:19336786 OVID-Medline.

Exclude: Not an eligible population treatment

Justine M, Hamid TA. A multicomponent exercise program for institutionalized older adults. *J Gerontol Nurs.* 2010;36(10):32-41. PMID:20438009 OVID-Medline.

Exclude: Not an eligible population treatment

Kaas MJ, Lewis ML. Cognitive behavioral group therapy for residents in assisted-living facilities. *J Psychosoc Nurs Ment Health Serv.* 1999;37(10):9-15. PMID:10529958 OVID-Medline.

Exclude: Not an eligible study design

Kagan BL, Sultzer DL, Rosenlicht N, et al. Oral S-adenosylmethionine in depression: A randomized, double-blind, placebo-controlled trial. *Am J Psychiatry.* 1990;147(5):591-5. PMID:2183633 OVID-Medline.

Exclude: Not an eligible population treatment

Kahan JS, Mitchell JM, Kemp BJ, et al. The results of a 6-month treatment for depression on symptoms, life satisfaction, and community activities among individuals aging with a disability. *Rehabil Psychol*. 2006;51(1):13-22. OVID-Embase.

Exclude: Not an eligible population treatment

Kahn JS, Kehle TJ, Jenson WR, et al. Comparison of cognitive-behavioral, relaxation, and self-modeling interventions for depression among middle-school students. *School Psychol Rev*. 1990;19(2):196-211. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Kalb R, Trautmann-Sponsel RD, Kieser M. Efficacy and tolerability of hypericum extract WS 5572 versus placebo in mildly to moderately depressed patients. A randomized double-blind multicenter clinical trial. *Pharmacopsychiatr*. 2001;34(3):96-103. PMID:11434406 OVID-Medline.

Exclude: Not an eligible population treatment

Kallepalli BR, Bhatara VS, Fogas BS, et al. Trazodone is only slightly faster than fluoxetine in relieving insomnia in adolescents with depressive disorders. *J Child Adolesc Psychopharmacol*. 1997;7(2):97-107. PMID:9334895 OVID-Medline.

Exclude: Not an eligible population treatment

Kaltenthaler E, Parry G, Beverley C, et al. Computerised cognitive-behavioural therapy for depression: Systematic review. *Br J Psychiatr*. 2008;193(3):181-4. PMID:18757972 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Kamlet MS, Wade M, Kupfer DJ, et al. Economics and mental health, Baltimore, MD, US: Johns Hopkins University Press;1992. Cost-utility analysis of maintenance treatment for recurrent depression: A theoretical framework and numerical illustration. OVID-PsycINFO.

Exclude: Not an eligible study design.

Kamlet MS, Paul N, Greenhouse J, et al. Cost utility analysis of maintenance treatment for recurrent depression. *Control Clin Trials*. 1995;16(1):17-40. PMID:7743786 OVID-Medline.

Exclude: Not an eligible population treatment

Kane JM, Quitkin FM, Rifkin A, et al. Lithium carbonate and imipramine in the prophylaxis of unipolar and bipolar II illness: A prospective, placebo-controlled comparison. *Arch Gen Psychiatr*. 1982;39(9):1065-9. Wiley-CCTR.

Exclude: Not an eligible population treatment

Kang HS, Sok SR, Kang JS. Effects of Meridian acupuncture for stroke patients in Korea. *J Clin Nurs*. 2009;18(15):2145-52. PMID:19583646 OVID-Medline.

Exclude: Not an eligible population treatment

Kannappan R, Lakshmi Bai R. Cognitive behaviour therapy as an adjunct to drug therapy in the treatment of dysthymic disorder. *J Indian Acad Appl Psychol*. 2007;33(2):195-200. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Kannappan R. Intervention as an adjunct to drug therapy for childhood depression. *J Indian Acad Appl Psychol*. 2009;35(1):57-62. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Kantor D, McNevin S, Leichner P, et al. The benefit of lithium carbonate adjunct in refractory depression: Fact or fiction? *Can J Psychiatr*. 1986;31(5):416-8. Wiley-CCTR.

Exclude: Not an eligible population treatment

Kaplan EM. Efficacy of venlafaxine in patients with major depressive disorder who have unsustained or no response to selective serotonin reuptake inhibitors: An open-label, uncontrolled study. *Clin Ther*. 2002;24(7):1194-200. OVID-PsycINFO.

Exclude: Not an eligible study design

Kaplan K, Mendelson LB, Ploener DM. The effect of a jogging program on psychiatric inpatients with symptoms of depression. *Occup Ther J Res*. 1983;3(3):173-5. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Karavidas MK, Lehrer PM, Vaschillo E, et al. Preliminary results of an open label study of heart rate variability biofeedback for the treatment of major depression. *Appl Psychophysiol Biofeedback*. 2007;32(1):19-30. PMID:17333315 OVID-Medline.

Exclude: Not an eligible study design

Karp JF, Whyte EM, Lenze EJ, et al. Rescue pharmacotherapy with duloxetine for selective serotonin reuptake inhibitor nonresponders in late-life depression: Outcome and tolerability. *J Clin Psychiatry*. 2008;69(3):457-63. PMID:18251622 OVID-Medline.

Exclude: Not an eligible study design

Karp JF, Weiner DK, Dew MA, et al. Duloxetine and care management treatment of older adults with comorbid major depressive disorder and chronic low back pain: Results of an open-label pilot study. *Int J Geriatr Psychiatry*. 2010;25(6):633-42. PMID:19750557 OVID-Medline.

Exclude: Not an eligible study design

Kasckow JW, Mohamed S, Thallasinos A, et al. Citalopram augmentation of antipsychotic treatment in older schizophrenia patients. *Int J Geriatr Psychiatry*. 2001;16(12):1163-7. PMID:11748776 OVID-Medline.

Exclude: Not an eligible population treatment

Kashner TM, Henley SS, Golden RM, et al. Assessing the preventive effects of cognitive therapy following relief of depression: A methodological innovation. *J Affect Disord*. 2007;104(1-3):251-61. PMID:17509693 OVID-Medline.

Exclude: Not an eligible population treatment

Kashner TM, Trivedi MH, Wicker A, et al. The impact of nonclinical factors on care use for patients with depression: A STAR*D report. *CNS Neurosci Therapeut*. 2009;15(4):320-32. PMID:19712127 OVID-Medline.

Exclude: Not an eligible population treatment

Kashner TM, Trivedi MH, Wicker A, et al. Release bias in accessing medical records in clinical trials: A STAR*D report. *Int J Meth Psychiatr Res*. 2009;18(3):147-58. OVID-Embase.

Exclude: Not an eligible population treatment

Kaslow NJ, Leiner AS, Reviere S, et al. Suicidal, abused African American women's response to a culturally informed intervention. *J Consult Clin Psychol*. 2010;78(4):449-58. OVID-PsycINFO.

Exclude: Not an eligible population/treatment

Kasper S, Yieira A. Stimulation with dl-fenfluramine and antidepressive medication in major depressed inpatients. *Pharmacopsychiatr*. 1989;22(5):201 OVID-Embase.

Exclude: Not an eligible study design

Kasper S, Voll G, Vieira A, et al. Response to total sleep deprivation before and during treatment with fluvoxamine or maprotiline in patients with major depression: Results of a double-blind study. *Pharmacopsychiatr*. 1990;23(3):135-42.

PMID:2115680 OVID-Medline.

Exclude: Not an eligible population treatment

Kasper S, Angheliescu IG, Szegedi A, et al. Superior efficacy of St John's wort extract WS 5570 compared to placebo in patients with major depression: A randomized, double-blind, placebo-controlled, multi-center trial. *BMC Med*. 2006;4:14 PMID:16796730 OVID-Medline.

Exclude: Not an eligible population treatment

Kasper S, Angheliescu IG, Szegedi A, et al. Placebo controlled continuation treatment with Hypericum extract WS 5570 after recovery from a mild or moderate depressive episode. *Wien Med Wochenschr*. 2007;157(13-14):362-6.

PMID:17704988 OVID-Medline.

Exclude: Not an eligible population treatment

Kasper S, Gastpar G, Muller WE, et al. Efficacy of St. John's wort extract WS 5570 in acute treatment of mild depression: A reanalysis of data from controlled clinical trials. *Eur Arch Psychiatry Clin Neurosci*. 2011;258(1):59-63. PMID:18084790 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Kataoka SH, Stein BD, Jaycox LH, et al. A school-based mental health program for traumatized Latino immigrant children. *J Am Acad Child Adolesc Psychiatry*. 2003;42(3):311-8. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Katona CL, Abou-Saleh MT, Harrison DA, et al. Placebo-controlled trial of lithium augmentation of fluoxetine and lofepramine. *Br J Psychiatr*. 1995;166(1):80-6. PMID:7894881 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Katzelnick DJ, Simon GE, Pearson SD, et al. Randomized trial of a depression management program in high utilizers of medical care. *Arch Fam Med*. 2000;9(4):345-51. PMID:10776363 OVID-Medline.

Exclude: Not an eligible population treatment

Kaufmann MW, Cassem NH, Murray GB, et al. Use of psychostimulants in medically ill patients with neurological disease and major depression. *Can J Psychiatr*. 1984;29(1):46-9. PMID:6704886 OVID-Medline.

Exclude: Not an eligible study design

Kay-Lambkin FJ, Baker AL, Lewin TJ, et al. Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: A randomized controlled trial of clinical efficacy. *Addiction*. 2009;104(3):378-88. PMID:19207345 OVID-Medline.

Exclude: Not an eligible population treatment

Kay-Lambkin FJ, Baker AL, McKetin R, et al. Stepping through treatment: Reflections on an adaptive treatment strategy among methamphetamine users with depression. *Drug Alcohol Rev*. 2010;29(5):475-82. PMID:20887570 OVID-Medline.

Exclude: Not an eligible population treatment

Keller M. Cross-over study of sertraline versus imipramine in chronic depression. In 1996; 1996. Wiley-CCTR.

Exclude: Not an eligible study design

Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *N Engl J Med.* 2000;342(20):1462-70. PMID:10816183 OVID-Medline.

Exclude: Not an eligible population treatment

Kellner CH, Knapp RG, Petrides G, et al. Continuation electroconvulsive therapy vs pharmacotherapy for relapse prevention in major depression: A multisite study from the consortium for research in electroconvulsive therapy (CORE). *Arch Gen Psychiatr.* 2006;63(12):1337-44. OVID-Embase.

Exclude: Not an eligible population treatment

Kelly AC, Zuroff DC, Shapira LB. Soothing oneself and resisting self-attacks: The treatment of two intrapersonal deficits in depression vulnerability. *Cognit Ther Res.* 2009;33(3):301-13. OVID-Embase.

Exclude: Not an eligible population treatment

Kelly FD, Dowd ET, Duffey DK. A comparison of cognitive and behavioural intervention strategies in the treatment of depression. *Br J Cognit Psychother.* 1983;1(2):51-8. OVID-PsycINFO.

Exclude: Mixed antidepressants:some failed on SSRI

Kelly JA, Murphy DA, Bahr GR, et al. Outcome of cognitive-behavioral and support group brief therapies for depressed, HIV-infected persons. *Am J Psychiatry.* 1993;150(11):1679-86. PMID:8214177 OVID-Medline.

Exclude: Not an eligible population treatment

Kelly TF, Lieberman DZ. Long term augmentation with T3 in refractory major depression. *J Affect Disord.* 2009;115(1-2):230-3. PMID:19108898 OVID-Medline.

Exclude: Not an eligible study design

Kemp BJ, Kahan JS, Krause JS, et al. Treatment of major depression in individuals with spinal cord injury. *J Spinal Cord Med.* 2004;27(1):22-8. PMID:15156933 OVID-Medline.

Exclude: Not an eligible study design

Kemp BJ, Corgiat M, Gill C. Effects of brief cognitive-behavioral group psychotherapy on older persons with and without disabling illness. *Behav Health Aging.* 1991;2(1):21-8. OVID-PsycINFO.

Exclude: Not an eligible study design

Kendrick T, Simons L, Mynors-Wallis L, et al. A trial of problem-solving by community mental health nurses for anxiety, depression and life difficulties among general practice patients. The CPN-GP study. *Health Technol Assess.* 2005;9(37):iii-59 OVID-Embase.

Exclude: Not an eligible population treatment

Kendrick T, Chatwin J, Dowrick C, et al. Randomised controlled trial to determine the clinical effectiveness and cost-effectiveness of selective serotonin reuptake inhibitors plus supportive care, versus supportive care alone, for mild to moderate depression with somatic symptoms in primary care: The THREAD (THREshold for AntiDepressant response) study. *Health Technol Assess.* 2009;13(22):1-159. OVID-Embase.

Exclude: Not an eligible population treatment

Kennard B, Silva S, Vitiello B, et al. Remission and residual symptoms after short-term treatment in the Treatment of Adolescents with Depression Study (TADS). *J Am Acad Child Adolesc Psychiatry.* 2006;45(12):1404-11. PMID:17135985 OVID-Medline.

Exclude: Not an eligible population treatment

Kennard BD, Emslie GJ, Mayes TL, et al. Cognitive-behavioral therapy to prevent relapse in pediatric responders to pharmacotherapy for major depressive disorder. *J Am Acad Child Adolesc Psychiatry.* 2008;47(12):1395-404. PMID:18978634 OVID-Medline.

Exclude: Not an eligible population treatment

Kennard BD, Stewart SM, Hughes JL, et al. Developing cognitive behavioral therapy to prevent depressive relapse in youth. *Cognit Behav Pract.* 2008;15(4):387-99. OVID-Embase.

Exclude: Not an eligible study design

Kennard BD, Silva SG, Mayes TL, et al. Assessment of safety and long-term outcomes of initial treatment with placebo in TADS. *Am J Psychiatry.* 2009;166(3):337-44. PMID:19147693 OVID-Medline.

Exclude: Not an eligible population treatment

Kennard BD, Silva SG, Tonev S, et al. Remission and recovery in the treatment for adolescents with depression study (TADS): Acute and long-term outcomes. *J Am Acad Child Adolesc Psychiatry.* 2009;48(2):186-95. OVID-Embase.

Exclude: Not an eligible population treatment

Kennard BD, Clarke GN, Weersing VR, et al. Effective components of TORDIA cognitive-behavioral therapy for adolescent depression: Preliminary findings. *J Consult Clin Psychol*. 2009;77(6):1033-41. PMID:19968380 OVID-Medline.

Exclude: Not an eligible population treatment

Kennedy N, Paykel ES. Treatment and response in refractory depression: results from a specialist affective disorders service. *J Affect Disord*. 2004;81(1):49-53. PMID:15183599 OVID-Medline.

Exclude: Not an eligible study design

Kennedy P, Duff J, Evans M, et al. Coping effectiveness training reduces depression and anxiety following traumatic spinal cord injuries. *Br J Clin Psychol*. 2003;42(1):41-52. OVID-Embase.

Exclude: Not an eligible population treatment

Kennedy SH, Eisfeld BS, Meyer JH, et al. Antidepressants in clinical practice: Limitations of assessment methods and drug response. *Hum Psychopharmacol*. 2001;16(1):105-14. OVID-Embase.

Exclude: Not an eligible population treatment

Kennedy SH, Lam RW, Cohen NL, et al. Clinical guidelines for the treatment of depressive disorders. IV. Medications and other biological treatments. *Can J Psychiatr*. 2001;46(Suppl-58S) PMID:11441771 OVID-Medline.

Exclude: Not an eligible guideline

Kennedy SH, Cohen NL, Lam RW, et al. Combining psychotherapy and pharmacotherapy. *Can J Psychiatr*. 2001;46(SUPPL. 1):59S-62S. OVID-Embase.

Exclude: Not an eligible guideline

Kennedy SH, Lam RW, Cohen NL, et al. Medications and other biological treatments. *Can J Psychiatr*. 2001;46(SUPPL. 1):38S-58S. OVID-Embase.

Exclude: Not an eligible guideline

Kennedy S H, Srinivasan J, Fulton K. SSRI augmentation with raloxifene for treatment-resistant depression sophie grigoriadis. In 2001. Wiley-CCTR.

Exclude: Not an eligible study design

Kennedy SH, McCann SM, Masellis M, et al. Combining bupropion SR with venlafaxine, paroxetine, or fluoxetine: A preliminary report on pharmacokinetic, therapeutic, and sexual dysfunction effects. *J Clin Psychiatry*. 2002;63(3):181-6.

Exclude: Mixed antidepressants:some failed on SSRI

Kennedy SH, Lam RW, Cohen NL, et al. Reboxetine: a preliminary report on its use through the Special Access Program. *J Psychiatr Neurosci*. 2002;27(6):418-22. PMID:12491574 OVID-Medline.

Exclude: Not an eligible study design

Kennedy SH, Lam RW, Morris B. Clinical guidelines for depressive disorders: Summary of recommendations relevant to family physicians. *Can Fam Physician*. 2003;49(APR.):489-91. OVID-Embase.

Exclude: Not an eligible guideline

Kennedy SH, Segal ZV, Cohen NL, et al. Lithium carbonate versus cognitive therapy as sequential combination treatment strategies in partial responders to antidepressant medication: an exploratory trial. *J Clin Psychiatry*. 2003;64(4):439-44. PMID:12716247 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Kennedy SH, Emsley R. Placebo-controlled trial of agomelatine in the treatment of major depressive disorder. *Eur Neuropsychopharmacol*. 2006;16(2):93-100. OVID-Embase.

Exclude: Not an eligible population treatment

Kennedy SH, Konarski JZ, Segal ZV, et al. Differences in brain glucose metabolism between responders to CBT and venlafaxine in a 16-week randomized controlled trial. *Am J Psychiatry*. 2007;164(5):778-88. PMID:17475737 OVID-Medline.

Exclude: Not an eligible population treatment

Kennedy SH, Milev R, Giacobbe P, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. IV. Neurostimulation therapies. *J Affect Disord*. 2009;117(Suppl. 1):S44-S53 OVID-Embase.

Exclude: Not an eligible guideline

Kenny MA, Williams JM. Treatment-resistant depressed patients show a good response to Mindfulness-based Cognitive Therapy. *Behav Res Ther*. 2007;45(3):617-25. PMID:16797486 OVID-Medline.

Exclude: Not an eligible study design

Kerfoot M, Harrington R, Harrington V, et al. A step too far? Randomized trial of cognitive-behaviour therapy delivered by social workers to depressed adolescents. *Eur Child Adolesc Psychiatry*. 2004;13(2):92-9. PMID:15103534 OVID-Medline.

Exclude: Not an eligible population treatment

Kerr J, Calfas KJ, Caparosa S, et al. A pilot study to assess the feasibility and acceptability of a community based physical activity intervention (involving internet, telephone, and pedometer support), integrated with medication and mood management for depressed patients. *Ment Health Phys Activ.* 2008;1(1):40-5. OVID-Embase.
Exclude: Not an eligible study design

Kerse N, Hayman KJ, Moyes SA, et al. Home-based activity program for older people with depressive symptoms: DeLLITE--a randomized controlled trial. *Ann Fam Med.* 2010;8(3):214-23. PMID:20458104 OVID-Medline.

Exclude: Not an eligible population treatment

Kessler D, Lewis G, Kaur S, et al. Therapist-delivered Internet psychotherapy for depression in primary care: A randomised controlled trial. *Lancet.* 2009;374(9690):628-34. PMID:19700005 OVID-Medline.

Exclude: Not an eligible population treatment

Ketter TA, Post RM, Parekh PI, et al. Addition of monoamine oxidase inhibitors to carbamazepine: Preliminary evidence of safety and antidepressant efficacy in treatment-resistant depression. *J Clin Psychiatry.* 1995;56(10):471-5. Wiley-CCTR.
Exclude: Not an eligible population treatment

Khandker RK, Kruzikas DT, McLaughlin TP. Pharmacy and medical costs associated with switching between venlafaxine and SSRI antidepressant therapy for the treatment of major depressive disorder. *J Manage Care Pharm.* 2008;14(5):426-41. PMID:18597572 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Khullar A, Chokkha P, Fullerton DL, et al. A double-blind, randomized, placebo-controlled study of quetiapine as augmentation therapy to SSRI/SNRI agents in the treatment of non-psychotic unipolar depression with residual symptoms. [Abstract] *Am Psychiatr Assoc Ann Meeting: New Res Abst* 2006;

Khumar SS, Kaur P, Kaur S. Effectiveness of Shavasana on depression among university students. *Indian J Clin Psychol.* 1993;20(2):82-7. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Kiloh LG, Moore G. An open trial of zimelidine in patients with endogenous depression. *Int Pharmacopsychiatry.* 1982;17(1):28-35. PMID:6211416 OVID-Medline.
Exclude: Not an eligible study design

Kim KB, Cohen SM, Oh HK, et al. The effects of meridian exercise on anxiety, depression, and self-esteem of female college students in Korea. *Holist Nurs Pract.* 2004;18(5):230-4. EBSCO-CINAHL.
Exclude: Not an eligible population treatment

Kim SW, Shin IS, Kim JM, et al. Amisulpride versus risperidone in the treatment of depression in patients with schizophrenia: A randomized, open-label, controlled trial. *Prog Neuropsychopharmacol Biol Psychiatry.* 2007;31(7):1504-9. PMID:17692448 OVID-Medline.

Exclude: Not an eligible population treatment

Kim W, Lim S-K, Chung E-J, et al. The effect of cognitive behavior therapy-based psychotherapy applied in a forest environment on physiological changes and remission of major depressive disorder. *Psychiatr Investig.* 2009;6(4):245-54. OVID-Embase.

Exclude: Not an eligible population treatment

Kim Y, Bowers J. Efficacy of acupuncture for treating depression. *Altern Ther Womens Health.* 2007;9(7):49-53. EBSCO-CINAHL.
Exclude: Not an eligible study design

Kinder LS, Katon WJ, Ludman E, et al. Improving depression care in patients with diabetes and multiple complications. *J Gen Intern Med.* 2006;21(10):1036-41. PMID:16836628 OVID-Medline.
Exclude: Not an eligible population treatment

King C, Kennedy P. Coping effectiveness training for people with spinal cord injury: Preliminary results of a controlled trial. *Br J Clin Psychol.* 1999;38 (Pt 1):5-14. Wiley-CCTR.
Exclude: Not an eligible population treatment

King DJ. Drug management of depression. *Ir Med J.* 1983;76(1):44-50. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

King M, Sibbald B, Ward E, et al. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. *Health Technol Assess.* 2000;4(19):1-83. PMID:11086269 OVID-Medline.

Exclude: Not an eligible population treatment

Kingston T, Dooley B, Bates A, et al. Mindfulness-based cognitive therapy for residual depressive symptoms. *Psychol Psychother.* 2007;80(Pt:2):203. PMID:17535594 OVID-Medline.

Exclude: Not an eligible population treatment

Kinsinger SW, Lattie E, Mohr DC. Relationship between depression, fatigue, subjective cognitive impairment, and objective neuropsychological functioning in patients with Multiple Sclerosis. *Neuropsychology*. 2010;24(5):573-80. OVID-Embase.

Exclude: Not an eligible population treatment

Kinzie JD, Leung P. Clonidine in Cambodian patients with posttraumatic stress disorder. *J Nerv Ment Dis*. 1989;177(9):546-50. PMID:2769247 OVID-Medline.

Exclude: Not an eligible study design

Kiosses DN, Arean PA, Teri L, et al. Home-delivered problem adaptation therapy (PATH) for depressed, cognitively impaired, disabled elders: A preliminary study. *Am J Geriatr Psychiatry*. 2010;18(11):988-98. OVID-Embase.

Exclude: Not an eligible population/treatment

Kirkham MA. Two-year follow-up of skills training with mothers of children with disabilities. *Am J Ment Retard*. 1993;97(5):509-20. OVID-Embase.

Kirstein L. Neuroendocrine dysfunction and response to tricyclic antidepressants. *J Clin Psychiatry*. 1984;45(9):385-6. PMID:6432772 OVID-Medline.

Exclude: Not an eligible population treatment

Kissane DW, Grabsch B, Clarke DM, et al. Supportive-expressive group therapy for women with metastatic breast cancer: Survival and psychosocial outcome from a randomized controlled trial. *Psychooncol*. 2007;16(4):277-86. PMID:17385190 OVID-Medline.

Exclude: Not an eligible population treatment

Kitsumban V, Thapinta D, Sirindharo PB, et al. Effect of cognitive mindfulness practice program on depression among elderly Thai women. *Thai J Nurs*. 2009;13(2):95-107. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Klaiber EL, Broverman DM, Vogel W, et al. Estrogen therapy for severe persistent depressions in women. *Arch Gen Psychiatry*. 1979;36(5):550-4. Wiley-CCTR.

Exclude: Not an eligible population treatment

Klausner EJ, Clarkin JF, Spielman L, et al. Late-life depression and functional disability: The role of goal-focused group psychotherapy. *Int J Geriatr Psychiatry*. 1998;13(10):707-16. PMID:9818307 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Kleber HD, Weissman MM, Rounsaville BJ, et al. Imipramine as treatment for depression in addicts. *Arch Gen Psychiatry*. 1983;40(6):649-53. PMID:6342564 OVID-Medline.

Exclude: Not an eligible population treatment

Klein DN, Santiago NJ, Vivian D, et al. Cognitive-behavioral analysis system of psychotherapy as a maintenance treatment for chronic depression. *J Consult Clin Psychol*. 2004;72(4):681-8. PMID:15301653 OVID-Medline.

Exclude: Not an eligible population treatment

Klein DN, Arnow BA, Barkin JL, et al. Early adversity in chronic depression: Clinical correlates and response to pharmacotherapy. *Depress Anxiety*. 2009;26(8):701-10. OVID-Embase.

Exclude: Not an eligible study design

Klein JB, Jacobs RH, Reinecke MA. Cognitive-behavioral therapy for adolescent depression: A meta-analytic investigation of changes in effect-size estimates. *J Am Acad Child Adolesc Psychiatry*. 2007;46(11):1403-13. PMID:18049290 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Klein MH, Greist JH, Gurman AS. A comparative outcome study of group psychotherapy vs. exercise treatments for depression. *Int J Ment Health*. 1985;13(3-4):148-77. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Klein, R.A. Expectancy enhancement as a precursor to cognitive therapy for depression: A pilot investigation 2009. OVID-PsycINFO.

Exclude: Not an eligible study design

Klieser E, Lehmann E. Experimental comparison between the effect of standardized trazodone-amitriptyline and placebo treatment in vitalized depressive patients. *Psychopharmacol*.

1988;95:Suppl-5 PMID:3133710 OVID-Medline.

Exclude: Not an eligible population treatment

Kline NS, Shah BK. Comparable therapeutic efficacy of tryptophan and imipramine: Average therapeutic ratings versus "true" equivalence. An important difference. *Curr Ther Res Clin Exp*. 1973;15(7):484-7. Wiley-CCTR.

Exclude: Not an eligible study design

Knapen J, Van d, V, van Coppenolle H, et al. Comparison of changes in physical self-concept, global self-esteem, depression and anxiety following two different psychomotor therapy programs in nonpsychotic psychiatric inpatients. *Psychother Psychosom.* 2005;74(6):353-61. OVID-Embase.
Exclude: Not an eligible population treatment

Knapen J, Sommerijns E, Vancampfort D, et al. State anxiety and subjective well-being responses to acute bouts of aerobic exercise in patients with depressive and anxiety disorders. *Br J Sports Med.* 2009;43(10):756-9. OVID-Embase.
Exclude: Not an eligible population treatment

Knoth RL, Bolge SC, Kim E, et al. Effect of inadequate response to treatment in patients with depression. *Am J Manag Care.* 2010;16(8):e188-e196 PMID:20690785 OVID-Medline.
Exclude: Not an eligible population treatment

Knowlton L. Investigating SAM-e for depression. *Psychiatr Times.* 2001;18(5):-10p EBSCO-CINAHL.
Exclude: Not an eligible study design

Knubben K, Reischies FM, Adli M, et al. A randomised, controlled study on the effects of a short-term endurance training programme in patients with major depression. *Br J Sports Med.* 2007;41(1):29-33. PMID:17062659 OVID-Medline.
Exclude: Not an eligible population treatment

Kobayashi N, Sawamura T, Yoshida T, et al. The effectiveness of lithium augmentation of milnacipran: Preliminary data using the modified Japanese Psychopharmacology Algorithm. *Nihon Shinkei Seishin Yakurigaku Zasshi.* 2004;24(5):279-81. PMID:15658504 OVID-Medline.
Exclude: Not an eligible study design

Koch JM, Hinze-Selch D, Stinge K, et al. Changes in CREB phosphorylation and BDNF plasma levels during psychotherapy of depression. *Psychother Psychosom.* 2009;78(3):187-92. PMID:19321972 OVID-Medline.
Exclude: Not an eligible study design

Kocsis JH, Friedman RA, Markowitz JC, et al. Maintenance therapy for chronic depression: A controlled clinical trial of desipramine. *Arch Gen Psychiatr.* 1996;53(9):769-76. OVID-Embase.
Exclude: Not an eligible population treatment

Kocsis JH, Rush AJ, Markowitz JC, et al. Continuation treatment of chronic depression: A comparison of nefazodone, cognitive behavioral analysis system of psychotherapy, and their combination. *Psychopharmacol Bull.* 2003;37(4):73-87. PMID:15131518 OVID-Medline.
Exclude: Not an eligible population treatment

Koertge J, Janszky I, Sundin O, et al. Effects of a stress management program on vital exhaustion and depression in women with coronary heart disease: A randomized controlled intervention study. *J Intern Med.* 2008;263(3):281-93. PMID:18067552 OVID-Medline.
Exclude: Not an eligible population treatment

Kohlenberg RH, Kanter JW, Bolling MY, et al. Enhancing cognitive therapy for depression with functional analytic psychotherapy: Treatment guidelines and empirical findings. *Cognit Behav Pract.* 2002;9(3):213-29. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Kohler WK, Pelzer A, Schmidt K-P, et al. Bright light and dim light in the therapy of depression: Effects on the circadian system and clinical results. *Pharmacopsychiatr.* 1989;22(5):202 OVID-Embase.
Exclude: Not an eligible study design

Kohn-Wood, Laura, Hudson, Glenetta, Graham, Erin T. Ethnic minorities. 2008:351-72. 2008. OVID-PsycINFO.
Exclude: Not an eligible study design

Kohn CS, Petrucci RJ, Baessler C, et al. The effect of psychological intervention on patients' long-term adjustment to the ICD: A prospective study. *Pacing Clin Electrophysiol.* 2000;23(4:Pt 1):t-6 PMID:10793433 OVID-Medline.
Exclude: Not an eligible population treatment

Koike K, Ohno S, Takahashi N, et al. Efficacy of the herbal medicine Unkei-to as an adjunctive treatment to hormone replacement therapy for postmenopausal women with depressive symptoms. *Clin Neuropharmacol.* 2004;27(4):157-62. PMID:15319700 OVID-Medline.
Exclude: Not an eligible population treatment

Kojima R, Fujisawa D, Tajima M, et al. Efficacy of cognitive behavioral therapy training using brief e-mail sessions in the workplace: A controlled clinical trial. *Ind Health.* 2010;48(4):495-502. PMID:20720342 OVID-Medline.
Exclude: Not an eligible population treatment

Kok RM, Vink D, Heeren TJ, et al. Lithium augmentation compared with phenelzine in treatment-resistant depression in the elderly: An open, randomized, controlled trial. *J Clin Psychiatry*. 2007;68(8):1177-85. Wiley-CCTR.

Exclude: Not an eligible population treatment

Kok RM, Nolen WA, Heeren TJ. Outcome of late-life depression after 3 years of sequential treatment. *Acta Psychiatr Scand*. 2009;119(4):274-81. PMID:19053970 OVID-Medline.

Exclude: Not an eligible population treatment

Komossa K, Depping AM, Gaudchau A, et al. Second-generation antipsychotics for major depressive disorder and dysthymia. *Cochrane Database Syst Rev*. 2010;12:CD008121. PMID:21154393 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Konarski JZ, Kennedy SH, Segal ZV, et al. Predictors of nonresponse to cognitive behavioural therapy or venlafaxine using glucose metabolism in major depressive disorder. *J Psychiatr Neurosci*. 2009;34(3):175-80. PMID:19448846 OVID-Medline.

Exclude: Not an eligible population treatment

Kong S. Day treatment programme for patients with eating disorders: Randomized controlled trial. *J Adv Nurs*. 2005;51(1):5-14. Wiley-CCTR.

Exclude: Not an eligible population treatment

Koniak-Griffin D. Aerobic exercise, psychological well-being, and physical discomforts during adolescent pregnancy. *Res Nurs Health*. 1994;17(4):253-63. OVID-PsycINFO.

Exclude: Not an eligible study design

Konig F, Wolfersdorf M. Combination therapy using moclobemide with tricyclic and tetracyclic antidepressants to treat therapy-resistant depression. *Pharmacopsychiatr*. 1997;30(3):93-6. PMID:9211570 OVID-Medline.

Exclude: Not an eligible population treatment

Konuk N, Atasoy N, Atik L, et al. Open-label study of adjunct modafinil for the treatment of patients with fatigue, sleepiness, and major depression treated with selective serotonin reuptake inhibitors. *Adv Ther*. 2006;23(4):646-54. PMID:17050507 OVID-Medline.

Exclude: Not an eligible study design

Koo JR, Yoon JY, Joo MH, et al. Treatment of depression and effect of antidepressant treatment on nutritional status in chronic hemodialysis patients. *Am J Med Sci*. 2005;329(1):1-5. PMID:15654172 OVID-Medline.

Exclude: Not an eligible population treatment

Kool S, Dekker J, Duijsens IJ, et al. Changes in personality pathology after pharmacotherapy and combined therapy for depressed patients. *J Personal Disord*. 2003;17(1):60-72. PMID:12659547 OVID-Medline.

Exclude: Not an eligible population treatment

Kool S, Dekker J, Duijsens IJ, et al. Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. *Harv Rev Psychiatry*. 2003;11(3):133-41. PMID:12893503 OVID-Medline.

Exclude: Not an eligible population treatment

Kopecek M, Bares M, Svarc J, et al. Hyperprolactinemia after low dose of amisulpride. *Neuroendocrinol Lett*. 2004;25(6):419-22. PMID:15665803 OVID-Medline.

Exclude: Not an eligible study design

Kopecek M, Bares M, Horacek J, et al. Low-dose risperidone augmentation of antidepressants or anxiolytics is associated with hyperprolactinemia. *Neuroendocrinol Lett*. 2006;27(6):803-6. PMID:17187006 OVID-Medline.

Exclude: Not an eligible study design

Koran LM, Aboujaoude EN, Gamel NN. Duloxetine treatment of dysthymia and double depression: An open-label trial. *J Clin Psychiatry*. 2007;68(5):761-5. PMID:17503986 OVID-Medline.

Exclude: Not an eligible study design

Korn L, Logsdon RG, Polissar NL, et al. A randomized trial of a cam therapy for stress reduction in American Indian and Alaskan native family caregivers. *Gerontologist*. 2009;49(3):368-77. OVID-Embase.

Exclude: Not an eligible population treatment

Kornstein SG, Dunner DL, Meyers AL, et al. A randomized, double-blind study of increasing or maintaining duloxetine dose in patients without remission of major depressive disorder after initial duloxetine therapy. *J Clin Psychiatry*. 2008;69(9):1383-92. PMID:19193339 OVID-Medline.

Exclude: Not an eligible population treatment

Koszycki D, Lafontaine S, Frasure-Smith N, et al. An open-label trial of interpersonal psychotherapy in depressed patients with coronary disease. *Psychosom.* 2004;45(4):319-24. OVID-Embase. Exclude: Not an eligible population treatment

Kouidi E, Karagiannis V, Grekas D, et al. Depression, heart rate variability, and exercise training in dialysis patients. *Eur J Cardiovasc Prev Rehab.* 2010;17(2):160-7. OVID-Embase. Exclude: Not an eligible population treatment

Koutra A, Katsiadrami A, Diakogiannis G. The effect of group psychological counselling in Greek university students' anxiety, depression, and self-esteem. *Eur J Psychother Counsell.* 2010;12(2):101-11. OVID-PsycINFO. Exclude: Not an eligible study design

Kovac SH, Range LM. Does writing about suicidal thoughts and feelings reduce them? *Suicide Life Threat Behav.* 2002;32(4):428-40. Wiley-CCTR. Exclude: Not an eligible population treatment

Kovach-Anta, C.M. The effects of physical activity on levels of depression, anxiety, and hypochondriasis in the elderly 1998. OVID-PsycINFO. Exclude: Not an eligible study design

Kowalenko N, Rapee RM, Simmons J, et al. Short-term effectiveness of a school-based early intervention program for adolescent depression. *Clin Child Psychol Psychiatry.* 2005;10(4):493-507. EBSCO-CINAHL. Exclude: Not an eligible population treatment

Kozel FA, Trivedi MH, Wisniewski SR, et al. Treatment outcomes for older depressed patients with earlier versus late onset of first depressive episode: A Sequenced Treatment Alternatives to Relieve Depression (STAR*D) report. *Am J Geriatr Psychiatry.* 2008;16(1):58-64. PMID:18165462 OVID-Medline. Exclude: Not an eligible population treatment

Kraaij V, van EA, Garnefski N, et al. Effects of a cognitive behavioral self-help program and a computerized structured writing intervention on depressed mood for HIV-infected people: a pilot randomized controlled trial. *Patient Educ Couns.* 2010;80(2):200-4. PMID:19781889 OVID-Medline. Exclude: Not an eligible population treatment

Kramer, M.M. The effects of exercise on psychological well-being in women recovering from breast cancer 1996. OVID-PsycINFO. Exclude: Not an eligible study design

Kramer MS, Vogel WH, DiJohnson C, et al. Antidepressants in 'depressed' schizophrenic inpatients. A controlled trial. *Arch Gen Psychiatry.* 1989;46(10):922-8. PMID:2679483 OVID-Medline. Exclude: Not an eligible population design

Kramlinger KG, Post RM. The addition of lithium to carbamazepine. Antidepressant efficacy in treatment-resistant depression. *Arch Gen Psychiatry.* 1989;46(9):794-800. Wiley-CCTR. Exclude: Not an eligible population treatment

Krampen G. Long-term evaluation of the effectiveness of additional autogenic training in the psychotherapy of depressive disorders. *Eur Psychol.* 1999;4(1):11-8. Exclude: Not an eligible population treatment

Kranzler HR, Burleson JA, Korner P, et al. Placebo-controlled trial of fluoxetine as an adjunct to relapse prevention in alcoholics. *Am J Psychiatry.* 1995;152(3):391-7. PMID:7864265 OVID-Medline. Exclude: Not an eligible population treatment

Kratochvil C, Emslie G, Silva S, et al. Acute time to response in the Treatment for Adolescents with Depression Study (TADS). *J Am Acad Child Adolesc Psychiatry.* 2006;45(12):1412-8. PMID:17135986 OVID-Medline. Exclude: Not an eligible population treatment

Kratochvil CJ, Newcorn JH, Arnold LE, et al. Atomoxetine alone or combined with fluoxetine for treating ADHD with comorbid depressive or anxiety symptoms. *J Am Acad Child Adolesc Psychiatry.* 2005;44(9):915-24. PMID:16113620 OVID-Medline. Exclude: Not an eligible population treatment

Kraus RP, Diaz P, McEachran A. Managing rapid metabolizers of antidepressants. *Depress Anxiety.* 1996;4(6):320-7. PMID:9166660 OVID-Medline. Exclude: Not an eligible study design

Kravitz HM, Sabelli HC, Fawcett J. Dietary supplements of phenylalanine and other amino acid precursors of brain neuroamines in the treatment of depressive disorders. *J Am Osteopath Assoc.* 1984;84(1 SUPPL.):119-23. OVID-Embase

OVID-Embase. Exclude: Not an eligible study design

Kripke DF, Mullaney DJ, Klauber MR, et al. Controlled trial of bright light for nonseasonal major depressive disorders. *Biol Psychiatry.* 1992;31(2):119-34. PMID:1737074 OVID-Medline. Exclude: Not an eligible population treatment

Krishna M, Jauhari A, Lepping P, et al. Is group psychotherapy effective in older adults with depression? A systematic review. *Int J Geriatr Psychiatry*. 2011;26(4):331-40. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Krishnamurthy MN, Telles S. Assessing depression following two ancient Indian interventions. *J Gerontol Nurs*. 2007;33(2):17-23. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Kroenke K, Bair MJ, Damush TM, et al. Optimized antidepressant therapy and pain self-management in primary care patients with depression and musculoskeletal pain: A randomized controlled trial. *JAMA*. 2009;301(20):2099-110. PMID:19470987 OVID-Medline.

Exclude: Not an eligible population treatment

Krogh J, Saltin B, Gluud C, et al. The DEMO trial: A randomized, parallel-group, observer-blinded clinical trial of strength versus aerobic versus relaxation training for patients with mild to moderate depression. *J Clin Psychiatry*. 2009;70(6):790-800. PMID:19573478 OVID-Medline.

Exclude: Not an eligible population treatment

Kroll L, Harrington R, Jayson D, et al. Pilot study of continuation cognitive-behavioral therapy for major depression in adolescent psychiatric patients. *J Am Acad Child Adolesc Psychiatry*. 1996;35(9):1156-61. PMID:8824059 OVID-Medline.

Exclude: Not an eligible population treatment

Kronsoble, K.M. Psychological effects of habitual aerobic exercise on cardiac patients 1996. OVID-PsycINFO.

Exclude: Not an eligible study design

Krystal A, Fava M, Rubens R, et al. Evaluation of eszopiclone discontinuation after cotherapy with fluoxetine for insomnia with coexisting depression. *J Clin Sleep Med*. 2007;3(1):48-55. PMID:17557453 OVID-Medline.

Exclude: Not an eligible population treatment

Kua EH. Pharmacotherapy and psychotherapy in the treatment of depression in the elderly. *Singapore Med J*. 2000;41(3 SUPPL.):35-6. OVID-Embase. Excluded: Not an eligible population treatment

Kudoh A, Ishihara H, Matsuki A. Effect of carbamazepine on pain scores of unipolar depressed patients with chronic pain: A trial of off-on-off-on design. *Clin J Pain*. 1998;14(1):61-5. Wiley-CCTR. Excluded: Not an eligible study design

Kuehner C. An evaluation of the 'Coping with Depression Course' for relapse prevention with unipolar depressed patients. *Psychother Psychosom*. 2005;74(4):254-9. PMID:15947516 OVID-Medline. Excluded: Not an eligible study design

Kufferle B, Grunberger J. Early clinical double-blind study with S-adenosyl-L-methionine: A new potential antidepressant. *Adv Biochem Psychopharmacol*. 1982;32:175-80. PMID:7046363 OVID-Medline. Excluded: Not an eligible population treatment

Kuhner C, Angermeyer MC, Veiel HOF. Cognitive-behavioral group intervention as a means of tertiary prevention in depressed patients: Acceptance and short-term efficacy. *Cognit Ther Res*. 1996;20(4):391-409. OVID-PsycINFO. Excluded: Not an eligible study design

Kuhs H, Färber D, Borgstädt S, et al. Amitriptyline in combination with repeated late sleep deprivation versus amitriptyline alone in major depression. A randomised study. *J Affect Disord*. 1996;37(1):31-41. Wiley-CCTR.

Exclude: Not an eligible population treatment

Kuhs H, Kemper B, Lippe-Neubauer U, et al. Repeated sleep deprivation once versus twice a week in combination with amitriptyline. *J Affect Disord*. 1998;47(1-3):97-103. Wiley-CCTR.

Exclude: Not an eligible population treatment

Kuk AY, Li J, Rush AJ. Recursive subsetting to identify patients in the STAR*D: A method to enhance the accuracy of early prediction of treatment outcome and to inform personalized care. *J Clin Psychiatr*. 2010;71(11):1502-8. PMID:21114950 OVID-Medline.

Exclude: Systematic Review before 2005

Kulcu DG, Kurtais Y, Tur BS, et al. The effect of cardiac rehabilitation on quality of life, anxiety and depression in patients with congestive heart failure. A randomized controlled trial, short-term results. *Eur Medicophys*. 2007;43(4):489-97. EBSCO-CINAHL. Excluded: Not an eligible population treatment

Kumagai R, Ichimiya Y. Efficacy of blonanserin in combination therapy for treatment-resistant depression. *Psychiatry Clin Neurosci*. 2009;63(4):593-4. PMID:19659567 OVID-Medline. Excluded: Not an eligible study design

Kundermann B, Hemmeter-Spernal J, Huber MT, et al. Effects of total sleep deprivation in major depression: Overnight improvement of mood is accompanied by increased pain sensitivity and augmented pain complaints. *Psychosom Med*. 2008;70(1):92-101. PMID:18158380 OVID-Medline.

Exclude: Not an eligible population treatment

Kundermann B, Strate P, Hemmeter-Spernal J, et al. Mid-term effects of serial sleep deprivation therapy implemented in cognitive-behavioral treatment on the neuroendocrine response to clomipramine in patients with major depression. *J Psychiatr Res*. 2009;43(7):711-20. PMID:18930473 OVID-Medline.

Exclude: Not an eligible population treatment

Kunik ME, Pollock BG, Perel JM, et al. Clomipramine in the elderly: Tolerance and plasma levels. *J Geriatr Psychiatry Neurol*. 1994;7(3):139-43. PMID:7916936 OVID-Medline.

Exclude: Not an eligible study design

Kunik ME, Braun U, Stanley MA, et al. One session cognitive behavioural therapy for elderly patients with chronic obstructive pulmonary disease. *Psychol Med*. 2001;31(4):717-23. PMID:11352373 OVID-Medline.

Exclude: Not an eligible population treatment

Kunik ME, Veazey C, Cully JA, et al. COPD education and cognitive behavioral therapy group treatment for clinically significant symptoms of depression and anxiety in COPD patients: A randomized controlled trial. *Psychol Med*. 2008;38(3):385-96. PMID:17922939 OVID-Medline.

Exclude: Not an eligible population treatment

Kupfer DJ, Spiker DG. Refractory depression: Prediction of non-response by clinical indicators. *J Clin Psychiatry*. 1981;42(8):307-12. PMID:7251567 OVID-Medline.

Exclude: Not an eligible study design

Kupfer DJ, Perel JM, Frank E. Adequate treatment with imipramine in continuation treatment. *J Clin Psychiatry*. 1989;50(7):250-5. PMID:2661546 OVID-Medline.

Exclude: Not an eligible study design

Kurland AA, Nagaraju A. Viloxazine and the depressed schizophrenic: Methodological issues. *J Clin Pharmacol*. 1981;21(1):37-41. PMID:7012190 OVID-Medline.

Exclude: Not an eligible population treatment

Kush FR, Fleming LM. An innovative approach to short-term group cognitive therapy in the combined treatment of anxiety and depression. *Group Dynam*. 2000;4(2):176-83. OVID-Embase.

Exclude: Not an eligible study design

Kutcher S, LeBlanc J, Maclaren C, et al. A randomized trial of a specific adherence enhancement program in setraline-treated adults with major depressive disorder in a primary care setting. *Prog Neuropsychopharmacol Biol Psychiatry*. 2002;26(3):591-6. OVID-PsycINFO.

Exclude: Mixed antidepressants:some failed on SSRI

Kuyken W, Byford S, Taylor RS, et al. Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *J Consult Clin Psychol*. 2008;76(6):966-78. PMID:19045965 OVID-Medline.

Exclude: Not an eligible population treatment

Kvist J, Kirkegaard C. Effect of repeated sleep deprivation on clinical symptoms and the TRH test in endogenous depression. *Acta Psychiatr Scand*. 1980;62(5):494-502. PMID:6782834 OVID-Medline.

Exclude: Not an eligible study design

Kwamie Y, Persad E, Stancer H. The use of carbamazepine as an adjunctive medication in the treatment of affective disorders: A clinical report. *Can J Psychiatry*. 1984;29(7):605-8. PMID:6150757 OVID-Medline.

Exclude: Not an eligible study design

Laakmann G, Schule C, Baghai T, et al. St. John's wort in mild to moderate depression: The relevance of hyperforin for the clinical efficacy. *Pharmacopsychiatr*. 1998;31:Suppl-9 PMID:9684948 OVID-Medline.

Exclude: Not an eligible population treatment

Labbé EE, Welsh MC, Delaney D. Effects of consistent aerobic exercise on the psychological functioning of women. *Percept Motor Skills*. 1988;67(3):919-25. Wiley-CCTR.

Exclude: Not an eligible population treatment

Lafferman J, Solomon K, Ruskin P. Lithium augmentation for treatment-resistant depression in the elderly. *J Geriatr Psychiatry Neurol*. 1988;1(1):49-52. PMID:3150926 OVID-Medline.

Exclude: Not an eligible study design

Lai SM, Studenski S, Richards L, et al. Therapeutic exercise and depressive symptoms after stroke. *J Am Geriatr Soc*. 2006;54(2):240-7. PMID:16460374 OVID-Medline.

Exclude: Not an eligible population design

Lai Y. Effects of music listening on depressed women in Taiwan. *Issues Ment Health Nurs.* 1999;20(3):229-46. EBSCO-CINAHL.
Exclude: Not an eligible population treatment

Laidlaw K, Davidson K, Toner H, et al. A randomised controlled trial of cognitive behaviour therapy vs treatment as usual in the treatment of mild to moderate late life depression. *Int J Geriatr Psychiatry.* 2008;23(8):843-50. PMID:18311844 OVID-Medline.
Exclude: Not an eligible population treatment

Laje G, Paddock S, Manji H, et al. Genetic markers of suicidal ideation emerging during citalopram treatment of major depression. *Am J Psychiatry.* 2007;164(10):1530-8. PMID:17898344 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Laje G, Allen AS, Akula N, et al. Genome-wide association study of suicidal ideation emerging during citalopram treatment of depressed outpatients. *Pharmacogenetics Genom.* 2009;19(9):666-74. PMID:19724244 OVID-Medline.
Exclude: Not an eligible population treatment

Laje G, Perlis RH, Rush AJ, et al. Pharmacogenetics studies in STAR*D: Strengths, limitations, and results. *Psychiatr Serv.* 2009;60(11):1446-57. PMID:19880459 OVID-Medline.
Exclude: Not an eligible population treatment

Lam JY, Freeman MK, Cates ME. Modafinil augmentation for residual symptoms of fatigue in patients with a partial response to antidepressants. *Ann Pharmacother.* 2007;41(6):1005-12. PMID:17519297 Excluded - Systematic review - relevant topic, citations cross-matched

Lam RW, Hossie H, Solomons K, et al. Citalopram and bupropion-SR: Combining versus switching in patients with treatment-resistant depression. *J Clin Psychiatry.* 2004;65(3):337-40. PMID:15096072 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Lam RW, Lonn SL, Despiegel N. Escitalopram versus serotonin noradrenaline reuptake inhibitors as second step treatment for patients with major depressive disorder: A pooled analysis. *Int Clin Psychopharmacol.* 2010;25(4):199-203. PMID:20357664 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Lam RW, Lutz K, Preece M, et al. Telephone-administered cognitive-behavioral therapy for clients with depressive symptoms in an employee assistance program: A pilot study. *Ann Clin Psychiatr.* 2011;23(1):11-6. OVID-PsycINFO.
Exclude: Not an eligible study design

Lamers F, Jonkers CC, Bosma H, et al. A minimal psychological intervention in chronically ill elderly patients with depression: A randomized trial. *Psychother Psychosom.* 2010;79(4):217-26. PMID:20424499 OVID-Medline.
Exclude: Not an eligible population treatment

Lamers F, Jonkers CCM, Bosma H, et al. Improving quality of life in depressed COPD patients: Effectiveness of a minimal psychological intervention. *J Chron Obstruct Pulmonary Dis.* 2010;7(5):315-22. OVID-Embase.
Exclude: Not an eligible population treatment

Lancer,R. The effect of aerobic exercise on obsessive compulsive disorder, anxiety, and depression 2005. OVID-PsycINFO.
Exclude: Not an eligible study design

Landaas,J.A. The effect of aerobic exercise on self-efficacy perceptions body-esteem, anxiety and depression 2006. OVID-PsycINFO.
Exclude: Not an eligible study design

Landreville P. Cognitive bibliotherapy for depression in older adults with a disability. *Clin Gerontol.* 1998;19(3):69-75. OVID-Embase.
Exclude: Not an eligible population treatment

Landreville P, Bissonnette L. Effects of cognitive bibliotherapy for depressed older adults with a disability. *Clinical Gerontologist: The Journal of Aging and Mental Health.* 1997;17(4):35-55. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Lane AM, Lovejoy DJ. The effects of exercise on mood changes: The moderating effect of depressed mood. *J Sports Med Phys Fitness.* 2001;41(4):539-45. OVID-Embase.
Exclude: Not an eligible study design

Lane DA, Chong AY, Lip Gregory YH. Psychological interventions for depression in heart failure. *Cochrane Database Syst Rev.* 2005;(1):CD003329. Wiley-CDSR.
Excluded - Systematic review - relevant topic, citations cross-matched

Langer G, Karazman R, Neumark J, et al. Isoflurane narcotherapy in depressive patients refractory to conventional antidepressant drug treatment. A double-blind comparison with electroconvulsive treatment. *Neuropsychobiol.* 1995;31(4):182-94. PMID:7659199 OVID-Medline.

Exclude: Not an eligible population treatment

Lantz JE. Depression and social interest tasks. *J Individ Psychol.* 1981;37(1):113-6. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Laperriere A, Ironson GH, Antoni MH, et al. Decreased depression up to one year following CISM+ intervention in depressed women with AIDS: The smart/EST women's project. *J Health Psychol.* 2005;10(2):223-31. PMID:15723892 OVID-Medline.

Exclude: Not an eligible population treatment

Larcombe NA, Wilson PH. An evaluation of cognitive-behaviour therapy for depression in patients with multiple sclerosis. *Br J Psychiatr.* 1984;145(OCT.):366-71. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Larsen JK, Rafaelsen OJ. Long-term treatment of depression with isocarboxazide. *Acta Psychiatr Scand.* 1980;62(5):456-63. PMID:7211430 OVID-Medline.

Exclude: Not an eligible study design

Larun L, Nordheim LV, Ekeland E, et al. Exercise in prevention and treatment of anxiety and depression among children and young people. *Cochrane Database Syst Rev.* 2006;(3):CD004691. PMID:16856055 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Latour D, Cappeliez P. Pretherapy training for group cognitive therapy with depressed older adults. *Can J Aging.* 1994;13(2):221-35. OVID-Embase.

Exclude: Not an eligible population treatment

Lattanzi L, Dell'Osso L, Cassano P, et al. Pramipexole in treatment-resistant depression: A 16-week naturalistic study. *Bipolar Disorders.* 2002;4(5):307-14. PMID:12479663 OVID-Medline.

Exclude: Not an eligible study design

Lauritzen L, Clemmesen L, Klysner R, et al. Combined treatment with imipramine and mianserin. A controlled pilot study. *Pharmacopsychiatr.* 1992;25(4):182-6. PMID:1528957 OVID-Medline.

Exclude: Not an eligible population treatment

Lauritzen L, Bendsen BB, Vilmar T, et al. Post-stroke depression: combined treatment with imipramine or desipramine and mianserin. A controlled clinical study. *Psychopharmacol.* 1994;114(1):119-22. PMID:7846193 OVID-Medline.

Exclude: Not an eligible population design

Lauterbach E, Felber W, Muller-Oerlinghausen B, et al. Adjunctive lithium treatment in the prevention of suicidal behaviour in depressive disorders: A randomised, placebo-controlled, 1-year trial. *Acta Psychiatr Scand.* 2008;118(6):469-79. PMID:18808400 OVID-Medline.

Exclude: Not an eligible population treatment

Laux G, Koenig W, Pfaff G. Antidepressant combination therapy of endogenous depressions with benzodiazepines or neuroleptics: A study comparing adjuvant treatment with oxazolam versus chlorprothixene. *Pharmacopsychiatr.* 1988;21(2):87-92. PMID:2899329 OVID-Medline.

Exclude: Not an eligible population treatment

Lave JR, Frank RG, Schulberg HC, et al. Cost-effectiveness of treatments for major depression in primary care practice. *Arch Gen Psychiatr.* 1998;55(7):645-51. PMID:9672056 OVID-Medline.

Exclude: Not an eligible population treatment

Lavertue NE, Kumar VK, Pekala RJ. The effectiveness of a hypnotic ego-strengthening procedure for improving self-esteem and depression. *Aust J Clin Exp Hypnosis.* 2002;30(1):1-23.

Exclude: Not an eligible population treatment

Lavie CJ, Milani RV, Cassidy MM, et al. Effects of cardiac rehabilitation and exercise training programs in women with depression. *Am J Cardiol.* 1999;83(10):1480-3. OVID-Embase.

Exclude: Not an eligible study design

Lavretsky H, Kim MD, Kumar A, et al. Combined treatment with methylphenidate and citalopram for accelerated response in the elderly: An open trial. *J Clin Psychiatry.* 2003;64(12):1410-4. PMID:14728100 OVID-Medline.

Exclude: Not an eligible study design

Lavretsky H, Park S, Siddarth P, et al. Methylphenidate-enhanced antidepressant response to citalopram in the elderly: A double-blind, placebo-controlled pilot trial. *Am J Geriatr Psychiatr.* 2006;14(2):181-5. PMID:16473984 OVID-Medline.

Exclude: Not an eligible population treatment

Lavretsky H, Kumar A. Methylphenidate augmentation of citalopram in elderly depressed patients. *Am J Geriatr Psychiatry*. 2001;9(3):298-303. OVID-PsycINFO.

Exclude: Not an eligible study design

Layne CM, Saltzman WR, Poppleton L, et al. Effectiveness of a school-based group psychotherapy program for war-exposed adolescents: A randomized controlled trial. *J Am Acad Child Adolesc Psychiatry*. 2008;47(9):1048-62. OVID-Embase.

Exclude: Not an eligible population treatment

Learmonth D, Rai S. Taking computerized CBT beyond primary care. *Br J Clin Psychol*. 2008;47(Pt:1):1-8. PMID:17939879 OVID-Medline.

Exclude: Not an eligible study design

Learmonth D, Trosh J, Rai S, et al. The role of computer-aided psychotherapy within an NHS CBT specialist service. *Couns Psychother Res*. 2008;8(2):117-23. EBSCO-CINAHL.

Exclude: Not an eligible study design

Lebowitz BD, Pearson JL, Schneider LS, et al. Diagnosis and treatment of depression in late life: Consensus statement update. *JAMA*. 1997;278(14):1186-90. OVID-Embase.

Exclude: Not an eligible guideline

Lecrubier Y, Clerc G, Didi R, et al. Efficacy of St. John's wort extract WS 5570 in major depression: A double-blind, placebo-controlled trial. *Am J Psychiatry*. 2002;159(8):1361-6. PMID:12153829 OVID-Medline.

Exclude: Not an eligible population treatment

Lee MR, Cohen L, Hadley SW, et al. Cognitive-behavioral group therapy with medication for depressed gay men with AIDS or symptomatic HIV infection. *Psychiatr Serv*. 1999;50(7):948-52. PMID:10402618 OVID-Medline.

Exclude: Not an eligible study design

Lee MS, Jang J, Jang H, et al. Effects of Qi-therapy on blood pressure, pain and psychological symptoms in the elderly: A randomized controlled pilot trial. *Complement Ther Med*. 2003;11(3):159-64. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Leff J, Vearnals S, Brewin CR, et al. The London depression intervention trial. Randomised controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: Clinical outcome and costs. *Br J Psychiatry*. 2000;177(AUG.):95-100. OVID-Embase.

Exclude: Not an eligible population treatment

Legrand FD, Mille CR. The effects of 60 minutes of supervised weekly walking (in a single vs. 3-5 session format) on depressive symptoms among older women: Findings from a pilot randomized trial. *Ment Health Phys Activ*. 2009;2(2):71-5. OVID-Embase.

Exclude: Not an eligible population treatment

Legrand F, Heuze JP. Antidepressant effects associated with different exercise conditions in participants with depression: A pilot study. *J Sport Exerc Psychol*. 2007;29(3):348-64. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Leibenluft E, Moul DE, Schwartz PJ, et al. A clinical trial of sleep deprivation in combination with antidepressant medication. *Psychiatry Res*. 1993;46(3):213-27. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Leinonen E, Niemi H. The influence of educational information on depressed outpatients treated with escitalopram: A semi-naturalistic study. *Nord J Psychiatr*. 2007;61(2):109-14. PMID:17454725 OVID-Medline.

Exclude: Not an eligible population treatment

Leite JR, FL, Amemiya TM, et al. Effect of progressive self-focus meditation on attention, anxiety, and depression scores. *Percept Motor Skills*. 2010;110(3 Part 1):840-8. EBSCO-CINAHL.

Exclude: Not an eligible population/treatment

Lekman M, Laje G, Charney D, et al. The FKBP5-gene in depression and treatment response: An association study in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Cohort. *Biol Psychiatry*. 2008;63(12):1103-10. PMID:18191112 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Lemmens GM, Eisler I, Buysse A, et al. The effects on mood of adjunctive single-family and multi-family group therapy in the treatment of hospitalized patients with major depression. A 15-month follow-up study. *Psychother Psychosom*. 2009;78(2):98-105. PMID:19218828 OVID-Medline.

Exclude: Not an eligible population treatment

Lemon K. An assessment of treating depression and anxiety with aromatherapy. *Int J Aromather*. 2004;14(2):63-9. OVID-Embase.

Exclude: Not an eligible population treatment

Lenoir S, Degenring FH, Saller R. A double-blind randomised trial to investigate three different concentrations of a standardised fresh plant extract obtained from the shoot tips of *Hypericum perforatum* L. *Phytomed*. 1999;6(3):141-6. PMID:10439477 OVID-Medline.

Exclude: Not an eligible population treatment

Lenox-Smith AJ, Schaeffer P, Willard L. A double-blind study of venlafaxine XR versus citalopram in patients with treatment-resistant depression.

[Abstract] Presented at the Annual Meeting of the British Association for Psychopharmacology, July 2001, Harrogate, Yorkshire, England, UK. 2001;

Lenze EJ, Dew MA, Mazumdar S, et al. Combined pharmacotherapy and psychotherapy as maintenance treatment for late-life depression: Effects on social adjustment. *Am J Psychiatry*. 2002;159(3):466-8. PMID:11870013 OVID-Medline.

Exclude: Not an eligible population treatment

Lenze EJ, Sheffrin M, Driscoll HC, et al. Incomplete response in late-life depression: Getting to remission. *Dialog Clin Neurosci*. 2008;10(4):419-30. OVID-Embase.

Exclude: Not an eligible study design

Leo RJ, Ligot J. A systematic review of randomized controlled trials of acupuncture in the treatment of depression. *J Affect Disord*. 2007;97(1-3):13-22. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Leppamaki S, Haukka J, Lonnqvist J, et al. Drop-out and mood improvement: A randomised controlled trial with light exposure and physical exercise. *BMC Psychiatr*. 2004;4:22 PMID:15306031 OVID-Medline.

Exclude: Not an eligible population treatment

Lerber-Good WF. Neurotransmitter precursor therapies in affective disorders. *Int J Vitam Nutr Res*. 1986;56(SUPPL. 29):69-82. OVID-Embase.

OVID-Embase.

Exclude: Not an eligible study design

Lesperance F, Frasere-Smith N, Koszycki D, et al. Effects of citalopram and interpersonal psychotherapy on depression in patients with coronary artery disease: The Canadian Cardiac Randomized Evaluation of Antidepressant and Psychotherapy Efficacy (CREATE) trial. *JAMA*. 2007;297(4):367-79. PMID:17244833 OVID-Medline.

Exclude: Not an eligible population treatment

Lesser I, Rosales A, Zisook S, et al. Depression outcomes of Spanish- and english-speaking Hispanic outpatients in STAR*D. *Psychiatr Serv*. 2008;59(11):1273-84. PMID:18971403 OVID-Medline.

Exclude: Not an eligible population treatment

Lesser IM, Castro DB, Gaynes BN, et al. Ethnicity/race and outcome in the treatment of depression: Results from STAR*D. *Med Care*. 2007;45(11):1043-51. PMID:18049344 OVID-Medline.

Exclude: Not an eligible population treatment

Lett HS, Davidson J, Blumenthal JA. Nonpharmacologic treatments for depression in patients with coronary heart disease. *Psychosom Med*. 2005;67(Suppl 1):S58-62. PMID:15953803 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Leucht S, Hackl HJ, Steimer W, et al. Effect of adjunctive paroxetine on serum levels and side-effects of tricyclic antidepressants in depressive inpatients. *Psychopharmacol*. 2000;147(4):378-83. PMID:10672631 OVID-Medline.

Exclude: Not an eligible study design

Leuchter AF, Lesser IM, Trivedi MH, et al. An open pilot study of the combination of escitalopram and bupropion-SR for outpatients with major depressive disorder. *J Psychiatr Pract*. 2008;14(5):271-80. PMID:18832958 OVID-Medline.

Exclude: Not an eligible study design

Leuchter AF, Husain MM, Cook IA, et al. Painful physical symptoms and treatment outcome in major depressive disorder: A STAR*D (Sequenced Treatment Alternatives to Relieve Depression) report. *Psychol Med*. 2010;40(2):239-51. PMID:19493369 OVID-Medline.

Exclude: Not an eligible population treatment

Leung SN, Orrell MW. A brief cognitive behavioural therapy group for the elderly: Who benefits? *Int J Geriatr Psychiatry*. 1993;8(7):593-8. OVID-PsycINFO.

Exclude: Not an eligible study design

Levendoglu F, Altintepe L, Okudan N, et al. A twelve week exercise program improves the psychological status, quality of life and work capacity in hemodialysis patients. *J Nephrol*. 2004;17(6):826-32. OVID-Embase.

Exclude: Not an eligible study design

Levesque M, Savard J, Simard S, et al. Efficacy of cognitive therapy for depression among women with metastatic cancer: A single-case experimental study. *J Behav Ther Exp Psychiatr*. 2004;35(4):287-305. PMID:15530844 OVID-Medline.
Exclude: Not an eligible study design

Levin A, Schlebusch L. Mianserin is better tolerated and more effective in depression than a nomifensine-clobazam combination: A double-blind study. *Acta Psychiatr Scand Suppl*. 1985;320:75-80. PMID:3863470 OVID-Medline.
Exclude: Not an eligible population treatment

Levine J, Gonsalves M, Babur I, et al. Inositol 6 g daily may be effective in depression but not in schizophrenia. *Hum Psychopharmacol*. 1993;8(1):49-53. OVID-Embase.
Exclude: Not an eligible study design

Levine J. Controlled trials of inositol in psychiatry. *Eur Neuropsychopharmacol*. 1997;7(2):147-55. OVID-Embase.
Exclude: Not an eligible study design

Levine J, Mishori A, Susnosky M, et al. Combination of inositol and serotonin reuptake inhibitors in the treatment of depression. *Biol Psychiatr*. 1999;45(3):270-3. PMID:10023500 OVID-Medline.
Exclude: Not an eligible population treatment

Levitan RD, Shen JH, Jindal R, et al. Preliminary randomized double-blind placebo-controlled trial of tryptophan combined with fluoxetine to treat major depressive disorder: Antidepressant and hypnotic effects. *J Psychiatr Neurosci*. 2000;25(4):337-46. PMID:11022398 OVID-Medline.
Exclude: Not an eligible population treatment

Levitt AJ, Joffe RT, Kennedy SH. Bright light augmentation in antidepressant nonresponders. *J Clin Psychiatry*. 1991;52(8):336-7. PMID:1869495 OVID-Medline.
Exclude: Not an eligible study design

Lewinsohn PM, Clarke GN, Hops H, et al. Cognitive-behavioral treatment for depressed adolescents. *Behav Ther*. 1990;21(4):385-401. OVID-Embase.
Exclude: Not an eligible population treatment

Lewinsohn, Peter M., Clarke, Gregory N., Rohde, Paul et al. A course in coping: A cognitive-behavioral approach to the treatment of adolescent depression. 1996:109-35. 1996. OVID-PsycINFO.
Exclude: Not an eligible study design

Lewis CC, Simons AD, Silva SG, et al. The role of readiness to change in response to treatment of adolescent depression. *J Consult Clin Psychol*. 2009;77(3):422-8. PMID:19485584 OVID-Medline.
Exclude: Not an eligible population treatment

Lewis FM, Cochrane BB, Fletcher KA, et al. Helping Her Heal: A pilot study of an educational counseling intervention for spouses of women with breast cancer. *Psychooncol*. 2008;17(2):131-7. PMID:17429834 OVID-Medline.
Exclude: Not an eligible study design

Leykin Y, Amsterdam JD, DeRubeis RJ, et al. Progressive resistance to a selective serotonin reuptake inhibitor but not to cognitive therapy in the treatment of major depression. *J Consult Clin Psychol*. 2007;75(2):267-76. PMID:17469884 OVID-Medline.
Exclude: Not an eligible population treatment

Li C, Huang Y, Li Y, et al. Treating post-stroke depression with mind-refreshing antidepressive acupuncture therapy. *Int J Clin Acupunct*. 1994;5(4):389-93. Exclude: Not an eligible population treatment

Li LT, Wang SH, Ge HY, et al. The beneficial effects of the herbal medicine Free and Easy Wanderer Plus (FEWP) and fluoxetine on post-stroke depression. *J Altern Complement Med*. 2008;14(7):841-6. PMID:18721085 OVID-Medline.
Exclude: Not an eligible population design

Lichtenberg PA, Kimbarow ML, Morris P, et al. Behavioral treatment of depression in predominantly African-American medical patients. *Clin Gerontol*. 1996;17(2):15-33. Exclude: Not an eligible population treatment

Lieber AL, Newbury ND. Diagnosis, treatment, and outcome in refractory depression. *Ann Clin Psychiatr*. 1991;3(2):119-24. OVID-Embase.
Exclude: Not an eligible study design

Lieverse R, Nielen MMA, Veltman DJ, et al. Bright light in elderly subjects with nonseasonal major depressive disorder: A double blind randomised clinical trial using early morning bright blue light comparing dim red light treatment. *Trials*. 2008;9(Article Number 48): OVID-Embase.
Exclude: Not an eligible study design

Lieverse R, Van Someren EJ, Nielen MM, et al. Bright light treatment in elderly patients with nonseasonal major depressive disorder: A randomized placebo-controlled trial. *Arch Gen Psychiatr*. 2011;68(1):61-70. PMID:21199966 OVID-Medline.

Exclude: Not an eligible population/treatment

Lii YC, Tsay SL, Wang TJ. Group intervention to improve quality of life in haemodialysis patients. *J Clin Nurs*. 2007;16(11C):268-75. PMID:17931320 OVID-Medline.

Exclude: Not an eligible population treatment

Lim HJ, Moon YI, Lee MS. Effects of home-based daily exercise therapy on joint mobility, daily activity, pain, and depression in patients with ankylosing spondylitis. *Rheumatol Int*. 2005;25(3):225-9. PMID:15650833 OVID-Medline.

Exclude: Not an eligible population treatment

Lim YM, Hong GR. Effect of 16-week Kouk-Sun-Do exercise on physical fitness, emotional state, and immunoglobulin A in community-dwelling elders in Korea. *Appl Nurs Res*. 2010;23(2):91-100. PMID:20420996 OVID-Medline.

Exclude: Not an eligible population treatment

Limosin F, Loze JY, Zylberman-Bouhassira M, et al. The course of depressive illness in general practice. *Can J Psychiatr*. 2004;49(2):119-23. OVID-PsycINFO.

Exclude: Not an eligible study design

Lin PY, Su KP. A meta-analytic review of double-blind, placebo-controlled trials of antidepressant efficacy of omega-3 fatty acids. *J Clin Psychiatr*. 2007;68(7):1056-61. PMID:17685742 OVID-Medline.

Exclude: Systematic review - relevant topic, citations cross-matched

Lincoln NB, Flannaghan T, Sutcliffe L, et al. Evaluation of cognitive behavioural treatment for depression after stroke: A pilot study. *Clin Rehabil*. 1997;11(2):114-22. PMID:9199863 OVID-Medline.

Exclude: Not an eligible study design

Lincoln NB, Flannaghan T. Cognitive behavioral psychotherapy for depression following stroke: A randomized controlled trial. *Stroke*. 2003;34(1):111-5. PMID:12511760 OVID-Medline.

Exclude: Not an eligible population design

Lindberg D, Ahlfors UG, Dencker SJ, et al. Symptom reduction in depression after treatment with L-tryptophan or imipramine. Item analysis of Hamilton rating scale for depression. *Acta Psychiatr Scand*. 1979;60(3):287-94. Wiley-CCTR.

Exclude: Not an eligible population treatment

Linde K, Knuppel L. Large-scale observational studies of hypericum extracts in patients with depressive disorders--a systematic review. *Phytomed*. 2005;12(1-2):148-57. PMID:15693723 OVID-Medline.

Exclude: Systematic review - relevant topic, citations cross-matched

Linde K, Mulrow CD, Berner M, et al. St John's wort for depression. *Cochrane Database Syst Rev*. 2005;(2):CD000448. PMID:15846605 OVID-Medline.

Exclude: Systematic review - relevant topic, citations cross-matched

Linde K, Berner M, Egger M, et al. St John's wort for depression: Meta-analysis of randomised controlled trials. *Br J Psychiatr*. 2005;186:99-107. PMID:15684231 OVID-Medline.

Exclude: Systematic review - relevant topic, citations cross-matched

Lingjaerde O, Edlund AH, Gormsen CA, et al. The effects of lithium carbonate in combination with tricyclic antidepressants in endogenous depression. A double-blind, multicenter trial. *Acta Psychiatr Scand*. 1974;50(2):233-42. Wiley-CCTR.

Exclude: Not an eligible population treatment

Lingjaerde O, Bratfos O, Bratlid T, et al. A double-blind comparison of zimelidine and desipramine in endogenous depression. *Acta Psychiatr Scand*. 1983;68(1):22-30. PMID:6225313 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Liou CP, Her JR. The effectiveness of psychotherapies on hospitalized depressive patients. *Chin Med J*. 1996;58(3):163-70. PMID:8940787 OVID-Medline.

Exclude: Not an eligible population treatment

Lipinski JF, Cohen BM, Frankenburg F, et al. Open trial of S-adenosylmethionine for treatment of depression. *Am J Psychiatry*. 1984;141(3):448-50. PMID:6367496 OVID-Medline.

Exclude: Not an eligible study design

Listman PJ. Cognitive therapy is effective in diabetic patients with depression. *Am Fam Physician*. 1997;56(2):566 OVID-Embase.

Exclude: Not an eligible study design

Little A, Hansen RA, Gartlehner G, et al. Impact of the STAR*D trial from the perspective of the payer. *Psychiatr Serv*. 2009;60(11):1463-5. PMID:19880462 OVID-Medline.

Exclude: Not an eligible population treatment

Little SAS, Kligler B, Homel P, et al. Multimodal mind/body group therapy for chronic depression: A pilot study. *Explore*. 2009;5(6):330-7. OVID-Embase.

Exclude: Not an eligible study design

Liu C-F, Hedrick SC, Chaney EF, et al. Cost-effectiveness of collaborative care for depression in a primary care veteran population. *Psychiatr Serv*. 2003;54(5):698-704. OVID-Embase.

Exclude: Not an eligible population treatment

Liu ETH, Chen W-L, Li Y-H, et al. Exploring the efficacy of cognitive bibliotherapy and a potential mechanism of change in the treatment of depressive symptoms among the Chinese: A randomized controlled trial. *Cognit Ther Res*. 2009;33(5):449-61. OVID-Embase.

Exclude: Not an eligible population treatment

Liu P, He FF, Bai WP, et al. Menopausal depression: Comparison of hormone replacement therapy and hormone replacement therapy plus fluoxetine. *Chin Med J*. 2004;117(2):189-94. PMID:14975200 OVID-Medline.

Exclude: Not an eligible population treatment

Liu S-J, Lin C-J, Chen Y-M, et al. The effects of reminiscence group therapy on self-esteem, depression, loneliness and life satisfaction of elderly people living alone. *Mid-Taiwan J Med*. 2007;12(3):133-42. OVID-Embase.

Exclude: Not an eligible population treatment

Lobstein DD, Rasmussen CL. Decreases in resting plasma beta-endorphin and depression scores after endurance training. *J Sports Med Phys Fitness*. 1991;31(4):543-51. OVID-Embase.

Exclude: Not an eligible population treatment

Locca J-F, Bula CJ, Zumbach S, et al. Pharmacological treatment of Behavioral and Psychological Symptoms of Dementia (BPSD) in nursing homes: Development of practice recommendations in a Swiss canton. *J Am Med Dir Assoc*. 2008;9(8):611 OVID-Embase.

Exclude: Not an eligible guideline

Lojko D, Rybakowski JK. L-thyroxine augmentation of serotonergic antidepressants in female patients with refractory depression. *J Affect Disord*. 2007;103(1-3):253-6. PMID:17289154 OVID-Medline.

Exclude: Not an eligible study design

Lolak S, Connors GL, Sheridan MJ, et al. Effects of progressive muscle relaxation training on anxiety and depression in patients enrolled in an outpatient pulmonary rehabilitation program. *Psychother Psychosom*. 2008;77(2):119-25. OVID-Embase.

Exclude: Not an eligible population treatment

Lombardo NBE, Dresser MVB, Malivert M, et al. Acupuncture as treatment for anxiety and depression in persons with dementia: Results of a feasibility and effectiveness study. *Alzheimers Care Q*. 2001;2(4):28-41. EBSCO-CINAHL.

Exclude: Not an eligible study design

Londborg PD, Smith WT, Glaudin V, et al. Short-term cotherapy with clonazepam and fluoxetine: Anxiety, sleep disturbance and core symptoms of depression. *J Affect Disord*. 2000;61(1-2):73-9. PMID:11099743 OVID-Medline.

Exclude: Not an eligible population treatment

Lopez-Munoz F, Alamo C, Rubio G, et al. Reboxetine combination in treatment-resistant depression to selective serotonin reuptake inhibitors. *Pharmacopsychiatr*. 2007;40(1):14-9.

ISI:000244859800003 Exclude: Not an eligible study design

Lopez MA, Basco MR. Feasibility of dissemination of cognitive behavioral therapy to Texas community mental health centers. *J Behav Health Serv Res*. 2011;38(1):91-104. PMID:20162373 OVID-Medline.

Exclude: Not an eligible study design

Lorenz KA, Lynn J, Dy SM, et al. Evidence for improving palliative care at the end of life: A systematic review. *Ann Intern Med*. 2008;148(2):147-59. PMID:18195339 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Louis M, Kowalski SD. Use of aromatherapy with hospice patients to decrease pain, anxiety, and depression and to promote an increased sense of well-being. *Am J Hospice Palliat Care*. 2002;19(6):381-6. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Loving RT, Kripke DF, Shuchter SR. Bright light augments antidepressant effects of medication and wake therapy. *Depress Anxiety*. 2002;16(1):1-3. PMID:12203667 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Loving RT, Kripke DF, Knickerbocker NC, et al. Bright green light treatment of depression for older adults. *BMC Psychiatr.* 2005;5:42 PMID:16283926 OVID-Medline.

Exclude: Not an eligible population treatment

Loving RT, Kripke DF, Elliot JA. Bright light treatment of depression for older adults. *BMC Psychiatr.* 2005;(5):41 Exclude: Not an eligible population treatment

Lowry F, Wachter K, Worcester S. Meta-analysis supports gabapentin/new antidepressants. *Oncol Rep.* 2008;(Fall):104 OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

López J, Crespo M. Analysis of the efficacy of a psychotherapeutic program to improve the emotional status of caregivers of elderly dependent relatives. *Aging Ment Health.* 2008;12(4):451-61. Wiley-CCTR.

Exclude: Not an eligible population treatment

Lucas M, Asselin G, Merette C, et al. Ethyl-eicosapentaenoic acid for the treatment of psychological distress and depressive symptoms in middle-aged women: A double-blind, placebo-controlled, randomized clinical trial. *Am J Clin Nutr.* 2009;89(2):641-51. PMID:19116322 OVID-Medline.

Exclude: Not an eligible population treatment

Luciano, J.S.Jr. Neural network modeling of unipolar depression: Patterns of recovery and prediction of outcome 1996. OVID-PsycINFO.

Exclude: Not an eligible study design

Ludman EJ, Simon GE, Grothaus LC, et al. A pilot study of telephone care management and structured disease self-management groups for chronic depression. *Psychiatr Serv.* 2007;58(8):1065-72. PMID:17664517 OVID-Medline.

Exclude: Not an eligible population treatment

Ludman EJ, Simon GE, Tutty S, et al. A randomized trial of telephone psychotherapy and pharmacotherapy for depression: Continuation and durability of effects. *J Consult Clin Psychol.* 2007;75(2):257-66. OVID-Embase.

Exclude: Not an eligible population treatment

Luo H, Meng F, Jia Y, et al. Clinical research on the therapeutic effect of the electro-acupuncture treatment in patients with depression. *Psychiatry Clin Neurosci.* 1998;52:Suppl-40 PMID:9895187 OVID-Medline.

Exclude: Not an eligible population treatment

Luo HC, Jia YK, Li Z. Electro-acupuncture vs. amitriptyline in the treatment of depressive states. *J Tradit Chin Med.* 1985;5(1):3-8. PMID:3849629 OVID-Medline.

Exclude: Not an eligible population treatment

Luo HC, Ureil H, Shen YC, et al. Comparative study of electroacupuncture and fluoxetine for treatment of depression. *Chin J Psychiatry.* 2003;(36):215-9.

Exclude: Paper cannot be located

Lustman PJ, Griffith LS, Freedland KE, et al. The course of major depression in diabetes. *Gen Hosp Psychiatry.* 1997;19(2):138-43. OVID-Embase.

Exclude: Not an eligible population treatment

Lustman PJ, Griffith LS, Freedland KE, et al. Cognitive behavior therapy for depression in type 2 diabetes mellitus. A randomized, controlled trial. *Ann Intern Med.* 1998;129(8):613-21.

PMID:9786808 OVID-Medline.

Exclude: Not an eligible population treatment

Lustman PJ, Clouse RE. Depression in diabetic patients: The relationship between mood and glycemic control. *J Diabetes Complications.* 2005;19(2):113-22. PMID:15745842 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Luty SE, Carter JD, McKenzie JM, et al. Randomised controlled trial of interpersonal psychotherapy and cognitive-behavioural therapy for depression. *Br J Psychiatry.* 2007;190:496-502. PMID:17541109 OVID-Medline.

Exclude: Not an eligible population treatment

Lydecker KP, Tate SR, Cummins KM, et al. Clinical outcomes of an integrated treatment for depression and substance use disorders. *Psychol Addict Behav.* 2010;24(3):453-65. PMID:20853931 OVID-Medline.

Exclude: Not an eligible population treatment

Lykouras L, Avgoustides D, Papakostas Y, et al. Medication response to ECT-resistant melancholic patients. *Acta Psychiatr Belg.* 1995;95(3):113-21. PMID:8525854 OVID-Medline.

Exclude: Not an eligible study design

Lynch D, Laws KR, McKenna PJ. Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. *Psychol Med.* 2010;40(1):9-24. PMID:19476688 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Lynch DJ, Tamburrino MB, Nagel R. Telephone counseling for patients with minor depression: Preliminary findings in a family practice setting. *J Fam ily Pract.* 1997;44(3):293-8. Wiley-CCTR. Exclude: Not an eligible population treatment

Lynch TR, Morse JQ, Mendelson T, et al. Dialectical behavior therapy for depressed older adults: A randomized pilot study. *Am J Geriatr Psychiatr.* 2003;11(1):33-45. PMID:12527538 OVID-Medline. Exclude: Not an eligible population treatment

Ma SH, Teasdale JD. Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *J Consult Clin Psychol.* 2004;72(1):31-40. PMID:14756612 OVID-Medline. Exclude: Not an eligible population treatment

Maag, John W., Swearer, Susan M., Toland, Michael D. Cognitive-behavioral interventions for depression in children and adolescents: Meta-analysis, promising programs, and implications for school personnel. 2009:235-65. 2009. OVID-PsycINFO. Exclude: Not an eligible study design

Macaskill ND, Macaskill A. Rational-emotive therapy plus pharmacotherapy versus pharmacotherapy alone in the treatment of high cognitive dysfunction depression. *Cognit Ther Res.* 1996;20(6):575-92. Exclude: Not an eligible population treatment

MacEwan GW, Remick RA. Treatment resistant depression: A clinical perspective. *Can J Psychiatr.* 1988;33(9):788-92. PMID:3214826 OVID-Medline. Exclude: Not an eligible study design

Mackert A, Volz H-P, Stieglitz R-D, et al. Light treatment of non-seasonal affective disorder. *Pharmacopsychiatr.* 1989;22(5):206 OVID-Embase. Exclude: Not an eligible study design

Mackert A, Volz HP, Stieglitz RD, et al. Effect of bright white light on non-seasonal depressive disorder. *Pharmacopsychiatr.* 1990;23(3):151-4. PMID:2374772 OVID-Medline. Exclude: Not an eligible population treatment

Mackert A, Volz HP, Stieglitz RD, et al. Phototherapy in nonseasonal depression. *Biol Psychiatr.* 1991;30(3):257-68. PMID:1912117 OVID-Medline. Exclude: Not an eligible population treatment

Mackin RS, Areal PA. Evidence-based psychotherapeutic interventions for geriatric depression. *Psychiatr Clin North Am.* 2005;28(4):805-20. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Mackinnon A, Griffiths KM, Christensen H. Comparative randomised trial of online cognitive-behavioural therapy and an information website for depression: 12-month outcomes. *Br J Psychiatr.* 2008;192(2):130-4. PMID:18245031 OVID-Medline. Exclude: Not an eligible population treatment

Macrodimitris S, Wershler J, Hatfield M, et al. Group cognitive-behavioral therapy for patients with epilepsy and comorbid depression and anxiety. *Epilepsy Behav.* 2011;20(1):83-8. OVID-Embase. Exclude: Not an eligible study design

Maes M, Vandoolaeghe E, Desnyder R. Efficacy of treatment with trazodone in combination with pindolol or fluoxetine in major depression. *J Affect Disord.* 1996;41(3):201-10. PMID:8988452 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Maes M, Vandoolaeghe E, van Hunsel F, et al. Immune disturbances in treatment-resistant depression: Modulation by antidepressive treatments. *Hum Psychopharmacol.* 1997;12(2):153-62. OVID-Embase. Exclude: Not an eligible study design

Maes M, Verkerk R, Vandoolaeghe E, et al. Serum levels of excitatory amino acids, serine, glycine, histidine, threonine, taurine, alanine and arginine in treatment-resistant depression: Modulation by treatment with antidepressants and prediction of clinical responsivity. *Acta Psychiatr Scand.* 1998;97(4):302-8. Wiley-CCTR. Exclude: Not an eligible population treatment

Maes M, Libbrecht I, van Hunsel F, et al. Pindolol and mianserin augment the antidepressant activity of fluoxetine in hospitalized major depressed patients, including those with treatment resistance. *J Clin Psychopharmacol.* 1999;19(2):177-82. PMID:10211920 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Mahoney,S.H. Depression, anxiety, and stress among the elderly: A comparison of treatment outcome between two cognitive-behavioral interventions 1998. OVID-PsycINFO. Exclude: Not an eligible study design

Maina G, Rosso G, Crespi C, et al. Combined brief dynamic therapy and pharmacotherapy in the treatment of major depressive disorder: A pilot study. *Psychother Psychosom.* 2007;76(5):298-305. PMID:17700050 OVID-Medline.

Exclude: Not an eligible population treatment

Maina G, Rosso G, Bogetto F. Brief dynamic therapy combined with pharmacotherapy in the treatment of major depressive disorder: Long-term results. *J Affect Disord.* 2009;114(1-3):200-7. OVID-Embase.

Exclude: Not an eligible population treatment

Maina G, Rosso G, Rigardetto S, et al. No effect of adding brief dynamic therapy to pharmacotherapy in the treatment of obsessive-compulsive disorder with concurrent major depression. *Psychother Psychosom.* 2010;79(5):295-302. PMID:20616624 OVID-Medline.

Exclude: Not an eligible population treatment

Malhi GS, Ng F, Berk M. Dual-dual action? Combining venlafaxine and mirtazapine in the treatment of depression. *Aust NZ J Psychiatr.* 2008;42(4):346-9. PMID:18330778 OVID-Medline.

Exclude: Not an eligible study design

Malison RT, Anand A, Pelton GH, et al. Limited efficacy of ketoconazole in treatment-refractory major depression. *J Clin Psychopharmacol.* 1999;19(5):466-70. Wiley-CCTR.

Exclude: Not an eligible population treatment

Malone DC. A budget-impact and cost-effectiveness model for second-line treatment of major depression. *J Manage Care Pharm.* 2007;13(6 Suppl A):S8-18. PMID:17874482 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Malt UF, Robak OH, Madsbu HP, et al. The Norwegian naturalistic treatment study of depression in general practice (NORDEP)-I: Randomised double blind study. *Br Med J.* 1999;318(7192):1180-4. PMID:10221945 OVID-Medline.

Exclude: Not an eligible population treatment

Malyszczak K, Frydecka D, Pawlowski T, et al. Mixed anxiety and depressive disorder before and after psychodynamic group psychotherapy: A 1-year follow-up study. *Int J Psychiatr Clin Pract.* 2010;14(4):298-302. OVID-Embase.

Exclude: Not an eligible study design

Manassis K, Wilansky-Traynor P, Farzan N, et al. The feelings club: Randomized controlled evaluation of school-based CBT for anxious or depressive symptoms. *Depress Anxiety.* 2010;27(10):945-52. PMID:20602433 OVID-Medline.

Exclude: Not an eligible population treatment

Manber R, Arnow B, Blasey C, et al. Patient's therapeutic skill acquisition and response to psychotherapy, alone or in combination with medication. *Psychol Med.* 2003;33(4):693-702. PMID:12785471 OVID-Medline.

Exclude: Not an eligible population treatment

Manber R, Schnyer RN, Allen JJ, et al. Acupuncture: A promising treatment for depression during pregnancy. *J Affect Disord.* 2004;83(1):89-95. PMID:15546651 OVID-Medline.

Exclude: Not an eligible population treatment

Manber R, Edinger JD, Gress JL, et al. Cognitive behavioral therapy for insomnia enhances depression outcome in patients with comorbid major depressive disorder and insomnia. *Sleep.* 2008;31(4):489-95. PMID:18457236 OVID-Medline.

Exclude: Not an eligible population treatment

Manber R, Kraemer HC, Arnow BA, et al. Faster remission of chronic depression with combined psychotherapy and medication than with each therapy alone. *J Consult Clin Psychol.* 2008;76(3):459-67. PMID:18540739 OVID-Medline.

Exclude: Not an eligible population treatment

Manber R, Rush AJ, Thase ME, et al. The effects of psychotherapy, nefazodone, and their combination on subjective assessment of disturbed sleep in chronic depression. *Sleep J Sleep Sleep Disord Res.* 2003;26(2):130-6. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Mancini C, Van Ameringen M, Farvolden P. Does SSRI augmentation with antidepressants that influence noradrenergic function resolve depression in obsessive-compulsive disorder? *J Affect Disord.* 2002;68(1):59-65. PMID:11869783 OVID-Medline.

Exclude: Not an eligible study design

Mancini M, Gianni W, Rossi A, et al. Duloxetine in the management of elderly patients with major depressive disorder: An analysis of published data. *Expert Opin Pharmacother.* 2009;10(5):847-60. PMID:19351233 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Maneeton N, Thongkam A, Maneeton B. Cognitive-behavioral therapy added to fluoxetine in major depressive disorder after 4 weeks of fluoxetine-treatment: 16-week open label study. *J Med Assoc Thai*. 2010;93(3):337-42. PMID:20420109 OVID-Medline.

Exclude: Not an eligible study design

Manger TA, Motta RW. The impact of an exercise program on posttraumatic stress disorder, anxiety, and depression. *Int J Emerg Ment Health*. 2005;7(1):49-57. PMID:15869081 OVID-Medline.

Exclude: Not an eligible study design

Mannel M, Kuhn U, Schmidt U, et al. St. John's wort extract LI160 for the treatment of depression with atypical features: A double-blind, randomized, and placebo-controlled trial. *J Psychiatr Res*. 2010;44(12):760-7. OVID-PsycINFO.

Exclude: Not an eligible population/treatment

Manschreck TC, Redmond DA, Beaudette SM. Clozapine in the back wards. *Ann Clin Psychiatr*. 1994;6(4):215-25. OVID-PsycINFO.

Exclude: Not an eligible study design

Manson SM. Mashkiki: Old medicine nourishing the new, Lanham, MD, England:University Press of America;1992. Depression and related mental illnesses among American Indians: The current state of the art in treatment. OVID-PsycINFO.

Exclude: Not an eligible study design.

Marangell LB, George MS, Callahan AM, et al. Effects of intrathecal thyrotropin-releasing hormone (protirelin) in refractory depressed patients. *Arch Gen Psychiatr*. 1997;54(3):214-22. PMID:9075462 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Marangell LB, Martinez JM, Zboyan HA, et al. A double-blind, placebo-controlled study of the omega-3 fatty acid docosahexaenoic acid in the treatment of major depression. *Am J Psychiatry*. 2003;160(5):996-8. PMID:12727707 OVID-Medline.

Exclude: Not an eligible population treatment

Maratos AS, Gold C, Wang X, et al. Music therapy for depression. *Cochrane Database Syst Rev*. 2008;(1): OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

March J, Silva S, Petrycki S, et al. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *JAMA*.

2004;292(7):807-20. PMID:15315995 OVID-Medline.

Exclude: Not an eligible population treatment

March J, Silva S, Vitiello B, et al. The Treatment for Adolescents with Depression Study (TADS): Methods and message at 12 weeks. *J Am Acad Child Adolesc Psychiatry*. 2006;45(12):1393-403. PMID:17135984 OVID-Medline.

Exclude: Not an eligible population treatment

March JS, Silva S, Petrycki S, et al. Fluoxetine plus cognitive behavioural therapy was most effective for adolescents with major depressive disorder. *Evid Based Med*. 2005;10(2):46 OVID-Embase.

Exclude: Not an eligible study design

March JS, Silva S, Petrycki S, et al. The Treatment for Adolescents With Depression Study (TADS): Long-term effectiveness and safety outcomes. *Arch Gen Psychiatr*. 2007;64(10):1132-43. PMID:17909125 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

March JS, Vitiello B. Clinical messages from the Treatment for Adolescents with Depression Study (TADS). *Am J Psychiatry*. 2009;166(10):1118-23. OVID-PsycINFO.

Exclude: Not an eligible study design

Marchand E, Ng J, Rohde P, et al. Effects of an indicated cognitive-behavioral depression prevention program are similar for Asian American, Latino, and European American adolescents. *Behav Res Ther*. 2010;48(8):821-5. PMID:20537319 OVID-Medline.

Exclude: Not an eligible population treatment

Marchioro G, Azzarello G, Checchin F, et al. The impact of a psychological intervention on quality of life in non-metastatic breast cancer. *Eur J Canc*. 1996;32A(9):1612-5. Wiley-CCTR.

Exclude: Not an eligible population treatment

Marco EJ, Wolkowitz OM, Vinogradov S, et al. Double-blind ant glucocorticoid treatment in schizophrenia and schizoaffective disorder: A pilot study. *World J Biol Psychiatr*. 2002;3(3):156-61. PMID:12478881 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Marcus AC, Garrett KM, Cella D, et al. Can telephone counseling post-treatment improve psychosocial outcomes among early stage breast cancer survivors? *Psychooncol*. 2010;19(9):923-32. OVID-Embase.

Exclude: Not an eligible population treatment

Marcus SC, Hassan M, Olfson M. Antidepressant switching among adherent patients treated for depression. *Psychiatr Serv*. 2009;60(5):617-23. PMID:19411348 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Marcus SM, Young EA, Kerber KB, et al. Gender differences in depression: Findings from the STAR*D study. *J Affect Disord*. 2005;87(2-3):141-50. PM:15982748 Exclude: Not an eligible population treatment

Markopoulou K, Papadopoulos A, Juruena MF, et al. The ratio of cortisol/DHEA in treatment resistant depression. *Psychoneuroendocrinol*. 2009;34(1):19-26. PMID:18805642 OVID-Medline.

Exclude: Not an eligible population treatment

Markowitz JC, Klerman GL, Clougherty KF, et al. Individual psychotherapies for depressed HIV-positive patients. *Am J Psychiatry*. 1995;152(10):1504-9. PM:7573591 Exclude: Not an eligible population treatment

Markowitz JC, Kocsis JH, Fishman B, et al. Treatment of depressive symptoms in human immunodeficiency virus-positive patients. *Arch Gen Psychiatr*. 1998;55(5):452-7. PMID:9596048 OVID-Medline.

Exclude: Not an eligible population treatment

Markowitz JC, Kocsis JH, Fishman B, et al. Treatment of depressive symptoms in human immunodeficiency virus-positive patients. *Arch Gen Psychiatr*. 1998;55(5):452-7. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Markowitz JC, Spielman LA, Sullivan M, et al. An exploratory study of ethnicity and psychotherapy outcome among HIV-positive patients with depressive symptoms. *J Psychother Pract Res*. 2000;9(4):226-31. OVID-Embase.

Exclude: Not an eligible population treatment

Markowitz JC, Kocsis JH, Bleiberg KL, et al. A comparative trial of psychotherapy and pharmacotherapy for "pure" dysthymic patients. *J Affect Disord*. 2005;89(1-3):167-75. PMID:16263177 OVID-Medline.

Exclude: Not an eligible population treatment

Markowitz, John C., Klerman, Gerald L., Perry, Samuel W. et al. Interpersonal psychotherapy for depressed HIV-seropositive patients. 1993:199-224. 1993. OVID-PsycINFO.

Exclude: Not an eligible study design

Markowitz JC, Kocsis JH, Christos P, et al. Pilot study of interpersonal psychotherapy versus supportive psychotherapy for dysthymic patients with secondary alcohol abuse or dependence. *J Nerv Ment Dis*. 2008;196(6):468-74. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Marks IM, Mataix-Cols D, Kenwright M, et al. Pragmatic evaluation of computer-aided self-help for anxiety and depression. *Br J Psychiatr*. 2003;183(JULY):57-65. OVID-Embase.

Exclude: Not an eligible study design

Marmar CR, Gaston L, Gallagher D, et al. Alliance and outcome in late-life depression. *J Nerv Ment Dis*. 1989;177(8):464-72. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Maron E, Eller T, Vasar V, et al. Effects of bupropion augmentation in escitalopram-resistant patients with major depressive disorder: An open-label, naturalistic study. *J Clin Psychiatry*. 2009;70(7):1054-6. PMID:19653982 OVID-Medline.

Exclude: Not an eligible study design

Marquez-Gonzalez M, Losada A, Izal M, et al. Modification of dysfunctional thoughts about caregiving in dementia family caregivers: Description and outcomes of an intervention programme. *Aging Ment Health*. 2007;11(6):616-25. PMID:18074249 OVID-Medline.

Exclude: Not an eligible population treatment

Marriott M, Kellett S. Evaluating a cognitive analytic therapy service; practice-based outcomes and comparisons with person-centred and cognitive-behavioural therapies. *Psychol Psychother*. 2009;82(Pt:1):1-72. PMID:18759998 OVID-Medline.

Exclude: Not an eligible population treatment

Marsden CA, Tyrer P, Casey P, et al. Changes in human whole blood 5-hydroxytryptamine (5-HT) and platelet 5-HT uptake during treatment with paroxetine, a selective 5-HT uptake inhibitor. *J Psychopharmacol*. 1987;1(4):244-50. OVID-Embase.

Exclude: Not an eligible population treatment

Marshall TK, Mazie AS. A cognitive approach to treating depression. *Soc Casework*. 1987;68(9):540-5. OVID-PsycINFO.

Exclude: Not an eligible study design

Marti A, Barrachina MTM. The effects of mindfulness-based cognitive therapy: A qualitative approach. *Psychol Spain*. 2009;13(1):9-16. OVID-PsycINFO.

Exclude: Not an eligible study design

Martin A, Sanderson K, Cocker F. Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. *Scand J Work Environ Health*. 2009;35(1):7-18. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Martin E, Martin S. IPT for treatment-resistant depression. In 2006. Wiley-CCTR.

Exclude: Not an eligible study design

Martins JG. EPA but not DHA appears to be responsible for the efficacy of omega-3 long chain polyunsaturated fatty acid supplementation in depression: evidence from a meta-analysis of randomized controlled trials. *J Am Coll Nutr*. 2009;28(5):525-42. PMID:20439549 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Martinsen EW, Medhus A, Sandvik L. Effects of aerobic exercise on depression: A controlled study. *Br Med J*. 1985;291(6488):109 OVID-Embase.

OVID-Embase.

Exclude: Not an eligible population treatment

Martinsen EW, Hoffart A, Solberg O. Comparing aerobic with nonaerobic forms of exercise in the treatment of clinical depression: A randomized trial. *Compr Psychiatry*. 1989;30(4):324-31. OVID-Embase.

Exclude: Not an eligible population treatment

Martiny K. Adjunctive bright light in non-seasonal major depression. *Acta Psychiatr Scand Suppl*. 2004;(425):7-28. PMID:15527426 OVID-Medline.

Exclude: Not an eligible population treatment

Martiny K, Lunde M, Unden M, et al. Adjunctive bright light in non-seasonal major depression: Results from clinician-rated depression scales. *Acta Psychiatr Scand*. 2005;112(2):117-25. PMID:15992393 OVID-Medline.

Exclude: Not an eligible population treatment

Martiny K, Lunde M, Unden M, et al. Adjunctive bright light in non-seasonal major depression: Results from patient-reported symptom and well-being scales. *Acta Psychiatr Scand*. 2005;111(6):453-9. PMID:15877712 OVID-Medline.

Exclude: Not an eligible population treatment

Martiny K, Lunde M, Unden M, et al. The lack of sustained effect of bright light, after discontinuation, in non-seasonal major depression. *Psychol Med*. 2006;36(9):1247-52. PMID:16756691 OVID-Medline.

Exclude: Not an eligible population treatment

Masand P, Peindl K, Hooper-Wood C and others. A randomized, double-blind, placebo-controlled, flexible-dose trial of augmentation with OROS methylphenidate in treatment-resistant depression. In 2006. Wiley-CCTR.

Exclude: Not an eligible study design

Mason, R.A. Efficacy of prosocial behavior as an adjunct to short-term psychotherapy in treating clinically depressed college students 2004. OVID-PsycINFO.

Exclude: Not an eligible study design

Masuda A, Nakazato M, Kihara T, et al. Repeated thermal therapy diminishes appetite loss and subjective complaints in mildly depressed patients. *Psychosom Med*. 2005;67(4):643-7. OVID-Embase.

Exclude: Not an eligible population treatment

Mathe G, Lopez MD, Frechet M, et al. A comparative trial of a MAOI, iproniazide, and a polycyclic agent, mianserine, for the search of the most rapidly and frequently active treatment of depressive syndromes in an oncology service. *Biomed Pharmacother*. 1987;41(1):13-26. PMID:3300808 OVID-Medline.

Exclude: Not an eligible population treatment

Mather AS, Rodriguez C, Guthrie MF, et al. Effects of exercise on depressive symptoms in older adults with poorly responsive depressive disorder: Randomised controlled trial. *Br J Psychiatry*. 2002;180:411-5. PMID:11983637 OVID-Medline.

Exclude: Not an eligible population treatment

Mathew KL, Whitford HS, Kenny MA, et al. The long-term effects of mindfulness-based cognitive therapy as a relapse prevention treatment for major depressive disorder. *Behav Cognit Psychother*. 2010;38(5):561-76. PMID:20374671 OVID-Medline.

Exclude: Not an eligible study design

Matinsen EW, Medhus A. Adherence to exercise and patients' evaluation of physical exercise in a comprehensive treatment programme for depression. *Nord Psykiatr Tidsskr*. 1989;43(5):411-5. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Matsunaga M, Okamoto Y, Suzuki S, et al. Psychosocial functioning in patients with treatment-resistant depression after group cognitive behavioral therapy. *BMC Psychiatr*. 2010;10:22. PMID:20230649 OVID-Medline. Exclude: Not an eligible study design

Mattes JA. Pergolide to augment the effectiveness of antidepressants: Clinical experience and a small double-blind study. *Ann Clin Psychiatr*. 1997;9(2):87-8. PMID:9242894 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Mattingly G, Ilivicky H, Canale J and others. Quetiapine augmentation for treatment-resistant depression. In 2006. Wiley-CCTR. Exclude: Not an eligible study design

Matussek N, Angst J, Benkert O, et al. The effect of L-5-hydroxytryptophan alone and in combination with a decarboxylase inhibitor (Ro-4-4602) in depressive patients. *Adv Biochem Psychopharmacol*. 1974;11(0):399-404. Wiley-CCTR. Exclude: Not an eligible population treatment

Mausbach BT, Moore R, Roesch S, et al. The relationship between homework compliance and therapy outcomes: An updated meta-analysis. *Cognit Ther Res*. 2010;34(5):429-38. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Mauskopf JA, Simon GE, Kalsekar A, et al. Nonresponse, partial response, and failure to achieve remission: Humanistic and cost burden in major depressive disorder. *Depress Anxiety*. 2009;26(1):83-97. PMID:18833573 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Mayers AG, Baldwin DS, Dyson R, et al. Use of St. John's wort (*Hypericum perforatum* L) in members of a depression self-help organisation: A 12-week open prospective pilot study using the HADS scale. *Prim Care Psychiatr*. 2003;9(1):15-20. OVID-Embase. Exclude: Not an eligible study design

Maynard CK. Comparison of effectiveness of group interventions for depression in women. *Arch Psychiatr Nurs*. 1993;7(5):277-83. OVID-PsycINFO. Exclude: Not an eligible population treatment

Mayur PM, Gangadhar BN, Subbakrishna DK, et al. Discontinuation of antidepressant drugs during electroconvulsive therapy: A controlled study. *J Affect Disord*. 2000;58(1):37-41. PMID:10760556 OVID-Medline. Exclude: Not an eligible population treatment

Mazeh D, Shahal B, Saraf R, et al. Venlafaxine for the treatment of depressive episode during the course of schizophrenia. *J Clin Psychopharmacol*. 2004;24(6):653-5. OVID-Embase. Exclude: Not an eligible study design

Mbaya P. Safety and efficacy of high dose of venlafaxine XL in treatment resistant major depression. *Hum Psychopharmacol*. 2002;17(7):335-9. PMID:12415551 OVID-Medline. Exclude: Not an eligible study design

McCabe MP, McGillivray JA, Newton DC. Effectiveness of treatment programmes for depression among adults with mild/moderate intellectual disability. *J Intellect Disabil Res*. 2006;50(Pt:4):4-47. PMID:16507028 OVID-Medline. Exclude: Not an eligible population treatment

McCaffrey R. The effect of healing gardens and art therapy on older adults with mild to moderate depression. *Holist Nurs Pract*. 2007;21(2):79-84. EBSCO-CINAHL. Exclude: Not an eligible study design

McCaffrey R, Hanson C, McCaffrey W. Garden walking for depression: A research report. *Holist Nurs Pract*. 2010;24(5):252-9. PMID:20706087 OVID-Medline. Exclude: Not an eligible study design

McCall WV, Blocker JN, D'Agostino R, Jr., et al. Treatment of insomnia in depressed insomniacs: Effects on health-related quality of life, objective and self-reported sleep, and depression. *J Clin Sleep Med*. 2010;6(4):322-9. PMID:20726279 OVID-Medline. Exclude: Not an eligible population treatment

McCann IL, Holmes DS. Influence of aerobic exercise on depression. *J Pers Soc Psychol*. 1984;46(5):1142-7. OVID-PsycINFO. Exclude: Not an eligible population treatment

Mcclanahan,T.M. A comparative evaluation of cognitive-behavioral therapy and insight-oriented psychotherapy in the treatment of comorbid substance abuse, anxiety, and depression in substance abusing females Mcclanahan. 2001. OVID-PsycINFO. Exclude: Not an eligible study design

McClernon FJ, Hiott FB, Westman EC, et al. Transdermal nicotine attenuates depression symptoms in nonsmokers: A double-blind, placebo-controlled trial. *Psychopharmacol*. 2006;189(1):125-33. PMID:16977477 OVID-Medline. Exclude: Not an eligible population treatment

McClintock SM, Husain MM, Wisniewski SR, et al. Residual symptoms in depressed outpatients who respond by 50% but do not remit to antidepressant medication. *J Clin Psychopharmacol*. 2011;31(2):180-6. OVID-Embase.
Exclude: Systematic Review before 2005

McCrone P, Knapp M, Proudfoot J, et al. Cost-effectiveness of computerised cognitive-behavioural therapy for anxiety and depression in primary care: Randomised controlled trial. *Br J Psychiatr*. 2004;185:55-62. PMID:15231556 OVID-Medline.
Exclude: Not an eligible population treatment

McCue RE, Aronowitz J. Accelerated antidepressant response in geriatric inpatients. *Am J Geriatr Psychiatr*. 1994;2(3):244-6. OVID-Embase.
Exclude: Not an eligible study design

McCusker J, Cole M, Yaffe M, et al. Project direct: Pilot study of a collaborative intervention for depressed seniors. *Can J Commun Ment Health*. 2008;27(2):201-18. OVID-Embase.
Exclude: Not an eligible population treatment

McDowell DM, Levin FR, Seracini AM, et al. Venlafaxine treatment of cocaine abusers with depressive disorders. *Am J Drug Alcohol Abuse*. 2000;26(1):25-31. PMID:10718161 OVID-Medline.
Exclude: Not an eligible study design

McEnany GW, Lee KA. Effects of light therapy on sleep, mood, and temperature in women with nonseasonal major depression. *Issues Ment Health Nurs*. 2005;26(7):781-94. PMID:16126652 OVID-Medline.
Exclude: Not an eligible population treatment

McEvoy PM, Nathan P. Effectiveness of cognitive behavior therapy for diagnostically heterogeneous groups: A benchmarking study. *J Consult Clin Psychol*. 2007;75(2):344-50. PMID:17469892 OVID-Medline.
Exclude: Not an eligible study design

McGillivray JA, McCabe MP, Kershaw MM. Depression in people with intellectual disability: An evaluation of a staff-administered treatment program. *Res Dev Disabil*. 2008;29(6):524-36. PMID:17981010 OVID-Medline.
Exclude: Not an eligible population treatment

McGrath PJ, Stewart JW, Harrison W, et al. Treatment of tricyclic refractory depression with a monoamine oxidase inhibitor antidepressant. *Psychopharmacol Bull*. 1987;23(1):169-72. Wiley-CCTR.
Exclude: Not an eligible population treatment

McGrath PJ, Stewart JW, Nunes EV, et al. A double-blind crossover trial of imipramine and phenelzine for outpatients with treatment-refractory depression. *Am J Psychiatry*. 1993;150(1):118-23. PMID:8417553 OVID-Medline.
Exclude: Not an eligible population treatment

McGrath PJ, Stewart JW, Nunes EN, et al. Treatment response of depressed outpatients unresponsive to both a tricyclic and a monoamine oxidase inhibitor antidepressant. *J Clin Psychiatry*. 1994;55(8):336-9. PMID:8071301 OVID-Medline.
Exclude: Not an eligible population treatment

McGrath PJ, Khan AY, Trivedi MH, et al. Response to a selective serotonin reuptake inhibitor (citalopram) in major depressive disorder with melancholic features: A STAR*D report. *J Clin Psychiatry*. 2008;69(12):1847-55. PMID:19026268 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

McIntyre A, Gendron A, McIntyre A. Quetiapine adjunct to selective serotonin reuptake inhibitors or venlafaxine in patients with major depression, comorbid anxiety, and residual depressive symptoms: A randomized, placebo-controlled pilot study. *Depress Anxiety*. 2007;24(7):487-94. PMID:17177199 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

McKnight DL, Nelson RO, Hayes SC, et al. Importance of treating individually assessed response classes in the amelioration of depression. *Behav Ther*. 1984;15(4):315-35. OVID-Embase

OVID-Embase.
Exclude: Not an eligible population treatment

McLean P, Taylor S. Severity of unipolar depression and choice of treatment. *Behav Res Ther*. 1992;30(5):443-51. PMID:1520230 OVID-Medline.
Exclude: Not an eligible population treatment

McLean PD, Hakstian AR. Clinical depression: Comparative efficacy of outpatient treatments. *J Consult Clin Psychol*. 1979;47(5):818-36. Wiley-CCTR.
Exclude: Not an eligible population treatment

McLean PD, Hakstian AR. Relative endurance of unipolar depression treatment effects: Longitudinal follow-up. *J Consult Clin Psychol*. 1990;58(4):482-8. PMID:2212186 OVID-Medline.
Exclude: Not an eligible population treatment

McMahon FJ, Buervenich S, Charney D, et al. Variation in the gene encoding the serotonin 2A receptor is associated with outcome of antidepressant treatment. *Am J Hum Genet.* 2006;78(5):804-14. PMID:16642436 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

McMahon L, Foran KM, Forrest SD, et al. Graduate mental health worker case management of depression in UK primary care: A pilot study. *Br J Gen Pract.* 2007;57(544):880-5. OVID-Embase.

Exclude: Not an eligible population treatment

McNamara K, Horan JJ. Experimental construct validity in the evaluation of cognitive and behavioral treatments for depression. *J Couns Psychol.* 1986;33(1):23-30. OVID-PsycINFO.

Exclude: Not an eligible population treatment

McNaughton JL. Brief interventions for depression in primary care: A systematic review. *Can Fam Physician.* 2009;55(8):789-96. PMID:19675262 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

McNeil JK, LeBlanc EM, Joyner M. The effect of exercise on depressive symptoms in the moderately depressed elderly. *Psychol Aging.* 1991;6(3):487-8. OVID-PsycINFO.

Exclude: Not an eligible population treatment

McPherson S, Cairns P, Carlyle J, et al. The effectiveness of psychological treatments for treatment-resistant depression: A systematic review. *Acta Psychiatr Scand.* 2005;111(5):331-40. PMID:15819726

Excluded - Systematic review - relevant topic, citations cross-matched

McPherson S, Evans C, Richardson P. The NICE Depression Guidelines and the recovery model: Is there an evidence base for IAPT? *J Ment Health.* 2009;18(5):405-14. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

McPherson S, Walker C, Carlyle JA. Primary care counsellors' experiences of working with treatment resistant depression: A qualitative pilot study. *Couns Psychother Res.* 2006;6(4):250-7. OVID-PsycINFO.

Exclude: Not an eligible study design

McShane G, Mihalich M, Walter G, et al. Outcome of patients with unipolar, bipolar and psychotic disorders admitted to a specialist child and adolescent mental health service. *Australas Psychiatr.* 2006;14(2):198-201. PMID:16734650 OVID-Medline.

Exclude: Not an eligible study design

Mead GE, Morley W, Campbell P, et al. Exercise for depression. *Cochrane Database Syst Rev.* 2008;(4): OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Mead N, MacDonald W, Bower P, et al. The clinical effectiveness of guided self-help versus waiting-list control in the management of anxiety and depression: A randomized controlled trial. *Psychol Med.* 2005;35(11):1633-43. OVID-Embase.

Exclude: Not an eligible population treatment

Mead N, Lester H, Chew-Graham C, et al. Effects of befriending on depressive symptoms and distress: Systematic review and meta-analysis. *Br J Psychiatr.* 2010;196(2):96-101. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Means KM, O'Sullivan PS, Rodell DE. Psychosocial effects of an exercise program in older persons who fall. *J Rehabil Res Dev.* 2003;40(1):49-58. OVID-Embase.

Exclude: Not an eligible population treatment

Medhus A, Heskestad S, Tjemsland L. Mianserin added to tricyclic antidepressants in depressed patients not responding to a tricyclic antidepressant alone: A randomized, placebo-controlled, double-blind study. *Nord J Psychiatr.* 1994;48(5):355-8. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Meeks S, Looney SW, Van Haitsma K, et al. BE-ACTIV: A staff-assisted behavioral intervention for depression in nursing homes. *Gerontologist.* 2008;48(1):105-14. PMID:18381837 OVID-Medline.

Exclude: Not an eligible population treatment

Meeks TW, Wetherell JL, Irwin MR, et al. Complementary and alternative treatments for late-life depression, anxiety, and sleep disturbance: A review of randomized controlled trials. *J Clin Psychiatr.* 2007;68(10):1461-71. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Mehdi PR, Sen AK, Sen Mazumdar DP. The usefulness of psychodrama in the treatment of depressed patients. *Indian J Clin Psychol.* 1997;24(1):82-92. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Mehta P, Sharma M. Yoga as a complementary therapy for clinical depression. *Complement Health Pract Rev.* 2010;15(3):156-70. OVID-PsycINFO.

Exclude: Not an eligible study design

- Meier RM. Group treatment of depression and withdrawal at a day-treatment center. *Int J Partial Hosp.* 1982;1(4):349-53. OVID-PsycINFO. Exclude: Not an eligible study design
- Mello MF, Myczcowisk LM, Menezes PR. A randomized controlled trial comparing moclobemide and moclobemide plus interpersonal psychotherapy in the treatment of dysthymic disorder. *J Psychother Pract Res.* 2001;10(2):117-23. Exclude: Not an eligible population treatment
- Melvin GA, Tonge BJ, King NJ, et al. A comparison of cognitive-behavioral therapy, sertraline, and their combination for adolescent depression. *J Am Acad Child Adolesc Psychiatry.* 2006;45(10):1151-61. PMID:17003660 OVID-Medline. Exclude: Not an eligible population treatment
- Melzer J, Brignoli R, Keck ME, et al. A hypericum extract in the treatment of depressive symptoms in outpatients: An open study. *Forschende Komplementarmedizin.* 2010;17(1):7-14. PMID:20215757 OVID-Medline. Exclude: Not an eligible study design
- Mendels J, Stinnett JL, Burns D, et al. Amine precursors and depression. *Arch Gen Psychiatr.* 1975;32(1):22-30. Wiley-CCTR. Exclude: Not an eligible population treatment
- Mendes De Leon CF, Czajkowski SM, Freedland KE, et al. The effect of a psychosocial intervention and quality of life after acute myocardial infarction: The Enhancing Recovery in Coronary Heart Disease (ENRICH) clinical trial. *J Cardpulm Rehabil.* 2006;26(1):9-15. OVID-Embase. Exclude: Not an eligible population treatment
- Mendlewicz J, Youdim MB. Antidepressant potentiation of 5-hydroxytryptophan by L-deprenil in affective illness. *J Affect Disord.* 1980;2(2):137-46. PMID:6448885 OVID-Medline. Exclude: Not an eligible population treatment
- Mendlewicz J, Kriwin P, Oswald P, et al. Shortened onset of action of antidepressants in major depression using acetylsalicylic acid augmentation: A pilot open-label study. *Int Clin Psychopharmacol.* 2006;21(4):227-31. PMID:16687994 OVID-Medline. Exclude: Not an eligible study design
- Mendlowitz SL, Manassis K, Bradley S, et al. Cognitive-behavioral group treatments in childhood anxiety disorders: The role of parental involvement. *J Am Acad Child Adolesc Psychiatry.* 1999;38(10):1223-9. Wiley-CCTR. Exclude: Not an eligible population treatment
- Mendoza RJ, Pittenger DJ, Weinstein CS. Unit management of depression of patients with multiple sclerosis using cognitive remediation strategies: A preliminary study. *Neurorehabil Neural Repair.* 2001;15(1):9-14. PMID:11527284 OVID-Medline. Exclude: Not an eligible population treatment
- Mercier MA, Stewart JW, Quitkin FM. A pilot sequential study of cognitive therapy and pharmacotherapy of atypical depression. *J Clin Psychiatry.* 1992;53(5):166-70. PMID:1592844 OVID-Medline. Exclude: Not an eligible study design
- Merrill KA, Tolbert VE, Wade WA. Effectiveness of cognitive therapy for depression in a community mental health center: A benchmarking study. *J Consult Clin Psychol.* 2003;71(2):404-9. PMID:12699035 OVID-Medline. Exclude: Not an eligible study design
- Merrill RM, Taylor P, Aldana SG. Coronary Health Improvement Project (CHIP) is associated with improved nutrient intake and decreased depression. *Nutr.* 2008;24(4):314-21. PMID:18296026 OVID-Medline. Exclude: Not an eligible population treatment
- Meyer B, Berger T, Caspar F, et al. Effectiveness of a novel integrative online treatment for depression (Deprexis): Randomized controlled trial. *J Med Internet Res.* 2009;11(2):e15 PMID:19632969 OVID-Medline. Exclude: Not an eligible population treatment
- Milak MS, Parsey RV, Lee L, et al. Pretreatment regional brain glucose uptake in the midbrain on PET may predict remission from a major depressive episode after three months of treatment. *Psychiatry Res.* 2009;173(1):63-70. PMID:19446443 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI
- Milani RV, Lavie CJ, Cassidy MM. Effects of cardiac rehabilitation and exercise training programs on depression in patients after major coronary events. *Am Heart J.* 1996;132(4):726-32. PMID:8831359 OVID-Medline. Exclude: Not an eligible study design
- Milani RV, Lavie CJ. Impact of cardiac rehabilitation on depression and its associated mortality. *Am J Med.* 2007;120(9):799-806. OVID-Embase. Exclude: Not an eligible population treatment
- Milani RV, Lavie CJ, Mehra MR, et al. Impact of exercise training and depression on survival in heart failure due to coronary heart disease. *Am J Cardiol.* 2011;107(1):64-8. PMID:21146688 OVID-Medline. Exclude: Not an eligible study design

Milea D, Guelfucci F, Bent-Ennakhl N, et al. Antidepressant monotherapy: A claims database analysis of treatment changes and treatment duration. *Clin Ther*. 2010;32(12):2057-72. PMID:21118742 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Miljkovic BR, Pokrajac M, Timotijevic I, et al. The influence of lithium on fluvoxamine therapeutic efficacy and pharmacokinetics in depressed patients on combined fluvoxamine-lithium therapy. *Int Clin Psychopharmacol*. 1997;12(4):207-12. PMID:9347381 OVID-Medline.

Exclude: Not an eligible population treatment

Miller IW, Bishop SB, Norman WH, et al. Cognitive/behavioural therapy and pharmacotherapy with chronic, drug-refractory depressed inpatients: A note of optimism. *Behav Psychother*. 1985;13(4):320-7. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Miller IW, Norman WH, Keitner GI, et al. Cognitive-behavioral treatment of depressed inpatients. *Behav Ther*. 1989;20(1):25-47. OVID-Embase.

Exclude: Not an eligible population treatment

Miller IW, Norman WH, Keitner GI. Cognitive-behavioral treatment of depressed inpatients: Six- and twelve-month follow-up. *Am J Psychiatry*. 1989;146(10):1274-9. OVID-Embase.

Exclude: Not an eligible population treatment

Miller IW, Norman WH, Keitner GI. Treatment response of high cognitive dysfunction depressed inpatients. *Compr Psychiatry*. 1990;31(1):62-71. PMID:2404660 OVID-Medline.

Exclude: Not an eligible population treatment

Miller IW, Norman WH, Keitner GI. Combined treatment for patients with double depression. *Psychother Psychosom*. 1999;68(4):180-5. OVID-Embase.

Exclude: Not an eligible population treatment

Miller IW, Keitner GI, Ryan CE, et al. Treatment matching in the posthospital care of depressed patients. *Am J Psychiatry*. 2005;162(11):2131-8. PMID:16263854 OVID-Medline.

Exclude: Not an eligible population treatment

Miller KK, Perlis RH, Papakostas GI, et al. Low-dose transdermal testosterone augmentation therapy improves depression severity in women. *CNS Spectrums*. 2009;14(12):688-94. PMID:20394176 OVID-Medline.

Exclude: Not an eligible study design

Miller L, Weissman M. Interpersonal psychotherapy delivered over the telephone to recurrent depressives: A pilot study. *Depress Anxiety*. 2002;16(3):114-7. PM:12415535 Exclude: Not an eligible population treatment

Miller MD, Pollock BG, Rifai AH, et al. Longitudinal analysis of nortriptyline side effects in elderly depressed patients. *J Geriatr Psychiatry Neurol*. 1991;4(4):226-30. PMID:1789911 OVID-Medline.

Exclude: Not an eligible study design

Miller MD, Paradis CF, Houck PR, et al. Chronic medical illness in patients with recurrent major depression. *Am J Geriatr Psychiatry*. 1996;4(4):281-90. OVID-PsycINFO.

Exclude: Not an eligible study design

Mindham RH. Continuation therapy with tricyclic antidepressants in relapsing depressive illness. *Bibl Psychiatry*. 1981;(160):49-55. Wiley-CCTR.

Exclude: Not an eligible study design

Mino Y, Babazono A, Tsuda T, et al. Can stress management at the workplace prevent depression? A randomized controlled trial. *Psychother Psychosom*. 2006;75(3):177-82. PMID:16636633 OVID-Medline.

Exclude: Not an eligible population treatment

Miranda J, Munoz R. Intervention for minor depression in primary care patients. *Psychosom Med*. 1994;56(2):136-41. PMID:8008800 OVID-Medline.

Exclude: Not an eligible population treatment

Miranda J, Chung JY, Green BL, et al. Treating depression in predominantly low-income young minority women: A randomized controlled trial. *JAMA*. 2003;290(1):57-65. PMID:12837712 OVID-Medline.

Exclude: Not an eligible population treatment

Miranda J, Azocar F, Organista KC, et al. Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatr Serv*. 2003;54(2):219-25. PMID:12556604 OVID-Medline.

Exclude: Not an eligible population treatment

Miranda J, Green BL, Krupnick JL, et al. One-year outcomes of a randomized clinical trial treating depression in low-income minority women. *J Consult Clin Psychol*. 2006;74(1):99-111. PMID:16551147 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Mischoulon D, Opitz G, Kelly K, et al. A preliminary open study of the tolerability and effectiveness of nefazodone in major depressive disorder: Comparing patients who recently discontinued an SSRI with those on no recent antidepressant treatment. *Depress Anxiety*. 2004;19(1):43-50. PMID:14978785 OVID-Medline.
Exclude: Not an eligible study design

Mischoulon D, Best-Popescu C, Laposata M, et al. A double-blind dose-finding pilot study of docosahexaenoic acid (DHA) for major depressive disorder. *Eur Neuropsychopharmacol*. 2008;18(9):639-45. PMID:18539007 OVID-Medline.
Exclude: Not an eligible population treatment

Mischoulon D, Papakostas GI, Dording CM, et al. A double-blind, randomized controlled trial of ethyl-eicosapentaenoate for major depressive disorder. *J Clin Psychiatr*. 2009;70(12):1636-44. PMID:19709502 OVID-Medline.
Exclude: Not an eligible population treatment

Miser WF. Exercise as an effective treatment option for major depression in older adults. *J Fam Pract*. 2000;49(2):109-10. PMID:10718684 OVID-Medline.
Exclude: Not an eligible study design

Mishra M, Sinha RK. Effect of yogic practices on depression and anxiety. *J Projective Psychol Ment Health*. 2001;8(1):23-7. OVID-PsycINFO.
Exclude: Not an eligible study design

Miskowiak KW, Vinberg M, Harmer CJ, et al. Effects of erythropoietin on depressive symptoms and neurocognitive deficits in depression and bipolar disorder. *Trials*. 2010;11:97. PMID:20942940 OVID-Medline.
Exclude: Not an eligible study design

Misri S, Kendrick K. Treatment of perinatal mood and anxiety disorders: A review. *Can J Psychiatry*. 2007;52(8):489-98. PMID:17955910 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Mitchell N, Dunn K. Pragmatic evaluation of the viability of CCBT self-help for depression in higher education. *Couns Psychother Res*. 2007;7(3):144-50. OVID-PsycINFO.
Exclude: Not an eligible study design

Mitchell PB, Schweitzer I, Burrows G, et al. Efficacy of venlafaxine and predictors of response in a prospective open-label study of patients with treatment-resistant major depression. *J Clin Psychopharmacol*. 2000;20(4):483-7. PMID:10917411 OVID-Medline.
Exclude: Not an eligible study design

Mitchell PH, Teri L, Veith R, et al. Living well with stroke: Design and methods for a randomized controlled trial of a psychosocial behavioral intervention for poststroke depression. *J Stroke Cerebrovasc Dis*. 2008;17(3):109-15. PMID:18436150 OVID-Medline.
Exclude: Not an eligible population design

Mitchell PH, Veith RC, Becker KJ, et al. Brief psychosocial-behavioral intervention with antidepressant reduces poststroke depression significantly more than usual care with antidepressant: Living well with stroke: Randomized, controlled trial. *Stroke*. 2009;40(9):3073-8. PMID:19661478 OVID-Medline.
Exclude: Not an eligible population design

Mitchell P. The pharmacological treatment of tricyclic-resistant depression: Review and management guidelines. *Aust NZ J Psychiatr*. 1987;21(4):442-51. OVID-PsycINFO.
Exclude: Not an eligible guideline

Mittelman MS, Brodaty H, Wallen AS, et al. A three-country randomized controlled trial of a psychosocial intervention for caregivers combined with pharmacological treatment for patients with Alzheimer disease: Effects on caregiver depression. *Am J Geriatr Psychiatry*. 2008;16(11):893-904. Wiley-CCTR.
Exclude: Not an eligible population treatment

Miyasaki JM, Shannon K, Voon V, et al. Practice Parameter: Evaluation and treatment of depression, psychosis, and dementia in Parkinson disease (an evidence-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology*. 2006;66(7):996-1002. PMID:16606910 OVID-Medline.
Exclude: Not an eligible guideline

Miyasaki JM, Shannon K, Voon V, et al. Appendix F: Practice parameter: Evaluation and treatment of depression, psychosis, and dementia in Parkinson disease (evidenced-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology. *CONTINUUM Lifelong Learn Neurol*. 2007;13(1):193-9. OVID-Embase.
Exclude: Not an eligible guideline

Moak DH, Anton RF, Latham PK, et al. Sertraline and cognitive behavioral therapy for depressed alcoholics: results of a placebo-controlled trial. *J Clin Psychopharmacol*. 2003;23(6):553-62. PMID:14624185 OVID-Medline.

Exclude: Not an eligible population treatment

Mohr DC, Likosky W, Bertagnolli A, et al. Telephone-administered cognitive-behavioral therapy for the treatment of depressive symptoms in multiple sclerosis. *J Consult Clin Psychol*. 2000;68(2):356-61. PMID:10780138 OVID-Medline.

Exclude: Not an eligible population treatment

Mohr DC, Boudewyn AC, Goodkin DE, et al. Comparative outcomes for individual cognitive-behavior therapy, supportive-expressive group psychotherapy, and sertraline for the treatment of depression in multiple sclerosis. *J Consult Clin Psychol*. 2001;69(6):942-9. PMID:11777121 OVID-Medline.

Exclude: Not an eligible population treatment

Mohr DC, Hart SL, Julian L, et al. Telephone-administered psychotherapy for depression. *Arch Gen Psychiatr*. 2005;62(9):1007-14. PMID:16143732 OVID-Medline.

Exclude: Not an eligible population treatment

Mohr DC, Hart SL, Marmar C. Telephone administered cognitive-behavioral therapy for the treatment of depression in a rural primary care clinic. *Cognit Ther Res*. 2006;30(1):29-37. OVID-Embase.

Exclude: Not an eligible study design

Moldenhauer Z. Adolescent depression: A primary care pilot intervention study 2004. OVID-PsycINFO.

Exclude: Not an eligible study design

Moleiro C, Beutler LE. Clinically significant change in psychotherapy for depressive disorders. *J Affect Disord*. 2009;115(1-2):220-4. OVID-Embase.

Exclude: Not an eligible population treatment

Molenaar PJ, Dekker J, Van R, et al. Does adding psychotherapy to pharmacotherapy improve social functioning in the treatment of outpatient depression? *Depress Anxiety*. 2007;24(8):553-62. PMID:17131302 OVID-Medline.

Exclude: Not an eligible population treatment

Moller H-J. Evidence for beneficial effects of antidepressants on suicidality in depressive patients: A systematic review. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(6):329-43. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Moller HJ, Bottlender R, Grunze H, et al. Are antidepressants less effective in the acute treatment of bipolar I compared to unipolar depression? *J Affect Disord*. 2001;67(1-3):141-6. PMID:11869761 OVID-Medline.

Exclude: Not an eligible study design

Montes JM, Ferrando L, Saiz-Ruiz J. Remission in major depression with two antidepressant mechanisms: results from a naturalistic study. *J Affect Disord*. 2004;79(1-3):229-34. PMID:15023499 OVID-Medline.

Exclude: Not an eligible study design

Montgomery EC, Kunik ME, Wilson N, et al. Can paraprofessionals deliver cognitive-behavioral therapy to treat anxiety and depressive symptoms? *Bull Menninger Clin*. 2010;74(1):45-62. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Montoya A, Weiss AP, Price BH, et al. Magnetic resonance imaging-guided stereotactic limbic leukotomy for treatment of intractable psychiatric disease. *Neurosurgery*. 2009;65(5):1043-9. PMID:1950407 OVID-Medline.

Exclude: Not an eligible study design

Moore J.D. The effectiveness of bright light treatment on depression in an HIV population 2009. OVID-PsycINFO.

Exclude: Not an eligible study design

Moore RG, Blackburn I-M. Cognitive therapy in the treatment of non-responders to antidepressant medication: A controlled pilot study. *Behav Cognit Psychother*. 1997;25(3):251-9. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Moorey S, Cort E, Kapari M, et al. A cluster randomized controlled trial of cognitive behaviour therapy for common mental disorders in patients with advanced cancer. *Psychol Med*. 2009;39(5):713-23. PMID:18761755 OVID-Medline.

Exclude: Not an eligible population treatment

Moreno FA, Gelenberg AJ, Bachar K, et al. Pindolol augmentation of treatment-resistant depressed patients. *J Clin Psychiatry*. 1997;58(10):437-9. PMID:9375594 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Moreno RA, Teng CT, Almeida KM, et al. Hypericum perforatum versus fluoxetine in the treatment of mild to moderate depression: A randomized double-blind trial in a Brazilian sample. *Revista Brasileira de Psiquiatria*. 2006;28(1):29-32. PMID:16612487 OVID-Medline.

Exclude: Not an eligible population treatment

Moreno R, Cunningham AC, Gatchel RJ, et al. Functional restoration for chronic low back pain: Changes in depression, cognitive distortion, and disability. *J Occup Rehabil.* 1991;1(3):207-16. OVID-PsycINFO.

Exclude: Not an eligible study design

Morgan AJ, Jorm AF. Self-help interventions for depressive disorders and depressive symptoms: A systematic review. *Ann Gen Psychiatry.* 2008;7:13. PMID:18710579 Excluded - Systematic review - relevant topic, citations cross-matched

Morgan ML, Cook IA, Rapkin AJ, et al. Estrogen augmentation of antidepressants in perimenopausal depression: A pilot study. *J Clin Psychiatry.* 2005;66(6):774-80. PMID:15960574 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Morgan ML, Cook IA, Rapkin AJ, et al. Neurophysiologic changes during estrogen augmentation in perimenopausal depression. *Maturitas.* 2007;56(1):54-60. PMID:16835012 OVID-Medline.

Exclude: Not an eligible study design

Morishita S, Aoki S. Clonazepam in the treatment of prolonged depression. *J Affect Disord.* 1999;53(3):275-8. PMID:10404714 OVID-Medline. Exclude: Not an eligible population treatment

Morishita S, Aoki S. Clonazepam augmentation of antidepressants: Does it distinguish unipolar from bipolar depression? *J Affect Disord.* 2002;71(1-3):217-20. PMID:12167520 OVID-Medline. Exclude: Not an eligible study design

Morishita S, Arita S. Prophylactic effect of clonazepam augmentation on protracted depression as a mood stabilizer. *Int Med J.* 2002;9(4):261-4. OVID-Embase. Exclude: Not an eligible population treatment

Morishita S, Arita S. Lithium augmentation of antidepressants in the treatment of protracted depression. *Int Med J.* 2003;10(1):29-32. OVID-Embase. Exclude: Not an eligible study design

Morishita S, Arita S. Predictors of response to clonazepam as a mood stabilizer in protracted depression. *Int Med J.* 2003;10(2):101-4. OVID-Embase. Exclude: Not an eligible study design

Morishita S, Arita S. Response period of combined fluvoxamine and milnacipran treatment for depression. *Int Med J.* 2005;12(1):25-6. OVID-Embase.

Exclude: Not an eligible study design

Morishita S, Arita S. Clonazepam augmentation of antidepressants: Which is the suitable combined antidepressant? *Int Med J.* 2007;14(3):195-7. OVID-Embase.

Exclude: Not an eligible study design

Morishita S, Arita S. Possible predictors of response to clonazepam augmentation therapy in patients with protracted depression. *Hum Psychopharmacol.* 2007;22(1):27-31. PMID:17191267 OVID-Medline. Exclude: Not an eligible population treatment

Morishita S, Sawamura J, Ishigooka J. Characteristics associated with response to clonazepam augmentation therapy in patients with protracted depression. *Int Med J.* 2009;16(1):9-12. OVID-Embase.

Exclude: Not an eligible study design

Morishita S, Arita S. The period of onset of action of clonazepam augmentation as a mood stabilizer for protracted depression. *Int Med J.* 2003;10(1):3-6. OVID-PsycINFO.

Exclude: Not an eligible study design

Morris DW, Trivedi MH, Fava M, et al. Diurnal mood variation in outpatients with major depressive disorder. *Depress Anxiety.* 2009;26(9):851-63. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Morris RG, Morris LW. Cognitive and behavioural approaches with the depressed elderly. *Int J Geriatr Psychiatry.* 1991;6(6):407-13. OVID-Embase. OVID-Embase.

Exclude: Not an eligible study design

Morrissey M. Mood enhancement and anxiety reduction using physical exercise in a clinical sample. *Int J Psychiatr Nurs Res.* 1997;3(2):336-44. EBSCO-CINAHL.

Exclude: Mixed antidepressants:some failed on SSRI

Moscovici L, Kotler M. A multistage chronobiologic intervention for the treatment of depression: A pilot study. *J Affect Disord.* 2009;116(3):201-7. PMID:19232745 OVID-Medline.

Exclude: Not an eligible study design

Moshiri E, Basti AA, Noorbala AA, et al. Crocus sativus L. (petal) in the treatment of mild-to-moderate depression: A double-blind, randomized and placebo-controlled trial. *Phytomed*. 2006;13(9-10):607-11. PMID:16979327 OVID-Medline.
Exclude: Not an eligible population treatment

Motl RW, Konopack JF, McAuley E, et al. Depressive symptoms among older adults: Long-term reduction after a physical activity intervention. *J Behav Med*. 2005;28(4):385-94. OVID-Embase.
Exclude: Not an eligible population treatment

Mow KE. Treatment of psychoneurosis and depression with medical hypnoanalysis: San Antonio Conference September 22-25, 1994. *Med Hypnoanalysis J*. 1994;9(4):167-76. OVID-AMED.
Exclude: Not an eligible study design

Möller HJ, Kissling W, Herberger B, et al. Controlled trial on the possible advantages of a combined therapy with maprotiline and haloperidol in endogenous depression. *Pharmacopsychiatr*. 1986;19(5):362-4. Wiley-CCTR.
Exclude: Not an eligible population treatment

Mrazek DA, Rush AJ, Biernacka JM, et al. SLC6A4 variation and citalopram response. *Am J Med Genet*. 2009;Part(3):341-51. PMID:18618621 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Mueller BM. St. John's Wort for depressive disorders: Results of an outpatient study with the Hypericum preparation HYP 811. *Adv Ther*. 1998;15(2):109-16. PMID:10180997 OVID-Medline.
Exclude: Not an eligible study design

Mufson L, Fairbanks J. Interpersonal psychotherapy for depressed adolescents: A one-year naturalistic follow-up study. *J Am Acad Child Adolesc Psychiatry*. 1996;35(9):1145-55. PM:8824058
Exclude: Not an eligible study design

Mufson L, Weissman MM, Moreau D, et al. Efficacy of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry*. 1999;56(6):573-9. PM:10359475
Exclude: Not an eligible population treatment

Mukaino Y, Park J, White A, et al. The effectiveness of acupuncture for depression: A systematic review of randomised controlled trials. *Acupuncture Med*. 2005;23(2):70-6. PMID:16025787 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Mulcahy, K.A. Beck's cognitive therapy and aerobic exercise for the treatment of depression Mulcahy. 1998. OVID-PsycINFO.
Exclude: Not an eligible study design

Mulder RT, Joyce PR, Frampton CM, et al. Antidepressant treatment is associated with a reduction in suicidal ideation and suicide attempts. *Acta Psychiatr Scand*. 2008;118(2):116-22. PMID:18384467 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Muller-Oerlinghausen B, Rao ML, Stieglitz RD, et al. Fluvoxamine challenge test, phototherapy, and successive fluvoxamine treatment in patients with non-seasonal depression. *Pharmacopsychiatr*. 1989;22(5):209-10. OVID-Embase.
Exclude: Not an eligible study design

Muller-Siecheneder F, Muller MJ, Hillert A, et al. Risperidone versus haloperidol and amitriptyline in the treatment of patients with a combined psychotic and depressive syndrome. *J Clin Psychopharmacol*. 1998;18(2):111-20. PMID:9555596 OVID-Medline.
Exclude: Not an eligible population treatment

Muller D, Pfeil T, von dD, V. Treating depression comorbid with anxiety: Results of an open, practice-oriented study with St John's wort WS 5572 and valerian extract in high doses. *Phytomed*. 2003;10:Suppl-30 PMID:12807339 OVID-Medline.
Exclude: Not an eligible population treatment

Muller MJ, Seifritz E, Hatzinger M, et al. Side effects of adjunct light therapy in patients with major depression. *Eur Arch Psychiatry Clin Neurosci*. 1997;247(5):252-8. PMID:9444494 OVID-Medline.
Exclude: Not an eligible population treatment

Mulsant BH, Alexopoulos GS, Reynolds CF, III, et al. Pharmacological treatment of depression in older primary care patients: The PROSPECT algorithm. *Int J Geriatr Psychiatry*. 2001;16(6):585-92. PMID:11424167 OVID-Medline.
Exclude: Not an eligible guideline

Murck H, Held K, Ziegenbein M, et al. Intravenous administration of the neuropeptide galanin has fast antidepressant efficacy and affects the sleep EEG. *Psychoneuroendocrinol*. 2004;29(9):1205-11. Wiley-CCTR.
Exclude: Not an eligible population treatment

Murck H, Fava M, Alpert J, et al. Hypericum extract in patients with MDD and reversed vegetative signs: Re-analysis from data of a double-blind, randomized trial of hypericum extract, fluoxetine, and placebo. *Int J Neuropsychopharmacol*. 2005;8(2):215-21. PMID:15458612 OVID-Medline.
Exclude: Not an eligible population treatment

Muris P, Bogie N, Hoogsteder A. Effects of an early intervention group program for anxious and depressed adolescents: A pilot study. *Psychol Rep.* 2001;88(2):481-2. PMID:11351893 OVID-Medline.
Exclude: Not an eligible study design

Murphy BE, Dhar V, Ghadirian AM, et al. Response to steroid suppression in major depression resistant to antidepressant therapy. *J Clin Psychopharmacol.* 1991;11(2):121-6. PMID:1829098 OVID-Medline.
Exclude: Not an eligible study design

Murphy BEP, Filipini D, Ghadirian AM. Possible use of glucocorticoid receptor antagonists in the treatment of major depression: Preliminary results using RU 486. *J Psychiatr Neurosci.* 1993;18(5):209-13. OVID-PsycINFO.
Exclude: Not an eligible study design

Murphy DL, Baker M, Goodwin FK, et al. L-tryptophan in affective disorders: Indoleamine changes and differential clinical effects. *Psychopharmacologia.* 1974;34(1):11-20. Wiley-CCTR.
Exclude: Not an eligible population treatment

Murphy GE, Simons AD, Wetzel RD, et al. Cognitive therapy and pharmacotherapy: Singly and together in the treatment of depression. *Arch Gen Psychiatr.* 1984;41(1):33-41. OVID-Embase

OVID-Embase.
Exclude: Not an eligible population treatment

Murphy GE, Carney RM, Kneesevich MA, et al. Cognitive behavior therapy, relaxation training, and tricyclic antidepressant medication in the treatment of depression. *Psychol Rep.* 1995;77(2):403-20. PMID:8559866 OVID-Medline.
Exclude: Not an eligible population treatment

Murray G, Michalak EE, Axler A, et al. Relief of Chronic or Resistant Depression (Re-ChORD): A pragmatic, randomized, open-treatment trial of an integrative program intervention for chronic depression. *J Affect Disord.* 2010;123(1-3):243-8. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Muscettola G, Galzenati M, Balbi A. SAME versus placebo: A double blind comparison in major depressive disorders. *Adv Biochem Psychopharmacol.* 1982;32:151-6. PMID:7046362 OVID-Medline.
Exclude: Not an eligible population treatment

Mussini M, Agricola R, Coletti MG, et al. A preliminary study on the use of calcitonin in clinical psychopathology. *J Int Med Res.* 1984;12(1):23-9. PMID:6141115 OVID-Medline.
Exclude: Not an eligible study design

Müller N, Schwarz MJ, Dehning S, et al. The cyclooxygenase-2 inhibitor celecoxib has therapeutic effects in major depression: Results of a double-blind, randomized, placebo controlled, add-on pilot study to reboxetine. *Mol Psychiatry.* 2006;11(7):680-4. Wiley-CCTR.
Exclude: Not an eligible population treatment

Mynatt S, Wicks M, Bolden L. Pilot study of INSIGHT therapy in African American women. *Arch Psychiatr Nurs.* 2008;22(6):364-74. PMID:19026925 OVID-Medline.
Exclude: Not an eligible study design

Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, et al. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *Br Med J.* 1995;310(6977):441-5. OVID-Embase.
Exclude: Not an eligible population treatment

Mynors-Wallis LM, Gath DH, Day A, et al. Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *Br Med J.* 2000;320(7226):26-30. PMID:10617523 OVID-Medline.
Exclude: Not an eligible population treatment

Myskja A, Nord PG. "The day the music died": A pilot study on music and depression in a nursing home. *Nord J Music Ther.* 2008;17(1):30-40. EBSCO-CINAHL.
Exclude: Not an eligible study design

Nabkasorn C, Miyai N, Sootmongkol A, et al. Effects of physical exercise on depression, neuroendocrine stress hormones and physiological fitness in adolescent females with depressive symptoms. *Eur J Public Health.* 2006;16(2):179-84. OVID-Embase.
Exclude: Not an eligible population treatment

Naeem F, Waheed W, Gobbi M, et al. Preliminary evaluation of culturally sensitive CBT for depression in Pakistan: Findings from Developing Culturally-sensitive CBT Project (DCCP). *Behav Cognit Psychother.* 2011;39(2):165-73. OVID-PsycINFO.
Exclude: Not an eligible population/treatment

Nagata H, Nozaki M, Nakano H. Short-term combinational therapy of low-dose estrogen with selective serotonin re-uptake inhibitor (fluvoxamine) for oophorectomized women with hot flashes and depressive tendencies. *J Obstet Gynaecol Res.* 2005;31(2):107-14. PMID:15771635 OVID-Medline.

Exclude: Not an eligible population treatment

Nahas Z, Kunik ME, Orenco CA, et al. Depression in male geropsychiatric inpatients with and without dementia: A naturalistic study. *J Affect Disord.* 1997;46(3):243-6. PMID:9547120 OVID-Medline.

Exclude: Not an eligible study design

Nahunek K, Svestka J, Rysanek R, et al. Further clinical experience with maprotiline in endogenous depressions. *Act Nerv Super.* 1981;23(3):214-5. OVID-PsycINFO.

Exclude: Not an eligible study design

Nahunek K, Svestka J, Rysanek R, et al. Full therapeutic success of repeated treatment in most "drug resistant" cases of endogenous depression. *Act Nerv Super.* 1986;28(4):302-3. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Naismith SL, Diamond K, Carter PE, et al. Enhancing memory in late-life depression: The effects of a combined psychoeducation and cognitive training program. *Am J Geriatr Psychiatr.* 2011;19(3):240-8. OVID-Embase.

Exclude: Not an eligible population/treatment

Nakajima S, Ishida T, Akaishi R, et al. Impacts of switching antidepressants after successful electroconvulsive therapy on the maintenance of clinical remission in patients with treatment-resistant depression: A chart review. *J ECT.* 2009;25(3):178-81. OVID-Embase.

Exclude: Not an eligible study design

Nalini NR, Kumaraiah V, Subbakrishna DK. Cognitive behaviour therapy in the treatment of neurotic depression. *Nimhans J.* 1996;14(1):31-5. OVID-PsycINFO.

Exclude: Not an eligible study design

Naqvi F, Cervo F, Fields S. Evidence-based review of interventions to improve palliation of pain, dyspnea, depression. *Geriatr.* 2009;64(8):8-14. OVID-Embase.

Exclude: Not an eligible study design

Nardini M, De Stefano R, Iannuccelli M, et al. Treatment of depression with L-5-hydroxytryptophan combined with chlorimipramine, a double-blind study. *Int J Clin Pharmacol Res.* 1983;3(4):239-50. PMID:6381336 OVID-Medline.

Exclude: Not an eligible population treatment

Naylor EV, Antonuccio DO, Johnson G, et al. A pilot study investigating behavioral prescriptions for depression. *J Clin Psychol Med Settings.* 2007;14(2):152-9. OVID-Embase.

Exclude: Not an eligible study design

Naylor,E.V. A five-minute bibliotherapy prescription as a physician-delivered treatment for depression 2008. OVID-PsycINFO.

Exclude: Not an eligible study design

Naylor EV, Antonuccio DO, Litt M, et al. Bibliotherapy as a treatment for depression in primary care. *J Clin Psychol Med Settings.* 2010;17(3):258-71. PMID:20803165 OVID-Medline.

Exclude: Not an eligible population treatment

Neidig,J.L. Aerobic exercise training: Effects on depressive symptoms in HIV-infected adults Ohio State University. 1998. EBSCO-CINAHL.

Exclude: Not an eligible study design

Neidig JL, Smith BA, Brashers DE. Aerobic exercise training for depressive symptom management in adults living with HIV infection. *J Assoc Nurses AIDS Care.* 2003;14(2):30-40. PMID:12698764 OVID-Medline.

Exclude: Not an eligible population treatment

Neil AL, Christensen H. Australian school-based prevention and early intervention programs for anxiety and depression: A systematic review. *Med J Aust.* 2007;186(6):305-8. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Neimeyer RA, Baker KD, Haykal RF, et al. Patterns of symptomatic change in depressed patients in a private inpatient mood disorders program. *Bull Menninger Clin.* 1995;59(4):460-71. PMID:8535385 OVID-Medline.

Exclude: Not an eligible study design

Nelson-Gray RO, Herbert JD, Herbert DL, et al. Effectiveness of matched, mismatched, and package treatments of depression. *J Behav Ther Exp Psychiatr.* 1989;20(4):281-94. PMID:2636233 OVID-Medline.

Exclude: Not an eligible population treatment

Nelson EL, Barnard M, Cain S. Treating childhood depression over videoconferencing. *Telemed J EHealth.* 2003;9(1):49-55. PMID:12699607 OVID-Medline.

Exclude: Not an eligible population treatment

Nelson, E.L. Cognitive behavioral therapy for childhood depression: A comparison of face-to-face and interactive televideo settings 2004. OVID-PsycINFO.

Exclude: Not an eligible study design

Nelson EL, Barnard M, Cain S. Feasibility of telemedicine intervention for childhood depression. *Couns Psychother Res.* 2006;6(3):191-5. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Nelson JC, Jatlow P, Quinlan DM, et al. Desipramine plasma concentration and antidepressant response. *Arch Gen Psychiatr.* 1982;39(12):1419-22. PMID:7149903 OVID-Medline.

Exclude: Not an eligible study design

Nelson JC, Mazure CM, Bowers MB, Jr., et al. A preliminary, open study of the combination of fluoxetine and desipramine for rapid treatment of major depression. *Arch Gen Psychiatr.* 1991;48(4):303-7. PMID:2009031 OVID-Medline.

Exclude: Not an eligible population treatment

Nelson JC, Docherty JP, Henschen GM, et al. C. Algorithms for the treatment of subtypes of unipolar major depression. *Psychopharmacol Bull.* 1995;31(3):475-83. OVID-Embase.

Exclude: Not an eligible study design

Nelson JC, Mazure CM, Jatlow PI. Desipramine treatment of major depression in patients over 75 years of age. *J Clin Psychopharmacol.* 1995;15(2):99-105. PMID:7782495 OVID-Medline.

Exclude: Not an eligible study design

Nelson JC, Mazure CM, Jatlow PI, et al. Combining norepinephrine and serotonin reuptake inhibition mechanisms for treatment of depression: A double-blind, randomized study. *Biol Psychiatr.* 2004;55(3):296-300. PMID:14744472 OVID-Medline.

Exclude: Not an eligible population treatment

Nelson JC, Papakostas GI. Atypical antipsychotic augmentation in major depressive disorder: A meta-analysis of placebo-controlled randomized trials. *Am J Psychiatry.* 2009;166(9):980-91. PMID:19687129 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Nelson, M.K. Meta-analysis: Hypnotherapy/cognitive-behavioral therapy and its efficacy on depression compared to pharmacotherapy 2002. OVID-PsycINFO.

Exclude: Not an eligible study design

Nemeroff CB, Heim CM, Thase ME, et al. Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proc Natl Acad Sci USA.* 2003;100(24):14293-6.

PMID:14615578 OVID-Medline.

Exclude: Not an eligible population treatment

Nemeroff CB, Gharabawi GM, Canuso CM, et al. Augmentation with risperidone in chronic resistant depression: A double-blind placebo-controlled maintenance trial. [Abstract] *Neuropsychopharmacol* 2004;29:(Supplement 1)S159

Nemets B, Stahl Z, Belmaker RH. Addition of omega-3 fatty acid to maintenance medication treatment for recurrent unipolar depressive disorder. *Am J Psychiatry.* 2002;159(3):477-9.

PMID:11870016 OVID-Medline.

Exclude: Not an eligible population treatment

Nemets B, Osher Y, Belmaker RH. Omega-3 fatty acids and augmentation strategies in treating resistant depression. *Essential Psychopharmacol.* 2004;(6):59-64. Exclude: Not an eligible study design

Nemets H, Nemets B, Apter A, et al. Omega-3 treatment of childhood depression: A controlled, double-blind pilot study. *Am J Psychiatry.* 2006;163(6):1098-100. PMID:16741212 OVID-Medline.

Exclude: Not an eligible population treatment

Netz Y, Yaretzki A, Salganik I, et al. The effect of supervised physical activity on cognitive and affective state of geriatric and psychogeriatric in-patients. *Clin Gerontol.* 1994;15(1):47-56. OVID-Embase.

Exclude: Not an eligible population design

Neuberger GB, Aaronson LS, Gajewski B, et al. Predictors of exercise and effects of exercise on symptoms, function, aerobic fitness, and disease outcomes of rheumatoid arthritis. *Arthritis Rheum.* 2007;57(6):943-52. Wiley-CCTR.

Exclude: Not an eligible population treatment

Neumeister A, Goessler R, Lucht M, et al. Bright light therapy stabilizes the antidepressant effect of partial sleep deprivation. *Biol Psychiatr.* 1996;39(1):16-21. PMID:8719121 OVID-Medline.

Exclude: Mixed antidepressants: some failed on SSRI

Neumeister A, Praschak-Rieder N, Hesselmann B, et al. Effects of tryptophan depletion in drug-free depressed patients who responded to total sleep deprivation. *Arch Gen Psychiatr.* 1998;55(2):167-72. PMID:9477931 OVID-Medline.

Exclude: Not an eligible population treatment

Nezu AM. Efficacy of a social problem-solving therapy approach for unipolar depression. *J Consult Clin Psychol.* 1986;54(2):196-202. PM:3700806
Exclude: Not an eligible population treatment

Nezu AM, Perri MG. Social problem-solving therapy for unipolar depression: An initial dismantling investigation. *J Consult Clin Psychol.* 1989;57(3):408-13. OVID-Embase.
Exclude: Not an eligible population treatment

Ng BHP, Tsang HWH. Psychophysiological outcomes of health qigong for chronic conditions: A systematic review. *Psychophysiol.* 2009;46(2):257-69. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Nguyen PH, Grajeda R, Melgar P, et al. Micronutrient supplementation may reduce symptoms of depression in Guatemalan women. *Arch Latinoam Nutr.* 2009;59(3):278-86. PMID:19886513 OVID-Medline.
Exclude: Not an eligible population treatment

Nguyen,S.D. Simultaneous technique of exercise and psychotherapy (STEP) as an adjunct to multidisciplinary treatment in acute inpatient psychiatric hospitalized older adults with depressive symptoms 2008. OVID-PscINFO.
Exclude: Not an eligible study design

Nickel MK, Nickel C, Lahmann C, et al. Changes in instrumental activities of daily living disability after treatment of depressive symptoms in elderly women with chronic musculoskeletal pain: A double-blind, placebo-controlled trial. *Aging Clin Exp Res.* 2005;17(4):293-6. OVID-Embase.
Exclude: Not an eligible population treatment

Nierenberg AA, Price LH, Charney DS, et al. After lithium augmentation: A retrospective follow-up of patients with antidepressant-refractory depression. *J Affect Disord.* 1990;18(3):167-75. PMID:2139061 OVID-Medline.
Exclude: Not an eligible study design

Nierenberg AA, Feighner JP, Rudolph R, et al. Venlafaxine for treatment-resistant unipolar depression. *J Clin Psychopharmacol.* 1994;14(6):419-23. PMID:7884023 OVID-Medline.
Exclude: Not an eligible study design

Nierenberg AA, Papakostas GI, Petersen T, et al. Lithium augmentation of nortriptyline for subjects resistant to multiple antidepressants. *J Clin Psychopharmacol.* 2003;23(1):92-5. PMID:12544380 OVID-Medline.
Exclude: Not an eligible population treatment

Nierenberg AA, Trivedi MH, Gaynes BN, et al. Effectiveness study of venlafaxine-XR combined with aripiprazole for chronic or recurrent major depressive disorder. *Aust NZ J Psychiatr.* 2009;43(10):956-67. OVID-Embase.
Exclude: Not an eligible study design

Nierenberg AA, Husain MM, Trivedi MH, et al. Residual symptoms after remission of major depressive disorder with citalopram and risk of relapse: A STAR*D report. *Psychol Med.* 2010;40(1):41-50. PMID:19460188 OVID-Medline.
Exclude: Not an eligible population treatment

Nieuwenhuijsen K, Bultmann U, Neumeyer-Gromen A, et al. Interventions to improve occupational health in depressed people. *Cochrane Database Syst Rev.* 2008;(2):CD006237. PMID:18425942 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Nilforooshan P, Ahmadi A, Abedi MR, et al. Studying the effect of cognitive-behavioral counseling based on interacting cognitive subsystems on depression of infertile couples. *Mid East Fertil Soc J.* 2006;11(1):43-7. OVID-Embase.
Exclude: Not an eligible population treatment

Ninan PT, Hassman HA, Glass SJ, et al. Adjunctive modafinil at initiation of treatment with a selective serotonin reuptake inhibitor enhances the degree and onset of therapeutic effects in patients with major depressive disorder and fatigue. *J Clin Psychiatry.* 2004;65(3):414-20. PMID:15096082 OVID-Medline.
Exclude: Not an eligible study design

Nisbet Wallis DA. Depression, anxiety and self-esteem: A clinical field study. *Behav Change.* 2002;19(2):112-20. OVID-Embase.
Exclude: Not an eligible study design

Nitkin-Kaner,Y. Relationships between expressive writing about traumatic events and reduction in depressive symptomatology 2009. OVID-PscINFO.
Exclude: Not an eligible study design

Nolen WA, van de Putte JJ, Dijken WA, et al. L-5HTP in depression resistant to re-uptake inhibitors. An open comparative study with tranylcypromine. *Br J Psychiatr.* 1985;147:16-22. PMID:3933601 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Nolen WA, van de Putte JJ, Dijken WA, et al. Treatment strategy in depression. I. Non-tricyclic and selective reuptake inhibitors in resistant depression: A double-blind partial crossover study on the effects of oxaprotiline and fluvoxamine. *Acta Psychiatr Scand.* 1988;78(6):668-75. PMID:3146890 OVID-Medline.

Exclude: Not an eligible population treatment

Nolen WA, van de Putte JJ, Dijken WA, et al. Treatment strategy in depression. II. MAO inhibitors in depression resistant to cyclic antidepressants: Two controlled crossover studies with tranylcypromine versus L-5-hydroxytryptophan and nomifensine. *Acta Psychiatr Scand.* 1988;78(6):676-83. PMID:3146891 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Nolen WA. Tranylcypromine in depression resistant to cyclic antidepressants. *Prog Neuropsychopharmacol Biol Psychiatry.* 1989;13(1-2):155-8. PMID:2664883 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Nolen WA, Haffmans PMJ, Bouvy PF, et al. Hypnotics as concurrent medication in depression. A placebo-controlled, double-blind comparison of flunitrazepam and lormetazepam in patients with major depression, treated with a (tri)cyclic antidepressant. *J Affect Disord.* 1993;28(3):179-88. OVID-Embase.

Exclude: Not an eligible population treatment

Nolen WA, Haffmans PM, Bouvy PF, et al. Monoamine oxidase inhibitors in resistant major depression. A double-blind comparison of brofaromine and tranylcypromine in patients resistant to tricyclic antidepressants. *J Affect Disord.* 1993;28(3):189-97. PMID:8408980 OVID-Medline.

Exclude: Not an eligible population treatment

Noorbala AA, Akhondzadeh S, Tahmacebi-Pour N, et al. Hydro-alcoholic extract of *Crocus sativus* L. versus fluoxetine in the treatment of mild to moderate depression: A double-blind, randomized pilot trial. *J Ethnopharmacol.* 2005;97(2):281-4. PMID:15707766 OVID-Medline.

Exclude: Not an eligible population treatment

Noorbala AA, Ramazanzadeh F, Malekafzali H, et al. Effects of a psychological intervention on depression in infertile couples. *Int J Gynaecol Obstet.* 2008;101(3):248-52. PMID:18321515 OVID-Medline.

Exclude: Not an eligible population treatment

Nordstrom G, Despiegel N, Marteau F, et al. Cost effectiveness of escitalopram versus SNRIs in second-step treatment of major depressive disorder in Sweden. *J Med Econ.* 2010;13(3):516-26. OVID-Embase.

Exclude: Not an eligible study design

Norman J, Lowry CE. Evaluating inpatient treatment for women with clinical depression. *Res Soc Work Pract.* 1995;5(1):10-9. OVID-PsycINFO.

Exclude: Not an eligible study design

Norman SB, Tate SR, Wilkins KC, et al. Posttraumatic stress disorder's role in integrated substance dependence and depression treatment outcomes. *J Subst Abuse Treat.* 2010;38(4):346-55. OVID-Embase.

Exclude: Not an eligible population treatment

Normann C, Hummel B, Scharer LO, et al. Lamotrigine as adjunct to paroxetine in acute depression: A placebo-controlled, double-blind study. *J Clin Psychiatry.* 2002;63(4):337-44. PMID:12000208 OVID-Medline.

Exclude: Not an eligible population treatment

Normann C. Olanzapine augmentation therapy in treatment-resistant depression: A double-blind placebo-controlled trial. In 2006. Wiley-CCTR.

Exclude: Not an eligible study design

Nowak G, Siwek M, Dudek D, et al. Effect of zinc supplementation on antidepressant therapy in unipolar depression: A preliminary placebo-controlled study. *Pol J Pharmacol.* 2003;55(6):1143-7. PMID:14730113 OVID-Medline.

Exclude: Not an eligible population treatment

Nozawa K, Sekine A, Hozumi S, et al. Effect of augmentation with olanzapine in outpatients with depression in partial remission with melancholic features: Consecutive case series. *Psychiatry Clin Neurosci.* 2011;65(2):199-202. OVID-Embase.

Exclude: Not an eligible study design

Nunes DF, Rodriguez AL, da Silva HF, et al. Relaxation and guided imagery program in patients with breast cancer undergoing radiotherapy is not associated with neuroimmunomodulatory effects. *J Psychosom Res.* 2007;63(6):647-55. PMID:18061756 OVID-Medline.

Exclude: Not an eligible population treatment

Nurnberg HG, Thompson PM, Hensley PL. Antidepressant medication change in a clinical treatment setting: A comparison of the effectiveness of selective serotonin reuptake inhibitors. *J Clin Psychiatry.* 1999;60(9):574-9. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Nutzinger DO, Cayiroglu S, Sachs G, et al. Emotional problems during weight reduction: Advantages of a combined behavior therapy and antidepressive drug therapy for obesity. *J Behav Ther Exp Psychiatr*. 1985;16(3):217-21. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Nystrom C, Hallstrom T. Comparison between a serotonin and a noradrenaline reuptake blocker in the treatment of depressed outpatients: A cross-over study. *Acta Psychiatr Scand*. 1987;75(4):377-82. PMID:3035878 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

O'Brien S, McKeon P, O'Regan M. The efficacy and tolerability of combined antidepressant treatment in different depressive subgroups. *Br J Psychiatr*. 1993;162:363-8. PMID:8453432 OVID-Medline.

Exclude: Not an eligible population treatment

O'Brien SM, Scully P, Fitzgerald P, et al. Plasma cytokine profiles in depressed patients who fail to respond to selective serotonin reuptake inhibitor therapy. *J Psychiatr Res*. 2007;41(3-4):326-31. PMID:16870211 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

O'Dwyer AM, Lightman SL, Marks MN, et al. Treatment of major depression with metyrapone and hydrocortisone. *J Affect Disord*. 1995;33(2):123-8. Wiley-CCTR.

Exclude: Not an eligible population treatment

O'Kearney R, Gibson M, Christensen H, et al. Effects of a cognitive-behavioural internet program on depression, vulnerability to depression and stigma in adolescent males: A school-based controlled trial. *Cognit Behav Ther*. 2006;35(1):43-54. PMID:16500776 OVID-Medline.

Exclude: Not an eligible population treatment

O'Kearney R, Kang K, Christensen H, et al. A controlled trial of a school-based Internet program for reducing depressive symptoms in adolescent girls. *Depress Anxiety*. 2009;26(1):65-72. PMID:18828141 OVID-Medline.

Exclude: Not an eligible population treatment

O'Kearney, Richard, Kang, Kanwal, Gibson, Malcolm et al. A CBT internet program for depression in adolescents (MoodGYM): Effects on depressive symptoms, attributional style, self-esteem and beliefs about depression. 2007:197-204. 2007. OVID-PsycINFO.

Exclude: Not an eligible study design

O'Laoire S. An experimental study of the effects of distant, intercessory prayer on self-esteem, anxiety, and depression. *Altern Ther Health Med*. 1997;3(6):38 EBSCO-CINAHL.

Exclude: Not an eligible study design

O'Leary D, Costello F, Gormley N, et al. Remission onset and relapse in depression: An 18-month prospective study of course for 100 first admission patients. *J Affect Disord*. 2000;57(1-3):159-71. OVID-Embase.

Exclude: Not an eligible study design

O'Leary KD, Beach SR. Marital therapy: A viable treatment for depression and marital discord. *Am J Psychiatry*. 1990;147(2):183-6. PMID:2301656 OVID-Medline.

Exclude: Not an eligible population treatment

Obrocea GV, Dunn RM, Frye MA, et al. Clinical predictors of response to lamotrigine and gabapentin monotherapy in refractory affective disorders. *Biol Psychiatr*. 2002;51(3):253-60. Wiley-CCTR.

Exclude: Not an eligible population treatment

Odeberg H, Rodriguez-Silva B, Salander P, et al. Individualized continuation electroconvulsive therapy and medication as a bridge to relapse prevention after an index course of electroconvulsive therapy in severe mood disorders: A naturalistic 3-year cohort study. *J ECT*. 2008;24(3):183-90. OVID-Embase.

Exclude: Not an eligible study design

Oei TP, Yeoh AE. Pre-existing antidepressant medication and the outcome of group cognitive-behavioural therapy. *Aust NZ J Psychiatr*. 1999;33(1):70-6. PMID:10197887 OVID-Medline.

Exclude: Not an eligible population treatment

Oei TP, Bullbeck K, Campbell JM. Cognitive change process during group cognitive behaviour therapy for depression. *J Affect Disord*. 2006;92(2-3):231-41. PMID:16542734 OVID-Medline.

Exclude: Not an eligible study design

Oei TPS, Dingle G. The effectiveness of group cognitive behaviour therapy for unipolar depressive disorders. *J Affect Disord*. 2008;107(1-3):5-21. OVID-PsycINFO.

Excluded - Systematic review - relevant topic, citations cross-matched

Oeland A-M, Laessoe U, Olesen AV, et al. Impact of exercise on patients with depression and anxiety. *Nord J Psychiatr*. 2010;64(3):210-7. OVID-Embase.

Exclude: Not an eligible population treatment

Oh H, Seo W. Decreasing pain and depression in a health promotion program for people with rheumatoid arthritis. *J Nurs Scholarsh*. 2003;35(2):127-32. EBSCO-CINAHL.
Exclude: Not an eligible population treatment

Okamoto A, Kuriyama H, Watanabe S, et al. The effect of aromatherapy massage on mild depression: A pilot study. *Psychiatry Clin Neurosci*. 2005;59(3):363 PMID:15896234 OVID-Medline.
Exclude: Not an eligible study design

Okumura K, Furukawa TA. Remission rates with milnacipran 100 mg/day and 150 mg/day in the long-term treatment of major depression. *Clin Drug Investig*. 2006;26(3):135-42. PMID:17163244 OVID-Medline.
Exclude: Not an eligible population treatment

Oliwenstein L. Lifting moods by losing sleep: An adjunct therapy for treating depression. *Alternative Compl Ther*. 2006;12(2):66-70. EBSCO-CINAHL.
Exclude: Not an eligible study design

Olver JS, Ignatiadis S, Maruff P, et al. Quetiapine augmentation in depressed patients with partial response to antidepressants. *Hum Psychopharmacol*. 2008;23(8):653-60. PMID:18816504 OVID-Medline.
Exclude: Not an eligible study design

Onder E, Tural U. Faster response in depressive patients treated with fluoxetine alone than in combination with buspirone. *J Affect Disord*. 2003;76(1-3):223-7. PMID:12943952 OVID-Medline.
Exclude: Not an eligible population treatment

Ong MK, Rubenstein LV. Wishing upon a STAR*D: The promise of ideal depression care by primary care providers. *Psychiatr Serv*. 2009;60(11):1460-2. PMID:19880461 OVID-Medline.
Exclude: Not an eligible population treatment

Ontiveros A, Fontaine R, Elie R. Refractory depression: The addition of lithium to fluoxetine or desipramine. *Acta Psychiatr Scand*. 1991;83(3):188-92. PMID:1903237 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Orengo CA, Fullerton L, Kunik ME. Safety and efficacy of testosterone gel 1% augmentation in depressed men with partial response to antidepressant therapy. *J Geriatr Psychiatry Neurol*. 2005;18(1):20-4. PMID:15681624 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Organista KC, Munoz RF, Gonzalez G. Cognitive-behavioral therapy for depression in low-income and minority medical outpatients: Description of a program and exploratory analyses. *Cognit Ther Res*. 1994;18(3):241-59. OVID-PsycINFO.
Exclude: Not an eligible study design

Ormrod JA, Kennedy L, Scott J, et al. Computerised cognitive behavioural therapy in an adult mental health service: A pilot study of outcomes and alliance. *Cognit Behav Ther*. 2010;39(3):188-92. PMID:20485996 OVID-Medline.
Exclude: Not an eligible study design

Osborn RL, Demoncada AC, Feuerstein M. Psychosocial interventions for depression, anxiety, and quality of life in cancer survivors: Meta-analyses. *Int J Psychiatry Med*. 2006;36(1):13-34. PMID:16927576 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Osgood-Hynes DJ, Greist JH, Marks IM, et al. Self-administered psychotherapy for depression using a telephone-accessed computer system plus booklets: An open U.S.-U.K. study. *J Clin Psychiatr*. 1998;59(7):358-65. OVID-PsycINFO.
Exclude: Not an eligible study design

Oslin DW, Sayers S, Ross J, et al. Disease management for depression and at-risk drinking via telephone in an older population of veterans. *Psychosom Med*. 2003;65(6):931-7. OVID-Embase.
Exclude: Not an eligible population treatment

Oslin DW. Treatment of late-life depression complicated by alcohol dependence. *Am J Geriatr Psychiatr*. 2005;13(6):491-500. PMID:15956269 OVID-Medline.
Exclude: Not an eligible population treatment

Ostacher MJ, Huffman J, Perlis R, et al. Evidence-based psychopharmacology, New York, NY:Cambridge University Press;2005. Evidence-based pharmacotherapy of major depressive disorder. OVID-PsycINFO.
Exclude: Not an eligible study design.

Ostroff RB, Nelson JC. Risperidone augmentation of selective serotonin reuptake inhibitors in major depression. *J Clin Psychiatry*. 1999;60(4):256-9. PMID:10221288 OVID-Medline.
Exclude: Not an eligible study design

Otero FJ, Hernandez-Herrero C, Martinez-Arevalo M-J, et al. Fluoxetine/benzazepam combination in the treatment of dysthymic disorders. *Curr Ther Res Clin Exp*. 1994;55(5):519-31. OVID-Embase.
Exclude: Not an eligible population treatment

Otte C, Hinkelmann K, Moritz S, et al. Modulation of the mineralocorticoid receptor as add-on treatment in depression: A randomized, double-blind, placebo-controlled proof-of-concept study. *J Psychiatr Res.* 2010;44(6):339-46. OVID-Embase.
Exclude: Not an eligible population treatment

Otto MW, Powers MB, Stathopoulou G, et al. Adapting cognitive therapy for depression: Managing complexity and comorbidity., New York, NY, US:Guilford Press;2008. Panic disorder and social phobia. OVID-PsycINFO.
Exclude: Systematic review - relevant topic, citations cross-matched.

Overall JE, Brown D, Williams JD, et al. Drug treatment of anxiety and depression in detoxified alcoholic patients. *Arch Gen Psychiatr.* 1973;29(2):218-25. Wiley-CCTR.
Exclude: Not an eligible population treatment

Overholser JC, Schubert DS. Cognitive-behavioral treatment of depression, Part VI: Integrating the use of antidepressant medications. *J Contemp Psychother.* 1996;26(3):235-50. OVID-PsycINFO.
Exclude: Not an eligible guideline

Owenby RK, Brown LT, Brown JN. Use of risperidone as augmentation treatment for major depressive disorder. *Ann Pharmacother.* 2011;45(1):95-100. OVID-Embase.
Exclude: Systematic review - relevant topic, citations cross-matched

Oxman TE, Barrett JE, Sengupta A, et al. Status of minor depression or dysthymia in primary care following a randomized controlled treatment. *Gen Hosp Psychiatry.* 2001;23(6):301-10. PMID:11738460 OVID-Medline.
Exclude: Not an eligible population treatment

Ozmenler NK, Karlidere T, Bozkurt A, et al. Mirtazapine augmentation in depressed patients with sexual dysfunction due to selective serotonin reuptake inhibitors. *Hum Psychopharmacol.* 2008;23(4):321-6. PMID:18278806 OVID-Medline.
Exclude: Not an eligible study design

Pace TM, Dixon DN. Changes in depressive self-schemata and depressive symptoms following cognitive therapy. *J Couns Psychol.* 1993;40(3):288-94. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Paddock S, Laje G, Charney D, et al. Association of GRIK4 with outcome of antidepressant treatment in the STAR*D cohort. *Am J Psychiatry.* 2007;164(8):1181-8. PMID:17671280 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Pae C-U, Serretti A, Patkar AA, et al. Aripiprazole in the treatment of depressive and anxiety disorders: A review of current evidence. *CNS Drugs.* 2008;22(5):367-88. OVID-Embase.
Exclude: Systematic review - relevant topic, citations cross-matched

Pae CU, Patkar AA, Jun TY, et al. Aripiprazole augmentation for treatment of patients with inadequate antidepressants response. *Depress Anxiety.* 2007;24(7):522-6. PMID:17111388 OVID-Medline.
Exclude: Not an eligible study design

Page AC, Hooke GR. Outcomes for depressed and anxious inpatients discharged before or after group cognitive behavior therapy: A naturalistic comparison. *J Nerv Ment Dis.* 2003;191(10):653-9. PMID:14555867 OVID-Medline.
Exclude: Not an eligible study design

Page K. Late-life depression. *J Compl Med.* 2006;5(2):23-9. OVID-AMED.
Exclude: Not an eligible study design

Pagoto S, Bodenlos JS, Schneider KL, et al. Initial investigation of behavioral activation therapy for comorbid major depressive disorder and obesity. *Psychother.* 2008;45(3):410-5. OVID-Embase.
Exclude: Not an eligible study design

Paleacu D, Shutzman A, Giladi N, et al. Effects of pharmacological therapy on gait and cognitive function in depressed patients. *Clin Neuropharmacol.* 2007;30(2):63-71. OVID-Embase.
Exclude: Not an eligible study design

Palinkas LA, Reedy KR, Shepanek M, et al. A randomized placebo-controlled clinical trial of the effectiveness of thyroxine and triiodothyronine and short-term exposure to bright light in prevention of decrements in cognitive performance and mood during prolonged Antarctic residence. *Clin Endocrinol.* 2010;72(4):543-50. PMID:19650782 OVID-Medline.
Exclude: Not an eligible population treatment

Palladino, L. Vine of soul: A phenomenological study of ayahuasca and its effect on depression Lisa: Pacifica Graduate Inst., US Palladino. 2010. OVID-PsycINFO.
Exclude: Not an eligible study design

Palleschi L, De Gennaro E, Sottosanti G, et al. The role of exercise training in aged subjects with anxiety-depression syndrome. *Arch Gerontol Geriatr.* 1998;27(Suppl. 6):381-4. OVID-Embase.
Exclude: Not an eligible study design

Palmer J, Vacc N, Epstein J. Adult inpatient alcoholics: Physical exercise as a treatment intervention. *J Stud Alcohol*. 1988;49(5):418-21. OVID-Embase.

Exclude: Not an eligible population treatment

Palmer JA, Palmer LK, Michiels K, et al. Effects of type of exercise on depression in recovering substance abusers. *Percept Motor Skills*. 1995;80(2):523-30. OVID-AMED.

Exclude: Not an eligible population treatment

Pancheri P, Scapicchio P, Chiaie RD. A double-blind, randomized parallel-group, efficacy and safety study of intramuscular S-adenosyl-L-methionine 1,4-butanedisulphonate (SAME) versus imipramine in patients with major depressive disorder. *Int J Neuropsychopharmacol*. 2002;5(4):287-94. PMID:12466028 OVID-Medline.

Exclude: Not an eligible population treatment

Papadimitriou GN, Christodoulou GN, Katsouyanni K, et al. Therapy and prevention of affective illness by total sleep deprivation. *J Affect Disord*. 1993;27(2):107-16. PMID:8440806 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Petersen T, Worthington JJ, et al. A pilot, open study of sertraline in outpatients with treatment-resistant depression (TRD) or with a history of TRD who responded but later relapsed. *Int Clin Psychopharmacol*. 2003;18(5):293-6. PMID:12920390 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Petersen T, Pava J, et al. Hopelessness and suicidal ideation in outpatients with treatment-resistant depression: Prevalence and impact on treatment outcome. *J Nerv Ment Dis*. 2003;191(7):444-9. PMID:12891091 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Petersen TJ, Farabaugh AH, et al. Psychiatric comorbidity as a predictor of clinical response to nortriptyline in treatment-resistant major depressive disorder. *J Clin Psychiatry*. 2003;64(11):1357-61. PMID:14658951 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Petersen TJ, Nierenberg AA, et al. Ziprasidone augmentation of selective serotonin reuptake inhibitors (SSRIs) for SSRI-resistant major depressive disorder. *J Clin Psychiatry*. 2004;65(2):217-21. PMID:15003076 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Petersen TJ, Green C, et al. A description of next-step switching versus augmentation practices for outpatients with treatment-resistant major depressive disorder enrolled in an academic specialty clinic. *Ann Clin Psychiatr*. 2005;17(3):161-5. PMID:16433058 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Papakostas GI, Petersen TJ, Kinrys G, et al. Aripiprazole augmentation of selective serotonin reuptake inhibitors for treatment-resistant major depressive disorder. *J Clin Psychiatry*. 2005;66(10):1326-30. PMID:16259548 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Petersen TJ, Burns AM, et al. Adjunctive atomoxetine for residual fatigue in major depressive disorder. *J Psychiatr Res*. 2006;40(4):370-3. PMID:15978621 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Worthington JJ, III, Iosifescu DV, et al. The combination of duloxetine and bupropion for treatment-resistant major depressive disorder. *Depress Anxiety*. 2006;23(3):178-81. PMID:16528701 OVID-Medline.

Exclude: Not an eligible study design

Papakostas GI, Shelton RC, Smith J, et al. Augmentation of antidepressants with atypical antipsychotic medications for treatment-resistant major depressive disorder: A meta-analysis. *J Clin Psychiatr*. 2007;68(6):826-31. PMID:17592905 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Papakostas GI, Fava M, Thase ME. Treatment of SSRI-resistant depression: A meta-analysis comparing within- versus across-class switches. *Biol Psychiatr*. 2008;63(7):699-704. PMID:17919460 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Papakostas GI, Cooper-Kazaz R, Appelhof BC, et al. Simultaneous initiation (coinitiation) of pharmacotherapy with triiodothyronine and a selective serotonin reuptake inhibitor for major depressive disorder: A quantitative synthesis of double-blind studies. *Int Clin Psychopharmacol*. 2009;24(1):19-25. PMID:19092448 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Papakostas GI, Clain A, Ameral VE, et al. Fluoxetine-clonazepam cotherapy for anxious depression: An exploratory, post-hoc analysis of a randomized, double blind study. *Int Clin Psychopharmacol*. 2010;25(1):17-21. PMID:19898245 OVID-Medline.

Exclude: Not an eligible population treatment

Papakostas GI, Mischoulon D, Shyu I, et al. S-adenosyl methionine (SAME) augmentation of serotonin reuptake inhibitors for antidepressant nonresponders with major depressive disorder: A double-blind, randomized clinical trial. *Am J Psychiatry*. 2010;167(8):942-8. PMID:20595412 OVID-Medline.

Exclude: Mixed antidepressants; some failed on SSRI

Papakostas GI, Petersen T, Sonawalla SB, et al. Serum cholesterol in treatment-resistant depression. *Neuropsychobiol*. 2003;47(3):146-51. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Pappas GP, Golin S, Meyer DL. Reducing symptoms of depression with exercise. *Psychosom*. 1990;31(1):112-3. OVID-PsycINFO.

Exclude: Not an eligible study design

Parker AG, Hetrick SE, Jorm AF, et al. The effectiveness of simple psychological and exercise interventions for high prevalence mental health problems in young people: A factorial randomised controlled trial. *Trials*. 2011;12:76. OVID-Embase.

Exclude: Not an eligible study design

Parker G, Brotchie H, Parker K. Is combination olanzapine and antidepressant medication associated with a more rapid response trajectory than antidepressant alone? *Am J Psychiatry*. 2005;162(4):796-8. PMID:15800157 OVID-Medline.

Exclude: Not an eligible population treatment

Parker G, Crawford J. Atypical depression: Retrospective self-reporting of treatment effectiveness. *Acta Psychiatr Scand*. 2009;120(3):213-21. OVID-Embase.

Exclude: Not an eligible population treatment

Parker G, Brotchie H. Do the old psychostimulant drugs have a role in managing treatment-resistant depression? *Acta Psychiatr Scand*. 2010;121(4):308-14. OVID-Embase.

Exclude: Not an eligible study design

Parker GB, Crawford J, Hadzi-Pavlovic D. Quantified superiority of cognitive behaviour therapy to antidepressant drugs: A challenge to an earlier meta-analysis. *Acta Psychiatr Scand*. 2008;118(2):91-7. PMID:18452571 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Parker JC, Smarr KL, Slaughter JR, et al. Management of depression in rheumatoid arthritis: A combined pharmacologic and cognitive-behavioral approach. *Arthritis Rheum*. 2003;49(6):766-77. PMID:14673962 OVID-Medline.

Exclude: Not an eligible population treatment

Parker KL, Mittmann N, Shear NH, et al. Lithium augmentation in geriatric depressed outpatients: A clinical report. *Int J Geriatr Psychiatry*. 1994;9(12):995-1002. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Parrish BP, Cohen LH, Gunthert KC, et al. Effects of cognitive therapy for depression on daily stress-related variables. *Behav Res Ther*. 2009;47(5):444-8. OVID-Embase.

Exclude: Not an eligible study design

Pasquini M, Picardi A, Specia A, et al. Combining an SSRI with an anticonvulsant in depressed patients with dysphoric mood: An open study. *Clin Pract Epidemiol Ment Health*. 2007;3:3. OVID-Embase.

Exclude: Not an eligible study design

Passeri M, Cucinotta D, Abate G, et al. Oral 5'-methyltetrahydrofolic acid in senile organic mental disorders with depression: Results of a double-blind multicenter study. *Aging Clin Exp Res*. 1993;5(1):63-71. PMID:8257478 OVID-Medline.

Exclude: Not an eligible population design

Passmore T, Lane S. Exercise as treatment for depression: A therapeutic recreation intervention. *Am J Rec Ther*. 2006;5(3):31-41. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Patel V, Weiss HA, Chowdhary N, et al. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomised controlled trial. *Lancet*. 2010;376(9758):2086-95. PMID:21159375 OVID-Medline.

Exclude: Not an eligible population treatment

Patkar AA, Masand PS, Pae CU, et al. A randomized, double-blind, placebo-controlled trial of augmentation with an extended release formulation of methylphenidate in outpatients with treatment-resistant depression. *J Clin Psychopharmacol*. 2006;26(6):653-6. PMID:17110825 OVID-Medline. Exclude: Not an eligible population treatment

Patkar AA, Peindl K, Mago R, et al. An open-label, rater-blinded, augmentation study of aripiprazole in treatment-resistant depression. *Prim Care Comp J Clin Psychiatr*. 2006;8(2):82-7. OVID-Embase. Exclude: Not an eligible study design

Pavao TS, Vianna P, Pillat MM, et al. Acupuncture is effective to attenuate stress and stimulate lymphocyte proliferation in the elderly. *Neurosci Lett*. 2010;484(1):47-50. PMID:20709154 OVID-Medline. Exclude: Not an eligible study design

Paykel ES, Scott J, Teasdale JD, et al. Prevention of relapse in residual depression by cognitive therapy: A controlled trial. *Arch Gen Psychiatr*. 1999;56(9):829-35. PMID:12884889 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Paykel ES, Scott J, Cornwall PL, et al. Duration of relapse prevention after cognitive therapy in residual depression: Follow-up of controlled trial. *Psychol Med*. 2005;35(1):59-68. PMID:15842029 OVID-Medline. Exclude: Not an eligible population treatment

Payne DL. Antidepressant therapies in the elderly. *Clin Gerontol*. 1987;7(2):31-41. OVID-Embase. Exclude: Not an eligible study design

Payne H, Stott D. Change in the moving bodymind: Quantitative results from a pilot study on the use of the BodyMind approach (BMA) to psychotherapeutic group work with patients with medically unexplained symptoms (MUSs). *Couns Psychother Res*. 2010;10(4):295-306. EBSCO-CINAHL. Exclude: Not an eligible study design

Payne JK, Held J, Thorpe J, et al. Effect of exercise on biomarkers, fatigue, sleep disturbances, and depressive symptoms in older women with breast cancer receiving hormonal therapy. *Oncol Nurs Forum*. 2008;Online.(4):635-42. PMID:18591167 OVID-Medline. Exclude: Not an eligible population treatment

Paz-Diaz H, Montes dO, Lopez JM, et al. Pulmonary rehabilitation improves depression, anxiety, dyspnea and health status in patients with COPD. *Am J Phys Med Rehab*. 2007;86(1):30-6. PMID:17304686 OVID-Medline.

Exclude: Not an eligible population treatment

Pecheur DR, Edwards KJ. A comparison of secular and religious versions of cognitive therapy with depressed Christian college students. *J Psychol Theol*. 1984;12(1):45-54. OVID-PsycINFO. Exclude: Not an eligible population treatment

Peden AR, Rayens MK, Hall LA. A community-based depression prevention intervention with low-income single mothers. *J Am Psychiatr Nurs Assoc*. 2005;11(1):18-25. EBSCO-CINAHL. Exclude: Not an eligible population treatment

Peden AR, Rayens MK, Hall LA, et al. Testing an intervention to reduce negative thinking, depressive symptoms, and chronic stressors in low-income single mothers. *J Nurs Scholarsh*. 2005;37(3):268-74. PMID:16235869 OVID-Medline. Exclude: Not an eligible population treatment

Peet M. Essential fatty acids: Theoretical aspects and treatment implications for schizophrenia and depression. *Adv Psychiatr Treatment*. 2002;8(3):223-9. Exclude: Not an eligible study design

Peet M, Horrobin DF. A dose-ranging study of the effects of ethyl-eicosapentaenoate in patients with ongoing depression despite apparently adequate treatment with standard drugs. *Arch Gen Psychiatr*. 2002;59(10):913-20. OVID-PsycINFO. Exclude: Not an eligible population treatment

Pelham TW, Campagna PD, Ritvo PG, et al. The effects of exercise therapy on clients in a psychiatric rehabilitation program. *Psychosoc Rehabil J*. 1993;16(4):75-84. OVID-PsycINFO. Exclude: Not an eligible study design

Pelton GH, Harper OL, Tabert MH, et al. Randomized double-blind placebo-controlled donepezil augmentation in antidepressant-treated elderly patients with depression and cognitive impairment: A pilot study. *Int J Geriatr Psychiatry*. 2008;23(7):670-6. PMID:18088076 OVID-Medline. Exclude: Not an eligible population design

Penalba V, McGuire H, Leite JR. Psychosocial interventions for prevention of psychological disorders in law enforcement officers. *Cochrane Database Syst Rev*. 2008;(3):CD005601. PMID:18646132 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Pendola,D.P. Effects of scientific weight training and muscle building nutrition on self-reports of mild to moderate depression 1996. OVID-PsycINFO. Exclude: Not an eligible study design

Peng XD, Huang CQ, Chen LJ, et al. Cognitive behavioural therapy and reminiscence techniques for the treatment of depression in the elderly: A systematic review. J Int Med Res. 2009;37(4):975-82. PMID:19761679 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Peniston EG, Hughes RB, Kulkosky PJ. EMG biofeedback-assisted relaxation training in the treatment of reactive depression in chronic pain patients. Psychol Record. 1986;36(4):471-81. OVID-PsycINFO. Exclude: Not an eligible population treatment

Penninx BW, Rejeski WJ, Pandya J, et al. Exercise and depressive symptoms: A comparison of aerobic and resistance exercise effects on emotional and physical function in older persons with high and low depressive symptomatology. J Gerontol B Psychol Sci Soc Sci. 2002;57(2):124-32. PMID:11867660 OVID-Medline. Exclude: Not an eligible population treatment

Perahia DG, Quail D, Gandhi P, et al. A randomized, controlled trial of duloxetine alone vs. duloxetine plus a telephone intervention in the treatment of depression. J Affect Disord. 2008;108(1-2):33-41. PMID:17905442 OVID-Medline. Exclude: Not an eligible population treatment

Perez V, Gilaberte I, Faries D, et al. Randomised, double-blind, placebo-controlled trial of pindolol in combination with fluoxetine antidepressant treatment. Lancet. 1997;349(9065):1594-7. PMID:9174562 OVID-Medline. Exclude: Not an eligible population treatment

Perez V, Puiigdemont D, Gilaberte I, et al. Augmentation of fluoxetine's antidepressant action by pindolol: Analysis of clinical, pharmacokinetic, and methodologic factors. J Clin Psychopharmacol. 2001;21(1):36-45. PMID:11199945 OVID-Medline. Exclude: Not an eligible population treatment

Perez V, Soler J, Puidgemont D, et al. A double-blind, randomized, placebo-controlled trial of pindolol augmentation in depressive patients resistant to serotonin reuptake inhibitors. Arch Gen Psychiatr. 1999;56(4):375-9. OVID-PsycINFO. Exclude: Mixed antidepressants:some failed on SSRI

Perini S, Titov N, Andrews G. Clinician-assisted Internet-based treatment is effective for depression: Randomized controlled trial. Aust NZ J Psychiatr. 2009;43(6):571-8. PMID:19440890 OVID-Medline. Exclude: Not an eligible population treatment

Perino C, Rago R, Cicolini A, et al. Mood and behavioural disorders following traumatic brain injury: Clinical evaluation and pharmacological management. Brain Inj. 2001;15(2):139-48. PMID:11260764 OVID-Medline. Exclude: Not an eligible study design

Perlis RH, Nierenberg AA, Alpert JE, et al. Effects of adding cognitive therapy to fluoxetine dose increase on risk of relapse and residual depressive symptoms in continuation treatment of major depressive disorder. J Clin Psychopharmacol. 2002;22(5):474-80. PMID:12352270 OVID-Medline. Exclude: Not an eligible population treatment

Perlis RH, Purcell S, Fava M, et al. Association between treatment-emergent suicidal ideation with citalopram and polymorphisms near cyclic adenosine monophosphate response element binding protein in the STAR*D study. Arch Gen Psychiatr. 2007;64(6):689-97. PMID:17548750 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Perlis RH, Laje G, Smoller JW, et al. Genetic and clinical predictors of sexual dysfunction in citalopram-treated depressed patients. Neuropsychopharmacol. 2009;34(7):1819-28. PMID:19295509 OVID-Medline. Exclude: Not an eligible population treatment

Perraton LG, Kumar S, Machotka Z. Exercise parameters in the treatment of clinical depression: A systematic review of randomized controlled trials. J Eval Clin Pract. 2010;16(3):597-604. PMID:20039997 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Persons JB, Bostrom A, Bertagnolli A. Results of randomized controlled trials of cognitive therapy for depression generalize to private practice. Cognit Ther Res. 1999;23(5):535-48. OVID-Embase. Exclude: Not an eligible population treatment

Persons JB, Roberts NA, Zalecki CA, et al. Naturalistic outcome of case formulation-driven cognitive-behavior therapy for anxious depressed outpatients. Behav Res Ther. 2006;44(7):1041-51. PMID:16209865 OVID-Medline. Exclude: Not an eligible study design

Persons JB, Burns DD, Perloff JM. Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognit Ther Res*. 1988;12(6):557-75. OVID-PsycINFO.
Exclude: Not an eligible study design

Peselow ED, Sanfilipo MP, DiFiglia C, et al. Melancholic/endogenous depression and response to somatic treatment and placebo. *Am J Psychiatry*. 1992;149(10):1324-34. OVID-Embase.
Exclude: Not an eligible population treatment

Peter K, Kuhne GE, Kowalik A. Bright light: Therapy in endogenous depression. *Psychiatria Danubina*. 1992;4(3-4):289-93. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Peters EJ, Slager SL, Kraft JB, et al. Pharmacokinetic genes do not influence response or tolerance to citalopram in the STAR*D sample. *PLoS ONE*. 2008;3(4):e1872 PMID:18382661 OVID-Medline.
Exclude: Not an eligible population treatment

Petersen CL, Zettle RD. Treating inpatients with comorbid depression and alcohol use disorders: A comparison of acceptance and commitment therapy versus treatment as usual. *Psychol Record*. 2009;59(4):521-36. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Petersen TJ, Pava JA, Buchin J, et al. The role of cognitive-behavioral therapy and fluoxetine in prevention of recurrence of major depressive disorder. *Cognit Ther Res*. 2010;34(1):13-23. OVID-Embase.
Exclude: Not an eligible population treatment

Peterson AL, Halstead TS. Group cognitive behavior therapy for depression in a community setting: A clinical replication series. *Behav Ther*. 1998;29(1):3-18. OVID-Embase.
Exclude: Not an eligible study design

Pettinati HM, Oslin DW, Kampman KM, et al. A double-blind, placebo-controlled trial combining sertraline and naltrexone for treating co-occurring depression and alcohol dependence. *Am J Psychiatry*. 2010;167(6):668-75. OVID-Embase.
Exclude: Not an eligible population treatment

Pfeiffer E, Baxter D, Candelora E, et al. Finding and treating depression in Alzheimer's patients: A study of the effects on patients and caregivers. *Psychopharmacol Bull*. 1997;33(4):721-9. OVID-Embase.
Exclude: Not an eligible study design

Pfeiffer PN, Heisler M, Piette JD, et al. Efficacy of peer support interventions for depression: A meta-analysis. *Gen Hosp Psychiatry*. 2011;33(1):29-36. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Phelps LE, Brutsche N, Moral JR, et al. Family history of alcohol dependence and initial antidepressant response to an N-methyl-D-aspartate antagonist. *Biol Psychiatry*. 2009;65(2):181-4. PMID:18996507 OVID-Medline.
Exclude: Not an eligible study design

Philip NS, Carpenter LL, Tyrka AR, et al. Augmentation of antidepressants with atypical antipsychotics: A review of the current literature. *J Psychiatr Pract*. 2008;14(1):34-44. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Philip NS, Carpenter LL, Tyrka AR, et al. Varenicline augmentation in depressed smokers: An 8-week, open-label study. *J Clin Psychiatry*. 2009;70(7):1026-31. PMID:19323966 OVID-Medline.
Exclude: Not an eligible study design

Philipp M, Kohnen R, Hiller KO. Hypericum extract versus imipramine or placebo in patients with moderate depression: Randomised multicentre study of treatment for eight weeks. *Br Med J*. 1999;319(7224):1534-8. PMID:10591711 OVID-Medline.
Exclude: Not an eligible population treatment

Philips B, Wennberg P, Werbart A, et al. Young adults in psychoanalytic psychotherapy: Patient characteristics and therapy outcome. *Psychol Psychother*. 2006;79(Pt 1):89-106. PM:16611424
Exclude: Not an eligible population treatment

Philp F, Lucock MP, Wilson AR. Primary care-based guided self-help for depression provided by a nurse practitioner: A pilot evaluation. *Prim Care Ment Health*. 2006;4(3):159-64. OVID-Embase.
Exclude: Not an eligible study design

Pierre OJ, Kasper S. Efficacy of agomelatine, a MT₁/MT₂ receptor agonist with 5-HT_{2C} antagonistic properties, in major depressive disorder. *Int J Neuropsychopharmacol*. 2007;10(5):661-73. OVID-Embase.
Exclude: Not an eligible population treatment

Pierson K, Addington D, Addington J, et al. Serum monitoring of antipsychotic drug levels during concomitant administration of sertraline and antipsychotic medication. *Can J Psychiatr*. 2006;51(11):715-8. PMID:17121171 OVID-Medline.

Exclude: Not an eligible population treatment

Pigott HE, Leventhal AM, Alter GS, et al. Efficacy and effectiveness of antidepressants: Current status of research. *Psychother Psychosom*. 2010;79(5):267-79. OVID-Embase.

Exclude: Not an eligible study design

Pilkington K, Kirkwood G, Rampes H, et al. Homeopathy for depression: A systematic review of the research evidence. *Homeopath*. 2005;94(3):153-63. PMID:16060201 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Pilkington K, Kirkwood G, Rampes H, et al. Yoga for depression: The research evidence. *J Affect Disord*. 2005;89(1-3):13-24. PMID:16185770 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Pilkington K, Boshnakova A, Richardson J. St John's wort for depression: Time for a different perspective? *Complement Ther Med*. 2006;14(4):268-81. PMID:17105697 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Pilowsky DJ, Wickramaratne P, Talati A, et al. Children of depressed mothers 1 year after the initiation of maternal treatment: Findings from the STAR*D-child study. *Am J Psychiatry*. 2008;165(9):1136-47. OVID-Embase.

Exclude: Not an eligible population treatment

Pilu A, Sorba M, Hardoy MC, et al. Efficacy of physical activity in the adjunctive treatment of major depressive disorders: Preliminary results. *Clin Pract Epidemiol Ment Health*. 2007;3, 2007. Article Number: 8. Date of Publication: 09 Jul 2007.: OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Pinquart M, Duberstein PR, Lyness JM. Treatments for later-life depressive conditions: A meta-analytic comparison of pharmacotherapy and psychotherapy. *Am J Psychiatry*. 2006;163(9):1493-501. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Pinquart M, Duberstein PR, Lyness JM. Effects of psychotherapy and other behavioral interventions on clinically depressed older adults: A meta-analysis. *Aging Ment Health*. 2007;11(6):645-57.

PMID:18074252 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Piper WE, Debbane EG, Garant J. An outcome study of group therapy. *Arch Gen Psychiatr*. 1977;34(9):1027-32. Wiley-CCTR.

Exclude: Not an eligible population treatment

Piper WE, Azim HF, McCallum M, et al. Patient suitability and outcome in short-term individual psychotherapy. *J Consult Clin Psychol*. 1990;58(4):475-81. PMID:2212185 OVID-Medline.

Exclude: Not an eligible population treatment

Pischke CR, Frenda S, Ornish D, et al. Lifestyle changes are related to reductions in depression in persons with elevated coronary risk factors. *Psychol Health*. 2010;25(9):1077-100. PMID:20204946 OVID-Medline.

Exclude: Not an eligible population treatment

Pitchot W, Scantamburlo G, Ansseau M. Duloxetine in major depressed patients resistant to SSRIs and/or venlafaxine. *Psychiatria Danubina*. 2010;22(Suppl 1):S106-7. PMID:21057413 OVID-Medline.

Exclude: Not an eligible study design

Pittaway S, Cupitt C, Palmer D, et al. Comparative, clinical feasibility study of three tools for delivery of cognitive behavioural therapy for mild to moderate depression and anxiety provided on a self-help basis. *Ment Health Fam Med*. 2010;6(3):145-54. OVID-Embase.

Exclude: Not an eligible population treatment

Pitts J. Combination drug therapy in depression. *J Clin Psychiatr*. 1985;46(6):205 OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Platania-Solazzo A, Field TM, Blank J, et al. Relaxation therapy reduces anxiety in child and adolescent psychiatric patients. *Acta Paedopsychiatr*. 1992;55(2):115-20. PMID:1585802 OVID-Medline.

Exclude: Not an eligible population treatment

Plotkin BJ, Rodos JJ, Kappler R, et al. Adjunctive osteopathic manipulative treatment in women with depression: A pilot study. *J Am Osteopath Assoc*. 2001;101(9):517-23. PMID:11575038 OVID-Medline.

Exclude: Not an eligible population treatment

Pohl A, Nordin C. Clinical and biochemical observations during treatment of depression with electroacupuncture: A pilot study. *Hum Psychopharmacol.* 2002;17(7):345-8. PMID:12415553 OVID-Medline.
Exclude: Not an eligible study design

Poirier M-F, Boyer P. Venlafaxine and paroxetine in treatment-resistant depression: Double-blind, randomised comparison. *Br J Psychiatr.* 1999;175(JUL.):12-6. OVID-Embase.
Exclude: Mixed antidepressants:some failed on SSRI

Pons G, Rey E, Matheson I. Excretion of psychoactive drugs into breast milk: Pharmacokinetic principles and recommendations. *Clin Pharmacokinet.* 1994;27(4):270-89. OVID-Embase.
Exclude: Not an eligible guideline

Pope HG, Cohane GH, Kanayama G, et al. Testosterone gel supplementation for men with refractory depression: A randomized, placebo-controlled trial. *Am J Psychiatry.* 2003;160(1):105-11. Wiley-CCTR.
Exclude: Mixed antidepressants:some failed on SSRI

Pope J, Amiaz R, Brennan BP, et al. Parallel-group placebo-controlled trial of testosterone gel in men with major depressive disorder displaying an incomplete response to standard antidepressant treatment. *J Clin Psychopharmacol.* 2010;30(2):126-34. OVID-Embase.
Exclude: Mixed antidepressants:some failed on SSRI

Popkin MK, Callies AL, MacKenzie TB. The outcome of antidepressant use in the medically ill. *Arch Gen Psychiatr.* 1985;42(12):1160-3. PMID:4074108 OVID-Medline.
Exclude: Not an eligible study design

Portella MJ, Diego-Adelino J, Puigdemont D, et al. Pindolol augmentation enhances response outcomes in first depressive episodes. *Eur Neuropsychopharmacol.* 2009;19(7):516-9. PMID:19419845 OVID-Medline.
Exclude: Not an eligible population treatment

Possel P, Horn AB, Groen G, et al. School-based prevention of depressive symptoms in adolescents: A 6-month follow-up. *J Am Acad Child Adolesc Psychiatry.* 2004;43(8):1003-10. PMID:15266195 OVID-Medline.
Exclude: Not an eligible population treatment

Posternak M, Novak S, Stern R, et al. A pilot effectiveness study: Placebo-controlled trial of adjunctive L-triiodothyronine (T3) used to accelerate and potentiate the antidepressant response. *Int J Neuropsychopharmacol.* 2008;11(1):15-25. PMID:17352847 OVID-Medline.
Exclude: Not an eligible population treatment

Posternak MA, Zimmerman M. Switching versus augmentation: A prospective, naturalistic comparison in depressed, treatment-resistant patients. *J Clin Psychiatry.* 2001;62(2):135-42. PMID:11247104 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Posternak MA, Zimmerman M. Is there a delay in the antidepressant effect? A meta-analysis. *J Clin Psychiatry.* 2005;66(2):148-58. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Potkin SG, Bell K, Plon L, et al. Rapid antidepressant response with SAME: A double-blind study. *Ala J Med Sci.* 1988;25(3):313-6. PMID:3052140 OVID-Medline.
Exclude: Not an eligible population treatment

Pouwer F, Nijpels G, Beekman AT, et al. Fat food for a bad mood. Could we treat and prevent depression in Type 2 diabetes by means of omega-3 polyunsaturated fatty acids? A review of the evidence. *Diabet Med.* 2005;22(11):1465-75. PMID:16241908 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Powers DV, Thompson LW, Gallagher-Thompson D. The benefits of using psychotherapy skills following treatment for depression: An examination of "Afterwork" and a test of the skills hypothesis in older adults. *Cognit Behav Pract.* 2008;15(2):194-202. OVID-Embase.
Exclude: Not an eligible study design

Pöldinger W, Reinhardt B. Neurotropic drugs as co-medication to psychotropics: Combined administration of a neurotropic drug and a tetracyclic antidepressant. *Int Pharmacopsychiatry.* 1980;15(3):137-42. Wiley-CCTR.
Exclude: Not an eligible population treatment

Prasko J, Horacek J, Klaschka J, et al. Bright light therapy and/or imipramine for inpatients with recurrent non-seasonal depression. *Neuroendocrinol Lett.* 2002;23(2):109-13. PMID:12011795 OVID-Medline.
Exclude: Not an eligible population treatment

Price CS, Taylor FB. A retrospective chart review of the effects of modafinil on depression as monotherapy and as adjunctive therapy. *Depress Anxiety*. 2005;(29):149-53. Exclude: Not an eligible population treatment

Price LH, Charney DS, Heninger GR. Effects of tranylcypromine treatment on neuroendocrine, behavioral, and autonomic responses to tryptophan in depressed patients. *Life Sci*. 1985;37(9):809-18. PMID:4033356 OVID-Medline. Exclude: Not an eligible population treatment

Price LH, Charney DS, Heninger GR. Efficacy of lithium-tranylcypromine treatment in refractory depression. *Am J Psychiatry*. 1985;142(5):619-23. OVID-Embase. Exclude: Not an eligible study design

Price LH, Charney DS, Heninger GR. Variability of response to lithium augmentation in refractory depression. *Am J Psychiatry*. 1986;143(11):1387-92. Wiley-CCTR. Exclude: Mixed antidepressants:some failed on SSRI

Price LH, Charney DS, Heninger GR. Reserpine augmentation of desipramine in refractory depression: Clinical and neurobiological effects. *Psychopharmacol*. 1987;92(4):431-7. Wiley-CCTR. Exclude: Not an eligible population treatment

Price LH, Charney DS, Delgado PL, et al. Fenfluramine augmentation in tricyclic-refractory depression. *J Clin Psychopharmacol*. 1990;10(5):312-7. Wiley-CCTR. Exclude: Not an eligible population treatment

Price RB, Nock MK, Charney DS, et al. Effects of intravenous ketamine on explicit and implicit measures of suicidality in treatment-resistant depression. *Biol Psychiatry*. 2009;66(5):522-6. PMID:19545857 OVID-Medline. Exclude: Not an eligible study design

Prien RF, Kupfer DJ, Mansky PA, et al. Drug therapy in the prevention of recurrences in unipolar and bipolar affective disorders: Report of the NIMH Collaborative Study Group comparing lithium carbonate, imipramine, and a lithium carbonate-imipramine combination. *Arch Gen Psychiatr*. 1984;41(11):1096-104. PMID:6437366 OVID-Medline. Exclude: Not an eligible population treatment

Procter A. Enhancement of recovery from psychiatric illness by methylfolate. *Br J Psychiatr*. 1991;159:271-2. PMID:1773245 OVID-Medline. Exclude: Not an eligible study design

Propst LR, Ostrom R, Watkins P, et al. Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *J Consult Clin Psychol*. 1992;60(1):94-103. PMID:1556292 OVID-Medline.

Exclude: Not an eligible population treatment

Proudfoot J, Goldberg D, Mann A, et al. Computerized, interactive, multimedia cognitive-behavioural program for anxiety and depression in general practice. *Psychol Med*. 2003;33(2):217-27. PMID:12622301 OVID-Medline. Exclude: Not an eligible population treatment

Proudfoot J, Ryden C, Everitt B, et al. Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: Randomised controlled trial. *Br J Psychiatr*. 2004;185:46-54. PMID:15231555 OVID-Medline. Exclude: Not an eligible population treatment

Prusoff BA, Williams DH, Weissman MM, et al. A controlled clinical trial of amitriptyline added to perphenazine in the treatment of depressed schizophrenics. *Psychopharmacol Bull*. 1979;15(2):80-1. Wiley-CCTR. Exclude: Not an eligible population treatment

Prusoff BA, Williams DH, Weissman MM, et al. Treatment of secondary depression in schizophrenia: A double-blind, placebo-controlled trial of amitriptyline added to perphenazine. *Arch Gen Psychiatr*. 1979;36(5):569-75. Wiley-CCTR. Exclude: Not an eligible population treatment

Purves DG, Bennett M, Wellman N. An open trial in the NHS of Blues Begone: A new home based computerized CBT program. *Behav Cognit Psychother*. 2009;37(5):541-51. PMID:19703330 OVID-Medline. Exclude: Not an eligible study design

Pyne JM, Smith J, Fortney J, et al. Cost-effectiveness of a primary care intervention for depressed females. *J Affect Disord*. 2003;74(1):23-32. PMID:12646296 OVID-Medline. Exclude: Not an eligible population treatment

Qaseem A, Snow V, Shekelle P, et al. Evidence-based interventions to improve the palliative care of pain, dyspnea, and depression at the end of life: A clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2008;148(2):141-6. PMID:18195338 OVID-Medline. Exclude: Not an eligible guideline

Qu F, Cai X, Gu Y, et al. Chinese medicinal herbs in relieving perimenopausal depression: A randomized, controlled trial. *J Altern Complement Med*. 2009;15(1):93-100. OVID-Embase.

Exclude: Not an eligible population treatment

Qu W, Qin Y-Y. Improvement of sleep and anxiety in patients of major depression with fluoxetine combined with small dose of olanzapine. *Chin J Clin Rehab*. 2005;9(8):254-6. OVID-Embase.

Exclude: Not an eligible population treatment

Qu W, Meng P. Relationship between blood glucose levels in patients with type 2 diabetes mellitus, depression and anxiety and the anti-depression/anxiety intervention. *Chin J Clin Rehab*. 2005;9(24):213-5. OVID-Embase.

Exclude: Not an eligible population treatment

Quadbeck H, Lehmann E, Tegeler J. Comparison of the antidepressant action of tryptophan, tryptophan/5-hydroxytryptophan combination and nomifensine. *Neuropsychobiol*. 1984;11(2):111-5. PMID:6384815 OVID-Medline.

Exclude: Not an eligible population treatment

Quah-Smith JJ, Tang WM, Russell J. Laser acupuncture for mild to moderate depression in a primary care setting: A randomised controlled trial. *Acupuncture Med*. 2005;23(3):103-11. PMID:16259308 OVID-Medline.

Exclude: Not an eligible population treatment

Quayle D, Dziurawiec S, Roberts C. The effects of an optimism and lifeskills program on depressive symptoms in preadolescence. *Behav Change*. 2001;(18):194-203. Exclude: Not an eligible population treatment

Quitkin FM, McGrath PJ, Stewart JW, et al. Remission rates with 3 consecutive antidepressant trials: Effectiveness for depressed outpatients. *J Clin Psychiatry*. 2005;66(6):670-6. PMID:15960558 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Rabin AS, Kaslow NJ, Rehm LP. Changes in symptoms of depression during the course of therapy. *Cognit Ther Res*. 1984;8(5):479-87. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Rabindranath KS, Daly C, Butler J, et al. Psychosocial interventions for depression in dialysis patients. *Cochrane Database Syst Rev*. 2005;(3):CD004542. Wiley-CDSR.

Excluded - Systematic review - relevant topic, citations cross-matched

Rabkin JG, Rabkin R, Wagner G. Effects of fluoxetine on mood and immune status in depressed patients with HIV illness. *J Clin Psychiatry*. 1994;55(3):92-7. PMID:7915270 OVID-Medline.

Exclude: Not an eligible study design

Ragan, J.D. Excessive reassurance-seeking, interpersonal rejection, rejection sensitivity and depressive symptoms: An intervention focusing on mediating mechanisms 2006. OVID-PsycINFO.

Exclude: Not an eligible study design

Rahimi R, Nikfar S, Abdollahi M. Efficacy and tolerability of *Hypericum perforatum* in major depressive disorder in comparison with selective serotonin reuptake inhibitors: A meta-analysis. *Prog Neuropsychopharmacol Biol Psychiatry*. 2009;33(1):118-27. PMID:19028540 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Raisi F, Habibi N, Nasehi AA, et al. Combination of citalopram and nortriptyline in the treatment of severe major depression: A double-blind, placebo-controlled trial. *Therapy*. 2007;4(2):187-92. OVID-Embase.

Exclude: Not an eligible population treatment

Rajji TK, Mulsant BH, Lotrich FE, et al. Use of antidepressants in late-life depression. *Drugs and Aging*. 2008;25(10):841-53. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Ramakrishnan K, Kulkarni VN, Paul AD, et al. Clinical experience with dothiepin in an Indian population. *J Drug Develop*. 1991;4(3):151-9. OVID-Embase.

Exclude: Not an eligible study design

Ramana R, Paykel ES, Cooper Z, et al. Remission and relapse in major depression: A two-year prospective follow-up study. *Psychol Med*. 1995;25(6):1161-70. OVID-Embase.

Exclude: Not an eligible study design

Ramasubbu R. Treatment of resistant depression by adding noradrenergic agents to lithium augmentation of SSRIs. *Ann Pharmacother*. 2002;36(4):634-40. PMID:11918513 OVID-Medline.

Exclude: Not an eligible study design

Ramos L. SAME as a supplement: Can it really help treat depression and arthritis? *J Am Diet Assoc*. 2000;100(4):414 PMID:10767892 OVID-Medline.

Exclude: Not an eligible study design

Rampello L, Alvano A, Chiechio S, et al. Evaluation of the prophylactic efficacy of amitriptyline and citalopram, alone or in combination, in patients with comorbidity of depression, migraine, and tension-type headache. *Neuropsychobiol.* 2004;50(4):322-8. PMID:15539864 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Randall,F. Differences between Christian Cognitive Behavioral Therapy and cognitive behavioral therapy as measured by depression and resiliency 2004. OVID-PsycINFO.

Exclude: Not an eligible study design

Randlov C, Mehlsen J, Thomsen CF, et al. The efficacy of St. John's Wort in patients with minor depressive symptoms or dysthymia: A double-blind placebo-controlled study. *Phytomed.* 2006;13(4):215-21. PMID:16423519 OVID-Medline.

Exclude: Not an eligible population treatment

Rane LJ, Fekadu A, Wooderson S, et al. Discrepancy between subjective and objective severity in treatment-resistant depression: Prediction of treatment outcome. *J Psychiatr Res.* 2010;44(15):1082-7. PMID:20471031 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Rani NJ, Rao PVK. Impact of yoga training on body image and depression. *Psychol Stud.* 2005;50(1):98-100. OVID-PsycINFO.

Exclude: Not an eligible study design

Ransom D, Heckman TG, Anderson T, et al. Telephone-delivered, interpersonal psychotherapy for HIV-infected rural persons with depression: A pilot trial. *Psychiatr Serv.* 2008;59(8):871-7. PM:18678684 Exclude: Not an eligible population treatment

Rapaport MH, Gharabawi GM, Canuso CM, et al. Corrigendum: "Effects of risperidone augmentation in patients with treatment-resistant depression: Results of open-label treatment followed by double-blind continuation". *Neuropsychopharmacol.* 2007;32(5):1208 OVID-PsycINFO.

Exclude: Not an eligible study design

Rapp,S.L. A cognitive-behavioral treatment of older medical inpatients with depressive symptoms 1998. OVID-PsycINFO.

Exclude: Not an eligible study design

Rasanen P, Hakko H, Tiihonen J, Mitchell B, Balter Award--1998. Pindolol and major affective disorders: A three-year follow-up study of 30,485 patients. *J Clin Psychopharmacol.* 1999;19(4):297-302. PMID:10440455 OVID-Medline.

Exclude: Not an eligible population treatment

Rasanen P, Hakko H, Jokelainen J, et al. Outcome of different types of long-term antidepressant treatments: A 3-year follow-up study of 14182 patients. *J Affect Disord.* 1999;55(1):67-71. PMID:10512609 OVID-Medline.

Exclude: Not an eligible population treatment

Rasanen P, Hakko H, Tiihonen J. Pindolol and major affective disorders: A three-year follow-up study of 30,485 patients. *J Clin Psychopharmacol.* 1999;19(4):297-302. OVID-Embase.

Exclude: Not an eligible study design

Rasgon NL, Altshuler LL, Fairbanks LA, et al. Estrogen replacement therapy in the treatment of major depressive disorder in perimenopausal women. *J Clin Psychiatry.* 2002;63(Suppl 7):45-8. PMID:11995778 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Rasgon NL, Dunkin J, Fairbanks L, et al. Estrogen and response to sertraline in postmenopausal women with major depressive disorder: A pilot study. *J Psychiatr Res.* 2007;41(3-4):338-43. PMID:16697413 OVID-Medline.

Exclude: Not an eligible population treatment

Rasgon NL, Kenna HA, Williams KE, et al. Rosiglitazone add-on in treatment of depressed patients with insulin resistance: A pilot study. *Sci World J.* 2010;10:321-8. OVID-Embase.

Exclude: Not an eligible study design

Raskin A. High dosage chlorpromazine alone and in combination with an antiparkinsonian agent (procyclidine) in the treatment of hospitalized depressions. *J Nerv Ment Dis.* 1968;147(2):184-95. Wiley-CCTR.

Exclude: Not an eligible population treatment

Rasmussen N-A, Schroder P, Olsen LR, et al. Modafinil augmentation in depressed patients with partial response to antidepressants: A pilot study on self-reported symptoms covered by the Major Depression Inventory (MDI) and the Symptom Checklist (SCL-92). *Nord J Psychiatry.* 2005;59(3):173-8. OVID-Embase.

Exclude: Not an eligible study design

Ravindran AV, Anisman H, Merali Z, et al. Treatment of primary dysthymia with group cognitive therapy and pharmacotherapy: Clinical symptoms and functional impairments. *Am J Psychiatry*. 1999;156(10):1608-17. PMID:10518174 OVID-Medline.

Exclude: Not an eligible population treatment

Ravindran AV, Kennedy SH, O'Donovan MC, et al. Osmotic-release oral system methylphenidate augmentation of antidepressant monotherapy in major depressive disorder: Results of a double-blind, randomized, placebo-controlled trial. *J Clin Psychiatry*. 2008;69(1):87-94. PMID:18312042 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Ravindran L, Lam R, Chaput Y and others. Impact of low vs. high dose olanzapine or risperidone on outcome and side effects in non-psychotic treatment resistant depression. In 2006. Wiley-CCTR.

Exclude: Not an eligible study design

Razani J, White KL, White J, et al. The safety and efficacy of combined amitriptyline and tranylcypromine antidepressant treatment: A controlled trial. *Arch Gen Psychiatr*. 1983;40(6):657-61. PMID:6342565 OVID-Medline.

Exclude: Not an eligible population treatment

Ree MJ, Craigie MA. Outcomes following mindfulness-based cognitive therapy in a heterogeneous sample of adult outpatients. *Behav Change*. 2007;24(2):70-86. OVID-PsycINFO.

Exclude: Not an eligible study design

Reed C, Monz BU, Perahia DG, et al. Quality of life outcomes among patients with depression after 6 months of starting treatment: Results from FINDER. *J Affect Disord*. 2009;113(3):296-302. PMID:18603303 OVID-Medline.

Exclude: Not an eligible study design

Reeves H, Batra S, May RS, et al. Efficacy of risperidone augmentation to antidepressants in the management of suicidality in major depressive disorder: a randomized, double-blind, placebo-controlled pilot study. *J Clin Psychiatry*. 2008;69(8):1228-336. PMID:18681749 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Reimherr FW, Martin ML, Eudicone JM, et al. A pooled MADRS/IDS cross-correlation analysis: Clinician and patient self-report assessment of improvement in core depressive symptoms with adjunctive aripiprazole. *J Clin Psychopharmacol*. 2010;30(3):300-5. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Reis S, Grenyer BFS. Fearful attachment, working alliance and treatment response for individuals with major depression. *Clin Psychol Psychother*. 2004;(11):414-24. Exclude: Not an eligible study design

Rektorová I, Rektor I, Bares M, et al. Pramipexole and pergolide in the treatment of depression in Parkinson's disease: A national multicentre prospective randomized study. *Eur J Neurol*. 2003;10(4):399-406. Wiley-CCTR.

Exclude: Not an eligible population design

Rene,R. The efficacy of a portable HRV feedback device in conjunction with mental health treatment of clients with major depressive disorder enrolled in a county welfare-to-work program 2008. OVID-PsycINFO.

Exclude: Not an eligible study design

Repetto MJ, Petitto JM. Psychopharmacology in HIV-infected patients. *Psychosom Med*. 2008;70(5):585-92. OVID-PsycINFO.

Excluded - Systematic review - relevant topic, citations cross-matched

Replogle WH, Eicke FJ. Megavitamin therapy in the reduction of anxiety and depression among alcoholics. *J Orthomolecular Med*. 1989;4(4):221-4. OVID-Embase.

Exclude: Not an eligible population treatment

Resick PA, Nishith P, Weaver TL, et al. A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *J Consult Clin Psychol*. 2002;70(4):867-79. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Rethorst CD, Wipfli BM, Landers DM. The antidepressive effects of exercise: A meta-analysis of randomized trials. *Sports Med*. 2009;39(6):491-511. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Rethorst CD, Landers DM, Nagoshi CT, et al. Efficacy of exercise in reducing depressive symptoms across 5-HTTLPR genotypes. *Med Sci Sports Exerc.* 2010;42(11):2141-7. PMID:20351589 OVID-Medline.

Exclude: Not an eligible population treatment

Revicki DA, Simon GE, Chan K, et al. Depression, health-related quality of life, and medical cost outcomes of receiving recommended levels of antidepressant treatment. *J Fam Pract.* 1998;47(6):446-52. OVID-Embase.

Exclude: Not an eligible population treatment

Revicki DA, Siddique J, Frank L, et al. Cost-effectiveness of evidence-based pharmacotherapy or cognitive behavior therapy compared with community referral for major depression in predominantly low-income minority women. *Arch Gen Psychiatr.* 2005;62(8):868-75. PMID:16061764 OVID-Medline.

Exclude: Not an eligible population treatment

Reynaert-Dupuis C, Zdanowicz N, Leyman S, et al. Efficacy and tolerance of venlafaxine in depressed patients switched from prior antidepressant treatment. *Prim Care Psychiatr.* 2002;8(2):63-8. Exclude: Not an eligible study design

Reynaert C, Parent M, Mirel J, et al. Moclobemide versus fluoxetine for a major depressive episode. *Psychopharmacol.* 1995;118(2):183-7. PMID:7617806 OVID-Medline.

Exclude: Not an eligible population treatment

Reynolds CF, III, Kupfer DJ, Hoch CC, et al. Sleep deprivation effects in older endogenous depressed patients. *Psychiatry Res.* 1987;21(2):95-109. PMID:3615695 OVID-Medline.

Exclude: Not an eligible study design

Reynolds CF, III, Frank E, Perel JM, et al. Combined pharmacotherapy and psychotherapy in the acute and continuation treatment of elderly patients with recurrent major depression: a preliminary report. *Am J Psychiatry.* 1992;149(12):1687-92. PMID:1443245 OVID-Medline.

Exclude: Not an eligible population treatment

Reynolds CF, III, Frank E, Perel JM, et al. High relapse rate after discontinuation of adjunctive medication for elderly patients with recurrent major depression. *Am J Psychiatry.* 1996;153(11):1418-22. PMID:8890674 OVID-Medline.

Exclude: Not an eligible population treatment

Reynolds CF, III, Frank E, Kupfer DJ, et al. Treatment outcome in recurrent major depression: A post hoc comparison of elderly ("young old") and midlife patients. *Am J Psychiatry.* 1996;153(10):1288-92. PMID:8831436 OVID-Medline.

Exclude: Not an eligible population treatment

Reynolds CF, III, Frank E, Perel JM, et al. Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. *JAMA.* 1999;281(1):39-45. PM:9892449

Exclude: Not an eligible population treatment

Reynolds CF, III, Smith GS, Dew MA, et al. Accelerating symptom-reduction in late-life depression: A double-blind, randomized, placebo-controlled trial of sleep deprivation. *Am J Geriatr Psychiatr.* 2005;13(5):353-8. PMID:15879583 OVID-Medline.

Exclude: Not an eligible population treatment

Reynolds CF, III, Dew MA, Pollock BG, et al. Maintenance treatment of major depression in old age. *N Engl J Med.* 2006;354(11):1130-8. PMID:16540613 OVID-Medline.

Exclude: Not an eligible population treatment

Reynolds CF, III, Butters MA, Lopez O, et al. Maintenance treatment of depression in old age: A randomized, double-blind, placebo-controlled evaluation of the efficacy and safety of donepezil combined with antidepressant pharmacotherapy. *Arch Gen Psychiatr.* 2011;68(1):51-60. PMID:21199965 OVID-Medline.

Exclude: Not an eligible population treatment

Reynolds CFI, Schneider LS, Lebowitz BD, et al. Diagnosis and treatment of depression in late life: Results of the NIH Consensus Development Conference., Washington, DC, US:American Psychiatric Association;1994. Treatment of depression in elderly patients: Guidelines for primary care. OVID-PsycINFO.

Exclude: Not an eligible study design.

Reynolds WM, Coats KI. A comparison of cognitive-behavioral therapy and relaxation training for the treatment of depression in adolescents. *J Consult Clin Psychol.* 1986;54(5):653-60. PMID:3534032 OVID-Medline.

Exclude: Not an eligible population treatment

Richards A, Barkham M, Cahill J, et al. PHASE: A randomised, controlled trial of supervised self-help cognitive behavioural therapy in primary care. *Br J Gen Pract.* 2003;53(495):764-70. PMID:14601351 OVID-Medline.

Exclude: Not an eligible population treatment

Richards DA, Suckling R. Improving access to psychological therapies: Phase IV prospective cohort study. *Br J Clin Psychol.* 2009;48(Pt:4):4-96. PMID:19208291 OVID-Medline.

Exclude: Not an eligible study design

Richardson T, Stallard P, Velleman S. Computerised cognitive behavioural therapy for the prevention and treatment of depression and anxiety in children and adolescents: A systematic review. *Clin Child Fam Psychol Rev.* 2010;13(3):275-90. PMID:20532980 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Richelson E. Treatment of acute depression. *Psychiatr Clin North Am.* 1993;16(3):461-78. OVID-PsycINFO.

Exclude: Not an eligible guideline

Richeson NE, Spross JA, Lutz K, et al. Effects of Reiki on anxiety, depression, pain, and physiological factors in community-dwelling older adults: Physiological factors in community-dwelling older adults. *Res Gerontol Nurs.* 2010;3(3):187-99. EBSCO-CINAHL.

Exclude: Not an eligible population/treatment

Rickels K, Csanalosi I, Werblowsky J, et al. Amitriptyline-perphenazine and doxepin in depressed outpatients: A controlled double-blind study. *J Clin Psychiatry.* 1982;43(10):419-22. PMID:6749826 OVID-Medline.

Exclude: Not an eligible population treatment

Rickels K, Schweizer E, Case WG, et al. Nefazodone in major depression: adjunctive benzodiazepine therapy and tolerability. *J Clin Psychopharmacol.* 1998;18(2):145-53. PMID:9580369 OVID-Medline.

Exclude: Not an eligible population treatment

Riedel WJ, Schoenmakers E, Vermeeren A, et al. The influence of trazodone treatment on cognitive functions in outpatients with major depressive disorder. *Hum Psychopharmacol.* 1999;14(7):499-508. OVID-Embase.

Exclude: Not an eligible population treatment

Riemann D, Konig A, Hohagen F, et al. How to preserve the antidepressive effect of sleep deprivation: A comparison of sleep phase advance and sleep phase delay. *Eur Arch Psychiatry Clin Neurosci.* 1999;249(5):231-7. PMID:10591988 OVID-Medline.

Exclude: Not an eligible population treatment

Ries RK, Wittkowsky AK. Synergistic action of alprazolam with tranylcypromine in drug-resistant atypical depression with panic attacks. *Biol Psychiatry.* 1986;21(5-6):522-6. PMID:3697440 OVID-Medline.

Exclude: Not an eligible study design

Riggs PD, Mikulich-Gilbertson SK, Davies RD, et al. A randomized controlled trial of fluoxetine and cognitive behavioral therapy in adolescents with major depression, behavior problems, and substance use disorders. *Arch Pediatr Adolesc Med.* 2007;161(11):1026-34. PMID:17984403 OVID-Medline.

Exclude: Not an eligible population treatment

Rihmer Z, Satori M, Pestaloty P. Selegiline-citalopram combination in patients with Parkinson's disease and major depression. *Int J Psychiatr Clin Pract.* 2000;4(2):123-5. OVID-Embase.

Exclude: Not an eligible study design

Rihmer Z, Gonda X. Is drug-placebo difference in short-term antidepressant drug trials on unipolar major depression much greater than previously believed? *J Affect Disord.* 2008;108(3):195-8. PMID:18280581 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Riise IS, Holm P. Concomitant isocarboxazid/mianserin treatment of major depressive disorder. *J Affect Disord.* 1984;6(2):175-9. PMID:6233349 OVID-Medline.

Exclude: Not an eligible population treatment

Risos-Rio GER. The effects of a structured live music and arts program on depression, pain control and mood/behavior patterns among nursing home residents. *UPNAAI Nursing Journal.* 2009;5(1):9-15. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Ritchie, L.G. Group telepsychotherapy for reducing depression: An exploratory study 2008. OVID-PsycINFO.

Exclude: Not an eligible study design

Robb SL, Ebberts AG. Songwriting and digital video production interventions for pediatric patients undergoing bone marrow transplantation, part I: An analysis of depression and anxiety levels according to phase of treatment. *J Pediatr Oncol Nurs*. 2003;20(1):2-15. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Robbins DR, Alessi NE, Colfer MV. Treatment of adolescents with major depression: Implications of the DST and the melancholic clinical subtype. *J Affect Disord*. 1989;17(2):99-104. OVID-PsycINFO.

Exclude: Not an eligible study design

Robbins D R, McFarlane W. Lamotrigine use in treatment refractory depression in adolescents. In 2006. Wiley-CCTR.

Exclude: Not an eligible study design

Roberts SH, Bedson E, Hughes D, et al. Folate augmentation of treatment - evaluation of depression (FolATED): Protocol of a randomised controlled trial. *BMC Psychiatr*. 2007;7:65 PMID:18005429 OVID-Medline.

Exclude: Not an eligible study design

Robertson L, Smith M, Castle D, et al. Using the Internet to enhance the treatment of depression. *Australas Psychiatr*. 2006;14(4):413-7. PMID:17116083 OVID-Medline.

Exclude: Not an eligible study design

Robertson MM, Trimble MR. The treatment of depression in patients with epilepsy: A double-blind trial. *J Affect Disord*. 1985;9(2):127-36. PMID:2932485 OVID-Medline.

Exclude: Not an eligible population treatment

Robinson RG, Jorge RE, Clarence-Smith K. Double-blind randomized treatment of poststroke depression using nefiracetam. *J Neuropsychiatr Clin Neurosci*. 2008;20(2):178-84. Wiley-CCTR.

Exclude: Not an eligible population design

Rocco PL, Pacella G, Giavedoni A. Major depression in medical inpatients: A preliminary report on a tentative therapeutic approach with S-adenosyl-L-methionine. *Curr Ther Res Clin Exp*. 1993;54(2):177-85. OVID-Embase.

Exclude: Not an eligible study design

Rocha Araujo DM, Vilarim MM, Nardi AE. What is the effectiveness of the use of polyunsaturated fatty acid omega-3 in the treatment of depression? *Exp Rev Neurotherapeut*. 2010;10(7):1117-29. PMID:20586692 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Rocha FL, Hara C. Lamotrigine augmentation in unipolar depression. *Int Clin Psychopharmacol*. 2003;18(2):97-9. PMID:12598821 OVID-Medline.

Exclude: Not an eligible study design

Rodin G, Lloyd N, Katz M, et al. The treatment of depression in cancer patients: A systematic review. *Support Care Cancer*. 2007;15(2):123-36. PMID:17058100 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Roepke S, Merkl A, Dams A, et al. Preliminary evidence of improvement of depressive symptoms but not impulsivity in cluster B personality disorder patients treated with quetiapine: An open label trial. *Pharmacopsychiatr*. 2008;41(5):176-81. PMID:18763219 OVID-Medline.

Exclude: Not an eligible study design

Rofey DL, Szigethy EM, Noll RB, et al. Cognitive-behavioral therapy for physical and emotional disturbances in adolescents with polycystic ovary syndrome: A pilot study. *J Pediatr Psychol*. 2009;34(2):156-63. PMID:18556675 OVID-Medline.

Exclude: Not an eligible study design

Rogers DR, Ei S, Rogers KR, et al. Evaluation of a multi-component approach to cognitive-behavioral therapy (CBT) using guided visualizations, cranial electrotherapy stimulation, and vibroacoustic sound. *Complement Ther Clin Pract*. 2007;13(2):95-101. PMID:17400144 OVID-Medline.

Exclude: Not an eligible study design

Rogers PJ, Appleton KM, Kessler D, et al. No effect of n-3 long-chain polyunsaturated fatty acid (EPA and DHA) supplementation on depressed mood and cognitive function: A randomised controlled trial. *Br J Nutr*. 2008;99(2):421-31. PMID:17956647 OVID-Medline.

Exclude: Not an eligible population treatment

Rogoz Z, Skuza G, Wojcikowski J, et al. Effect of metyrapone supplementation on imipramine therapy in patients with treatment-resistant unipolar depression. *Pol J Pharmacol*. 2004;56(6):849-55. PMID:15662100 OVID-Medline.

Exclude: Not an eligible study design

Rogoz Z, Dziedzicka-Wasylewska M, Daniel WA, et al. Effects of joint administration of imipramine and amantadine in patients with drug-resistant unipolar depression. *Pol J Pharmacol*. 2004;56(6):735-42. PMID:15662086 OVID-Medline.

Exclude: Not an eligible study design

Rogoz Z, Skuza G, Daniel WA, et al. Amantadine as an additive treatment in patients suffering from drug-resistant unipolar depression. *Pharmacol Reports*. 2007;59(6):778-84. PMID:18195470 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Roh YS, Cho H, Oh JO, et al. Effects of skin rehabilitation massage therapy on pruritus, skin status, and depression in burn survivors. *Daehan Ganho Haghoeji*. 2007;37(2):221-6. PMID:17435407 OVID-Medline.

Exclude: Not an eligible population treatment

Rohde P, Clarke GN, Mace DE, et al. An efficacy/effectiveness study of cognitive-behavioral treatment for adolescents with comorbid major depression and conduct disorder. *J Am Acad Child Adolesc Psychiatry*. 2004;43(6):660-8. PMID:15167082 OVID-Medline.

Exclude: Not an eligible population treatment

Rohde P, Silva SG, Tonev ST, et al. Achievement and maintenance of sustained response during the Treatment for Adolescents With Depression Study continuation and maintenance therapy. *Arch Gen Psychiatr*. 2008;65(4):447-55. PMID:18391133 OVID-Medline.

Exclude: Not an eligible population treatment

Rohde P, Lewinsohn PM, Seeley JR. Response of depressed adolescents to cognitive-behavioral treatment: Do differences in initial severity clarify the comparison of treatments? *J Consult Clin Psychol*. 1994;62(4):851-4. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Rohen,N.A. Analysis of efficacy and mediators of outcome in minimal-contact cognitive bibliotherapy used in the treatment of depressive symptoms 2003. OVID-PsycINFO.

Exclude: Not an eligible study design

Rohini V, Pandey RS, Janakiramaiah N, et al. A comparative study of full and partial Sudarshan Kriya Yoga (SKY) in major depressive disorder. *Nimhans J*. 2000;18(1-2):53-7. Exclude: Not an eligible population treatment

Roitman S, Green T, Osher Y, et al. Creatine monohydrate in resistant depression: A preliminary study. *Bipolar Disorders*. 2007;9(7):754-8. PMID:17988366 OVID-Medline.

Exclude: Not an eligible study design

Rokke PD, Tomhave JA, Jovic Z. The role of client choice and target selection in self-management therapy for depression in older adults. *Psychol Aging*. 1999;14(1):155-69. PMID:10224639 OVID-Medline.

Exclude: Not an eligible population treatment

Rolland Y, Pillard F, Klapouszczak A, et al. Exercise program for nursing home residents with Alzheimer's disease: A 1-year randomized, controlled trial. *J Am Geriatr Soc*. 2007;55(2):158-65. Wiley-CCTR.

Exclude: Not an eligible population design

Romano S J, Amsterdam J D, Shelton R C and others. Adjunctive ziprasidone in treatment-resistant depression: Pilot study. In 156th Annual Meeting of the American Psychiatric Association, May 17 22, San Francisco CA. 2003. Wiley-CCTR.

Exclude: Not an eligible study design

Rondanelli M, Giacosa A, Opizzi A, et al. Effect of omega-3 fatty acids supplementation on depressive symptoms and on health-related quality of life in the treatment of elderly women with depression: A double-blind, placebo-controlled, randomized clinical trial. *J Am Coll Nutr*. 2010;29(1):55-64. PMID:20595646 OVID-Medline.

Exclude: Not an eligible population treatment

Roose SP, Glassman AH, Walsh BT, et al. Tricyclic nonresponders: phenomenology and treatment. *Am J Psychiatry*. 1986;143(3):345-8. PMID:3953869 OVID-Medline.

Exclude: Not an eligible study design

Roschke J, Wolf C, Muller MJ, et al. The benefit from whole body acupuncture in major depression. *J Affect Disord*. 2000;57(1-3):73-81. PMID:10708818 OVID-Medline.

Exclude: Not an eligible population treatment

Rosen J, Rogers JC, Marin RS, et al. Control-relevant intervention in the treatment of minor and major depression in a long-term care facility. *Am J Geriatr Psychiatry*. 1997;5(3):247-57. PM:9209567

Exclude: Not an eligible population/treatment

Rosenbaum JF, Fava M, Falk WE, et al. An open-label pilot study of oral S-adenosyl-L-methionine in major depression: Interim results. *Psychopharmacol Bull*. 1988;24(1):189-94. PMID:3387521 OVID-Medline.

Exclude: Not an eligible study design

Rosenbaum JF, Fava M, Falk WE, et al. An open-label pilot study of oral S-adenosylmethionine in major depression. An interim report. *Ala J Med Sci*. 1988;25(3):301-6. PMID:3052138 OVID-Medline.

Exclude: Not an eligible population treatment

Rosenbaum JF, Fava M, Falk WE, et al. The antidepressant potential of oral S-adenosyl-L-methionine. *Acta Psychiatr Scand*. 1990;81(5):432-6. PMID:2113347 OVID-Medline.

Exclude: Not an eligible study design

Rosenberg D, Depp CA, Vahia IV, et al. Exergames for subsyndromal depression in older adults: A pilot study of a novel intervention. *Am J Geriatr Psychiatry*. 2010;18(3):221-6. PMID:20173423 OVID-Medline.

Exclude: Not an eligible study design

Ross EA, Hollen TL, Fitzgerald BM. Observational study of an Arts-in-Medicine Program in an outpatient hemodialysis unit. *Am J Kidney Dis*. 2006;47(3):462-8. EBS-CINAHL.

Exclude: Not an eligible study design

Ross J. Discontinuation of lithium augmentation in geriatric patients with unipolar depression: A systematic review. *Can J Psychiatry*. 2008;53(2):117-20. PMID:18357930 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Ross LE, Doctor F, Dimito A, et al. Can talking about oppression reduce depression? Modified CBT group treatment for LGBT people with depression. *J Gay Lesbian Soc Serv*. 2007;19(1):1-15. OVID-PsycINFO.

Exclude: Not an eligible study design

Ross M, Scott M. An evaluation of the effectiveness of individual and group cognitive therapy in the treatment of depressed patients in an inner city health centre. *J Roy Coll Gen Pract*. 1985;(35):239-42.

Exclude: Not an eligible population treatment

Rossello J, Bernal G. Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice., Washington, DC, US:American Psychological Association;1996. Adapting cognitive-behavioral and interpersonal treatments for depressed Puerto Rican adolescents. OVID-PsycINFO.

Exclude: Not an eligible guideline.

Rossello J, Bernal G. The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *J Consult Clin Psychol*. 1999;67(5):734-45. PMID:10535240 OVID-Medline.

Exclude: Not an eligible population treatment

Rossello J, Bernal G, Rivera-Medina C. Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cult Divers Ethnic Minority Psychol*. 2008;14(3):234-45.

PMID:18624588 OVID-Medline.

Exclude: Not an eligible population treatment

Rossello JM, Jimenez-Chafey MI. Cognitive-behavioral group therapy for depression in adolescents with diabetes: A pilot study. *Revista Interamericana de Psicologia*. 2006;40(2):219-26. OVID-PsycINFO.

Exclude: Not an eligible study design

Rossini D, Magri L, Lucca A, et al. Does rTMS hasten the response to escitalopram, sertraline, or venlafaxine in patients with major depressive disorder? A double-blind, randomized, sham-controlled trial. *J Clin Psychiatry*. 2005;66(12):1569-75. OVID-Embase.

Exclude: Not an eligible population treatment

Roth D, Covi L. Cognitive group psychotherapy of depression: The open-ended group. *Int J Group Psychother*. 1984;34(1):67-82. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Rothschild AJ. The diagnosis and treatment of late-life depression. *J Clin Psychiatry*. 1996;57(Suppl 5):1996, pp-11. OVID-PsycINFO.

Exclude: Not an eligible guideline

Rounsaville BJ, Sholomskas D, Prusoff BA. Chronic mood disorders in depressed outpatient--diagnosis and response to pharmacotherapy. *J Affect Disord*. 1980;2(2):73-88. PMID:6448886 OVID-Medline.

Exclude: Not an eligible population treatment

Rousseau JJ. Effects of a levo-5-hydroxytryptophan-dihydroergocristine combination on depression and neuropsychic performance: A double-blind, placebo-controlled clinical trial in elderly patients. *Clin Ther*. 1987;9(3):267-72. PMID:3111702 OVID-Medline.

Excluded

Rubio G, San L, Lopez-Munoz F, et al. Combination therapy with reboxetine for major depression patients who are partial or nonresponders to serotonin selective reuptake inhibitors. *Actas Esp Psiquiatr*. 2003;(31):315-24. Exclude: Not an eligible study design

Rubio G, San L, Lopez-Munoz F, et al. Reboxetine adjunct for partial or nonresponders to antidepressant treatment. *J Affect Disord*. 2004;81(1):67-72. OVID-PsycINFO.

Exclude: Not an eligible study design

Rudas S, Schmitz M, Pichler P, et al. Treatment of refractory chronic depression and dysthymia with high-dose thyroxine. *Biol Psychiatr.* 1999;45(2):229-33. PMID:9951571 OVID-Medline.

Exclude: Not an eligible study design

Rude SS. Relative benefits of assertion or cognitive self-control treatment for depression as a function of proficiency in each domain. *J Consult Clin Psychol.* 1986;54(3):390-4. Exclude: Not an eligible population treatment

Ruffolo MC, Fischer D. Using an evidence-based CBT group intervention model for adolescents with depressive symptoms: Lessons learned from a school-based adaptation. *Child Fam Soc Work.* 2009;14(2):189-97. EBSCO-CINAHL.

Exclude: Not an eligible study design

Ruhe HG, Huyser J, Swinkels JA, et al. Dose escalation for insufficient response to standard-dose selective serotonin reuptake inhibitors in major depressive disorder: Systematic review. *Br J Psychiatr.* 2006;189:309-16. PMID:17012653 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Ruhe HG, Huyser J, Swinkels JA, et al. Switching antidepressants after a first selective serotonin reuptake inhibitor in major depressive disorder: A systematic review. *J Clin Psychiatry.* 2006;67(12):1836-55. PMID:17194261 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Rumi DO, Gattaz WF, Rigonatti SP, et al. Transcranial magnetic stimulation accelerates the antidepressant effect of amitriptyline in severe depression: A double-blind placebo-controlled study. *Biol Psychiatr.* 2005;57(2):162-6. PMID:15652875 OVID-Medline.

Exclude: Not an eligible population treatment

Rush AJ, Bose A, Heydorn WE. Naturalistic study of the early psychiatric use of citalopram in the United States. *Depress Anxiety.* 2002;16(3):121-7. PMID:12415537 OVID-Medline.

Exclude: Not an eligible study design

Rush AJ, Trivedi M, Carmody TJ, et al. One-year clinical outcomes of depressed public sector outpatients: A benchmark for subsequent studies. *Biol Psychiatr.* 2004;56(1):46-53. PMID:15219472 OVID-Medline.

Exclude: Not an eligible population treatment

Rush AJ, Zimmerman M, Wisniewski SR, et al. Comorbid psychiatric disorders in depressed outpatients: Demographic and clinical features. *J Affect Disord.* 2005;87(1):43-55. PM:15894381
Exclude: Not an eligible population treatment

Rush AJ. Limitations in efficacy of antidepressant monotherapy. *J Clin Psychiatry.* 2007;68(Suppl 10):8-10. PMID:17900203 OVID-Medline.

Exclude: Not an eligible population treatment

Rush AJ. Comparison of the effects of cognitive therapy and pharmacotherapy on hopelessness and self-concept. *Am J Psychiatry.* 1982;139(7):862-6. OVID-PsycINFO.

Exclude: Not an eligible study design

Rush AJ, Kilner J, Fava M, et al. Clinically relevant findings from STAR*D. *Psychiatr Ann.* 2008;38(3):188-93. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Rutherford B, Sneed J, Miyazaki M, et al. An open trial of aripiprazole augmentation for SSRI non-remitters with late-life depression. *Int J Geriatr Psychiatry.* 2007;22(10):986-91. PMID:17340654 OVID-Medline.

Exclude: Not an eligible study design

Ruwaard J, Schrieken B, Schrijver M, et al. Standardized web-based cognitive behavioural therapy of mild to moderate depression: a randomized controlled trial with a long-term follow-up. *Cognit Behav Ther.* 2009;38(4):206-21. PMID:19221919 OVID-Medline.

Exclude: Not an eligible population treatment

Ryan CE, Keitner GI, Bishop S. An adjunctive Management of Depression Program for difficult-to-treat depressed patients and their families. *Depress Anxiety.* 2010;27(1):27-34. PMID:20013959 OVID-Medline.

Exclude: Not an eligible study design

Ryan MP. Psychocultural differences in physical activity-based antidepressant effects. *Ment Health Phys Activ.* 2010;3(1):5-15. OVID-Embase.

Exclude: Not an eligible study design

Ryan ND, Meyer V, Dachille S, et al. Lithium antidepressant augmentation in TCA-refractory depression in adolescents. *J Am Acad Child Adolesc Psychiatry.* 1988;27(3):371-6. PMID:3379022 OVID-Medline.

Exclude: Not an eligible study design

Ryan ND, Puig-Antich J, Rabinovich H, et al. MAOIs in adolescent major depression unresponsive to tricyclic antidepressants. *J Am Acad Child Adolesc Psychiatry*. 1988;27(6):755-8. OVID-Embase.

Exclude: Not an eligible study design

Rybakowski J, Matkowski K. Adding lithium to antidepressant therapy: Factors related to therapeutic potentiation. *Eur Neuropsychopharmacol*. 1992;2(2):161-5. PMID:1633434 OVID-Medline.

Exclude: Not an eligible study design

Rybakowski JK, Suwalska A, Chlopocka W. Potentiation of antidepressants with lithium or carbamazepine in treatment-resistant depression. *Neuropsychobiol*. 1999;40(3):134-9. Wiley-CCTR. Exclude: Mixed antidepressants:some failed on SSRI

Rymaszewska J, Ramsey D, Chladzinska-Kiejna S. Whole-body cryotherapy as adjunct treatment of depressive and anxiety disorders. *Arch Immunol Ther Exp*. 2008;56(1):63-8. PMID:18250970 OVID-Medline.

Exclude: Not an eligible population treatment

Saab PG, Bang H, Williams RB, et al. The impact of cognitive behavioral group training on event-free survival in patients with myocardial infarction: The ENRICHHD experience. *J Psychosom Res*. 2009;67(1):45-56. PMID:19539818 OVID-Medline. Exclude: Not an eligible population treatment

Sabelli H, Fink P, Fawcett J, et al. Sustained antidepressant effect of PEA replacement. *J Neuropsychiatr Clin Neurosci*. 1996;8(2):168-71. PMID:9081552 OVID-Medline.

Exclude: Not an eligible study design

Sackeim HA, Roose SP, Lavori PW. Determining the duration of antidepressant treatment: Application of signal detection methodology and the need for duration adaptive designs (DAD). *Biol Psychiatry*. 2006;59(6):483-92. PMID:16517241 OVID-Medline.

Exclude: Not an eligible population treatment

Sacristan JA, Gilaberte I, Boto B, et al. Cost-effectiveness of fluoxetine plus pindolol in patients with major depressive disorder: Results from a randomized, double-blind clinical trial. *Int Clin Psychopharmacol*. 2000;15(2):107-13. PMID:10759342 OVID-Medline.

Exclude: Not an eligible population treatment

Sado M, Knapp M, Yamauchi K, et al. Cost-effectiveness of combination therapy versus antidepressant therapy for management of depression in Japan. *Aust NZ J Psychiatry*. 2009;43(6):539-47. OVID-Embase.

Exclude: Not an eligible study design

Safren SA, O'Cleirigh C, Tan JY, et al. A randomized controlled trial of cognitive behavioral therapy for adherence and depression (CBT-AD) in HIV-infected individuals. *Health Psychol*. 2009;28(1):1-10. PMID:19210012 OVID-Medline. Exclude: Not an eligible population treatment

Sagman D, McIntosh D, Lee MS, et al. Attributes of response in depressed patients switched to treatment with duloxetine. *Int J Clin Pract*. 2011;65(1):73-81. OVID-Embase.

Exclude: Not an eligible study design

Sagud M, Mihaljevic-Peles A, Muck-Seler D, et al. Quetiapine augmentation in treatment-resistant depression: A naturalistic study. *Psychopharmacol*. 2006;187(4):511-4. PMID:16802162 OVID-Medline.

Exclude: Not an eligible study design

Saiz-Ruiz J, Ibanez A, Diaz-Marsa M, et al. Efficacy of venlafaxine in major depression resistant to selective serotonin reuptake inhibitors. *Prog Neuropsychopharmacol Biol Psychiatry*. 2002;26(6):1129-34. PMID:12452535 OVID-Medline.

Exclude: Not an eligible study design

Sajatovic M, DiGiovanni S, Fuller M, et al. Nefazodone therapy in patients with treatment-resistant or treatment-intolerant depression and high psychiatric comorbidity. *Clin Ther*. 1999;21(4):733-40. PMID:10363738 OVID-Medline.

Exclude: Not an eligible study design

Saletu B, Gruenberger J. Changes in clinical symptomatology and psychometric assessments in depressed patients during mianserin and combined amitriptyline/chlordiazepoxide therapy: A double-blind comparison. *Curr Med Res Opin*. 1980;6(Suppl. 7):52-62. OVID-Embase.

OVID-Embase.

Exclude: Not an eligible population treatment

Salin-Pascual RJ, de IF, Jr., Galicia-Polo L, et al. Effects of transdermal nicotine on mood and sleep in nonsmoking major depressed patients. *Psychopharmacol*. 1995;121(4):476-9. PMID:8619011 OVID-Medline.

Exclude: Not an eligible population treatment

Salin-Pascual RJ, Rosas M, Jimenez-Genchi A, et al. Antidepressant effect of transdermal nicotine patches in nonsmoking patients with major depression. *J Clin Psychiatry*. 1996;57(9):387-9. PMID:9746444 OVID-Medline.

Exclude: Not an eligible study design

Salin-Pascual RJ. Relationship between mood improvement and sleep changes with acute nicotine administration in non-smoking major depressed patients. *Rev Invest Clin*. 2002;54(1):36-40. PMID:11995405 OVID-Medline.

Exclude: Not an eligible study design

Salkovskis PM, Atha C, Storer D. Cognitive-behavioural problem solving in the treatment of patients who repeatedly attempt suicide. A controlled trial. *Br J Psychiatr*. 1990;157:871-6. OVID-Embase.

Exclude: Not an eligible population treatment

Sallis JF. Anxiety and depression management for the elderly. *Int J Behav Geriatr*. 1983;1(4):3-12. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Salmaggi P, Bressa GM, Nicchia G, et al. Double-blind, placebo-controlled study of S-adenosyl-L-methionine in depressed postmenopausal women. *Psychother Psychosom*. 1993;59(1):34-40. PMID:8441793 OVID-Medline.

Exclude: Not an eligible population treatment

Salminen JK, Karlsson H, Hietala J, et al. Short-term psychodynamic psychotherapy and fluoxetine in major depressive disorder: A randomized comparative study. *Psychother Psychosom*. 2008;77(6):351-7. PMID:18701831 OVID-Medline.

Sanacora G, Berman RM, Cappiello A, et al. Addition of the alpha2-antagonist yohimbine to fluoxetine: Effects on rate of antidepressant response. *Neuropsychopharmacol*. 2004;29(6):1166-71. PMID:15010697 OVID-Medline.

Exclude: Not an eligible population treatment

Sanacora G, Kendell SF, Levin Y, et al. Preliminary evidence of riluzole efficacy in antidepressant-treated patients with residual depressive symptoms. *Biol Psychiatr*. 2007;61(6):822-5. PMID:17141740 OVID-Medline.

Exclude: Not an eligible study design

Sanchez VC, Lewinsohn PM, Larson DW. Assertion training: Effectiveness in the treatment of depression. *J Clin Psychol*. 1980;36(2):526-9. PMID:7372826

Exclude: Not an eligible population treatment

Sanders MR, McFarland M. Treatment of depressed mothers with disruptive children: A controlled evaluation of cognitive behavioral family intervention. *Behav Ther*. 2000;31(1):89-112. OVID-Embase.

Exclude: Not an eligible population treatment

Sanford M, Boyle M, McCleary L, et al. A pilot study of adjunctive family psychoeducation in adolescent major depression: Feasibility and treatment effect. *J Am Acad Child Adolesc Psychiatry*. 2006;45(4):386-495. PMID:16601642 OVID-Medline.

Exclude: Not an eligible population treatment

Sanger MD. The treatment of anxiety and depression in the allergic patient. *Ann Allergy*. 1969;27(10):506-10. Wiley-CCTR.

Exclude: Not an eligible study design

Santor DA, Kusumakar V. Open trial of interpersonal therapy in adolescents with moderate to severe major depression: Effectiveness of novice IPT therapists. *J Am Acad Child Adolesc Psychiatry*. 2001;40(2):236-40. OVID-Embase.

Exclude: Not an eligible study design

Santos MA, Rocha FL, Hara C. Efficacy and safety of antidepressant augmentation with lamotrigine in patients with treatment-resistant depression: A randomized, placebo-controlled, double-blind study. *Prim Care Comp J Clin Psychiatr*. 2008;10(3):187-90. OVID-Embase.

Exclude: Not an eligible population treatment

Saran AS. Depression after minor closed head injury: Role of dexamethasone suppression test and antidepressants. *J Clin Psychiatry*. 1985;46(8):335-8. PMID:4019422 OVID-Medline.

Exclude: Not an eligible study design

Sarris J. Herbal medicines in the treatment of psychiatric disorders: A systematic review. *Phytother Res*. 2007;21(8):703-16. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Sarris J, Kavanagh DJ, Deed G, et al. St. John's wort and Kava in treating major depressive disorder with comorbid anxiety: A randomised double-blind placebo-controlled pilot trial. *Hum Psychopharmacol*. 2009;24(1):41-8. PMID:19090505 OVID-Medline.

Exclude: Not an eligible population treatment

Sarris J, Kavanagh DJ, Byrne G, et al. The Kava Anxiety Depression Spectrum Study (KADSS): A randomized, placebo-controlled crossover trial using an aqueous extract of Piper methysticum. *Psychopharmacol.* 2009;205(3):399-407. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Sarris J, Kavanagh DJ. Kava and St. John's Wort: Current evidence for use in mood and anxiety disorders. *J Altern Complement Med.* 2009;15(8):827-36. EBSCO-CINAHL. Excluded - Systematic review - relevant topic, citations cross-matched

Sarris J, Schoendorfer N, Kavanagh DJ. Major depressive disorder and nutritional medicine: A review of monotherapies and adjuvant treatments. *Nutr Rev.* 2009;67(3):125-31. EBSCO-CINAHL. Excluded - Systematic review - relevant topic, citations cross-matched

Sarris J, Kavanagh DJ, Byrne G. Adjuvant use of nutritional and herbal medicines with antidepressants, mood stabilizers and benzodiazepines. *J Psychiatr Res.* 2010;44(1):32-41. PMID:19616220 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Sato Y, Yasui-Furukori N, Nakagami T, et al. Augmentation of antidepressants with perospirone for treatment-resistant major depressive disorder. *Prog Neuropsychopharmacol Biol Psychiatry.* 2009;33(3):416-8. PMID:19166896 OVID-Medline. Exclude: Not an eligible study design

Satterfield JM. Cognitive behavioral group therapy for depressed, low-income minority clients: Retention and treatment enhancement. *Cognit Behav Pract.* 1998;5(1):65-80. OVID-PsycINFO. Exclude: Not an eligible study design

Sava FA, Yates BT, Lupu V, et al. Cost-effectiveness and cost-utility of cognitive therapy, rational emotive behavioral therapy, and fluoxetine (Prozac) in treating depression: A randomized clinical trial. *J Clin Psychiatry.* 2009;65(1):36-52. PMID:19051275 OVID-Medline. Exclude: Not an eligible population treatment

Savard J, Laberge B, Gauthier JG, et al. Combination of fluoxetine and cognitive therapy for the treatment of major depression among people with HIV infection: A time-series analysis investigation. *Cognit Ther Res.* 1998;22(1):21-46. OVID-Embase. Exclude: Not an eligible population treatment

Savard J, Simard S, Giguere I, et al. Randomized clinical trial on cognitive therapy for depression in women with metastatic breast cancer: Psychological and immunological effects. *Palliat Support Care.* 2006;4(3):219-37. PMID:17066964 OVID-Medline. Exclude: Not an eligible population treatment

Sawka AM, Gerstein HC, Marriott MJ, et al. Does a combination regimen of thyroxine (T4) and 3,5,3'-triiodothyronine improve depressive symptoms better than T4 alone in patients with hypothyroidism? Results of a double-blind, randomized, controlled trial. *J Clin Endocrinol Metab.* 2003;88(10):4551-5. PMID:14557420 OVID-Medline. Exclude: Not an eligible population design

Saxby E, Peniston EG. Alpha-theta brainwave neurofeedback training: An effective treatment for male and female alcoholics with depressive symptoms. *J Clin Psychiatry.* 1995;51(5):685-93. OVID-Embase. Exclude: Not an eligible study design

Sayyah M, Sayyah M, Kamalinejad M. A preliminary randomized double blind clinical trial on the efficacy of aqueous extract of *Echium amoenum* in the treatment of mild to moderate major depression. *Prog Neuropsychopharmacol Biol Psychiatry.* 2006;30(1):166-9. PMID:16309809 OVID-Medline. Exclude: Not an eligible population treatment

Sayyah M, Boostani H, Pakseresht S, et al. Efficacy of hydroalcoholic extract of *Rheum ribes* L. in treatment of major depressive disorder. *J Medicinal Plant Res.* 2009;3(8):573-5. OVID-Embase. Exclude: Not an eligible population treatment

Schaeffer P, Poirier F M, Boyer P. Double-blind trial of venlafaxine and paroxetine for treatment-resistant depression. In 11th European College of Neuropsychopharmacology Congress. Paris, France. 31st October 4th November. 1998. Wiley-CCTR. Exclude: Not an eligible study design

Schatzberg AF, Rush AJ, Arnow BA, et al. Chronic depression: Medication (nefazodone) or psychotherapy (CBASP) is effective when the other is not. *Arch Gen Psychiatr.* 2005;62(5):513-20. PMID:15867104 OVID-Medline. Exclude: Not an eligible population treatment

Schene AH, Koeter MW, Kikkert MJ, et al. Adjuvant occupational therapy for work-related major depression works: Randomized trial including economic evaluation. *Psychol Med.* 2007;37(3):351-62. PMID:17112401 OVID-Medline. Exclude: Not an eligible population treatment

Schening, L.J. Refractory depression treatment options: A meta-analysis 2004. OVID-PsycINFO.
Exclude: Not an eligible study design

Schiffer F, Johnston AL, Ravichandran C, et al. Psychological benefits 2 and 4 weeks after a single treatment with near infrared light to the forehead: A pilot study of 10 patients with major depression and anxiety. *Behav Brain Func.* 2009;5:46. OVID-PsycINFO.
Exclude: Not an eligible study design

Schiffer RB, Wineman NM. Antidepressant pharmacotherapy of depression associated with multiple sclerosis. *Am J Psychiatry.* 1990;147(11):1493-7. PMID:2221162 OVID-Medline.
Exclude: Not an eligible population treatment

Schimmel-Spreuw A, Linssen AC, Heeren TJ. Coping with depression and anxiety: Preliminary results of a standardized course for elderly depressed women. *Int Psychogeriatr.* 2000;12(1):77-86. PMID:10798455 OVID-Medline.
Exclude: Not an eligible study design

Schindler F, Anghelescu IG. Lithium versus lamotrigine augmentation in treatment resistant unipolar depression: A randomized, open-label study. *Int Clin Psychopharmacol.* 2007;22(3):179-82. PMID:17414745 OVID-Medline.
Exclude: Mixed antidepressants: some failed on SSRI

Schloedt K, Varley CK. Current perspectives on the diagnosis and treatment of adolescent depression in the primary care setting. *JCOM.* 2005;12(5):260-74. OVID-Embase.
Exclude: Not an eligible study design

Schmauss M, Laakmann G, Dieterle D. Nomifensine: A double-blind comparison of intravenous versus oral administration in therapy - Resistant depressed patients. *Pharmacopsychiatr.* 1985;18(1):88-90. OVID-Embase

OVID-Embase.
Exclude: Not an eligible population treatment

Schmauss M, Laakmann G, Dieterle D. Yohimbine in combination with tricyclic antidepressants in the treatment of therapy-resistant depressed patients. *Pharmacopsychiatr.* 1986;19(4):264-5. OVID-Embase

OVID-Embase.
Exclude: Not an eligible study design

Schmauss M, Kapfhammer HP, Meyr P, et al. Combined MAO-inhibitor and tri- (tetra) cyclic antidepressant treatment in therapy resistant depression. *Prog Neuropsychopharmacol Biol Psychiatry.* 1988;12(4):523-32. PMID:3406429 OVID-Medline.
Exclude: Not an eligible study design

Schmauss M, Laakmann G, Dieterle D. Effects of alpha 2-receptor blockade in addition to tricyclic antidepressants in therapy-resistant depression. *J Clin Psychopharmacol.* 1988;8(2):108-11. PMID:3372705 OVID-Medline.
Exclude: Not an eligible study design

Schmidt MM, Miller WR. Amount of therapist contact and outcome in a multidimensional depression treatment program. *Acta Psychiatr Scand.* 1983;67(5):319-32. OVID-Embase

OVID-Embase.
Exclude: Not an eligible population treatment

Schmitt L, Tonnoir B, Arbus C. Safety and efficacy of oral escitalopram as continuation treatment of intravenous citalopram in patients with major depressive disorder. *Neuropsychobiol.* 2006;54(4):201-7. PMID:17337913 OVID-Medline.
Exclude: Not an eligible study design

Schmitz JM, Averill P, Stotts AL, et al. Fluoxetine treatment of cocaine-dependent patients with major depressive disorder. *Drug Alcohol Dependence.* 2001;63(3):207-14. PMID:11418225 OVID-Medline.
Exclude: Not an eligible population treatment

Schmitz JP. Focus of attention in the treatment of depression. *Psychother.* 1983;20(4):457-63. OVID-Embase

OVID-Embase.
Exclude: Not an eligible study design

Schneider CM, Hsieh CC, Sprod LK, et al. Cancer treatment-induced alterations in muscular fitness and quality of life: The role of exercise training. *Ann Oncol.* 2007;18(12):1957-62. PMID:17804476 OVID-Medline.
Exclude: Not an eligible study design

Schneider LS, Small GW, Clary CM. Estrogen replacement therapy and antidepressant response to sertraline in older depressed women. *Am J Geriatr Psychiatry.* 2001;9(4):393-9. PMID:11739065 OVID-Medline.
Exclude: Not an eligible population treatment

Schneider LS, Martinez RA, Lebowitz BD. Clinical psychopharmacology research in geriatrics: An agenda for research. *Int J Geriatr Psychiatry*. 1993;8(1):89-93. OVID-PsycINFO.

Exclude: Not an eligible guideline

Schneider LS, Small GW, Hamilton SH, et al. Estrogen replacement and response to fluoxetine in a multicenter geriatric depression trial. *Am J Geriatr Psychiatry*. 1997;5(2):97-106. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Schoenbaum M, Miranda J, Sherbourne C, et al. Cost-effectiveness of interventions for depressed Latinos. *J Ment Health Policy Econom*. 2004;7(2):69-76. OVID-Embase.

Exclude: Not an eligible population treatment

Scholz U, Knoll N, Sniehotta FF, et al. Physical activity and depressive symptoms in cardiac rehabilitation: Long-term effects of a self-management intervention. *Soc Sci Med*. 2006;62(12):3109-20. PMID:16388882 OVID-Medline.

Exclude: Not an eligible population treatment

Schopf J, Baumann P, Lemarchand T, et al. Treatment of endogenous depressions resistant to tricyclic antidepressants or related drugs by lithium addition. Results of a placebo-controlled double-blind study. *Pharmacopsychiatr*. 1989;22(5):183-7. PMID:2682692 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Schou M. Lithium treatment: A refresher course. *Br J Psychiatry*. 1986;149(NOV.):541-7. OVID-Embase.

OVID-Embase.

Exclude: Not an eligible guideline

Schrader E, Meier B, Brattstrom A. Hypericum treatment of mild-moderate depression in a placebo-controlled study. A prospective, double-blind, randomized, placebo-controlled, multicentre study. *Hum Psychopharmacol*. 1998;13(3):163-9. OVID-Embase.

Exclude: Not an eligible population treatment

Schrader E. Equivalence of St John's wort extract (Ze 117) and fluoxetine: A randomized, controlled study in mild-moderate depression. *Int Clin Psychopharmacol*. 2000;15(2):61-8. PMID:10759336 OVID-Medline.

Exclude: Not an eligible population treatment

Schramm E, van Calker D, Dykieriek P, et al. An intensive treatment program of interpersonal psychotherapy plus pharmacotherapy for depressed inpatients: Acute and long-term results. *Am J Psychiatry*. 2007;164(5):768-77. PMID:17475736 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Schramm E, Schneider D, Zobel I, et al. Efficacy of Interpersonal Psychotherapy plus pharmacotherapy in chronically depressed inpatients. *J Affect Disord*. 2008;109(1-2):65-73. PMID:18067973 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Schramm E, Zobel I, Dykieriek P, et al. Cognitive behavioral analysis system of psychotherapy versus interpersonal psychotherapy for early-onset chronic depression: A randomized pilot study. *J Affect Disord*. 2011;129(1-3):109-16. OVID-Embase.

Exclude: Not an eligible population/treatment

Schroer S, MacPherson H. Acupuncture, or non-directive counselling versus usual care for the treatment of depression: A pilot study. *Trials*. 2009;10:3. PMID:19134170 OVID-Medline.

Exclude: Not an eligible study design

Schulberg HC, Katon W, Simon GE, et al. Treating major depression in primary care practice: An update of the agency for health care policy and research practice guidelines. *Arch Gen Psychiatry*. 1998;55(12):1121-7. OVID-Embase.

Exclude: Not an eligible guideline

Schulberg HC, Post EP, Raue PJ, et al. Treating late-life depression with interpersonal psychotherapy in the primary care sector. *Int J Geriatr Psychiatry*. 2007;22(2):106-14. PMID:17096458 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Schule C, Baghai TC, Eser D, et al. Mirtazapine monotherapy versus combination therapy with mirtazapine and aripiprazole in depressed patients without psychotic features: A 4-week open-label parallel-group study. *World J Biol Psychiatry*. 2007;8(2):112-22. PMID:17455104 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Schule C, Baghai TC, Eser D, et al. Lithium but not carbamazepine augments antidepressant efficacy of mirtazapine in unipolar depression: An open-label study. *World J Biol Psychiatry*. 2009;10(4:Pt 2):390-9. PMID:18609420 OVID-Medline.

Exclude: Not an eligible population treatment

Schultz,C.L. The effect of cognitive group therapy in the treatment of depression among residents of senior communities 1996. OVID-PsycINFO.
Exclude: Not an eligible study design

Schwartz TL, Azhar N, Cole K, et al. An open-label study of adjunctive modafinil in patients with sedation related to serotonergic antidepressant therapy. *J Clin Psychiatry*. 2004;65(9):1223-7. PMID:15367049 OVID-Medline.
Exclude: Not an eligible study design

Schwartz TL, Nasra GS, Chilton M, et al. Aripiprazole augmentation of selective serotonin or serotonin norepinephrine reuptake inhibitors in the treatment of major depressive disorder. *Prim Psychiatr*. 2007;14(1):67-9. OVID-Embase.
Exclude: Not an eligible study design

Schweitzer I, Burrows G, Tuckwell V, et al. Sustained response to open-label venlafaxine in drug-resistant major depression. *J Clin Psychopharmacol*. 2001;21(2):185-9. PMID:11270915 OVID-Medline.
Exclude: Not an eligible study design

Schweizer E, Rickels K, Amsterdam JD, et al. What constitutes an adequate antidepressant trial for fluoxetine? *J Clin Psychiatry*. 1990;51(1):8-11. PMID:2403998 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Schweizer E, Rynn M, Mandos LA, et al. The antidepressant effect of sertraline is not enhanced by dose titration: Results from an outpatient clinical trial. *Int Clin Psychopharmacol*. 2001;16(3):137-43. PMID:11354235 OVID-Medline.
Exclude: Not an eligible population treatment

Scogin F, Jamison C, Gochneaur K. Comparative efficacy of cognitive and behavioral bibliotherapy for mildly and moderately depressed older adults. *J Consult Clin Psychol*. 1989;57(3):403-7. PMID:2738212 OVID-Medline.
Exclude: Not an eligible population treatment

Scogin F, Jamison C, Davis N. Two-year follow-up of bibliotherapy for depression in older adults. *J Consult Clin Psychol*. 1990;58(5):665-7. PMID:2254516 OVID-Medline.
Exclude: Not an eligible study design

Scogin F, Welsh D, Hanson A, et al. Evidence-based psychotherapies for depression in older adults. *Clin Psychol Sci Pract*. 2005;12(3):222-37. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Scogin F, Hamblin D, Beutler L. Bibliotherapy for depressed older adults: A self-help alternative. *Gerontologist*. 1987;27(3):383-7. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Scott AI, Freeman CP. Edinburgh primary care depression study: treatment outcome, patient satisfaction, and cost after 16 weeks. *Br Med J*. 1992;304(6831):883-7. PMID:1392754 OVID-Medline.
Exclude: Not an eligible population treatment

Scott C, Tacchi MJ, Jones R, et al. Acute and one-year outcome of a randomised controlled trial of brief cognitive therapy for major depressive disorder in primary care. *Br J Psychiatr*. 1997;171:131-4. PMID:9337947 OVID-Medline.
Exclude: Not an eligible population treatment

Scott CS, Scott JL, Tacchi MJ, et al. Abbreviated cognitive therapy for depression: A pilot study in primary care. *Behav Psychother*. 1994;22(1):57-64. OVID-Embase.
Exclude: Not an eligible study design

Scott J. Chronic depression: Can cognitive therapy succeed when other treatments fail? *Behav Psychother*. 1992;20(1):25-36. OVID-Embase.
Exclude: Not an eligible population treatment

Scott J, Moon CA, Blacker CV, et al. A. I. F. Scott & C. P. L. Freeman's "Edinburgh Primary Care Depression Study. *Br J Psychiatr*. 1994;164(3):410-5. PMID:8199795 OVID-Medline.
Exclude: Not an eligible study design

Scott J, Teasdale JD, Paykel ES, et al. Effects of cognitive therapy on psychological symptoms and social functioning in residual depression. *Br J Psychiatr*. 2000;177:440-6. PMID:11059998 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Scott J, Palmer S, Paykel E, et al. Use of cognitive therapy for relapse prevention in chronic depression. Cost-effectiveness study. *Br J Psychiatr*. 2003;182:221-7. PMID:12611785 OVID-Medline.
Exclude: Not an eligible population treatment

Scott MJ, Stradling SG. Group cognitive therapy for depression produces clinically significant reliable change in community-based settings. *Behav Psychother*. 1990;18(1):1-19. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Scott,T.M. Treating adult depression in rural areas through videoconferencing 2009. OVID-PsycINFO.
Exclude: Not an eligible study design

Segal ZV, Whitney DK, Lam RW, et al. Clinical guidelines for the treatment of depressive disorders. III. Psychotherapy. *Can J Psychiatr.* 2001;46(Suppl 1):29S-37S. PMID:11441770 OVID-Medline.
Exclude: Not an eligible guideline

Segal ZV, Kennedy SH, Cohen NL, et al. Clinical guidelines for the treatment of depressive disorders. V. Combining psychotherapy and pharmacotherapy. *Can J Psychiatr.* 2001;46(Suppl 1):59S-62S. PMID:11441772 OVID-Medline.
Exclude: Not an eligible guideline

Segal ZV, Bieling P, Young T, et al. Antidepressant monotherapy vs sequential pharmacotherapy and mindfulness-based cognitive therapy, or placebo, for relapse prophylaxis in recurrent depression. *Arch Gen Psychiatr.* 2010;67(12):1256-64. PMID:21135325 OVID-Medline.
Exclude: Not an eligible population treatment

Segar ML, Katch VL, Roth RS, et al. The effect of aerobic exercise on self-esteem and depressive and anxiety symptoms among breast cancer survivors. *Oncol Nurs Forum.* 1998;25(1):107-13. EBSCO-CINAHL.
Exclude: Not an eligible population treatment

Segui J, Lopez-Munoz F, Alamo C, et al. Effects of adjunctive reboxetine in patients with duloxetine-resistant depression: A 12-week prospective study. *J Psychopharmacol.* 2010;24(8):1201-7. PMID:19282423 OVID-Medline.
Exclude: Not an eligible study design

Seidman SN, Rabkin JG. Testosterone replacement therapy for hypogonadal men with SSRI-refractory depression. *J Affect Disord.* 1998;48(2-3):157-61. PMID:9543205 OVID-Medline.
Exclude: Not an eligible study design

Seligman ME, Schulman P, Tryon AM. Group prevention of depression and anxiety symptoms. *Behav Res Ther.* 2007;45(6):1111-26. PMID:17074301 OVID-Medline.
Exclude: Not an eligible population treatment

Selmi PM, Klein MH, Greist JH, et al. Computer-administered cognitive-behavioral therapy for depression. *Am J Psychiatry.* 1990;147(1):51-6. PMID:2403473 OVID-Medline.
Exclude: Not an eligible population treatment

Selmi PM, Klein MH, Greist JH, et al. Computer-administered therapy for depression. *MD Comput.* 1991;8(2):98-102. PMID:2038242 OVID-Medline.
Exclude: Not an eligible population treatment

Semla TP, Watanabe MD. ASHP therapeutic position statement on the recognition and treatment of depression in older adults. *Am J Health Syst Pharm.* 1998;55(23):2514-8. OVID-Embase.
Exclude: Not an eligible guideline

Sengoku M, Murata H, Kawahara T, et al. Does daily Naikan therapy maintain the efficacy of intensive Naikan therapy against depression? *Psychiatry Clin Neurosci.* 2010;64(1):44-51. PMID:20416025 OVID-Medline.
Exclude: Not an eligible population treatment

Seo HJ, Jung YE, Woo YS, et al. Effect of augmented atypical antipsychotics on weight change in patients with major depressive disorder in a naturalistic setting. *Hum Psychopharmacol.* 2009;24(2):135-43. PMID:19156709 OVID-Medline.
Exclude: Not an eligible population treatment

Sephton SE, Salmon P, Weissbecker I, et al. Mindfulness meditation alleviates depressive symptoms in women with fibromyalgia: Results of a randomized clinical trial. *Arthritis Rheum.* 2007;57(1):77-85. EBSCO-CINAHL.
Exclude: Not an eligible population treatment

Seppälä T, Linnoila M, Mattila MJ. Psychomotor skills in depressed out-patients treated with L-tryptophan, doxepin, or chlorimipramine. *Ann Clin Res.* 1978;10(4):214-21. Wiley-CCTR.
Exclude: Not an eligible population treatment

Serfaty MA, Haworth D, Blanchard M, et al. Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care: A randomized controlled trial. *Arch Gen Psychiatr.* 2009;66(12):1332-40. PMID:19996038 OVID-Medline.
Exclude: Not an eligible population treatment

Serfaty MA, Osborne D, Buszewicz MJ, et al. A randomized double-blind placebo-controlled trial of treatment as usual plus exogenous slow-release melatonin (6MG) or placebo for sleep disturbance and depressed mood. *Int Clin Psychopharmacol.* 2010;25(3):132-42. OVID-Embase.
Exclude: Not an eligible population treatment

Serre C, Clerc G, Escande M. An early clinical trial of midalcipran, 1-phenyl-1-diethyl aminocarbonyl 2-aminomethyl cyclopropane (Z) hydrochloride, a potential fourth generation antidepressant. *Curr Ther Res Clin Exp.* 1986;39(1):156-64. OVID-Embase.

OVID-Embase.
Exclude: Not an eligible study design

Serretti A, Calati R, Massat I, et al. Cytochrome p450 cyp1a2, cyp2c9, cyp2c19 and cyp2d6 genes are not associated with response and remission in a sample of depressive patients. *Int Clin Psychopharmacol.* 2009;24(5):250-6. PMID:19593158 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Serretti A, Chiesa A, Calati R, et al. A preliminary investigation of the influence of CREB1 gene on treatment resistance in major depression. *J Affect Disord.* 2011;128(1-2):56-63. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Seth R, Jennings AL, Bindman J, et al. Combination treatment with noradrenalin and serotonin reuptake inhibitors in resistant depression. *Br J Psychiatr.* 1992;161:562-5. PMID:1327396 OVID-Medline.

Exclude: Not an eligible study design

Sethi S, Campbell AJ, Ellis LA. The use of computerized self-help packages to treat adolescent depression and anxiety. *J Technol Human Serv.* 2010;28(3):144-60. OVID-PsycINFO.

Exclude: Not an eligible population/treatment

Sevar R. Audit of outcome in 455 consecutive patients treated with homeopathic medicines. *Homeopath.* 2005;94(4):215-21. OVID-Embase.

Exclude: Not an eligible study design

Shah IS, Yatham LN, Srisurapanont M, et al. Does the addition of pindolol accelerate the response to electroconvulsive therapy in patients with major depression? A double-blind, placebo-controlled pilot study. *J Clin Psychopharmacol.* 2000;20(3):373-8. PMID:10831027 OVID-Medline.

Excluded

Shahal B, Piel E, Mecz L, et al. Lack of advantage for imipramine combined with lithium versus imipramine alone in the treatment of major depression--a double-blind controlled study. *Biol Psychiatr.* 1996;40(11):1181-3. Wiley-CCTR.

Exclude: Not an eligible population treatment

Shahar B, Britton WB, Sbarra DA, et al. Mechanisms of change in mindfulness-based cognitive therapy for depression: Preliminary evidence from a randomized controlled trial. *Int J Cognit Ther.* 2010;3(4):402-18. OVID-PsycINFO.

Exclude: Mixed antidepressants; some failed on SSRI

Shahidi M, Mojtahed A, Modabbernia A, et al. Laughter yoga versus group exercise program in elderly depressed women: A randomized controlled trial. *Int J Geriatr Psychiatry.* 2011;26(3):322-7. OVID-Embase.

Exclude: Not an eligible population/treatment

Shamsaei F, Rahimi A, Zarabian MK, et al. Efficacy of pharmacotherapy and cognitive therapy, alone and in combination in major depressive disorder. *Hong Kong J Psychiatry.* 2008;18(2):76-80. OVID-Embase.

Exclude: Not an eligible population treatment

Shapira B, Kindler S, Lerer B. Medication outcome in ECT-resistant depression. *Convuls Ther.* 1988;4(3):192-8. OVID-Embase.

Exclude: Not an eligible study design

Shapira B. Lack of efficacy of estrogen supplementation to imipramine in resistant female depressives. *Biol Psychiatr.* 1985;20(5):576-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Shapiro D, Cook IA, Davydov DM, et al. Yoga as a complementary treatment of depression: Effects of traits and moods on treatment outcome. *Evid Based Compl Altern Med.* 2007;4(4):493-502. OVID-Embase.

Exclude: Not an eligible study design

Shapiro DA, Barkham M, Rees A, et al. Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *J Consult Clin Psychol.* 1994;62(3):522-34. PMID:8063978 OVID-Medline.

Exclude: Not an eligible population treatment

Shapiro DA, Rees A, Barkham M, et al. Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *J Consult Clin Psychol.* 1995;63(3):378-87. PMID:7608350 OVID-Medline.

Excluded

Shapiro DA, Firth J. Prescriptive v. exploratory psychotherapy: Outcomes of the Sheffield Psychotherapy Project. *Br J Psychiatr.* 1987;151:790-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Shapiro J, Sank LI, Shaffer CS, et al. Cost effectiveness of individual vs. group cognitive behavior therapy for problems of depression and anxiety in an HMO population. *J Clin Psychiatry.* 1982;38(3):674-7. OVID-Embase.

OVID-Embase.

Exclude: Not an eligible population treatment

Sharma V, Persad E, Kueneman K, et al. Lithium augmentation of valproic acid in treatment resistant depression. *Lithium*. 1994;5(2):99-103. OVID-Embase.

Exclude: Not an eligible study design

Sharpe L, Sensky T, Timberlake N, et al. A blind, randomized, controlled trial of cognitive-behavioural intervention for patients with recent onset rheumatoid arthritis: Preventing psychological and physical morbidity. *Pain*. 2001;89(2-3):275-83. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Sharpe M, Strong V, Allen K, et al. Management of major depression in outpatients attending a cancer centre: A preliminary evaluation of a multicomponent cancer nurse-delivered intervention. *Br J Cancer*. 2004;90(2):310-3. OVID-Embase.

Exclude: Not an eligible population treatment

Sharpley AL, Attenburrow ME, Hafizi S, et al. Olanzapine increases slow wave sleep and sleep continuity in SSRI-resistant depressed patients. *J Clin Psychiatry*. 2005;66(4):450-4. PMID:15816787 OVID-Medline.

Exclude: Not an eligible study design

Shaw DM. L-tryptophan in depression. *Lancet*. 1970;1(7656):1111 Wiley-CCTR.

Exclude: Not an eligible study design

Shaw DM, Johnson AL, MacSweeney DA. Tricyclic antidepressants and tryptophan in unipolar affective disorder. *Lancet*. 1972;2(7789):1245 Wiley-CCTR.

Exclude: Not an eligible study design

Shea MT, Elkin I, Imber SD, et al. Course of depressive symptoms over follow-up. Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Arch Gen Psychiatr*. 1992;49(10):782-7. PMID:1417430 OVID-Medline.

Exclude: Not an eligible population treatment

Sheffield JK, Spence SH, Rapee RM, et al. Evaluation of universal, indicated, and combined cognitive-behavioral approaches to the prevention of depression among adolescents. *J Consult Clin Psychol*. 2006;74(1):66-79. PMID:16551144 OVID-Medline.

Exclude: Not an eligible population treatment

Sheffrin M, Driscoll HC, Lenze EJ, et al. Pilot study of augmentation with aripiprazole for incomplete response in late-life depression: Getting to remission. *J Clin Psychiatry*. 2009;70(2):208-13. PMID:19210951 OVID-Medline.

Exclude: Not an eligible study design

Shelton RC, Loosen PT. Sleep deprivation accelerates the response to nortriptyline. *Prog Neuropsychopharmacol Biol Psychiatry*.

1993;17(1):113-23. PMID:8416598 OVID-Medline.

Exclude: Not an eligible study design

Shelton RC, Tohen M, Stahl S, et al. The study of olanzapine plus fluoxetine in treatment-resistant major depressive disorder without psychotic features. *Schizophr Res*. 2000;Number 1 - Special Issue: Wiley-CCTR.

Exclude: Not an eligible study design

Shelton RC, Keller MB, Gelenberg A, et al. Effectiveness of St John's wort in major depression: A randomized controlled trial. *JAMA*. 2001;285(15):1978-86. PMID:11308434 OVID-Medline.

Exclude: Not an eligible population treatment

Shelton RC, Addington S, Thakkar V. Risperidone vs. Bupropion Combined with SSRIs in Treatment Resistant Unipolar Major Depression. *Neuropsychopharmacol*. 2005;30 Suppl 1:S238 Wiley-CCTR.

Exclude: Not an eligible study design

Shelton RC, Papakostas GI. Augmentation of antidepressants with atypical antipsychotics for treatment-resistant major depressive disorder. *Acta Psychiatr Scand*. 2008;117(4):253-9. PMID:18190674 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Shelton RC. Symbyax-« (olanzapine and fluoxetine HCl) for the acute treatment of treatment-resistant depression. *Psychiatr Times*. 2009;20-7. EBSCO-CINAHL.

Exclude: Mixed antidepressants:some failed on SSRI

Shelton RC, Hollon SD, Wisniewski SR, et al. Factors associated with concomitant psychotropic drug use in the treatment of major depression: A STAR*D Report. *CNS Spectrums*. 2009;14(9):487-98. PMID:19890231 OVID-Medline.

Exclude: Not an eligible population treatment

Sher TG, Baucom DH, Larus JM. Communication patterns and response to treatment among depressed and nondepressed maritally distressed couples. *J Fam Psychol*. 1990;4(1):63-79. OVID-PsycINFO.

Exclude: Not an eligible study design

Sherbourne CD, Edelen MO, Zhou A, et al. How a therapy-based quality improvement intervention for depression affected life events and psychological well-being over time: A 9-year longitudinal analysis. *Med Care*. 2008;46(1):78-84. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Shergill SS, Robertson MM, Stein G, et al. Outcome in refractory depression. *J Affect Disord*. 1999;54(3):287-94. PMID:10467973 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Sherm DL, Moran H. STAR*D: Helping to close the gap between science and practice. *Psychiatr Serv*. 2009;60(11):1458-9. PMID:19880460 OVID-Medline.

Exclude: Not an eligible population treatment

Shih M, Yang Y, Koo M. A meta-analysis of hypnosis in the treatment of depressive symptoms: A brief communication. *Int J Clin Exp Hypnosis*. 2009;57(4):431-42. EBSCO-CINAHL.

Excluded - Systematic review - relevant topic, citations cross-matched

Shin KR, Kang Y, Park HJ, et al. Effects of exercise program on physical fitness, depression, and self-efficacy of low-income elderly women in South Korea. *Pub Health Nurs*. 2009;. 26(6):523-31. OVID-Embase.

Exclude: Not an eligible population treatment

Shippy RA, Mendez D, Jones K, et al. S-adenosylmethionine (SAM-e) for the treatment of depression in people living with HIV/AIDS. *BMC Psychiatr*. 2004;4:38. PMID:15538952 OVID-Medline.

Exclude: Not an eligible study design

Shirk SR, Kaplinski H, Gudmundsen G. School-based cognitive-behavioral therapy for adolescent depression: A benchmarking study. *J Emotion Behav Disord*. 2009;17(2):106-17. EBSCO-CINAHL.

Exclude: Not an eligible study design

Shore AG. Long-term effects of energetic healing on symptoms of psychological depression and self-perceived stress. *Altern Ther Health Med*. 2004;10(3):42-8. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Siepmann M, Aykac V, Unterdorfer J, et al. A pilot study on the effects of heart rate variability biofeedback in patients with depression and in healthy subjects. *Appl Psychophysiol Biofeedback*. 2008;33(4):195-201. PMID:18807175 OVID-Medline.

Exclude: Not an eligible population treatment

Silvers KM, Woolley CC, Hamilton FC, et al. Randomised double-blind placebo-controlled trial of fish oil in the treatment of depression. *Prostaglandins Leukotrienes & Essential Fatty Acids*. 2005;72(3):211-8. PMID:15664306 OVID-Medline.

Exclude: Not an eligible population treatment

Simeon J, Milin R, Walker S. A retrospective chart review of risperidone use in treatment-resistant children and adolescents with psychiatric disorders. *Prog Neuropsychopharmacol Biol Psychiatry*. 2002;26(2):267-75. OVID-Embase.

Exclude: Not an eligible study design

Simeon J, Nixon MK, Milin R, et al. Open-label pilot study of St. John's wort in adolescent depression. *J Child Adolesc Psychopharmacol*. 2005;15(2):293-301. PMID:15910213 OVID-Medline.

Exclude: Not an eligible study design

Simko A. Guidelines for the use of psychopharmaca in geriatric cases. *Ther Hung*. 1989;37(4):187-98. OVID-Embase.

Exclude: Not an eligible guideline

Simon GE, Lin EHB, Katon W, et al. Outcomes of 'inadequate' antidepressant treatment. *J Gen Intern Med*. 1995;10(12):663-70. OVID-Embase.

Exclude: Not an eligible population treatment

Simon GE, Revicki D, Heiligenstein J, et al. Recovery from depression, work productivity, and health care costs among primary care patients. *Gen Hosp Psychiatry*. 2000;22(3):153-62. OVID-Embase.

Exclude: Not an eligible population treatment

Simon GE, Manning WG, Katzelnick DJ, et al. Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. *Arch Gen Psychiatr*. 2001;58(2):181-7. OVID-Embase.

Exclude: Not an eligible study design

Simon GE, Ludman EJ, Tutty S, et al. Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: A randomized controlled trial. *JAMA*. 2004;292(8):935-42. PMID:15328325 OVID-Medline.

Exclude: Not an eligible population treatment

Simon GE, Von Korff M, Lin E. Clinical and functional outcomes of depression treatment in patients with and without chronic medical illness. *Psychol Med*. 2005;35(2):271-9. OVID-Embase.

Exclude: Not an eligible population treatment

Simon GE, Ludman EJ, Opersalski BH. Randomized trial of a telephone care management program for outpatients starting antidepressant treatment. *Psychiatr Serv*. 2006;57(10):1441-5. PMID:17035563 OVID-Medline.

Exclude: Not an eligible population treatment

Simon GE, Ludman EJ, Rutter CM. Incremental benefit and cost of telephone care management and telephone psychotherapy for depression in primary care. *Arch Gen Psychiatr*. 2009;66(10):1081-9. PMID:19805698 OVID-Medline.

Exclude: Not an eligible population treatment

Simon J, Pilling S, Burbeck R, et al. Treatment options in moderate and severe depression: Decision analysis supporting a clinical guideline. *Br J Psychiatr*. 2006;189:494-501. PMID:17139032 OVID-Medline.

Exclude: Not an eligible guideline

Simon JS, Nemeroff CB. Aripiprazole augmentation of antidepressants for the treatment of partially responding and nonresponding patients with major depressive disorder. *J Clin Psychiatry*. 2005;66(10):1216-20. PMID:16259533 OVID-Medline.

Exclude: Not an eligible study design

Simons AD, Garfield SL, Murphy GE. The process of change in cognitive therapy and pharmacotherapy for depression. Changes in mood and cognition. *Arch Gen Psychiatr*. 1984;41(1):45-51. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Simons AD, Murphy GE, Levine JL, et al. Cognitive therapy and pharmacotherapy for depression. Sustained improvement over one year. *Arch Gen Psychiatr*. 1986;43(1):43-8. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Simons AD, Padesky CA, Montemmarano J, et al. Training and dissemination of cognitive behavior therapy for depression in adults: A preliminary examination of therapist competence and client outcomes. *J Consult Clin Psychol*. 2010;78(5):751-6. PMID:20873911 OVID-Medline.

Exclude: Not an eligible population treatment

Simpson GM, Amin M, Angus JW, et al. Role of antidepressants and neuroleptics in the treatment of depression. *Arch Gen Psychiatr*. 1972;27(3):337-45. Wiley-CCTR.

Exclude: Not an eligible population treatment

Simpson S, Corney R, Beecham J. A randomized controlled trial to evaluate the effectiveness and cost-effectiveness of psychodynamic counselling for general practice patients with chronic depression. *Psychol Med*. 2003;33(2):229-39. OVID-Embase.

Exclude: Not an eligible population treatment

Simpson SW, Jackson A, Baldwin RC, et al. Subcortical hyperintensities in late-life depression: Acute response to treatment and neuropsychological impairment. *Int Psychogeriatr*. 1997;9(3):257-75. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Simpson S, Baldwin RC, Jackson A, et al. Is subcortical disease associated with a poor response to antidepressants? Neurological, neuropsychological and neuroradiological findings in late-life depression. *Psychol Med*. 1998;28(5):1015-26. OVID-PsycINFO.

Exclude: Not an eligible study design

Sims J, Hill K, Davidson S, et al. Exploring the feasibility of a community-based strength training program for older people with depressive symptoms and its impact on depressive symptoms. *BMC Geriatr*. 2006;6:18 PMID:17134517 OVID-Medline.

Exclude: Not an eligible population treatment

Sims J, Galea M, Taylor N, et al. Regenerate: Assessing the feasibility of a strength-training program to enhance the physical and mental health of chronic post stroke patients with depression. *Int J Geriatr Psychiatry*. 2009;24(1):76-83. PMID:18613281 OVID-Medline.

Exclude: Not an eligible population design

Sin NL, Lyubomirsky S. Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *J Clin Psychiatry*. 2009;65(5):467-87. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Sinclair JM, Walsh MR, Valle-Jones JC, et al. Treatment of anxiety/depressive conditions in the elderly: A double-blind comparative study of Motival and amitriptyline. *Age Ageing*. 1975;4(4):226-31. Wiley-CCTR.

Exclude: Not an eligible population treatment

Singer GH, Ethridge BL, Aldana SI. Primary and secondary effects of parenting and stress management interventions for parents of children with developmental disabilities: A meta-analysis. *Ment Retard Dev Disabil Res Rev*. 2007;13(4):357-69. PMID:17979202 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Singh NA, Clements KM, Fiatarone MA. A randomized controlled trial of progressive resistance training in depressed elders. *J Gerontol A Biol Sci Med Sci.* 1997;52(1):M27-M35 PMID:9008666 OVID-Medline.

Exclude: Not an eligible population treatment

Singh NA, Clements KM, Singh MAF. The efficacy of exercise as a long-term antidepressant in elderly subjects: A randomized, controlled trial. *J Gerontol A Biol Sci Med Sci.* 2001;56(8):M497-M504 OVID-Embase.

Exclude: Not an eligible population treatment

Singh NA, Stavrinou TM, Scarbek Y, et al. A randomized controlled trial of high versus low intensity weight training versus general practitioner care for clinical depression in older adults. *J Gerontol A Biol Sci Med Sci.* 2005;60(6):768-76. OVID-Embase.

Exclude: Not an eligible population treatment

Singh NA, Clements KM, Fiatarone MA. A randomized controlled trial of the effect of exercise on sleep. *Sleep J Sleep Res Sleep Med.* 1997;20(2):95-101. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Sinyor M, Schaffer A, Levitt A. The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial: A review. *Can J Psychiatr.* 2010;55(3):126-35. OVID-PsycINFO.

Exclude: Systematic Review before 2005

Sirey JA, Bruce ML, Alexopoulos GS. The Treatment Initiation Program: An intervention to improve depression outcomes in older adults. *Am J Psychiatry.* 2005;162(1):184-6. PMID:15625220

Exclude: Not an eligible population treatment

Siris SG, Rifkin A, Reardon GT, et al. Comparative side effects of imipramine, bupropion, or their combination in patients receiving fluphenazine decanoate. *Am J Psychiatry.* 1983;140(8):1069-71. PMID:6346910 OVID-Medline.

Exclude: Not an eligible population treatment

Siris SG, Cutler J, Owen K, et al. Adjunctive imipramine maintenance treatment in schizophrenic patients with remitted postpsychotic depression. *Am J Psychiatry.* 1989;146(11):1495-7. PMID:2817126 OVID-Medline.

Exclude: Not an eligible population treatment

Siwek M, Dudek D, Paul IA, et al. Zinc supplementation augments efficacy of imipramine in treatment resistant patients: A double blind, placebo-controlled study. *J Affect Disord.* 2009;118(1-3):187-95. OVID-Embase.

Exclude: Not an eligible population treatment

Sjosten N, Kivela S-L. The effects of physical exercise on depressive symptoms among the aged: A systematic review. *Int J Geriatr Psychiatry.* 2006;21(5):410-8. OVID-Embase.

Exclude - Systematic review - relevant topic, citations cross-matched

Skevington SM, Wright A. Changes in the quality of life of patients receiving antidepressant medication in primary care: Validation of the WHOQOL-100. *Br J Psychiatr.* 2001;178(3):261-7. OVID-AMED.

Exclude: Not an eligible study design

Skultety KM, Zeiss A. The treatment of depression in older adults in the primary care setting: An evidence-based review. *Health Psychol.* 2006;25(6):665-74. OVID-Embase.

Exclude - Systematic review - relevant topic, citations cross-matched

Slooman R. Relaxation and imagery for anxiety and depression control in community patients with advanced cancer. *Cancer Nurs.* 2002;25(6):432-5. PMID:12464834 OVID-Medline.

Exclude: Not an eligible population treatment

Small JG, Kellams JJ, Dennis JL, et al. Comparison of mirtazapine and nortriptyline in the treatment of refractory depression. *J Clin Pharmacol.* 1981;21(8-9):351-8. Wiley-CCTR.

Exclude: Not an eligible population treatment

Smeraldi E. Amitriptyline versus fluoxetine in patients with dysthymia or major depression in partial remission: A double-blind, comparative study. *J Affect Disord.* 1998;48(1):47-56. PMID:9495601 OVID-Medline.

Exclude: Not an eligible population treatment

Smit A, Kluiters H, Conradi HJ, et al. Short-term effects of enhanced treatment for depression in primary care: Results from a randomized controlled trial. *Psychol Med.* 2006;36(1):15-26. OVID-Embase.

Exclude: Not an eligible population treatment

Smit A, Tiemens BG, Ormel J. Improving long-term outcome of depression in primary care: A review of RCTs with psychological and supportive interventions. *Eur J Psychiatr.* 2007;21(1):37-48. OVID-Embase.

Exclude - Systematic review - relevant topic, citations cross-matched

Smit F, Willemse G, Koopmanschap M, et al. Cost-effectiveness of preventing depression in primary care patients: Randomised trial. *Br J Psychiatr.* 2006;188:330-6. PMID:16582059 OVID-Medline.

Exclude: Not an eligible population treatment

Smith Fawzi MC, Kaaya SF, Mbwapbo J, et al. Multivitamin supplementation in HIV-positive pregnant women: Impact on depression and quality of life in a resource-poor setting. *HIV Medicine*. 2007;8(4):203-12. PMID:17461847 OVID-Medline.
Exclude: Not an eligible population treatment

Smith A, Graham L, Senthinathan S. Mindfulness-based cognitive therapy for recurring depression in older people: A qualitative study. *Aging Ment Health*. 2007;11(3):346-57. PMID:17558586 OVID-Medline.
Exclude: Not an eligible study design

Smith CA, Hay PP. Acupuncture for depression. *Cochrane Database Syst Rev*. 2005;(2):CD004046. PMID:15846693 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Smith CA, Hay PP, MacPherson H. Acupuncture for depression. *Cochrane Database Syst Rev*. 2010;(1):CD004046. PMID:20091556 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Smith DF, Stromgren E, Petersen HN. Lack of effect of tryptophan treatment in demented gerontopsychiatric patients. A double-blind, crossover-controlled study. *Acta Psychiatr Scand*. 1984;70(5):470-7. OVID-Embase

OVID-Embase.
Exclude: Not an eligible population design

Smith GS, Reynolds CF, III, Houck PR, et al. Cerebral glucose metabolic response to combined total sleep deprivation and antidepressant treatment in geriatric depression: A randomized, placebo-controlled study. *Psychiatry Res*. 2009;171(1):1-9. PMID:19087899 OVID-Medline.
Exclude: Not an eligible population treatment

Smith NM, Floyd MR, Scogin F, et al. Three-year follow-up of bibliotherapy for depression. *J Consult Clin Psychol*. 1997;65(2):324-7. PMID:9086697 OVID-Medline.
Exclude: Not an eligible study design

Smith PJ, Blumenthal JA, Babyak MA, et al. Effects of exercise and weight loss on depressive symptoms among men and women with hypertension. *J Psychosom Res*. 2007;63(5):463-9. OVID-Embase.
Exclude: Not an eligible population treatment

Smith PS, Thompson M. Treadmill training post stroke: Are there any secondary benefits? A pilot study. *Clin Rehabil*. 2008;22(10-11):997-1002. Wiley-CCTR.
Exclude: Not an eligible population design

Smith WT, Londerborg PD, Glaudin V, et al. Short-term augmentation of fluoxetine with clonazepam in the treatment of depression: A double-blind study. *Am J Psychiatry*. 1998;155(10):1339-45. PMID:9766764 OVID-Medline.
Exclude: Not an eligible population treatment

Smith WT, Londerborg PD, Glaudin V, et al. Is extended clonazepam cotherapy of fluoxetine effective for outpatients with major depression? *J Affect Disord*. 2002;70(3):251-9. PMID:12128237 OVID-Medline.
Exclude: Not an eligible population treatment

Smits JA, Minhajuddin A, Jarrett RB. Cognitive therapy for depressed adults with comorbid social phobia. *J Affect Disord*. 2009;114(1-3):271-8. PMID:18804285 OVID-Medline.
Exclude: Not an eligible population treatment

Snow V, Lascher S, Mottur-Pilson C. Pharmacologic treatment of acute major depression and dysthymia. *American College of Physicians-American Society of Internal Medicine. Ann Intern Med*. 2000;132(9):738-42. PMID:10787369 OVID-Medline.
Exclude: Not an eligible guideline

Soares CN, Poitras JR, Prouty J, et al. Efficacy of citalopram as a monotherapy or as an adjunctive treatment to estrogen therapy for perimenopausal and postmenopausal women with depression and vasomotor symptoms. *J Clin Psychiatry*. 2003;64(4):473-9. PMID:12716252 OVID-Medline.
Exclude: Not an eligible population treatment

Soares CN, Thase ME, Clayton A, et al. Open-label treatment with desvenlafaxine in postmenopausal women with major depressive disorder not responding to acute treatment with desvenlafaxine or escitalopram. *CNS Drugs*. 2011;25(3):227-38. OVID-Embase.
Exclude: Mixed antidepressants; some failed on SSRI

Sobis J, Jarzab M, Hese RT, et al. Therapeutic efficacy assessment of weak variable magnetic fields with low value of induction in patients with drug-resistant depression. *J Affect Disord*. 2010;123(1-3):321-6. OVID-Embase.
Exclude: Not an eligible population treatment

Soden K, Vincent K, Craske S, et al. A randomized controlled trial of aromatherapy massage in a hospice setting. *Palliat Med.* 2004;18(2):87-92. PMID:15046404 OVID-Medline.

Exclude: Not an eligible population treatment

Sokolski KN, Reist C, Chen CC, et al. Antidepressant responses and changes in visual adaptation after sleep deprivation. *Psychiatry Res.* 1995;57(3):197-207. PMID:7501729 OVID-Medline.

Exclude: Not an eligible study design

Solomon DA, Leon AC, Mueller TI, et al. Tachyphylaxis in unipolar major depressive disorder. *J Clin Psychiatry.* 2005;66(3):283-90. OVID-Embase.

Exclude: Not an eligible population treatment

Solomon JL. A clinical study of the effect of the introduction of antidepressant medication on the psychoanalytic process in an analysis of long duration. *J Clin Psychoanalysis.* 1995;4(2):169-84. OVID-Embase.

Exclude: Not an eligible study design

Solvason B H. Mifepristone in refractory depression. In 2006. Wiley-CCTR.

Exclude: Not an eligible study design

Somasundaram D. Using cultural relaxation methods in post-trauma care among refugees in Australia. *Int J Cult Ment Health.* 2010;3(1):16-24. OVID-PscINFO.

Exclude: Not an eligible study design

Sommer H, Harrer G. Placebo-controlled double-blind study examining the effectiveness of an hypericum preparation in 105 mildly depressed patients. *J Geriatr Psychiatry Neurol.* 1994;7:Suppl-11 PMID:7857516 OVID-Medline.

Exclude: Not an eligible population treatment

Sondergaard MP, Jarden JO, Martiny K, et al. Dose response to adjunctive light therapy in citalopram-treated patients with post-stroke depression. A randomised, double-blind pilot study. *Psychother Psychosom.* 2006;75(4):244-8. PMID:16785774 OVID-Medline.

Exclude: Not an eligible population design

Song Y, Zhou D, Fan J, et al. Effects of electroacupuncture and fluoxetine on the density of GTP-binding-proteins in platelet membrane in patients with major depressive disorder. *J Affect Disord.* 2007;98(3):253-7. PMID:16919758 OVID-Medline.

Exclude: Not an eligible population treatment

Sood JR, Cisek E, Zimmerman J, et al. Treatment of depressive symptoms during short-term rehabilitation: An attempted replication of the DOUR project. *Rehabil Psychol.* 2003;48(1):44-9. OVID-Embase.

Exclude: Not an eligible population treatment

Sorensen L, Nielsen B, Stage KB, et al. Implementation of a rational pharmacotherapy intervention for inpatients at a psychiatric department. *Nord J Psychiatr.* 2008;62(3):242-9. OVID-Embase.

Exclude: Not an eligible study design

Souery D, Oswald P, Massat I, et al. Clinical factors associated with treatment resistance in major depressive disorder: Results from a European multicenter study. *J Clin Psychiatry.* 2007;68(7):1062-70. PMID:17685743 OVID-Medline.

Exclude: Not an eligible population treatment

Søgaard J, Lane R, Latimer P, et al. A 12-week study comparing moclobemide and sertraline in the treatment of outpatients with atypical depression. *J Psychopharmacol.* 1999;13(4):406-14. Wiley-CCTR.

Exclude: Not an eligible population treatment

Spek V, Nyklicek I, Smits N, et al. Internet-based cognitive behavioural therapy for subthreshold depression in people over 50 years old: A randomized controlled clinical trial. *Psychol Med.* 2007;37(12):1797-806. PMID:17466110 OVID-Medline.

Exclude: Not an eligible population treatment

Spek V, Cuijpers P, Nyklicek I, et al. Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: A meta-analysis. *Psychol Med.* 2007;37(3):319-28. PMID:17112400 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Spek V, Cuijpers P, Nyklicek I, et al. One-year follow-up results of a randomized controlled clinical trial on internet-based cognitive behavioural therapy for subthreshold depression in people over 50 years. *Psychol Med.* 2008;38(5):635-9. PMID:18205965 OVID-Medline.

Exclude: Not an eligible population treatment

Spielmans GI, Pasek LF, McFall JP. What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. *Clin Psychol Rev.* 2007;27(5):642-54. PMID:17368886 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Spielmans GI, Berman MI, Usitalo AN. Psychotherapy versus second-generation antidepressants in the treatment of depression: A meta-analysis. *J Nerv Ment Dis.* 2011;199(3):142-9. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Spier SA. Use of bupropion with SRIs and venlafaxine. *Depress Anxiety.* 1998;7(2):73-5. PMID:9614595 OVID-Medline.

Exclude: Not an eligible study design

Splevins K, Smith A, Simpson J. Do improvements in emotional distress correlate with becoming more mindful? A study of older adults. *Aging Ment Health.* 2009;13(3):328-35. PMID:19484596 OVID-Medline.

Exclude: Not an eligible study design

Spoov J, Lahdelma L. Should thyroid augmentation precede lithium augmentation--a pilot study. *J Affect Disord.* 1998;49(3):235-9. PMID:9629954 OVID-Medline.

Exclude: Not an eligible population treatment

Sporn J, Ghaemi SN, Sambur MR, et al. Pramipexole augmentation in the treatment of unipolar and bipolar depression: A retrospective chart review. *Ann Clin Psychiatr.* 2000;12(3):137-40. PMID:10984002 OVID-Medline.

Exclude: Not an eligible study design

Stabl M, Kasas A, Blajev B, et al. A double-blind comparison of moclobemide and thioridazine versus moclobemide and placebo in the treatment of refractory, severe depression. *J Clin Psychopharmacol.* 1995;15(4:Suppl 2):Suppl-45S PMID:7593730 OVID-Medline.

Exclude: Not an eligible population treatment

Stacciarini JM, O'Keeffe M, Mathews M. Group therapy as treatment for depressed Latino women: A review of the literature. *Issues Ment Health Nurs.* 2007;28(5):473-88. PMID:17613148 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Stahl SM. Enhancing outcomes from major depression: Using antidepressant combination therapies with multifunctional pharmacologic mechanisms from the initiation of treatment. *CNS Spectrums.* 2010;15(2):79-94. PMID:20414154 OVID-Medline.

Exclude: Not an eligible study design

Stamm TJ, Adli M, Kirchheiner J, et al. Serotonin transporter gene and response to lithium augmentation in depression. *Psychiatr Genet.* 2008;18(2):92-7. PMID:18349701 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Stant AD, Ten Vergert EM, den Boer PC, et al. Cost-effectiveness of cognitive self-therapy in patients with depression and anxiety disorders. *Acta Psychiatr Scand.* 2008;117(1):57-66. PMID:18005369 OVID-Medline.

Exclude: Not an eligible population treatment

Stant AD, Ten Vergert EM, Kluiters H, et al. Cost-effectiveness of a psychoeducational relapse prevention program for depression in primary care. *J Ment Health Policy Econom.* 2009;12(4):195-217+220. OVID-Embase.

Exclude: Not an eligible population treatment

Stathopoulou G, Powers MB, Berry AC, et al. Exercise interventions for mental health: A quantitative and qualitative review. *Clin Psychol Sci Pract.* 2006;13(2):179-93. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Steel JL, Nadeau K, Olek M, et al. Preliminary results of an individually tailored psychosocial intervention for patients with advanced hepatobiliary carcinoma. *Journal of Psychosocial Oncology.* 2007;25(3):19-42. Wiley-CCTR.

Exclude: Not an eligible population treatment

Steffen AM, Futterman A, Gallagher-Thompson D. Depressed caregivers: Comparative outcomes of two interventions. *Clin Gerontol.* 1998;19(4):3-15. OVID-PsycINFO.

Exclude: Systematic Review before 2005

Steffens DC, Doraiswamy PM, McQuoid DR. Bupropion SR in the naturalistic treatment of elderly patients with major depression. *Int J Geriatr Psychiatry.* 2001;16(9):862-5. PMID:11571765 OVID-Medline.

Exclude: Not an eligible population treatment

Stein BD, Jaycox LH, Kataoka SH, et al. A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. *JAMA*. 2003;290(5):603-11. PMID:12902363 OVID-Medline.

Exclude: Not an eligible population treatment

Stein G, Bernadt M. Lithium augmentation therapy in tricyclic-resistant depression. A controlled trial using lithium in low and normal doses. *Br J Psychiatr*. 1993;162:634-40. PMID:8149115 OVID-Medline.

Exclude: Not an eligible population treatment

Stein MD, Solomon DA, Herman DS, et al. Pharmacotherapy plus psychotherapy for treatment of depression in active injection drug users. *Arch Gen Psychiatr*. 2004;61(2):152-9. PMID:14757591 OVID-Medline.

Exclude: Not an eligible population treatment

Stein MD, Solomon DA, Anderson BJ, et al. Persistence of antidepressant treatment effects in a pharmacotherapy plus psychotherapy trial for active injection drug users. *Am J Addict*. 2005;14(4):346-57. PMID:16188715 OVID-Medline.

Exclude: Not an eligible population treatment

Stein MD, Herman DS, Kettavong M, et al. Antidepressant treatment does not improve buprenorphine retention among opioid-dependent persons. *J Subst Abuse Treat*. 2010;39(2):157-66. PMID:20598836 OVID-Medline.

Exclude: Not an eligible population treatment

Stein PN, Motta RW. Effects of aerobic and nonaerobic exercise on depression and self-concept. *Percept Motor Skills*. 1992;74(1):79-89. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Steinacher L, Vandel P, Zullino DF, et al. Carbamazepine augmentation in depressive patients non-responding to citalopram: A pharmacokinetic and clinical pilot study. *Eur Neuropsychopharmacol*. 2002;12(3):255-60. PMID:12007677 OVID-Medline.

Exclude: Not an eligible study design

Stella SG, Vilar AP, Lacroix C, et al. Effects of type of physical exercise and leisure activities on the depression scores of obese Brazilian adolescent girls. *Braz J Med Biol Res*. 2005;38(11):1683-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Stern MJ, Gorman PA, Kaslow L. The group counseling v exercise therapy study. A controlled intervention with subjects following myocardial infarction. *Arch Intern Med*. 1983;143(9):1719-25. Wiley-CCTR.

Exclude: Not an eligible population treatment

Stern WC, Harto-Truax N, Bauer N. Efficacy of bupropion in tricyclic-resistant or intolerant patients. *J Clin Psychiatry*. 1983;44(5:Pt 2):t-52. PMID:6406447 OVID-Medline.

Exclude: Not an eligible population treatment

Stevinson C. Preliminary results suggest that yoga can alleviate depression. *Focus Alternative Compl Ther*. 2001;6(1):27-8. OVID-AMED.

Exclude: Not an eligible study design

Stewart JW, Quitkin F, Fyer A, et al. Efficacy of desipramine in endogenomorphically depressed patients. *J Affect Disord*. 1980;2(3):165-76. PMID:6210722 OVID-Medline.

Exclude: Not an eligible population treatment

Stewart JW, Mercier MA, Agosti V, et al. Imipramine is effective after unsuccessful cognitive therapy: Sequential use of cognitive therapy and imipramine in depressed outpatients. *J Clin Psychopharmacol*. 1993;13(2):114-9. PMID:8463443 OVID-Medline.

Exclude: Not an eligible population treatment

Stewart JW, McGrath PJ, Deliyannides RA, et al. Does dual antidepressant therapy as initial treatment hasten and increase remission from depression? *J Psychiatr Pract*. 2009;15(5):337-45. PMID:19820552 OVID-Medline.

Exclude: Not an eligible study design

Stewart JW, McGrath PJ, Fava M, et al. Do atypical features affect outcome in depressed outpatients treated with citalopram? *Int J Neuropsychopharmacol*. 2010;13(1):15-30. PMID:19341509 OVID-Medline.

Exclude: Not an eligible population treatment

Stewart JW, McGrath PJ, Fava M, et al. Do atypical features affect outcome in depressed outpatients treated with citalopram? *Int J Neuropsychopharmacol*. 2010;13(1):15-30. OVID-PsycINFO.

Exclude: Systematic Review before 2005

Stewart NJ, McMullen LM, Rubin LD. Movement therapy with depressed inpatients: A randomized multiple single case design. *Arch Psychiatr Nurs*. 1994;8(1):22-9. PMID:8203940 OVID-Medline.

Exclude: Not an eligible population treatment

Stice E, Burton E, Bearman SK, et al. Randomized trial of a brief depression prevention program: An elusive search for a psychosocial placebo control condition. *Behav Res Ther.* 2007;45(5):863-76. PMID:17007812 OVID-Medline.

Exclude: Not an eligible population treatment

Stice E, Rohde P, Seeley JR, et al. Brief cognitive-behavioral depression prevention program for high-risk adolescents outperforms two alternative interventions: A randomized efficacy trial. *J Consult Clin Psychol.* 2008;76(4):595-606. PMID:18665688 OVID-Medline.

Exclude: Not an eligible population treatment

Stice E, Shaw H, Bohon C, et al. A meta-analytic review of depression prevention programs for children and adolescents: Factors that predict magnitude of intervention effects. *J Consult Clin Psychol.* 2009;77(3):486-503. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Stice E, Rohde P, Gau JM, et al. Efficacy trial of a brief cognitive-behavioral depression prevention program for high-risk adolescents: Effects at 1- and 2-year follow-up. *J Consult Clin Psychol.* 2010;78(6):856-67. PMID:20873893 OVID-Medline.

Exclude: Not an eligible population treatment

Stice E, Rohde P, Seeley JR, et al. Testing mediators of intervention effects in randomized controlled trials: An evaluation of three depression prevention programs. *J Consult Clin Psychol.* 2010;78(2):273-80. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Stinson CK, Kirk E. Structured reminiscence: An intervention to decrease depression and increase self-transcendence in older women. *J Clin Nurs.* 2006;15(2):208-18. PMID:16422738 OVID-Medline.

Exclude: Not an eligible population treatment

Stinson CK, Young EA, Kirk E, et al. Use of a structured reminiscence protocol to decrease depression in older women. *J Psychiatr Ment Health Nurs.* 2010;17(8):665-73. PMID:21050332 OVID-Medline.

Exclude: Not an eligible population treatment

Stinson D, Thompson C. Clinical experience with phototherapy. *J Affect Disord.* 1990;18(2):129-35. PMID:2137470 OVID-Medline.

Exclude: Not an eligible study design

Story TJ, Potter GG, Attix DK, et al. Neurocognitive correlates of response to treatment in late-life depression. *Am J Geriatr Psychiatry.* 2008;16(9):752-9. OVID-Embase.

Exclude: Not an eligible study design

Stoudemire A, Hill CD, Lewison BJ, et al. Lithium intolerance in a medical-psychiatric population. *Gen Hosp Psychiatry.* 1998;20(2):85-90. PMID:9582592 OVID-Medline.

Exclude: Not an eligible population treatment

Stoudemire A, Hill CD, Marquardt M, et al. Recovery and relapse in geriatric depression after treatment with antidepressants and ECT in a medical-psychiatric population. *Gen Hosp Psychiatry.* 1998;20(3):170-4. PMID:9650035 OVID-Medline.

Exclude: Not an eligible population treatment

Strachowski D, Khaylis A, Conrad A, et al. The effects of cognitive behavior therapy on depression in older patients with cardiovascular risk. *Depress Anxiety.* 2008;25(8):E1-10. PMID:17377961 OVID-Medline.

Exclude: Not an eligible population treatment

Strauman TJ, Vieth AZ, Merrill KA, et al. Self-system therapy as an intervention for self-regulatory dysfunction in depression: A randomized comparison with cognitive therapy. *J Consult Clin Psychol.* 2006;74(2):367-76. PMID:16649881 OVID-Medline.

Exclude: Not an eligible population treatment

Strauss W H. Combined cognitive-behavioral and pharmacotherapy in refractory depression. In 1996; 1996. Wiley-CCTR.

Exclude: Not an eligible population treatment

Strauss W H. Combined cognitive-behavioral and pharmacotherapy in refractory depression. In 2002. Wiley-CCTR.

Exclude: Not an eligible study design

Stravynski A, Shahar A, Verreault R. A pilot study of the cognitive treatment of dysthymic disorder. *Behav Psychother.* 1991;19(4):369-72. OVID-Embase OVID-Embase.

Exclude: Not an eligible study design

Stravynski A, Verreault R, Gaudette G, et al. The treatment of depression with group behavioural-cognitive therapy and imipramine. *Can J Psychiatr.* 1994;39(7):387-90. PMID:7987780 OVID-Medline.

Exclude: Not an eligible population treatment

Strober M, Freeman R, Rigali J, et al. The pharmacotherapy of depressive illness in adolescence: II. Effects of lithium augmentation in nonresponders to imipramine. *J Am Acad Child Adolesc Psychiatry*. 1992;31(1):16-20. PMID:1537769 OVID-Medline.

Exclude: Not an eligible population treatment

Strober M, DeAntonio M, Schmidt-Lackner S, et al. The pharmacotherapy of depressive illness in adolescents: An open-label comparison of fluoxetine with imipramine-treated historical controls. *J Clin Psychiatry*. 1999;60(3):164-9. PMID:10192591 OVID-Medline.

Exclude: Not an eligible population treatment

Strong DR, Kahler CW, Leventhal AM, et al. Impact of bupropion and cognitive-behavioral treatment for depression on positive affect, negative affect, and urges to smoke during cessation treatment. *Nicotine Tobacc Res*. 2009;11(10):1142-53. OVID-Embase.

Exclude: Not an eligible population treatment

Strunk DR, Brotman MA, DeRubeis RJ. The process of change in cognitive therapy for depression: Predictors of early inter-session symptom gains. *Behav Res Ther*. 2010;48(7):599-606. OVID-Embase.

Exclude: Not an eligible study design

Strunk DR, Brotman MA, DeRubeis RJ, et al. Therapist Competence in Cognitive Therapy for Depression: Predicting Subsequent Symptom Change. *J Consult Clin Psychol*. 2010;78(3):429-37. OVID-Embase.

Exclude: Not an eligible study design

Stryjer R, Strous RD, Shaked G, et al. Amantadine as augmentation therapy in the management of treatment-resistant depression. *Int Clin Psychopharmacol*. 2003;18(2):93-6. PMID:12598820 OVID-Medline.

Exclude: Not an eligible study design

Stump, J.E.L. Efficacy and process of cognitive bibliotherapy for the treatment of depression in prison Stump. 2004. OVID-PsycINFO.

Exclude: Not an eligible study design

Stuppaeck C, Barnas C, Miller C, et al. Carbamazepine in the prophylaxis of mood disorders. *J Clin Psychopharmacol*. 1990;10(1):39-42. PMID:2307735 OVID-Medline.

Exclude: Not an eligible population treatment

Stuppaeck CH, Barnas C, Schwitzer J, et al. Carbamazepine in the prophylaxis of major depression: A 5-year follow-up. *J Clin Psychiatry*. 1994;55(4):146-50. PMID:8071258 OVID-Medline.

Exclude: Not an eligible study design

Sturmey P. Behavioral activation is an evidence-based treatment for depression. *Behav Modif*. 2009;33(6):818-29. PMID:19933444 OVID-Medline.

Exclude - Systematic review - relevant topic, citations cross-matched

Su KP, Huang SY, Chiu CC, et al. Omega-3 fatty acids in major depressive disorder. A preliminary double-blind, placebo-controlled trial. *Eur Neuropsychopharmacol*. 2003;13(4):267-71. PMID:12888186 OVID-Medline.

Exclude: Not an eligible population treatment

Sudweeks, C. Effects of cognitive group hypnotherapy in the alteration of depressogenic schemas Sudweeks. 1998. OVID-PsycINFO.

Exclude: Not an eligible study design

Suffin S C, Gutierrez N M, Karan S and others. Neurometric EEG Predicts Pharmacotherapeutic Outcome in Depressed Outpatients: A Prospective Trial. In 1997; 1997. Wiley-CCTR.

Exclude: Not an eligible study design

Sugawara H, Sakamoto K, Harada T, et al. Predictors of efficacy in lithium augmentation for treatment-resistant depression. *J Affect Disord*. 2010;125(1-3):165-8. PMID:20089312 OVID-Medline.

Exclude: Not an eligible study design

Suija K, Pechter U, Kalda R, et al. Physical activity of depressed patients and their motivation to exercise: Nordic walking in family practice. *Int J Rehabil Res*. 2009;32(2):132-8. OVID-Embase.

Exclude: Not an eligible study design

Sullivan LE, Fiellin DA, O'Connor PG. The prevalence and impact of alcohol problems in major depression: A systematic review. *Am J Med*. 2005;118(4):330-41. PMID:15808128 OVID-Medline.

Exclude - Systematic review - relevant topic, citations cross-matched

Sullivan MJ, Adams H, Tripp D, et al. Stage of chronicity and treatment response in patients with musculoskeletal injuries and concurrent symptoms of depression. *Pain*. 2008;135(1-2):151-9. PMID:17646052 OVID-Medline.

Exclude: Not an eligible population treatment

Sullivan MJ, Wood L, Terry J, et al. The Support, Education, and Research in Chronic Heart Failure Study (SEARCH): A mindfulness-based psychoeducational intervention improves depression and clinical symptoms in patients with chronic heart failure. *Am Heart J*. 2009;157(1):84-90.

PMID:19081401 OVID-Medline.

Exclude: Not an eligible population treatment

Sumaya IC, Rienzi BM, Deegan JF, et al. Bright light treatment decreases depression in institutionalized older adults: A placebo-controlled crossover study. *J Gerontol A Biol Sci Med Sci*. 2001;56(6):M356-M360 PMID:11382795 OVID-Medline.

Exclude: Not an eligible population treatment

Sun Q, Zen D, Luo S et al. Comparative study of citalopram combined with buspirone for treatment of refractory depression. *J Clin Psychol Med*. 2004;14(4):221-2. Wiley-CCTR.

Exclude: Not an eligible study design

Sund KP, Huang SY, Chiu CC, et al. Omega-3 fatty acids in major depressive disorder A preliminary double-blind, placebo-controlled trial. *Eur Neuropsychopharmacol*. 2003;13(4):267-71. OVID-PscINFO.

Exclude: Not an eligible population treatment

Sunderland T, Cohen RM, Molchan S, et al. High-dose selegiline in treatment-resistant older depressive patients. *Arch Gen Psychiatr*. 1994;51(8):607-15. PMID:7519005 OVID-Medline.

Exclude: Not an eligible population treatment

Sussman N. Translating science into service: Lessons learned from the sequenced treatment alternatives to relieve depression (STAR*D) study. *Prim Care Comp J Clin Psychiatr*. 2007;9(5):331-7. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Sutherland JE, Sutherland SJ, Hoehns JD. Achieving the best outcome in treatment of depression. *J Fam ily Pract*. 2003;52(3):201-9. OVID-PscINFO.

Exclude: Not an eligible guideline

Suwalska A, Rybakowski J. Potentiation of antidepressants with lithium or carbamazepine. In 1996; 1996. Wiley-CCTR.

Exclude: Not an eligible study design

Suwalska A, Rybakowski J. Potentiation of antidepressants with lithium or carbamazepine: Factors associated with therapeutic efficacy. In 1998; 1998. Wiley-CCTR.

Exclude: Not an eligible study design

Suzuki Y, Tsuneyama N, Fukui N, et al. Differences in clinical effect and tolerance between fluvoxamine and paroxetine: A switching study in patients with depression. *Hum Psychopharmacol*. 2010;25(7-8):525-9. OVID-Embase.

Exclude: Not an eligible study design

Svanborg C, Wistedt AA, Svanborg P. Long-term outcome of patients with dysthymia and panic disorder: A naturalistic 9-year follow-up study. *Nord J Psychiatr*. 2008;62(1):17-24. PMID:18389421 OVID-Medline.

Exclude: Not an eligible population treatment

Swan J, Sorrell E, MacVicar B, et al. "Coping with depression": An open study of the efficacy of a group psychoeducational intervention in chronic, treatment-refractory depression. *J Affect Disord*. 2004;82(1):125-9. PMID:15465585 OVID-Medline.

Exclude: Not an eligible study design

Swartz HA, Frank E, Shear MK, et al. A pilot study of brief interpersonal psychotherapy for depression among women. *Psychiatr Serv*. 2004;55(4):448-50. PMID:15067162 OVID-Medline.

Exclude: Not an eligible population treatment

Swartz HA, Frank E, Zuckoff A, et al. Brief interpersonal psychotherapy for depressed mothers whose children are receiving psychiatric treatment. *Am J Psychiatry*. 2008;165(9):1155-62. OVID-Embase.

Exclude: Not an eligible population treatment

Szegedi A, Wetzel H, Leal M, et al. Combination treatment with clomipramine and fluvoxamine: Drug monitoring, safety, and tolerability data. *J Clin Psychiatry*. 1996;57(6):257-64. PMID:8666564 OVID-Medline.

Exclude: Not an eligible study design

Szegedi A, Kohnen R, Dienel A, et al. Acute treatment of moderate to severe depression with hypericum extract WS 5570 (St John's wort): Randomised controlled double blind non-inferiority trial versus paroxetine. *Br Med J*. 2005;330(7490):503 PMID:15708844 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Szigethy E, Whitton SW, Levy-Warren A, et al. Cognitive-behavioral therapy for depression in adolescents with inflammatory bowel disease: A pilot study. *J Am Acad Child Adolesc Psychiatry*. 2004;43(12):1469-77. PMID:15564816 OVID-Medline.

Exclude: Not an eligible study design

Szigethy E, Kenney E, Carpenter J, et al. Cognitive-behavioral therapy for adolescents with inflammatory bowel disease and subsyndromal depression. *J Am Acad Child Adolesc Psychiatry*. 2007;46(10):1290-8. PMID:17885570 OVID-Medline.

Exclude: Not an eligible population treatment

Szigethy E, Craig AE, Iobst EA, et al. Profile of depression in adolescents with inflammatory bowel disease: Implications for treatment. *Inflamm Bowel Dis*. 2009;15(1):69-74. PMID:18831071 OVID-Medline.

Exclude: Not an eligible population treatment

Szigethy E, Whitton SW, Levy-Warren A, et al. Cognitive-behavioral therapy for depression in adolescents with inflammatory bowel disease: A pilot study. *J Am Acad Child Adolesc Psychiatry*. 2004;43(12):1469-77. OVID-PsycINFO.

Exclude: Not an eligible study design

Szigethy E, Kenney E, Carpenter J, et al. Cognitive-behavioral therapy for adolescents with inflammatory bowel disease and subsyndromal depression. *J Am Acad Child Adolesc Psychiatry*. 2007;46(10):1290-8. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Takahashi H, Kamata M, Yoshida K, et al. Augmentation with olanzapine in TCA-refractory depression with melancholic features: A consecutive case series. *Hum Psychopharmacol*. 2008;23(3):217-20. OVID-Embase.

Exclude: Not an eligible study design

Talati A, Wickramaratne PJ, Pilowsky DJ, et al. Remission of maternal depression and child symptoms among single mothers. A STAR*D-child report. *Soc Psychiatr Psychiatr Epidemiol*. 2007;42(12):962-71. OVID-Embase.

Exclude: Not an eligible population treatment

Talbott S, Talbott J, Christopoulos A-M, et al. Ancient wisdom meets modern ailment - Traditional Asian medicine improves psychological vigor in stressed subjects. *Prog Nutr*. 2010;12(1):64-9. OVID-Embase.

Exclude: Not an eligible population treatment

Tang SW, Remington G, Persad E, et al. Coadministration of a beta-adrenergic antagonist and a tricyclic antidepressant: A pilot study. *Psychiatry Res*. 1990;33(2):101-6. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Tang YL, Mao PX, Jiang F, et al. Clozapine in China. *Pharmacopsychiatr*. 2008;41(1):1-9. PMID:18203045 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Tanghe A, Steeman J, Bollen E, et al. Moclobemide and amitriptyline, alone or in combination, in therapy resistant depression. *Hum Psychopharmacol Clin Exp*. 1997;12(5):509-10. OVID-PsycINFO.

Exclude: Not an eligible study design

Taragano FE, Allegri R, Vicario A, et al. A double blind, randomized clinical trial assessing the efficacy and safety of augmenting standard antidepressant therapy with nimodipine in the treatment of 'vascular depression'. *Int J Geriatr Psychiatry*. 2001;16(3):254-60. PMID:11288158 OVID-Medline.

Exclude: Not an eligible population treatment

Taragano FE, Bagnatti P, Allegri RF. A double-blind, randomized clinical trial to assess the augmentation with nimodipine of antidepressant therapy in the treatment of "vascular depression". *Int Psychogeriatr*. 2005;17(3):487-98. PMID:16252380 OVID-Medline.

Exclude: Not an eligible population treatment

Targ EF, Karasic DH, Diefenbach PN, et al. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. *Psychosom*. 1994;35(2):132-7. PMID:8171171 OVID-Medline.

Exclude: Not an eligible population treatment

Tarrier N, Maguire P, Kincey J. Locus of control and cognitive behaviour therapy with mastectomy patients: A pilot study. *Br J Med Psychol*. 1983;56(3):265-70. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Tavoni A, Vitali C, Bombardieri S, et al. Evaluation of S-adenosylmethionine in primary fibromyalgia. A double-blind crossover study. *Am J Med*. 1987;83(5A):107-10. OVID-Embase.

Exclude: Not an eligible population treatment

Taylor CB, Houston-Miller N, Ahn DK, et al. The effects of exercise training programs on psychosocial improvement in uncomplicated postmyocardial infarction patients. *J Psychosom Res*. 1986;30(5):581-7. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Taylor DJ, Lichstein KL, Weinstock J, et al. A pilot study of cognitive-behavioral therapy of insomnia in people with mild depression. *Behav Ther*. 2007;38(1):49-57. PMID:17292694 OVID-Medline.

Exclude: Not an eligible study design

Taylor FB, Prather MR. The efficacy of nefazodone augmentation for treatment-resistant depression with anxiety symptoms or anxiety disorder. *Depress Anxiety*. 2003;18(2):83-8. PMID:12964175 OVID-Medline.

Exclude: Not an eligible study design

Taylor MJ. Rapid onset of true antidepressant action. *Curr Psychiatry Rep.* 2007;9(6):475-9. OVID-Embase.

Exclude: Systematic review - relevant topic, citations cross-matched

Taylor MP, Reynolds CF, III, Frank E, et al. Which elderly depressed patients remain well on maintenance interpersonal psychotherapy alone?: Report from the Pittsburgh study of maintenance therapies in late-life depression. *Depress Anxiety.* 1999;10(2):55-60. PMID:10569127 OVID-Medline. Exclude: Not an eligible population treatment

Taylor WD, Steffens DC, Macfall JR, et al. White Matter Hyperintensity Progression and Late-Life Depression Outcomes. *Arch Gen Psychiatr.* 2003;60(11):1090-6. OVID-Embase. Exclude: Not an eligible study design

Teasdale JD, Fennell MJV. Immediate effects on depression of cognitive therapy interventions. *Cognit Ther Res.* 1982;6(3):343-52. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Teasdale JD, Fennell MJV, Hibbert GA, et al. Cognitive therapy for major depressive disorder in primary care. *Br J Psychiatr.* 1984;144(4):400-6. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Teasdale JD, Segal ZV, Williams JM, et al. Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *J Consult Clin Psychol.* 2000;68(4):615-23. PMID:10965637 OVID-Medline.

Exclude: Not an eligible population treatment

Teichman, Yona. Depression in a marital context. 1997:49-70. 1997. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Teichman Y, Bar-El Z, Shor H, et al. Changes in cognitions, emotions, and behaviors in depressed patients and their spouses following marital cognitive therapy, traditional cognitive therapy, pharmacotherapy, and no intervention. *J Psychother Integrat.* 1998;8(1):27-53. OVID-PsycINFO. Exclude: Not an eligible population treatment

Tempesta E, Casella L, Pirrongelli C, et al. L-acetylcarnitine in depressed elderly subjects. A cross-over study vs placebo. *Drugs Under Exp Clin Res.* 1987;13(7):417-23. PMID:3308388 OVID-Medline. Exclude: Not an eligible study design

Terao T. Lack of urinary side-effects with nefazodone as compared to other newer antidepressants. *Hum Psychopharmacol Clin Exp.* 1998;13(4):245-6. OVID-PsycINFO.

Exclude: Not an eligible study design

Teri L, Lewinsohn PM. Individual and group treatment of unipolar depression: Comparison of treatment outcome and identification of predictors of successful treatment outcome. *Behav Ther.* 1986;(17):215-28. Exclude: Not an eligible population treatment

Teri L, Logsdon RG, Uomoto J, et al. Behavioral treatment of depression in dementia patients: A controlled clinical trial. *J Gerontol B Psychol Sci Soc Science.* 1997;52(4):159-66. PM:9224439 Exclude: Not an eligible population/treatment

Teusch L, Bohme H, Finke J, et al. Effects of client-centered psychotherapy for personality disorders alone and in combination with psychopharmacological treatment: An empirical follow-up study. *Psychother Psychosom.* 2001;70(6):328-36. OVID-Embase.

Exclude: Not an eligible population treatment

Teusch L, Bohme H, Finke J, et al. Antidepressant medication and the assimilation of problematic experiences in psychotherapy. *Psychother Res.* 2003;13(3):307-22. OVID-Embase. Exclude: Not an eligible population treatment

Tew JD, Mulsant BH, Haskett RF, et al. Relapse during continuation pharmacotherapy after acute response to ECT: A comparison of usual care versus protocolized treatment. *Ann Clin Psychiatr.* 2007;19(1):1-4. OVID-Embase.

Exclude: Not an eligible population treatment

Tew JD, Jr., Mulsant BH, Houck PR, et al. Impact of prior treatment exposure on response to antidepressant treatment in late life. *Am J Geriatr Psychiatr.* 2006;14(11):957-65. PMID:17068318 OVID-Medline.

Exclude: Not an eligible population treatment

Thachil AF, Mohan R, Bhugra D. The evidence base of complementary and alternative therapies in depression. *J Affect Disord.* 2007;97(1-3):23-35. OVID-PsycINFO.

Exclude: Systematic review - relevant topic, citations cross-matched

Thangathurai D, Roby J, Roffey P. Treatment of resistant depression in patients with cancer with low doses of ketamine and desipramine. *J Palliat Med.* 2010;13(3):235 PMID:20178430 OVID-Medline. Exclude: Not an eligible study design

Thase M, Kremer C, Rodrigues H. Mirtazapine versus sertraline after SSRI non-response. In Annual meeting of the new clinical drug evaluation unit (NCDEU) of the national institute of mental health. 2001. Exclude: Not an eligible study design

Thase ME, Kupfer DJ, Jarrett DB. Treatment of imipramine-resistant recurrent depression: I. An open clinical trial of adjunctive L-triiodothyronine. *J Clin Psychiatry*. 1989;50(10):385-8. PMID:2676995 OVID-Medline.
Exclude: Not an eligible population treatment

Thase ME, Kupfer DJ, Frank E, et al. Treatment of imipramine-resistant recurrent depression: II. An open clinical trial of lithium augmentation. *J Clin Psychiatry*. 1989;50(11):413-7. PMID:2509437 OVID-Medline.
Exclude: Not an eligible population treatment

Thase ME, Simons AD, Cahalane JF, et al. Cognitive behavior therapy of endogenous depression: Part 1: An outpatient clinical replication series. *Behav Ther*. 1991;22(4):457-67. OVID-Embase.
Exclude: Not an eligible study design

Thase ME, Bowler K, Harden T. Cognitive behavior therapy of endogenous depression: Part 2: Preliminary findings in 16 unmedicated inpatients. *Behav Ther*. 1991;22(4):469-77. OVID-Embase.
Exclude: Not an eligible study design

Thase ME, Frank E, Mallinger AG, et al. Treatment of imipramine-resistant recurrent depression, III: Efficacy of monoamine oxidase inhibitors. *J Clin Psychiatry*. 1992;53(1):5-11. PMID:1737741 OVID-Medline.
Exclude: Not an eligible population treatment

Thase ME, Reynolds Iii CF, Frank E, et al. Response to cognitive-behavioral therapy in chronic depression. *J Psychother Pract Res*. 1994;3(3):204-14. OVID-Embase.
Exclude: Not an eligible study design

Thase ME, Blomgren SL, Birkett MA, et al. Fluoxetine treatment of patients with major depressive disorder who failed initial treatment with sertraline. *J Clin Psychiatry*. 1997;58:16-21.
Exclude: Not an eligible study design

Thase ME, Friedman ES, Berman SR, et al. Is cognitive behavior therapy just a 'nonspecific' intervention for depression? A retrospective comparison of consecutive cohorts treated with cognitive behavior therapy or supportive counseling and pill placebo. *J Affect Disord*. 2000;57(1-3):63-71. PMID:10708817 OVID-Medline.
Exclude: Not an eligible population treatment

Thase ME, Friedman ES, Fasiczka AL, et al. Treatment of men with major depression: A comparison of sequential cohorts treated with either cognitive-behavioral therapy or newer generation antidepressants. *J Clin Psychiatry*. 2000;61(7):466-72. PMID:10937603 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Thase ME, Feighner MD, Lydiard RB. Citalopram Treatment of Fluoxetine Nonresponders. *J Clin Psychiatry*. 2001;62(9):683-7. Exclude: Not an eligible study design

Thase ME, Ferguson JM, Lydiard RB, et al. Citalopram treatment of paroxetine-intolerant depressed patients. *Depress Anxiety*. 2002;16(3):128-33. PMID:12415538 OVID-Medline.
Exclude: Not an eligible study design

Thase ME, Rush AJ, Howland RH, et al. Double-blind switch study of imipramine or sertraline treatment of antidepressant-resistant chronic depression. *Arch Gen Psychiatr*. 2002;59(3):233-9. PMID:11879161 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Thase ME, Fava M, DeBattista C, et al. Modafinil augmentation of SSRI therapy in patients with major depressive disorder and excessive sleepiness and fatigue: A 12-week, open-label, extension study. *CNS Spectrums*. 2006;11(2):93-102. PMID:16520686 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Thomas SP, Nandhra HS, Jayaraman A. Systematic review of lamotrigine augmentation of treatment resistant unipolar depression (TRD). *J Ment Health*. 2010;19(2):168-75. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Thombs BD, de Jonge P, Coyne JC, et al. Depression screening and patient outcomes in cardiovascular care: A systematic review. *JAMA*. 2008;300(18):2161-71. PMID:19001627 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Thompson LW, Coon DW, Gallagher-Thompson D, et al. Comparison of desipramine and cognitive/behavioral therapy in the treatment of elderly outpatients with mild-to-moderate depression. *Am J Geriatr Psychiatr*. 2001;9(3):225-40. PMID:11481130 OVID-Medline.
Exclude: Not an eligible population treatment

Thompson LW, Gallagher D. Depression and its treatment in the elderly. *Aging*. 1985;348:14-8. OVID-PsycINFO.

Exclude: Not an eligible study design

Thompson LW, Gallagher D, Breckenridge JS. Comparative effectiveness of psychotherapies for depressed elders. *J Consult Clin Psychol*. 1987;55(3):385-90. OVID-PsycINFO.

Exclude: Not an eligible study design

Thompson NJ, Walker ER, Obolensky N, et al. Distance delivery of mindfulness-based cognitive therapy for depression: Project UPLIFT. *Epilepsy Behav*. 2010;19(3):247-54. PMID:20851055 OVID-Medline.

Exclude: Not an eligible population treatment

Thompson S, Herrmann N, Rapoport MJ, et al. Efficacy and safety of antidepressants for treatment of depression in Alzheimer's disease: A metaanalysis. *Can J Psychiatry*. 2007;52(4):248-55. PMID:17500306 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Thompson SB. Cognitive therapy in cognitive rehabilitation: Eight region study of older adults. *J Cognit Rehabil*. 2002;19(4):4-7. OVID-AMED.

Exclude: Not an eligible study design

Thomson J, Rankin H, Ashcroft GW, et al. The treatment of depression in general practice: A comparison of L-tryptophan, amitriptyline, and a combination of L-tryptophan and amitriptyline with placebo. *Psychol Med*. 1982;12(4):741-51. PMID:7156248 OVID-Medline.

Exclude: Not an eligible population treatment

Thomson RL, Buckley JD, Lim SS, et al. Lifestyle management improves quality of life and depression in overweight and obese women with polycystic ovary syndrome. *Fertil Steril*. 2010;94(5):1812-6. PMID:20004371 OVID-Medline.

Exclude: Not an eligible population treatment

Thorpe L, Whitney DK, Kutcher SP, et al. Special populations. *Can J Psychiatr*. 2001;46(SUPPL. 1):63S-76S. OVID-Embase.

Exclude: Not an eligible guideline

Thyme KE, Sundin EC, Stahlberg G, et al. The outcome of short-term psychodynamic art therapy compared to short-term psychodynamic verbal therapy for depressed women. *Psychoanalytic Psychother*. 2007;(21):250-64. Exclude: Not an eligible population treatment

Tiller JW, Mitchell P, Burrows GD. Monoamine oxidase inhibitors (MAOI) or reversible inhibitors of monoamine oxidase (RIMA)/tricyclic antidepressant (TCA) combination therapy. *Aust NZ J Psychiatr*. 1992;26(2):327-9. PMID:1642632 OVID-Medline.

Exclude: Not an eligible study design

Tiller JW, Johnson GF, Burrows GD. Moclobemide for depression: An Australian psychiatric practice study. *J Clin Psychopharmacol*. 1995;15(4:Suppl 2):Suppl-34S PMID:7593727 OVID-Medline.

Exclude: Not an eligible study design

Timbie JW, Horvitz-Lennon M, Frank RG, et al. A meta-analysis of labor supply effects of interventions for major depressive disorder. *Psychiatr Serv*. 2006;57(2):212-8. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Timotijevic I, Zdravkovic M, Pokrajac M, et al. Correlation of mono and combined amitriptyline/lithium therapy with therapeutic and side effects. *Rom J Physiol*. 1994;31(1-4):103-11. PMID:8640362 OVID-Medline.

Exclude: Not an eligible study design

Titievsky J, Seco G, Barranco M, et al. Doxepin as adjunctive therapy for depressed methadone maintenance patients: A double-blind study. *J Clin Psychiatry*. 1982;43(11):454-6. PMID:7174622 OVID-Medline.

Exclude: Not an eligible population treatment

Titov N, Andrews G, Davies M, et al. Internet treatment for depression: A randomized controlled trial comparing clinician vs. technician assistance. *PLoS ONE*. 2010;5(6):1-9. OVID-Embase.

Exclude: Not an eligible population treatment

Tohen M, Case M, Trivedi MH, et al. Olanzapine/fluoxetine combination in patients with treatment-resistant depression: Rapid onset of therapeutic response and its predictive value for subsequent overall response in a pooled analysis of 5 studies. *J Clin Psychiatr*. 2010;71(4):451-62. PMID:20361905 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Tolin DF. Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. *Clin Psychol Rev*. 2010;30(6):710-20. PMID:20547435 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Tollefson G D, Shelton R, Tohen M and others. Efficacy of olanzapine, fluoxetine and combination therapy in treatment-resistant major depressive disorder without psychotic features. In 1998; 1998. Wiley-CCTR.

Exclude: Not an eligible study design

Tollefson G D, Shelton R C, Tohen M F and others. The study of olanzapine plus fluoxetine in treatment-resistant MDD without psychotic features. In 1999 May 15; 1999. Wiley-CCTR.

Exclude: Not an eligible study design

Tome MB, Isaac MT, Harte R, et al. Paroxetine and pindolol: A randomized trial of serotonergic autoreceptor blockade in the reduction of antidepressant latency. *Int Clin Psychopharmacol*. 1997;12(2):81-9. PMID:9219043 OVID-Medline.

Exclude: Not an eligible population treatment

Tome MB, Cloninger CR, Watson JP, et al. Serotonergic autoreceptor blockade in the reduction of antidepressant latency: Personality variables and response to paroxetine and pindolol. *J Affect Disord*. 1997;44(2-3):101-9. PMID:9241570 OVID-Medline.

Exclude: Not an eligible population treatment

Tome MB, Isaac MT. Cost effectiveness study of a year follow-up of selective serotonin reuptake inhibitor (SSRI) and augmentor combination compared with SSRI and placebo. *Int Clin Psychopharmacol*. 1998;13(4):175-82. PMID:9727728 OVID-Medline.

Exclude: Not an eligible population treatment

Tome MB, Isaac MT. One year real world prospective follow-up study of a major depressive episode of patients treated with paroxetine and pindolol or paroxetine for 6 weeks. *Int Clin Psychopharmacol*. 1998;13(4):169-74. PMID:9727727 OVID-Medline.

Exclude: Not an eligible population treatment

Tondo L, Masia M, Silvetti F, et al. Fluoxetine in depressive episodes during prophylactic lithium treatment. *Eur Neuropsychopharmacol*. 1993;3(3):326 OVID-Embase.

Exclude: Not an eligible study design

Topolovec-Vranic J, Cullen N, Michalak A, et al. Evaluation of an online cognitive behavioural therapy program by patients with traumatic brain injury and depression. *Brain Inj*. 2010;24(5):762-72. OVID-Embase.

Exclude: Not an eligible study design

Trapp, M.D.C. The interaction of cognitive-behavioral therapy with integrated couple therapy for the treatment of depression in women Trapp. 1998. OVID-PsycINFO.

Exclude: Not an eligible study design

Trautmann-Sponsel RD. St. John's Wort extract in the treatment of depression -- an effective and well-tolerated antidepressant. *ÿÿÿÿ*. 2001;(1):44-9. EBSCO-CINAHL.

Exclude: Not an eligible study design

Travis J, Roeder K, Walters H, et al. Telephone-based mutual peer support for depression: A pilot study. *Chronic Illn*. 2010;6(3):183-91. PMID:20634226 OVID-Medline.

Exclude: Not an eligible study design

Treatment for Adolescents With Depression Study (TADS) Team, March J, Silva S, et al. The Treatment for Adolescents With Depression Study (TADS): Outcomes over 1 year of naturalistic follow-up. *Am J Psychiatry*. 2009;166(10):1141-9. PMID:19723787 OVID-Medline.

Exclude: Not an eligible population treatment

Trivedi MH, Rush AJ, Crismon ML, et al. Clinical results for patients with major depressive disorder in the Texas medication algorithm project. *Arch Gen Psychiatr*. 2004;61(7):669-80. OVID-Embase.

Exclude: Not an eligible population treatment

Trivedi MH, Morris DW, Grannemann BD, et al. Symptom clusters as predictors of late response to antidepressant treatment. *J Clin Psychiatry*. 2005;66(8):1064-70. PMID:16086624 OVID-Medline.

Exclude: Not an eligible study design

Trivedi MH, Greer TL, Grannemann BD, et al. Exercise as an augmentation strategy for treatment of major depression. *J Psychiatr Pract*. 2006;12(4):205-13. PMID:16883145 OVID-Medline.

Exclude: Not an eligible study design

Trivedi MH, Greer TL, Grannemann BD, et al. TREAD: Treatment with Exercise Augmentation for Depression: Study rationale and design. *Clin Trials*. 2006;3(3):291-305. PMID:16895046 OVID-Medline.

Exclude: Not an eligible study design

Trivedi MH, Rush AJ, Wisniewski SR, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: Implications for clinical practice. *Am J Psychiatry*. 2006;163(1):28-40. PMID:16390886 OVID-Medline.

Exclude: Not an eligible population treatment

Trivedi MH, Thase ME, Fava M, et al. Adjunctive aripiprazole in major depressive disorder: Analysis of efficacy and safety in patients with anxious and atypical features. *Am J Psychiatry*. 2008;69(12):1928-36. PMID:19192475 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Trivedi MH, Hollander E, Nutt D, et al. Clinical evidence and potential neurobiological underpinnings of unresolved symptoms of depression. *Am J Psychiatry*. 2008;69(2):246-58. PMID:18363453 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Trivedi MH, Corey-Lisle PK, Guo Z, et al. Remission, response without remission, and nonresponse in major depressive disorder: Impact on functioning. *Int Clin Psychopharmacol*. 2009;24(3):133-8. PMID:19318972 OVID-Medline. Exclude: Mixed antidepressants:some failed on SSRI

Trivedi MH, Thase ME, Osuntokun O, et al. An integrated analysis of olanzapine/fluoxetine combination in clinical trials of treatment-resistant depression. *Am J Psychiatry*. 2009;70(3):387-96. ISI:000264735200011 Excluded - Systematic review - relevant topic, citations cross-matched

Truax P. The cognitive behavioural analysis system of psychotherapy prevented recurrence in chronic major depression. *Evid Based Med*. 2005;10(3):85 OVID-Embase.

Exclude: Not an eligible study design

Tsai YF, Wong TK, Juang YY, et al. The effects of light therapy on depressed elders. *Int J Geriatr Psychiatry*. 2004;19(6):545-8. PMID:15211533 OVID-Medline.

Exclude: Not an eligible population treatment

Tsai YF, Wong TK, Tsai HH, et al. Self-worth therapy for depressive symptoms in older nursing home residents. *J Adv Nurs*. 2008;64(5):488-94. PMID:19146517 OVID-Medline.

Exclude: Not an eligible population treatment

Tsang HWH, Fung KMT, Chan ASM, et al. Effect of a qigong exercise programme on elderly with depression. *Int J Geriatr Psychiatry*. 2006;21(9):890-7. OVID-Embase.

Exclude: Not an eligible population treatment

Tsang HWH, Chan EP, Cheung WM. Effects of mindful and non-mindful exercises on people with depression: A systematic review. *Br J Clin Psychol*. 2008;47(3):303-22. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Tsay SL, Cho YC, Chen ML. Acupressure and Transcutaneous Electrical Acupoint Stimulation in improving fatigue, sleep quality and depression in hemodialysis patients. *Am J Chin Med*. 2004;32(3):407-16. PMID:15344424 OVID-Medline.

Exclude: Not an eligible population treatment

Tufan ZK, Arslan H, Yildiz F, et al. Acupuncture for depression and myalgia in patients with hepatitis: An observational study. *Acupuncture Med*. 2010;28(3):136-9. PMID:20530097 OVID-Medline. Exclude: Not an eligible study design

Turk DC, Zaki HS, Rudy TE. Effects of intraoral appliance and biofeedback/stress management alone and in combination in treating pain and depression in patients with temporomandibular disorders. *J Prosthet Dent*. 1993;70(2):158-64. PMID:8371179 OVID-Medline.

Exclude: Not an eligible population treatment

Turvey CL, Klein DM. Remission from Depression Comorbid with Chronic Illness and Physical Impairment. *Am J Psychiatry*. 2008;165(5):569-74. OVID-Embase.

Exclude: Not an eligible study design

Tutty S, Simon G, Ludman E. Telephone counseling as an adjunct to antidepressant treatment in the primary care system. A pilot study. *Eff Clin Pract*. 2000;3(4):170-8. PMID:11183432 OVID-Medline. Exclude: Not an eligible population treatment

Tutty S. Evaluating the effectiveness of teletherapy in rural depressed adults Tutty. 2008. OVID-PsycINFO.

Exclude: Not an eligible study design

Tutty S, Spangler DL, Poppleton LE, et al. Evaluating the effectiveness of cognitive-behavioral teletherapy in depressed adults. *Behav Ther*. 2010;41(2):229-36. OVID-PsycINFO. Exclude: Not an eligible study design

Tyrer P, Marsden CA, Casey P, et al. Clinical efficacy of paroxetine in resistant depression. *J Psychopharmacol*. 1987;1(4):251-7. OVID-Embase. Exclude: Not an eligible population treatment

Tyrer P, Seivewright N, Murphy S, et al. The Nottingham study of neurotic disorder: Comparison of drug and psychological treatments. *Lancet*. 1988;2(8605):235-40. PMID:2899234 OVID-Medline.

Exclude: Not an eligible population treatment

Uchida H, Takeuchi H, Suzuki T, et al. Combined treatment with sulpiride and paroxetine for accelerated response in patients with major depressive disorder. *J Clin Psychopharmacol*. 2005;25(6):545-51. PMID:16282835 OVID-Medline.

Exclude: Not an eligible population treatment

Udabe RU, Marquez CA, Traballi CA, et al. Double-blind comparison of moclobemide, imipramine and placebo in depressive patients. *Acta Psychiatr Scand Suppl*. 1990;82(360):54-6. OVID-Embase OVID-Embase.

Exclude: Not an eligible population treatment

Udry EM. Interventions for the anxious and depressed: Suggested links between control theory and exercise therapy. *J Reality Ther*. 1992;12(1):32-6. OVID-PsycINFO.

Exclude: Not an eligible guideline

Uebelacker LA, Tremont G, Epstein-Lubow G, et al. Open trial of Vinyasa yoga for persistently depressed individuals: Evidence of feasibility and acceptability. *Behav Modif*. 2010;34(3):247-64. OVID-PsycINFO.

Exclude: Not an eligible study design

Uebelhack R, Gruenwald J, Graubaum HJ, et al. Efficacy and tolerability of Hypericum extract STW 3-VI in patients with moderate depression: A double-blind, randomized, placebo-controlled clinical trial. *Adv Ther*. 2004;21(4):265-75. PMID:15605620 OVID-Medline.

Exclude: Not an eligible study design

Uehlinger C, Nil R, Amey M, et al. Citalopram-lithium combination treatment of elderly depressed patients: A pilot study. *Int J Geriatr Psychiatry*. 1995;10(4):281-7. OVID-Embase.

Exclude: Not an eligible study design

Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA*. 2002;288(22):2836-45. OVID-Embase.

Exclude: Not an eligible population treatment

Unutzer J, Hantke M, Powers D, et al. Care management for depression and osteoarthritis pain in older primary care patients: A pilot study. *Int J Geriatr Psychiatry*. 2008;23(11):1166-71. OVID-Embase.

Exclude: Not an eligible study design

Ushiroyama T, Ikeda A, Sakuma K, et al. Chai-hu-gui-zhi-gan-jiang-tang regulates plasma interleukin-6 and soluble interleukin-6 receptor concentrations and improves depressed mood in climacteric women with insomnia. *Am J Chin Med*. 2005;33(5):703-11. PMID:16265982 OVID-Medline.

Exclude: Not an eligible population treatment

Valliant PM, Asu ME. Exercise and its effects on cognition and physiology in older adults. *Percept Motor Skills*. 1985;61(3 II):1031-8. OVID-Embase

OVID-Embase.

Exclude: Not an eligible population treatment

Van't Veer-Tazelaar PJ, Van Marwijk HWJ, van OP, et al. Prevention of late-life anxiety and depression has sustained effects over 24 months: A pragmatic randomized trial. *Am J Geriatr Psychiatry*. 2011;19(3):230-9. OVID-Embase.

Exclude: Not an eligible population/treatment

van Bastelaar KM, Pouwer F, Cuijpers P, et al. Web-based cognitive behavioural therapy (W-CBT) for diabetes patients with co-morbid depression: Design of a randomised controlled trial. *BMC Psychiatry*. 2008;8:9 PMID:18284670 OVID-Medline.

Exclude: Not an eligible study design

van Bastelaar KMP, Pouwer F, Cuijpers P, et al. Web-based depression treatment for type 1 and type 2 diabetic patients: A randomized, controlled trial. *Diabet Care*. 2011;34(2):320-5. OVID-Embase.

Exclude: Not an eligible population/treatment

van Calker D, Zobel I, Dykieriek P, et al. Time course of response to antidepressants: Predictive value of early improvement and effect of additional psychotherapy. *J Affect Disord*. 2009;114(1-3):243-53. PMID:18849079 OVID-Medline.

Exclude: Not an eligible population treatment

van Coppenolle H, Pieters G, Knapen J, et al. Psychomotor therapy in depressive patients. *Issues Special Ed Rehab*. 1993;8(2):29-34. OVID-PsycINFO.

Exclude: Not an eligible study design

Van de Vliet P, Knapen J, Fox KR, et al. Changes in psychological well-being in female patients with clinically diagnosed depression: An exploratory approach in a therapeutic setting. *Psychol Health Med*. 2003;8(4):399-408. EBSCO-CINAHL.

Exclude: Not an eligible study design

van de RO, Geleijnse JM, Kok FJ, et al. Effect of fish-oil supplementation on mental well-being in older subjects: A randomized, double-blind, placebo-controlled trial. *Am J Clin Nutr.* 2008;88(3):706-13. PMID:18779287 Exclude: Not an eligible population treatment

Van Den Berg S, Shapiro DA, Bickerstaffe D, et al. Computerized cognitive-behaviour therapy for anxiety and depression: A practical solution to the shortage of trained therapists. *J Psychiatr Ment Health Nurs.* 2004;11(5):508-13. OVID-PsycINFO. Exclude: Not an eligible study design

van den Hout JH, Arntz A, Kunkels FH. Efficacy of a self-control therapy program in a psychiatric day-treatment center. *Acta Psychiatr Scand.* 1995;92(1):25-9. PMID:7572244 OVID-Medline. Exclude: Not an eligible population treatment

van den Hout M, Brouwers C, Oomen J. Clinically diagnosed axis II co-morbidity and the short term outcome of CBT for axis I disorders. *Clin Psychol Psychother.* 2006;13(1):56-63. OVID-PsycINFO. Exclude: Not an eligible study design

van den BW, Bouhuys AL, van den Hoofdakker RH, et al. Sleep deprivation in bright and dim light: Antidepressant effects on major depressive disorder. *J Affect Disord.* 1990;19(2):109-17. PMID:2142697 OVID-Medline. Exclude: Not an eligible population treatment

van der Kolk BA, Spinazzola J, Blaustein ME, et al. A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: Treatment effects and long-term maintenance. *J Clin Psychiatry.* 2007;68(1):37-46. PMID:17284128 OVID-Medline. Exclude: Not an eligible population treatment

van der Merwe I, Naude S. Exercise and depression: A treatment manual. *Health SA Gesondheid.* 2004;9(4):28-41. EBSCO-CINAHL. Exclude: Not an eligible population treatment

Van Der Waerden JEB, Hoefnagels C, Hosman CMH. Psychosocial preventive interventions to reduce depressive symptoms in low-SES women at risk: A meta-analysis. *J Affect Disord.* 2011;128(1-2):10-23. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

van Gorp G, Meterissian GB, Haiek LN, et al. St John's wort or sertraline? Randomized controlled trial in primary care. *Can Fam Physician.* 2002;48:905-12. PMID:12053635 OVID-Medline. Exclude: Not an eligible population treatment

van Hiele LJ. 1-5-Hydroxytryptophan in depression: The first substitution therapy in psychiatry? The treatment of 99 out-patients with 'therapy-resistant' depressions. *Neuropsychobiol.* 1980;6(4):230-40. PMID:6967194 OVID-Medline. Exclude: Not an eligible study design

Van Houdenhove B, Onghena P, Floris M, et al. An open study of sertraline in acute and continuation treatment of depressed out-patients. *J Int Med Res.* 1997;25(6):340-53. PMID:9427167 OVID-Medline. Exclude: Not an eligible study design

van Marwijk HW, Bekker FM, Nolen WA, et al. Lithium augmentation in geriatric depression. *J Affect Disord.* 1990;20(4):217-23. PMID:2149727 OVID-Medline. Exclude: Not an eligible study design

van Marwijk HW, Ader H, de Haan M, et al. Primary care management of major depression in patients aged > or =55 years: Outcome of a randomised clinical trial. *Br J Gen Pract.* 2008;58(555):680-6. PMID:18826778 OVID-Medline. Exclude: Not an eligible population treatment

van Melle JP, de Jonge P, Honig A, et al. Effects of antidepressant treatment following myocardial infarction. *Br J Psychiatry.* 2007;190(JUNE):460-6. OVID-Embase. Exclude: Not an eligible population treatment

van Moffaert M, Dierick M, De Meulemeester F, et al. Treatment of depressive anxiety states associated with psychosomatic symptoms. A double-blind multicentre clinical study: mianserin versus melitracen-flupentixol. *Acta Psychiatr Belg.* 1983;83(5):525-39. PMID:6670581 OVID-Medline. Exclude: Not an eligible population treatment

van Moffaert M, Bartholome F, Cosyns P, et al. A controlled comparison of sertraline and fluoxetine in acute and continuation treatment of major depression. *Hum Psychopharmacol.* 1995;10(5):393-405. OVID-Embase. Exclude: Mixed antidepressants:some failed on SSRI

van Os TW, van den Brink RH, Tiemens BG, et al. Communicative skills of general practitioners augment the effectiveness of guideline-based depression treatment. *J Affect Disord.* 2005;84(1):43-51. PMID:15620384 OVID-Medline. Exclude: Not an eligible study design

van Praag H, de Hann S. Depression vulnerability and 5-hydroxytryptophan prophylaxis. *Psychiatry Res.* 1980;3(1):75-83. PMID:6160599 OVID-Medline. Exclude: Not an eligible population treatment

- Van Praag HM, de Haan S. Chemoprophylaxis of depressions. An attempt to compare lithium with 5-hydroxytryptophan. *Acta Psychiatr Scand Suppl.* 1981;290:191-201. PMID:6164250 OVID-Medline. Exclude: Not an eligible population treatment
- van Roijen LH, van Straten A, Al M, et al. Cost-utility of brief psychological treatment for depression and anxiety. *Br J Psychiatr.* 2006;188:323-9. PMID:16582058 OVID-Medline. Exclude: Not an eligible population treatment
- van Schaik A, van Marwijk H, Ader H, et al. Interpersonal psychotherapy for elderly patients in primary care. *Am J Geriatr Psychiatry.* 2006;14(9):777-86. PM:16943174 Exclude: Not an eligible population treatment
- Van Voorhees BW, Fogel J, Reinecke MA, et al. Randomized clinical trial of an Internet-based depression prevention program for adolescents (Project CATCH-IT) in primary care: 12-week outcomes. *J Develop Behav Pediatr.* 2009;30(1):23-37. PMID:19194326 OVID-Medline. Exclude: Not an eligible population treatment
- Van HL, Dekker J, Koelen J, et al. Patient preference compared with random allocation in short-term psychodynamic supportive psychotherapy with indicated addition of pharmacotherapy for depression. *Psychother Res.* 2009;19(2):205-12. PMID:19396651 OVID-Medline. Exclude: Not an eligible population treatment
- van SA, Geraedts A, Verdonck-de L, I, et al. Psychological treatment of depressive symptoms in patients with medical disorders: A meta-analysis. *J Psychosom Res.* 2010;69(1):23-32. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched
- Vanelle J-M, Attar-Levy D, Poirier M-F, et al. Controlled efficacy study of fluoxetine in dysthymia. *Br J Psychiatr.* 1997;170(APR.):345-50. OVID-Embase. Exclude: Not an eligible population treatment
- Varney NR, Garvey MJ, Cook BL, et al. Identification of treatment-resistant depressives who respond favorably to carbamazepine. *Ann Clin Psychiatr.* 1993;5(2):117-22. PMID:8348203 OVID-Medline. Exclude: Not an eligible study design
- Veale D, Le Fevre K, Pantelis C, et al. Aerobic exercise in the adjunctive treatment of depression: A randomized controlled trial. *J R Soc Med.* 1992;85(9):541-4. PMID:1433121 OVID-Medline. Exclude: Not an eligible population treatment
- Veer-Tazelaar PJ, van Marwijk HW, van Oppen P, et al. Stepped-care prevention of anxiety and depression in late life: A randomized controlled trial. *Arch Gen Psychiatr.* 2009;66(3):297-304. PMID:19255379 OVID-Medline. Excluded
- Verduyn C, Barrowclough C, Roberts J, et al. Maternal depression and child behaviour problems. Randomised placebo-controlled trial of a cognitive-behavioural group intervention. *Br J Psychiatr.* 2003;183:342-8. PMID:14519613 OVID-Medline. Exclude: Not an eligible population treatment
- Vergouwen AC, Bakker A, Burger H, et al. A cluster randomized trial comparing two interventions to improve treatment of major depression in primary care. *Psychol Med.* 2005;35(1):25-33. PMID:15842026 OVID-Medline. Exclude: Not an eligible population treatment
- Verhoeven WMA. Antidepressive effects of the selective MAO-inhibitor brofaromine: An open trial. *Eur Psychiatr.* 1992;7(5):243-7. OVID-Embase. Exclude: Not an eligible study design
- Verkaik R, van Weert JCM, Francke AL. The effects of psychosocial methods on depressed, aggressive and apathetic behaviors of people with dementia: A systematic review. *Int J Geriatr Psychiatry.* 2005;20(4):301-14. EBSCO-CINAHL. Excluded - Systematic review - relevant topic, citations cross-matched
- Vernmark K, Lenndin J, Bjarehed J, et al. Internet administered guided self-help versus individualized e-mail therapy: A randomized trial of two versions of CBT for major depression. *Behav Res Ther.* 2010;48(5):368-76. OVID-Embase. Exclude: Not an eligible population treatment
- Vezmar S, Miljkovic B, Vucicevic K, et al. Pharmacokinetics and efficacy of fluvoxamine and amitriptyline in depression. *J Pharmacol Sci.* 2009;110(1):98-104. PMID:19444001 OVID-Medline. Exclude: Not an eligible population treatment
- Vigo DV, Baldessarini RJ. Anticonvulsants in the treatment of major depressive disorder: An overview. *Harv Rev Psychiatry.* 2009;17(4):231-41. OVID-PscINFO. Excluded - Systematic review - relevant topic, citations cross-matched
- Viinamaki H, Hintikka J, Tanskanen A, et al. Partial remission in major depression: A two-phase, 12-month prospective study. *Nord J Psychiatr.* 2002;56(1):33-7. Exclude: Not an eligible study design

Villafuerte SM, Vallabhaneni K, Sliwerska E, et al. SSRI response in depression may be influenced by SNPs in HTR1B and HTR1A. *Psychiatr Genet*. 2009;19(6):281-91. PMID:19829169 OVID-Medline.

Exclude: Not an eligible population treatment

Vinar O. Tranylcypromine in treatment of resistant depression. *Act Nerv Super*. 1984;26(4):239-41. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Vinar O, Dvorak A, Obrovská V, et al. Does sodium valproate increase clinical effects of antidepressants? *Act Nerv Super*. 1989;31(2):103-5. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Vinar O, Vinarova E. Tianeptine helps depressed patients resistant to serotonin function enhancing drugs. *Homeost Health Dis*. 1997;38(4):170-2. OVID-PsycINFO.

Exclude: Not an eligible study design

Vitiello B, Rohde P, Silva S, et al. Functioning and quality of life in the Treatment for Adolescents with Depression Study (TADS). *J Am Acad Child Adolesc Psychiatry*. 2006;45(12):1419-26. PMID:17135987 OVID-Medline.

Exclude: Not an eligible population treatment

Vitiello B. The Treatment of Resistant Depression in Adolescents (TORDIA) Study: A research update. In 2006. Wiley-CCTR.

Exclude: Not an eligible study design

Vitiello B, Brent DA, Greenhill LL, et al. Depressive Symptoms and Clinical Status During the Treatment of Adolescent Suicide Attempters (TASA) Study. *J Am Acad Child Adolesc Psychiatry*. 2009;48(10):997-1004. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Vitiello B. Combined fluoxetine with cognitive-behavioral therapy vs. monotherapy in the treatment of adolescents with major depressive disorder. *Dir Psychiatr*. 2007;27(2):73-82. OVID-PsycINFO.

Excluded - Systematic review - relevant topic, citations cross-matched

Vitriol VG, Ballesteros ST, Florenzano RU, et al. Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. *Psychiatr Serv*. 2009;60(7):936-42. PMID:19564224 Exclude: Not an eligible population treatment

Vittengl JR, Clark LA, Dunn TW, et al. Reducing relapse and recurrence in unipolar depression: A comparative meta-analysis of cognitive-behavioral therapy's effects. *J Consult Clin Psychol*. 2007;75(3):475-88. PMID:17563164 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Vittengl JR, Clark LA, Jarrett RB. Continuation-phase cognitive therapy's effects on remission and recovery from depression. *J Consult Clin Psychol*. 2009;77(2):367-71. PMID:19309197 OVID-Medline.

Exclude: Not an eligible population treatment

Vittengl JR, Clark LA, Jarrett RB. Moderators of continuation phase cognitive therapy's effects on relapse, recurrence, remission, and recovery from depression. *Behav Res Ther*. 2010;48(6):449-58. OVID-Embase.

Exclude: Not an eligible population treatment

Volz HP, Mackert A, Stieglitz RD, et al. Effect of bright white light therapy on non-seasonal depressive disorder. Preliminary results. *J Affect Disord*. 1990;19(1):15-21. PMID:2140842 OVID-Medline.

Exclude: Not an eligible population treatment

Volz HP, Faltus F, Magyar I, et al. Brofaromine in treatment-resistant depressed patients--a comparative trial versus tranylcypromine. *J Affect Disord*. 1994;30(3):209-17. PMID:8006247 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Von Korff M, Katon W, Bush T, et al. Treatment costs, cost offset, and cost-effectiveness of collaborative management of depression. *Psychosom Med*. 1998;60(2):143-9. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Voon V, Lang AE. Antidepressant treatment outcomes of psychogenic movement disorder. *J Clin Psychiatry*. 2005;66(12):1529-34. PMID:16401153 OVID-Medline.

Exclude: Not an eligible study design

Vorbach EU, Hubner WD, Arnoldt KH. Effectiveness and tolerance of the hypericum extract LI 160 in comparison with imipramine: Randomized double-blind study with 135 outpatients. *J Geriatr Psychiatry Neurol*. 1994;7:Suppl-23 PMID:7857502 OVID-Medline.

Exclude: Not an eligible population treatment

Vorbach EU, Arnoldt KH, Hubner WD. Efficacy and tolerability of St. John's wort extract LI 160 versus imipramine in patients with severe depressive episodes according to ICD-10. *Pharmacopsychiatr.* 1997;30:Suppl-5 PMID:9342765 OVID-Medline.
Exclude: Not an eligible population treatment

Vos T, Corry J, Haby MM, et al. Cost-effectiveness of cognitive-behavioural therapy and drug interventions for major depression. *Aust NZ J Psychiatr.* 2005;39(8):683-92. PMID:16050922 OVID-Medline.
Exclude: Not an eligible population treatment

Vostanis P, Feehan C, Grattan E, et al. A randomised controlled out-patient trial of cognitive-behavioural treatment for children and adolescents with depression: 9-month follow-up. *J Affect Disord.* 1996;40(1-2):105-16. PMID:8882920 OVID-Medline.
Exclude: Not an eligible population treatment

Vostanis P, Feehan C, Grattan E. Two-year outcome of children treated for depression. *Eur Child Adolesc Psychiatry.* 1998;7(1):12-8. PMID:9563808 OVID-Medline.
Exclude: Not an eligible population treatment

Vostanis P, Feehan C, Grattan E, et al. Treatment for children and adolescents with depression: Lessons from a controlled trial. *Clin Child Psychol Psychiatry.* 1996;1(2):199-212. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Wade AG. Use of the internet to assist in the treatment of depression and anxiety: A systematic review. *Prim Care Comp J Clin Psychiatr.* 2010;12(4):e1-e11 OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Wagner,J.J. A meta-analysis/literature review comparing the effectiveness of SSRI antidepressants, cognitive behavioral therapy, and placebo for the treatment of depression Wagner. 2005. OVID-PsycINFO.
Exclude: Not an eligible study design

Walderhaug E, Kasserman S, Aikins D, et al. Effects of duloxetine in treatment-refractory men with posttraumatic stress disorder. *Pharmacopsychiatr.* 2010;43(2):45-9. PMID:20108200 OVID-Medline.
Exclude: Not an eligible study design

Waldkoetter RO, Sanders GO. Auditory brainwave stimulation in treating alcoholic depression. *Percept Motor Skills.* 1997;84(1):226 PMID:9132712 OVID-Medline.
Exclude: Not an eligible population treatment

Walinder J, Skott A, Carlsson A, et al. Potentiation of the antidepressant action of clomipramine by tryptophan. *Arch Gen Psychiatr.* 1976;33(11):1384-9. Wiley-CCTR.
Exclude: Not an eligible population treatment

Walinder J, Carlsson A, Persson R, et al. Potentiation of the effect of antidepressant drugs by tryptophan. *Acta Psychiatr Scand Suppl.* 1980;280:243-9. PMID:6447432 OVID-Medline.
Exclude: Not an eligible population treatment

Walinder J, Carlsson A, Persson R. 5-HT reuptake inhibitors plus tryptophan in endogenous depression. *Acta Psychiatr Scand Suppl.* 1981;290:179-90. PMID:6452791 OVID-Medline.
Exclude: Not an eligible population treatment

Walker CE, Elliott C, Koehn R. Nitrous oxide: A potential unconditioned positive stimulus in cognitive therapy for depression. *Behav Therapist.* 1987;10(4):90-2. OVID-PsycINFO.
Exclude: Not an eligible population treatment

Walker JG, Mackinnon AJ, Batterham P, et al. Mental health literacy, folic acid and vitamin B12, and physical activity for the prevention of depression in older adults: Randomised controlled trial. *Br J Psychiatr.* 2010;197(1):45-54. PMID:20592433 OVID-Medline.
Exclude: Not an eligible population treatment

Walker R. Electroconvulsive therapy during high-risk pregnancy. *Gen Hosp Psychiatry.* 1994;16(5):348-53. OVID-Embase.
Exclude: Not an eligible guideline

Wallis DAN. Depression, anxiety and self-esteem: A clinical field study. *Behav Change.* 2002;19(2):112-20. OVID-PsycINFO.
Exclude: Not an eligible study design

Walter D, Hautmann C, Rizk S, et al. Short term effects of inpatient cognitive behavioral treatment of adolescents with anxious-depressed school absenteeism: An observational study. *Eur Child Adolesc Psychiatry.* 2010;19(11):835-44. PMID:20835738 OVID-Medline.
Exclude: Not an eligible study design

Walter M, Hanni B, Haug M, et al. Humour therapy in patients with late-life depression or Alzheimer's disease: A pilot study. *Int J Geriatr Psychiatry.* 2007;22(1):77-83. PMID:16977676 OVID-Medline.
Exclude: Not an eligible population treatment

Wan DD, Kundhur D, Solomons K, et al. Mirtazapine for treatment-resistant depression: A preliminary report. *J Psychiatr Neurosci*. 2003;28(1):55-9. PMID:12587851 OVID-Medline.
Exclude: Not an eligible study design

Wan H, Chen Y. Effects of antidepressive treatment of Saint John's Wort Extract related to autonomic nervous function in women with irritable bowel syndrome. *Int J Psychiatry Med*. 2010;40(1):45-56. EBSCO-CINAHL.
Exclude: Not an eligible population/treatment

Wang C, Bannuru R, Ramel J, et al. Tai Chi on psychological well-being: Systematic review and meta-analysis. *BMC Compl Altern Med*. 2010;10:23. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Wang H. Acupuncture treatment of depressive syndromes after cerebral vascular accidents. *J Tradit Chin Med*. 2002;22(4):274-5. PMID:16579090 OVID-Medline.
Exclude: Not an eligible study design

Wang H, Qi H, Wang BS, et al. Is acupuncture beneficial in depression: A meta-analysis of 8 randomized controlled trials? *J Affect Disord*. 2008;111(2-3):125-34. PMID:18550177 OVID-Medline.
Excluded - Systematic review - relevant topic, citations cross-matched

Wang L, Li J. Role of educational intervention in the management of comorbid depression and hypertension. *Blood Press*. 2003;12(4):198-202. OVID-Embase.
Exclude: Not an eligible population treatment

Wang PS, Simon GE, Avorn J, et al. Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: A randomized controlled trial. *JAMA*. 2007;298(12):1401-11. PMID:17895456 OVID-Medline.
Exclude: Not an eligible population treatment

Wang Y, Fang YR, Chen XS, et al. A follow-up study on features of sensory gating P50 in treatment-resistant depression patients. *Chin Med J*. 2009;122(24):2956-60. PMID:20137481 OVID-Medline.
Exclude: Mixed antidepressants:some failed on SSRI

Wang Z, Kemp DE, Chan PK, et al. Comparisons of the tolerability and sensitivity of quetiapine-XR in the acute treatment of schizophrenia, bipolar mania, bipolar depression, major depressive disorder, and generalized anxiety disorder. *Int J Neuropsychopharmacol*. 2011;14(1):131-42. OVID-PsycINFO.
Excluded - Systematic review - relevant topic, citations cross-matched

Ward E, King M, Lloyd M, et al. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I: Clinical effectiveness. *Br Med J*. 2000;321(7273):1383-8. PMID:11099284 OVID-Medline.
Exclude: Not an eligible population treatment

Ward EC. Examining differential treatment effects for depression in racial and ethnic minority women: A qualitative systematic review. *J Natl Med Assoc*. 2007;99(3):265-74. OVID-Embase.
Excluded - Systematic review - relevant topic, citations cross-matched

Warden DL, Gordon B, McAllister TW, et al. Guidelines for the pharmacologic treatment of neurobehavioral sequelae of traumatic brain injury. *J Neurotrauma*. 2006;23(10):1468-501. OVID-Embase.
Exclude: Not an eligible guideline

Warmerdam L, van Straten A, Twisk J, et al. Internet-based treatment for adults with depressive symptoms: Randomized controlled trial. *J Med Internet Res*. 2008;10(4):-December OVID-Embase.
Exclude: Not an eligible population treatment

Warmerdam L, van Straten A, Jongsma J, et al. Online cognitive behavioral therapy and problem-solving therapy for depressive symptoms: Exploring mechanisms of change. *J Behav Ther Exp Psychiatr*. 2010;41(1):64-70. PMID:19913781 OVID-Medline.
Exclude: Not an eligible population treatment

Warnock JK, Bundren JC, Morris DW. Sertraline in the treatment of depression associated with gonadotropin-releasing hormone agonist therapy. *Biol Psychiatr*. 1998;43(6):464-5. PMID:9532352 OVID-Medline.
Exclude: Not an eligible population treatment

Waslick BD, Walsh BT, Greenhill LL, et al. Open trial of fluoxetine in children and adolescents with dysthymic disorder or double depression. *J Affect Disord*. 1999;56(2-3):227-36. PMID:10701482 OVID-Medline.
Exclude: Not an eligible study design

Watanabe N, Hunot V, Omori IM, et al. Psychotherapy for depression among children and adolescents: A systematic review. *Acta Psychiatr Scand*. 2007;116(2):84-95. PMID:17650269 OVID-Medline.

Exclude - Systematic review - relevant topic, citations cross-matched

Watkins ER, Baeyens CB, Read R. Concreteness training reduces dysphoria: Proof-of-principle for repeated cognitive bias modification in depression. *J Abnorm Psychol*. 2009;118(1):55-64. PMID:19222314 OVID-Medline.

Exclude: Not an eligible population design

Watkins ER, Baeyens CB, Read R. Concreteness training reduces dysphoria: Proof-of-principle for repeated cognitive bias modification in depression. *J Abnorm Psychol*. 2009;118(1):55-64. PM:19222314

Exclude: Not an eligible population treatment

Watkins JT, Leber WR, Imber SD, et al. Temporal course of change of depression. *J Consult Clin Psychol*. 1993;61(5):858-64. PMID:8245283 OVID-Medline.

Exclude: Not an eligible population treatment

Watson HJ, Nathan PR. Role of gender in depressive disorder outcome for individual and group cognitive-behavioral treatment. *J Clin Psychiatry*. 2008;64(12):1323-37. PMID:18825696 OVID-Medline.

Exclude: Not an eligible population treatment

Watson JC, Gordon LB, Stermac L, et al. Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *J Consult Clin Psychol*. 2003;71(4):773-81. PMID:12924682 OVID-Medline.

Exclude: Not an eligible population treatment

Watt LM, Cappeliez P. Integrative and instrumental reminiscence therapies for depression in older adults: Intervention strategies and treatment effectiveness. *Aging Ment Health*. 2000;4(2):166-77. OVID-Embase.

Exclude: Not an eligible population treatment

Weber BA, Roberts BL, Resnick M, et al. The effect of dyadic intervention on self-efficacy, social support, and depression for men with prostate cancer. *Psychooncol*. 2004;13(1):47-60. OVID-Embase.

Exclude: Not an eligible population treatment

Weersing VR, Weisz JR. Community clinic treatment of depressed youth: Benchmarking usual care against CBT clinical trials. *J Consult Clin Psychol*. 2002;70(2):299-310. PMID:11952188 OVID-Medline.

Exclude: Not an eligible population treatment

Weersing VR, Iyengar S, Kolko DJ, et al. Effectiveness of cognitive-behavioral therapy for adolescent depression: A benchmarking investigation. *Behav Ther*. 2006;37(1):36-48. PMID:16942959 OVID-Medline.

Exclude: Not an eligible study design

Weilburg JB, Rosenbaum JF, Biederman J, et al. Fluoxetine added to non-MAOI antidepressants converts nonresponders to responders: A preliminary report. *J Clin Psychiatry*. 1989;50(12):447-9. PMID:2600061 OVID-Medline.

Exclude: Not an eligible study design

Weilburg JB, Rosenbaum JF, Meltzer-Brody S, et al. Tricyclic augmentation of fluoxetine. *Ann Clin Psychiatr*. 1991;3(3):209-13. OVID-Embase.

Exclude: Not an eligible study design

Weinstein AA, Deuster PA, Francis JL, et al. The role of depression in short-term mood and fatigue responses to acute exercise. *Int J Behav Med*. 2010;17(1):51-7. OVID-Embase.

Exclude: Not an eligible population treatment

Weintraub D, Streim JE, Datto CJ, et al. Effect of increasing the dose and duration of sertraline trial in the treatment of depressed nursing home residents. *J Geriatr Psychiatry Neurol*. 2003;16(2):109-11. PMID:12801161 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Weintraub D, Morales KH, Moberg PJ, et al. Antidepressant studies in Parkinson's disease: A review and meta-analysis. *Mov Disord*. 2005;20(9):1161-9. OVID-Embase.

Exclude - Systematic review - relevant topic, citations cross-matched

Weiss BD, Francis L, Senf JH, et al. Literacy education as treatment for depression in patients with limited literacy and depression: A randomized controlled trial. *J Gen Intern Med*. 2006;21(8):823-8. OVID-Embase.

Exclude: Not an eligible population treatment

Weiss, J.C. A comparison of cognitive group therapy to life review group therapy with older adults Weiss. 1994. OVID-PsycINFO.

Exclude: Not an eligible study design

Weiss M, Nordlie JW, Siegel EP. Mindfulness-based stress reduction as an adjunct to outpatient psychotherapy. *Psychother Psychosom*. 2005;74(2):108-12. PMID:15741760 OVID-Medline.

Exclude: Not an eligible population treatment

Weissman MM, Kasl SV, Klerman GL. Follow-up of depressed women after maintenance treatment. *Am J Psychiatry*. 1976;133(7):757-60. Wiley-CCTR.

Exclude: Not an eligible population treatment

Weissman MM, Klerman GL, Prusoff BA, et al. Depressed outpatients. Results one year after treatment with drugs and/or interpersonal psychotherapy. *Arch Gen Psychiatr*. 1981;38(1):51-5. Wiley-CCTR.

Exclude: Not an eligible population treatment

Weissman MM, Prusoff B, Sholomskas AJ, et al. A double-blind clinical trial of alprazolam, imipramine, or placebo in the depressed elderly. *J Clin Psychopharmacol*. 1992;12(3):175-82. PMID:1629383 OVID-Medline.

Exclude: Not an eligible population treatment

Weist MD, Paskewitz DA, Warner BS, et al. Treatment outcome of school-based mental health services for urban teenagers. *Community Ment Health J*. 1996;32(2):149-57. PMID:8777871 OVID-Medline.

Exclude: Not an eligible population treatment

Weisz JR, Southam-Gerow MA, Gordis EB, et al. Cognitive-behavioral therapy versus usual clinical care for youth depression: An initial test of transportability to community clinics and clinicians. *J Consult Clin Psychol*. 2009;77(3):383-96. PMID:19485581 OVID-Medline.

Exclude: Not an eligible population treatment

Weisz JR, Thurber CA, Sweeney L, et al. Brief treatment of mild-to-moderate child depression using primary and secondary control enhancement training. *J Consult Clin Psychol*. 1997;65(4):703-7. OVID-PscINFO.

Exclude: Not an eligible population treatment

Wells A, Fisher P, Myers S, et al. Metacognitive therapy in recurrent and persistent depression: A multiple-baseline study of a new treatment. *Cognit Ther Res*. 2009;33(3):291-300. OVID-Embase.

Exclude: Not an eligible study design

Wells BG, Evans RL, Ereshefsky L, et al. Clinical outcome and adverse effect profile associated with concurrent administration of alprazolam and imipramine. *J Clin Psychiatry*. 1988;49(10):394-9. PMID:3049560 OVID-Medline.

Exclude: Not an eligible study design

Werneke U. Risk management of nutritional supplements in chronic illness: The implications for the care of cancer and depression. *Proc Nutr Soc*. 2007;66(4):483-92. OVID-Embase.

Exclude - Systematic review - relevant topic, citations cross-matched

Whale R, Terao T, Cowen P, et al. Pindolol augmentation of serotonin reuptake inhibitors for the treatment of depressive disorder: A systematic review. *J Psychopharmacol*. 2010;24(4):513-20. OVID-Embase.

Exclude - Systematic review - relevant topic, citations cross-matched

Wheatley D. An adrenergic drug in depression. *Arch Gen Psychiatr*. 1975;32(5):653-5. Wiley-CCTR.

Exclude: Not an eligible population treatment

Wheatley D. LI 160, an extract of St. John's wort, versus amitriptyline in mildly to moderately depressed outpatients--a controlled 6-week clinical trial. *Pharmacopsychiatr*. 1997;30:Suppl-80 PMID:9342764 OVID-Medline.

Exclude: Not an eligible population treatment

Wheatley D. Side-effects are no problem with St John's wort in depression. *Prim Care Psychiatr*. 2002;8(1):31-3. Exclude: Not an eligible study design

White K, Pistole T, Boyd JL. Combined monoamine oxidase inhibitor-tricyclic antidepressant treatment: A pilot study. *Am J Psychiatry*. 1980;137(11):1422-5. PMID:7435677 OVID-Medline.

Exclude: Not an eligible population treatment

White K, Wykoff W, Tynes LL, et al. Fluvoxamine in the treatment of tricyclic-resistant depression. *Psychiatr J Univ Ott*. 1990;15(3):156-8. PMID:2123039 OVID-Medline.

Exclude: Not an eligible population treatment

Whitfield G, Hinshelwood R, Pashely A, et al. The impact of a novel computerized CBT CD Rom (overcoming depression) offered to patients referred to clinical psychology. *Behav Cognit Psychother*. 2006;34(1):1-11. OVID-Embase.

Exclude: Not an eligible study design

Whiting M, Leavey G, Scammell A, et al. Using acupuncture to treat depression: A feasibility study. *Complement Ther Med*. 2008;16(2):87-91. PMID:18514910 OVID-Medline.

Exclude: Not an eligible population treatment

Whyte EM, Basinski J, Farhi P, et al. Geriatric depression treatment in nonresponders to selective serotonin reuptake inhibitors. *J Clin Psychiatry*. 2004;65(12):1634-41. PMID:15641868 OVID-Medline.

Exclude: Not an eligible population treatment

Wiegand MH, Lauer CJ, Schreiber W. Patterns of response to repeated total sleep deprivations in depression. *J Affect Disord*. 2001;64(2-3):257-60. PMID:11313092 OVID-Medline.

Exclude: Not an eligible study design

Wiersma JE, van Schaik DJ, van Oppen P, et al. Treatment of chronically depressed patients: A multisite randomized controlled trial testing the effectiveness of 'Cognitive Behavioral Analysis System of Psychotherapy' (CBASP) for chronic depressions versus usual secondary care. *BMC Psychiatr*. 2008;8:18 PMID:18366729 OVID-Medline.

Exclude: Not an eligible study design

Wierzbicki M, Bartlett TS. The efficacy of group and individual cognitive therapy for mild depression. *Cognit Ther Res*. 1987;11(3):337-42. OVID-Embase.

Exclude: Not an eligible population treatment

Wiethoff K, Bauer M, Baghai TC, et al. Prevalence and treatment outcome in anxious versus nonanxious depression: Results from the German algorithm project. *J Clin Psychiatr*. 2010;71(8):1047-54. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Wignall A. Evaluation of a group CBT early intervention program for adolescents with comorbid depression and behaviour problems. *Aust J Guid Couns*. 2006;16(1):119-32. OVID-PsycINFO.

Exclude: Not an eligible study design

Wijeratne C, Sachdev P. Treatment-resistant depression: Critique of current approaches. *Aust NZ J Psychiatr*. 2008;42(9):751-62. PMID:18696279 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Wilhelm K, Niven H, Mitchell P, et al. Actions taken to cope with depression in patients seeking specialist care. *Aust NZ J Psychiatr*. 2006;40(3):239-44. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Wilkie MJ, Smith G, Day RK, et al. Polymorphisms in the SLC6A4 and HTR2A genes influence treatment outcome following antidepressant therapy. *Pharmacogenom J*. 2009;9(1):61-70.

PMID:18253134 OVID-Medline.

Exclude: Not an eligible study design

Wilkinson D, Holmes C, Woolford J, et al. Prophylactic therapy with lithium in elderly patients with Unipolar Major Depression. *Int J Geriatr Psychiatry*. 2002;17(7):619-22. Exclude: Not an eligible population treatment

Wilkinson P, Alder N, Juszcak E, et al. A pilot randomised controlled trial of a brief cognitive behavioural group intervention to reduce recurrence rates in late life depression. *Int J Geriatr Psychiatry*. 2009;24(1):68-75. PMID:18615497 OVID-Medline.

Exclude: Not an eligible population treatment

Wilkinson P. In adolescents with SSRI resistant depression, CBT/combined treatment is most effective in those with comorbid disorders. *Evid Based Ment Health*. 2009;12(4):108 EBSCO-CINAHL.

Exclude: Not an eligible study design

Wilkinson PO, Goodyer IM. The effects of cognitive-behavioural therapy on mood-related ruminative response style in depressed adolescents. *Child and Adolescent Psychiatry and Mental Health*. 2008;2, 2008. Article Number: 3. Date of Publication: 29 Jan 2008.: OVID-Embase.

Exclude: Not an eligible population treatment

Wilkinson SM, Love SB, Westcombe AM, et al. Effectiveness of aromatherapy massage in the management of anxiety and depression in patients with cancer: A multicenter randomized controlled trial. *J Clin Oncol*. 2007;25(5):532-9.

PMID:17290062 OVID-Medline.

Exclude: Not an eligible population treatment

Willemse GRWM, Smit F, Cuijpers P, et al. Minimal-contact psychotherapy for sub-threshold depression in primary care: Randomised trial. *Br J Psychiatr*. 2004;185(NOV.):416-21. OVID-Embase.

Exclude: Not an eligible population treatment

Williams A-L, Cotter A, Sabina A, et al. The role for vitamin B-6 as treatment for depression: A systematic review. *Fam Pract*. 2005;22(5):532-7. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Williams AL, Girard C, Jui D, et al. S-adenosylmethionine (S-AMe) as treatment for depression: A systematic review. *Clin Invest Med*. 2005;28(3):132-9. PMID:16021987 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Williams AL, Cotter A, Sabina A, et al. The role for vitamin B-6 as treatment for depression: A systematic review. *Fam Pract*. 2005;22(5):532-7. PMID:15964874 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Williams AL, Katz D, Ali A, et al. Do essential fatty acids have a role in the treatment of depression? *J Affect Disord*. 2006;93(1-3):117-23. PMID:16650900 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Williams CL, Tappen RM. Exercise training for depressed older adults with Alzheimer's disease. *Aging Ment Health*. 2008;12(1):72-80. PMID:18297481 OVID-Medline. Exclude: Not an eligible population design

Williams J, Graham C. Acupuncture for older adults with depression-a pilot study to assess acceptability and feasibility. *Int J Geriatr Psychiatry*. 2006;21(6):599-600. PMID:16783799 OVID-Medline. Exclude: Not an eligible study design

Williams JW, Jr., Mulrow CD, Chiquette E, et al. Clinical guideline, part 2. A systematic review of newer pharmacotherapies for depression in adults: Evidence report summary. *Ann Intern Med*. 2000;132(9):743-56. EBSCO-CINAHL. Exclude: Not an eligible guideline

Williams JW, Jr., Barrett J, Oxman T, et al. Treatment of dysthymia and minor depression in primary care: A randomized controlled trial in older adults. *JAMA*. 2000;284(12):1519-26. PMID:11000645 OVID-Medline. Exclude: Not an eligible population treatment

Williams JM, Getty D. Effect of levels of exercise on psychological mood states, physical fitness, and plasma beta-endorphin. *Percept Motor Skills*. 1986;63(3):1099-105. OVID-PsycINFO. Exclude: Not an eligible population treatment

Williams LS, Kroenke K, Bakas T, et al. Care management of poststroke depression: A randomized, controlled trial. *Stroke*. 2007;38(3):998-1003. PMID:17303771 OVID-Medline. Exclude: Not an eligible population design

Williams S, Dale J. The effectiveness of treatment for depression/depressive symptoms in adults with cancer: A systematic review. *Br J Cancer*. 2006;94(3):372-90. OVID-Embase. Excluded - Systematic review - relevant topic, citations cross-matched

Williams VP, Bishop-Fitzpatrick L, Lane JD, et al. Video-based coping skills to reduce health risk and improve psychological and physical well-being in Alzheimer's disease family caregivers. *Psychosom Med*. 2010;72(9):897-904. PMID:20978227 OVID-Medline. Exclude: Not an eligible population treatment

Wilson GL. Psychotherapy with depressed incarcerated felons: A comparative evaluation of treatments. *Psychol Rep*. 1990;67(3:Pt 1):t-41 PMID:2287655 OVID-Medline. Exclude: Not an eligible population treatment

Wilson KC, Scott M, Abou-Saleh M, et al. Long-term effects of cognitive-behavioural therapy and lithium therapy on depression in the elderly. *Br J Psychiatr*. 1995;167(5):653-8. PMID:8564323 OVID-Medline. Exclude: Not an eligible population treatment

Wilson KC, Mottram PG, Vassilas CA. Psychotherapeutic treatments for older depressed people. *Cochrane Database Syst Rev*. 2008;(1):CD004853. PMID:18254062 OVID-Medline. Excluded - Systematic review - relevant topic, citations cross-matched

Wilson PH. Combined pharmacological and behavioural treatment of depression. *Behav Res Ther*. 1982;20(2):173-84. OVID-Embase. OVID-Embase. Exclude: Not an eligible population treatment

Wilson PH. Cognitive-behaviour therapy for depression: Empirical findings and methodological issues in the evaluation of outcome. *Behav Change*. 1989;6(2):85-95. OVID-Embase. Exclude: Not an eligible study design

Wilson PH, Goldin JC, Charbonneau-Powis M. Comparative efficacy of behavioral and cognitive treatments of depression. *Cognit Ther Res*. 1983;7(2):111-24. OVID-PsycINFO. Exclude: Not an eligible population treatment

Wilz G, Barskova T. Evaluation of a cognitive behavioral group intervention program for spouses of stroke patients. *Behav Res Ther*. 2007;45(10):2508-17. OVID-Embase. Exclude: Not an eligible population treatment

Winkler D, Willeit M, Wolf R, et al. Clonazepam in the long-term treatment of patients with unipolar depression, bipolar and schizoaffective disorder. *Eur Neuropsychopharmacol.* 2003;13(2):129-34. PMID:12650958 OVID-Medline.

Exclude: Not an eligible study design

Winningham RG, Anunsen R, Hanson LM, et al. MemAerobics: A Cognitive Intervention to Improve Memory Ability and Reduce Depression in Older Adults. *J Ment Health Aging.* 2003;9(3):183-92. OVID-Embase.

Exclude: Not an eligible population treatment

Wisniewski SR, Fava M, Trivedi MH, et al. Acceptability of second-step treatments to depressed outpatients: A STAR*D report. *Am J Psychiatry.* 2007;164(5):753-60. PMID:17475734 OVID-Medline.

Exclude: Not an eligible population treatment

Wisniewski SR, Chen CC, Kim E, et al. Global benefit-risk analysis of adjunctive aripiprazole in the treatment of patients with major depressive disorder. *Pharmacoevidenciol Drug Saf.* 2009;18(10):965-72. PMID:19662630 OVID-Medline.

Exclude: Not an eligible population treatment

Wisniewski SR, Rush AJ, Nierenberg AA, et al. Can phase III trial results of antidepressant medications be generalized to clinical practice? A STAR*D report. *Am J Psychiatry.* 2009;166(5):599-607. PMID:19339358 OVID-Medline.

Exclude: Not an eligible population/treatment

Woelk H, Burkard G, Grunwald J. Benefits and risks of the hypericum extract LI 160: Drug monitoring study with 3250 patients. *J Geriatr Psychiatry Neurol.* 1994;7:Suppl-8 PMID:7857506 OVID-Medline.

Exclude: Not an eligible study design

Woelk H. Comparison of St John's wort and imipramine for treating depression: Randomised controlled trial. *Br Med J.* 2000;321(7260):536-9. PMID:10968813 OVID-Medline.

Exclude: Not an eligible population treatment

Woggon B, Angst J, Curtius HC. Tetrahydrobiopterin (BH₄) in endogenous depression. *Pharmacopsychiatr.* 1985;18(1):98-9. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Wohlrreich MM, Martinez JM, Mallinckrodt CH, et al. An open-label study of duloxetine for the treatment of major depressive disorder: Comparison of switching versus initiating treatment approaches. *J Clin Psychopharmacol.* 2005;25(6):552-60. PMID:16282837 OVID-Medline.

Exclude: Mixed antidepressants:some failed on SSRI

Wohlrreich MM, Mallinckrodt CH, Watkin JG, et al. Immediate switching of antidepressant therapy: Results from a clinical trial of duloxetine. *Ann Clin Psychiatr.* 2005;17(4):259-68. PMID:16402760 OVID-Medline.

Exclude: Not an eligible study design

Wolfe HL. Electroacupuncture compared to maprotiline in the treatment of depression. *Townsend Letter for Doctors and Patients.* 2003;235-236:168-9. OVID-AMED.

Exclude: Not an eligible population treatment

Wollersheim JP, Wilson GL. Group treatment of unipolar depression: A comparison of coping, supportive, bibliotherapy, and delayed treatment groups. *Prof Psychol Res Pract.* 1991;22(6):496-502. OVID-PsycINFO.

Exclude: Not an eligible population treatment

Wong DF. Cognitive and health-related outcomes of group cognitive behavioural treatment for people with depressive symptoms in Hong Kong: Randomized wait-list control study. *Aust NZ J Psychiatr.* 2008;42(8):702-11. PMID:18622778 OVID-Medline.

Exclude: Not an eligible population treatment

Wong DF. Cognitive behavioral treatment groups for people with chronic depression in Hong Kong: A randomized wait-list control design. *Depress Anxiety.* 2008;25(2):142-8. PMID:17340612 OVID-Medline.

Exclude: Not an eligible population treatment

Wong FKD. A six-month follow-up study of cognitive-behavioural treatment groups for Chinese people with depression in Hong Kong. *Behav Change.* 2009;26(2):130-40. OVID-Embase.

Exclude: Not an eligible study design

Wood A, Harrington R, Moore A. Controlled trial of a brief cognitive-behavioural intervention in adolescent patients with depressive disorders. *J Child Psychol Psychiatr Allied Discipl.* 1996;37(6):737-46. PMID:8894955 OVID-Medline.

Exclude: Not an eligible population treatment

Woods SW, Rizzo JA. Cost effectiveness of antidepressant treatment reassessed. *Br J Psychiatr.* 1997;170(MAR.):257-63. OVID-Embase.

Exclude: Not an eligible study design

Woody S, McLean PD, Taylor S, et al. Treatment of major depression in the context of panic disorder. *J Affect Disord.* 1999;53(2):163-74. PMID:10360411 OVID-Medline.

Exclude: Not an eligible population treatment

Woolery A, Myers H, Sternlieb B, et al. A yoga intervention for young adults with elevated symptoms of depression. *Altern Ther Health Med.* 2004;10(2):60-3. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Worley MJ, Trim RS, Tate SR, et al. Service utilization during and after outpatient treatment for comorbid substance use disorder and depression. *J Subst Abuse Treat.* 2010;39(2):124-31. OVID-Embase.

Exclude: Not an eligible population treatment

Worthington JJ, III, Kinrys G, Wygant LE, et al. Aripiprazole as an augmentor of selective serotonin reuptake inhibitors in depression and anxiety disorder patients. *Int Clin Psychopharmacol.* 2005;20(1):9-11. PMID:15602109 OVID-Medline.

Exclude: Not an eligible study design

Wright A, Cattani M. Physical activity and the management of depression. *Working Older People.* 2009;13(1):15-8. EBSCO-CINAHL.

Exclude: Not an eligible study design

Wright JH, Wright AS, Albano AM, et al. Computer-assisted cognitive therapy for depression: Maintaining efficacy while reducing therapist time. *Am J Psychiatry.* 2005;162(6):1158-64. PMID:15930065 OVID-Medline.

Exclude: Not an eligible population treatment

Wu HS, Lin LC, Wu SC, et al. The psychologic consequences of chronic dyspnea in chronic pulmonary obstruction disease: The effects of acupuncture on depression. *J Altern Complement Med.* 2007;13(2):253-61. PMID:17388769 OVID-Medline.

Exclude: Not an eligible population treatment

Wuerth D, Finkelstein SH, Finkelstein FO. The identification and treatment of depression in patients maintained on dialysis. *Seminars in Dialysis.* 2005;18(2):142-6. PMID:15771659 OVID-Medline.

Exclude: Not an eligible study design

Xia Q, Wang J, Zheng K. Rehabilitative therapy for the elderly chronic somatic disease complicated with depression. *Chin J Clin Rehab.* 2006;10(14):166-8. OVID-Embase.

Exclude: Not an eligible population treatment

Yamada K, Yagi G, Kanba S. Clinical efficacy of tandospirone augmentation in patients with major depressive disorder: A randomized controlled trial. *Psychiatry Clin Neurosci.* 2003;57(2):183-7. PMID:12667165 OVID-Medline.

Exclude: Not an eligible population treatment

Yamada K, Yagi G, Kanba S. Effectiveness of herbal medicine (Rokumigan and Hachimijiogan) for fatigue or loss of energy in patients with partial remitted major depressive disorder. *Psychiatry Clin Neurosci.* 2005;59(5):610-2. PMID:16194267 OVID-Medline.

Exclude: Not an eligible population treatment

Yamada N, Martin-Iverson MT, Daimon K, et al. Clinical and chronobiological effects of light therapy on nonseasonal affective disorders. *Biol Psychiatry.* 1995;37(12):866-73. PMID:7548461 OVID-Medline.

Exclude: Not an eligible population treatment

Yang C, Wen Q, Wang X, et al. Comparative study of citalopram combined with amitriptyline for treatment of refractory depression. *Int Med Health Guid News.* 2005;11(4):69-70. Wiley-CCTR.

Exclude: Not an eligible study design

Yang TT, Hsiao FH, Wang KC, et al. The effect of psychotherapy added to pharmacotherapy on cortisol responses in outpatients with major depressive disorder. *J Nerv Ment Dis.* 2009;197(6):401-6. PMID:19525739 OVID-Medline.

Exclude: Not an eligible population treatment

Yang X, Liu X, Luo H, et al. Clinical observation on needling extrachannel points in treating mental depression. *J Tradit Chin Med.* 1994;14(1):14-8. PMID:8196410 OVID-Medline.

Exclude: Not an eligible population treatment

Yasmin, S. Adjunctive Gabapentin in Treatment Resistant Depression: A retrospective chart review. Carpenter, L. L., Leon, Z, Siniscalchi, J. M., and Price, L. H. *J Affect Disord* 2001;63:243-7. 2001.

Exclude: Not an eligible study design

Yazicioglu B, Akkaya C, Sarandol A, et al. A comparison of the efficacy and tolerability of reboxetine and sertraline versus venlafaxine in major depressive disorder: A randomized, open-labeled clinical trial. *Prog Neuropsychopharmacol Biol Psychiatry.* 2006;30(7):1271-6. PMID:16820257 OVID-Medline.

Exclude: Not an eligible population treatment

Yerevanian BI, Anderson JL, Grota LJ, et al. Effects of bright incandescent light on seasonal and nonseasonal major depressive disorder. *Psychiatry Res.* 1986;18(4):355-64. PMID:3749392 OVID-Medline.

Exclude: Not an eligible study design

Yim VWC, Ng AKY, Tsang HWH, et al. A review on the effects of aromatherapy for patients with depressive symptoms. *J Altern Complement Med.* 2009;15(2):187-95. OVID-PsycINFO.

Excluded - Systematic review - relevant topic, citations cross-matched

Yohannes AM, Caton S. Management of depression in older people with osteoarthritis: A systematic review. *Aging Ment Health.* 2010;14(6):637-51. PMID:20686976 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Yoshimura R, Umene-Nakano W, Ueda N, et al. Addition of risperidone to sertraline improves sertraline-resistant refractory depression without influencing plasma concentrations of sertraline and desmethylsertraline. *Hum Psychopharmacol.* 2008;23(8):707-13. PMID:18803170 OVID-Medline.

Exclude: Not an eligible study design

Yoshimura R, Ikenouchi-Sugita A, Hori H, et al. Adding a low dose atypical antipsychotic drug to an antidepressant induced a rapid increase of plasma brain-derived neurotrophic factor levels in patients with treatment-resistant depression. *Prog Neuropsychopharmacol Biol Psychiatry.* 2010;34(2):308-12. PMID:20005280 OVID-Medline.

Exclude: Not an eligible study design

Yoshino A, Sawamura T, Kobayashi N, et al. Algorithm-guided treatment versus treatment as usual for major depression: Regular Article. *Psychiatry Clin Neurosci.* 2009;63(5):652-7. OVID-Embase.

Exclude: Mixed antidepressants:some failed on SSRI

Young EA, Kornstein SG, Marcus SM, et al. Sex differences in response to citalopram: A STAR*D report. *J Psychiatr Res.* 2009;43(5):503-11. PMID:18752809 OVID-Medline.

Exclude: Not an eligible population/treatment

Young JP, Lader MH, Hughes WC. Controlled trial of trimipramine, monoamine oxidase inhibitors, and combined treatment in depressed outpatients. *Br Med J.* 1979;2(6201):1315-7. Wiley-CCTR.

Exclude: Not an eligible population treatment

Youssef NA, Rich CL. Does acute treatment with sedatives/hypnotics for anxiety in depressed patients affect suicide risk? A literature review. *Ann Clin Psychiatr.* 2008;20(3):157-69. PMID:18633742 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Yuan R, Peng Q, Liao Q, et al. Efficacy of hormone replacement plus antidepressant for anxiety and depression in patients with menopause syndrome. *Chin J Clin Rehab.* 2006;10(2):162-3. OVID-Embase.

Exclude: Not an eligible population treatment

Yury CA, Fisher JE, Antonuccio DO, et al. Meta-analysis of antidepressant augmentation: Piling on in the absence of evidence. *Ethical Hum Psychol Psychiatry.* 2009;11(3):171-82. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Yury, C.A. Analysis of empirical research on augmentation strategies for unipolar depression Yury. 2009. OVID-PsycINFO.

Exclude: Not an eligible study design

Zajacka JM, Jeffriess H, Fawcett J. The efficacy of fluoxetine combined with a heterocyclic antidepressant in treatment-resistant depression: A retrospective analysis. *J Clin Psychiatry.* 1995;56(8):338-43. OVID-Embase.

Exclude: Not an eligible study design

Zanardi R, Artigas F, Franchini L, et al. How long should pindolol be associated with paroxetine to improve the antidepressant response? *J Clin Psychopharmacol.* 1997;17(6):446-50. PMID:9408806 OVID-Medline.

Exclude: Not an eligible population treatment

Zanardi R, Smeraldi E. A double-blind, randomised, controlled clinical trial of acetyl-L-carnitine vs. amisulpride in the treatment of dysthymia. *Eur Neuropsychopharmacol.* 2006;16(4):281-7. PMID:16316746 OVID-Medline.

Exclude: Not an eligible population treatment

Zanardi R, Rossini D, Magri L, et al. Response to SSRIs and role of the hormonal therapy in post-menopausal depression. *Eur Neuropsychopharmacol.* 2007;17(6-7):400-5. PMID:17196795 OVID-Medline.

Exclude: Not an eligible population treatment

Zaninelli R, Meister W. The treatment of depression with paroxetine in psychiatric practice in Germany: The possibilities and current limitations of drug monitoring. *Pharmacopsychiatr.* 1997;30(1:Suppl):Suppl-20 PMID:9035223 OVID-Medline.

Exclude: Not an eligible study design

Zaninelli R, Bauer M, Jobert M, et al. Changes in quantitatively assessed tremor during treatment of major depression with lithium augmented by paroxetine or amitriptyline. *J Clin Psychopharmacol.* 2001;21(2):190-8. PMID:11270916 OVID-Medline.

Exclude: Not an eligible population treatment

Zapletalek M, Zbytovsky J, Kudrnova K. Clinical experience with maprotilin and maprotilin/clomipramine infusions in resistant depression. *Act Nerv Super.* 1982;24(2):73-6. PMID:7102227 OVID-Medline.

Exclude: Not an eligible population treatment

Zarate CA, Jr., Payne JL, Quiroz J, et al. An open-label trial of riluzole in patients with treatment-resistant major depression. *Am J Psychiatry.* 2004;161(1):171-4. PMID:14702270 OVID-Medline.

Exclude: Not an eligible study design

Zarate CA, Jr., Singh JB, Carlson PJ, et al. A randomized trial of an N-methyl-D-aspartate antagonist in treatment-resistant major depression. *Arch Gen Psychiatr.* 2006;63(8):856-64. PMID:16894061 OVID-Medline.

Exclude: Not an eligible population treatment

Zarate J, Kando JC, Tohen M, et al. Does intolerance or lack of response with fluoxetine predict the same will happen with sertraline? *J Clin Psychiatr.* 1996;57(2):67-71. OVID-Embase.

Exclude: Not an eligible study design

Zarate J, Singh JB, Carlson PJ, et al. A randomized trial of an N-methyl-D-aspartate antagonist in treatment-resistant major depression. *Arch Gen Psychiatr.* 2006;63(8):856-64. OVID-Embase.

Exclude: Mixed antidepressants; some failed on SSRI

Zautra AJ, Davis MC, Reich JW, et al. Comparison of cognitive behavioral and mindfulness meditation interventions on adaptation to rheumatoid arthritis for patients with and without history of recurrent depression. *J Consult Clin Psychol.* 2008;76(3):408-21. PMID:18540734 OVID-Medline.

Exclude: Not an eligible population treatment

Zeidan F, Johnson S, Gordon N, et al. Effects of brief and sham mindfulness meditation on mood and cardiovascular variables. *J Altern Complement Med.* 2010;16(8):867-73. EBSCO-CINAHL.

Exclude: Not an eligible population/treatment

Zerhusen JD, Boyle K, Wilson W. Out of the darkness: Group cognitive therapy for depressed elderly. *J Psychosoc Nurs Ment Health Serv.* 1991;29(9):16-21. PMID:1941727 OVID-Medline.

Exclude: Not an eligible population treatment

Zerka Yoo, C. Hapkido vs. yoga: Analysis of choice, persistence and psychological benefits Zerka Yoo. 2008. OVID-PsycINFO.

Exclude: Not an eligible study design

Zetin M, Warren S, Pangan EA, et al. Refractory depression. *Stress Med.* 1986;2(2):153-67. OVID-Embase

OVID-Embase.

Exclude: Not an eligible study design

Zettle RD, Rains JC. Group cognitive and contextual therapies in treatment of depression. *J Clin Psychiatry.* 1989;45(3):436-45. OVID-Embase.

Exclude: Not an eligible population treatment

Zettle RD, Herring EL. Treatment utility of the sociotropy/autonomy distinction: Implications for cognitive therapy. *J Clin Psychiatry.* 1995;51(2):280-9. OVID-Embase.

Exclude: Not an eligible population treatment

Zhang C. The brain-resuscitation acupuncture method for treatment of post wind-stroke mental depression--a report of 45 cases. *J Tradit Chin Med.* 2005;25(4):243-6. PMID:16447661 OVID-Medline.

Exclude: Not an eligible population design

Zhang G-J, Shi Z-Y, Liu S, et al. Clinical observation on treatment of depression by electro-acupuncture combined with paroxetine. *Chin J Integrat Med.* 2007;13(3):228-30. OVID-Embase.

Exclude: Not an eligible population treatment

Zhang W, Yang X, Zhong B. Combination of acupuncture and fluoxetine for depression: A randomized, double-blind, sham-controlled trial. *J Altern Complement Med.* 2009;15(8):837-44. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Zhang Z-J, Kang W-H, Li Q, et al. The beneficial effects of the herbal medicine Free and Easy Wanderer Plus (FEWP) for mood disorders: Double-blind, placebo-controlled studies. *J Psychiatr Res.* 2007;41(10):828-36. OVID-Embase.

Exclude: Not an eligible population treatment

Zhang Z-J, Chen H-Y, Yip K, et al. The effectiveness and safety of acupuncture therapy in depressive disorders: Systematic review and meta-analysis. *J Affect Disord.* 2010;124(1-2):9-21. OVID-Embase.

Excluded - Systematic review - relevant topic, citations cross-matched

Zhao H, Wan X, Chen J. A mini review of traditional Chinese medicine for the treatment of depression in China. *Am J Chin Med.* 2009;37(2):207-13. EBSCO-CINAHL.

Excluded - Systematic review - relevant topic, citations cross-matched

Zhao L, Gan A. Clinical and psychological assessment on Xinwei decoction for treating functional dyspepsia accompanied with depression and anxiety. *Am J Chin Med.* 2005;33(2):249-57. EBSCO-CINAHL.

Exclude: Not an eligible population treatment

Zhao Z, Xian Y, Zhou Ha. A controlled trial of venlafaxine and paroxetine in treatment-refractory depression. *J Clin Psychol Med.* 2003;13(1):26-7. Wiley-CCTR.

Exclude: Not an eligible study design

Zimmer B, Rosen J, Thornton JE, et al. Adjunctive lithium carbonate in nortriptyline-resistant elderly depressed patients. *J Clin Psychopharmacol.* 1991;11(4):254-6. PMID:1918424 OVID-Medline.

Exclude: Not an eligible study design

Zisook S, Peterkin J, Goggin KJ, et al. Treatment of major depression in HIV-seropositive men. HIV Neurobehavioral Research Center Group. *J Clin Psychiatry.* 1998;59(5):217-24. PMID:9632030 OVID-Medline.

Exclude: Not an eligible population treatment

Zisook S, Rush AJ, Haight BR, et al. Use of bupropion in combination with serotonin reuptake inhibitors. *Biol Psychiatry.* 2006;59(3):203-10. PMID:16165100 OVID-Medline.

Excluded - Systematic review - relevant topic, citations cross-matched

Zisook S, Trivedi MH, Warden D, et al. Clinical correlates of the worsening or emergence of suicidal ideation during SSRI treatment of depression: An examination of citalopram in the STAR*D study. *J Affect Disord.* 2009;117(1-2):63-73. OVID-Embase.

Exclude: Not an eligible population treatment

Zmilacher K, Battegay R, Gastpar M. L-5-hydroxytryptophan alone and in combination with a peripheral decarboxylase inhibitor in the treatment of depression. *Neuropsychobiol.* 1988;20(1):28-35. PMID:3265988 OVID-Medline.

Exclude: Not an eligible population treatment

Zobel I, Kech S, van CD, et al. Long-term effect of combined interpersonal psychotherapy and pharmacotherapy in a randomized trial of depressed patients. *Acta Psychiatr Scand.* 2011;123(4):276-82. OVID-Embase.

Exclude: Not an eligible population/treatment

Zohar J, Drummer D, Edelstein ED, et al. Effect of lysine vasopressin in depressed patients on mood and 24-hour rhythm of growth hormone, cortisol, melatonin and prolactin. *Psychoneuroendocrinol.* 1985;10(3):273-9. PMID:3903821 OVID-Medline.

Exclude: Not an eligible population treatment

Zubenko GS, Mulsant BH, Rifai AH, et al. Impact of acute psychiatric inpatient treatment on major depression in late life and prediction of response. *Am J Psychiatry.* 1994;151(7):987-94. OVID-PscINFO.

Exclude: Not an eligible study design

Zusky PM, Biederman J, Rosenbaum JF, et al. Adjunct low dose lithium carbonate in treatment-resistant depression: A placebo-controlled study. *J Clin Psychopharmacol.* 1988;8(2):120-4. Wiley-CCTR.

Exclude: Not an eligible population treatment

Zust BL. Effect of cognitive therapy on depression in rural, battered women. *Arch Psychiatr Nurs.* 2000;14(2):51-63. EBSCO-CINAHL.

Exclude: Not an eligible population treatment