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A Psychoeducational Approach to the Treatment of Depression: A Meta-analysis of Lewinsohn's "Coping With Depression" Course

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The Coping With Depression course is a cognitive behavioral treatment for unipolar depression. The psychoeducational format allows this intervention to be used in several ways, for example, in bibliotherapy, primary prevention, relapse prevention, and treatment of specific populations. Possibly, depressed individuals who otherwise would not seek treatment can be reached with this course because of the nonstigmatizing format and active recruitment. In a literature search, 20 studies on the effects of one of the several forms of the Coping With Depression course were found. An important limitation is that few of the 20 studies made direct comparisons between the effects of the course and those of other psychological and pharmacological interventions. The results of a meta-analysis indicate that this course is an effective therapy for unipolar depression, with effect sizes that are comparable to those of other treatment modalities for depression.

The Coping With Depression course is a highly structured psychoeducational treatment modality for unipolar depression first developed by Lewinsohn and his colleagues (Lewinsohn, Antonucci, Breckenridge, & Teri, 1984). Theoretically, this course is based on the social learning theory according to which depression is associated with a decrease in pleasant and an increase in unpleasant person-environment interactions (Lewinsohn et al., 1984). The problems shown by depressed individuals are viewed as behavioral, with cognitive patterns that can be unlearned or relearned.

Although the Coping With Depression course was designed for use with adults, its effectiveness has also been tested with special populations. Several reviews have described these modified versions and the effects that were found (Cuijpers, 1995; Lewinsohn, Hoberman, & Clarke, 1989). An earlier review of this literature showed that the Coping With Depression course is an effective treatment modality for unipolar depression and that its effectiveness is comparable to other forms of psychotherapy in depression (Cuijpers,

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1996). That review contained only a subset of the studies. In this article a more complete meta-analysis of the effects and the efficacy of the course will be presented.

The contents of the course are cognitive-behavioral in nature and are designed to train skills that can be used in the alleviation of depression. The skill modules focus on relaxation, social skills, cognitive skills, and how to increase the number of pleasant events. The course consists of 12 sessions and 2 booster sessions, 1 month and 6 months after the end of treatment. The group leader's role is more like that of an instructor rather than a therapist, and the participants are viewed as students instead of patients.

The course is widely publicized in the media with newspaper advertisements, public-service announcements, and announcements on local radio and TV programs. Exclusion criteria are minimal, consistent with the educational philosophy of the course. People are excluded if they show evidence of mental retardation, dyslexia, bipolar disorder, schizophrenia, or acute substance abuse.

The psychoeducational format of the course is of special interest. This psychoeducational framework and the active outreach approach in the recruitment of participants make it possible to reach people who might not otherwise seek treatment (Cuijpers, 1995). Also, because of the highly structured character of the course, it can be used easily in bibliotherapeutic approaches (see, for example, Cuijpers, 1997a; Scogin, Jamison, & Davis, 1989). Furthermore, the course can easily be adapted for use with special populations. Variants of the course have been developed for adolescents (Clarke & Lewinsohn, 1989; Lewinsohn, Clarke, Hops, & Andrews, 1990; Lewinsohn, Clarke, Rohde, Hops, & Seeley, 1996), the elderly (Breckenridge, Zeiss, & Thompson, 1987), minority groups (Organista, Muñoz, & Gonzalez, 1994), and caregivers of the elderly (Lovett & Gallagher, 1988). Recently, the course has also been used in research as a method of relapse prevention (Kühner, Angermayer, & Veiel, 1994) and as a method for the primary and secondary prevention of depression (Clarke, Hawkins, & Murphy, 1995; Muñoz & Ying, 1993).

Another interesting aspect of the course is that there is no traditional therapeutic relationship between group leaders and participants. Group leaders are defined as teachers and the participants as pupils. Two studies showed that the group leaders differed significantly from each other in enthusiasm, clarity, "warmth," and group cohesiveness, as experienced by the participants (Antonucci, Davis, Lewinsohn, & Breckenridge, 1987; Antonuccio, Lewinsohn, & Steinmetz, 1982). These studies also showed no significant relationship between a range of characteristics of the group leaders and the effectiveness of the course. In more traditional forms of psychotherapy, such as in psychodynamic and client-centered therapy, the "working alliance" between patient and therapist is considered a necessary condition for psychotherapy to be effective (Weinberger, 1995). In cognitive and behavioral therapies, this working alliance is not seen as central, but as facilitative of therapeutic techniques (Beck, Rush, Shaw, & Emery, 1979).

Method

For the purposes of the current study, a computer search (PsycLit and MedLine) was conducted using several key words, including *Coping With Depression course*, and words as *psychoeducation*, *behavioral*, and *cognitive* in combination with *depression*. The search was conducted for the years 1984 to 1996. Furthermore, the references of known reviews of the course were screened (Cuijpers, 1996; Lewinsohn et al., 1984, 1989).

In order to be included in the meta-analysis, the study had to refer explicitly to the Coping With Depression course as the basic method used. Furthermore, the study had to report pretest and posttest data. Twenty-three studies met these criteria. Three of these were not used in the meta-analysis. One study was not used because insufficient quantitative data were presented in the publication (Kühner et al., 1994) and two studies were not used because they were conducted in a preventive framework in which neither the treatment of depression nor of depressive symptoms were primary goals (Clarke et al., 1995; Muñoz & Ying, 1993).

Selected characteristics of the remaining 20 studies are presented in Table 1. To evaluate the quality of the studies, each was screened by the author on a number of methodological criteria. The latter included aspects of the experimental design such as the use of a control group, random assignment to conditions, data on dropouts, and follow-up data; the degree to which the intervention is adequately described (description of the intervention, references to procedures); and the use of appropriate statistical analyses (reliability and validity of the measures).

In 10 of the 20 studies, a Coping With Depression course was compared to a control group (Table 1). In 7 of these studies the participants were randomly assigned to conditions. Six of these 7 were judged to be of high methodological quality. Apart from the inclusion of a control group and random assignment to treatment conditions, there were analyses of initial differences between conditions, valid and reliable measurement instruments were used, the contents of the course were clearly described, and adequate analyses were done. In 10 studies, only pre- and postmeasures were taken, without a control group. In 6 of these, follow-up data were also presented.

Though the quality of several of the 20 studies was high, a number of limitations can be identified. First, the samples in the experimental studies were small, sometimes less than 10. Second, in most of the studies a wait-list control group was used. It is known from other meta-analytic studies in depression (Robinson, Berman, & Neimeyer, 1990) that there are important differences between wait-list control groups, placebo control groups, and no-treatment control groups.

Furthermore, there are some differences between the interventions and the target populations used in the different studies. For example, the inclusion criteria differed substantially across studies. In 8 studies, only subjects who met rigorous (*DSM*) criteria for a depressive disorder were included. In the

TABLE 1
STUDIES EXAMINING THE EFFECTS OF THE COPING WITH DEPRESSION COURSE

Study	Participants	Conditions	*N*	Measurements	Measures	d_{ctr}	d_{impr}
Antonuccio et al., 1984	Adults with drug-refractory depression	CWD-course	9	Pre Post 1 month	BDI	–	1.09
Breckenridge et al., 1987	Elderly, with mild or intermittent depression	CWD-course	52	Pre Post	BDI	–	0.49
Brown & Lewinsohn, 1984	Adults	CWD-course CWD-individual CWD-bibliotherapy waiting list	31 15 12 13	Pre Post 1 month 6 months	BDI CES-D	0.84 0.54 0.39	1.66 1.83 1.27
Clarke, 1985	Adolescents	CWD-course (2 separate groups)	5 5	Pre Post	BDI	–	1.42 1.84
Cuijpers et al., 1995	Adults	CWD-course	24	Pre Post	BDI	–	1.47
Cuijpers, 1997b	Adults	CWD-bibliotherapy	11	Pre Post	BDI	–	1.48
Cuijpers, 1998	Adults with somatic chronic illness	CWD-course waiting list	9 7	Pre Post	BDI	1.63	1.52
González et al., 1993	Drug users	CWD-course no treatment	6 5	Pre Post	CES-D	0.18	0.84
Hoberman et al., 1988	Adults	CWD-course	40	Pre Post 1 month 6 months	BDI	–	2.08
Lewinsohn et al., 1990	Adolescents	CWD-course CWD-course with a course for parents waiting list	21 19 19	Pre Post 1 year 2 year	BDI CES-D	1.02 1.46	1.08 1.32
Lewinsohn et al., 1996	Adolescents	CWD-course CWD-course with a course for parents waiting list	37 32 37	Pre Post 1 year 2 year	BDI CES-D HDRS	0.51 0.21	1.58 1.33

Lovett & Gallagher, 1988	Caregivers of the elderly	CWD-course	23	Pre	BDI	0.49	0.39
		problem solving	20	Post			
		(not-CWD) waiting list	19				
Manson & Brenneman, 1995	Mildly and moderately depressed chronically ill elderly Indians	CWD-course	22	Pre	CES-D	0.78	0.73
		control group	26	Post			
Muñoz et al., 1982	Adults	CWD on television	12	Pre	CES-D	0.75	1.89
		control group	35	Post			
Organista et al., 1994	Low-income and minority medical outpatients	CWD-course	74	Pre Post	BDI	–	1.02
Scogin et al., 1989; 1990	Elderly	CWD-bibliotherapy	21	Pre	HRSD	0.35	0.95
		cognitive	19	Post	GSD		
		bibliotherapy	21	3 months			
		waiting list		2 years			
Steinmetz et al., 1983	Adults	CWD-course	93	Pre Post 1 month 6 months	BDI	–	1.73
Teri & Lewinsohn, 1986	Adults	CWD-course	56	Pre	BDI	–	1.77
		CWD-individual	26	Post			1.86
				1 month 6 months			
Thompson et al., 1983	Elderly	CWD-course (professional leaders)	29	Pre Post	BDI	–	0.29
		CWD-course (not profess. leaders)	27				0.49
Van der Meeren, 1996	Adults	CWD-course	16	Pre	BDI	0.88	1.02
		waiting list	11	Post			

Note. CWD-course = Coping With Depression course; BDI = Beck Depression Inventory; HRSD = Hamilton Rating Scale of Depression; GDS = Geriatric Depression Scale; CES-D = Center for Epidemiological Studies Depression Scale.

others the participants did not all meet specified criteria for a depressive disorder or no clinical interview for making a diagnosis was held with participants. An important question can therefore be raised by the comparability of the studies. Perhaps we mix apples and oranges if we perform a meta-analysis (Schwarzer, 1989). A test for homogeneity, which indicates if there are systematic differences in the outcome of studies, can reduce this danger somewhat. Still, it is felt that a meta-analysis can only give a general impression of the effectiveness of the course.

Another important limitation is that only 2 studies (Lovett & Gallagher, 1988; Scogin et al., 1989) compared the Coping With Depression course to another intervention. No comparisons of the course with more traditional forms of psychotherapy (cognitive therapy, behavior therapy, interpersonal therapy) or pharmacotherapy, which are known to be effective in the treatment of depression, are available. Therefore, the studies cannot provide direct evidence on the relative efficacy of the course compared to other treatment forms.

The limitations of the resulting set of studies are considerable. Still, it is considered appropriate to conduct a meta-analysis. Such a meta-analysis can give a general impression of the effectiveness of the Coping With Depression course. Such a rough estimation of the effectiveness is important for three reasons. First, it is possible that the course reaches people who might not otherwise seek treatment and thus has an additional value in mental health care. Second, this course is a short and time-efficient treatment modality for depression that can easily be adapted for use with a broad range of populations. If it is as effective as other treatment modalities, it could be a serious alternative for longer and more time-consuming interventions. And third, this course can easily be adapted for use with several populations, and can thus be applied in a broad range of situations. Therefore, despite the limitations of the set of studies, a meta-analysis is considered appropriate.

The meta-analytic method has undergone major development in recent years and has been used in the research for interventions in depression (Cuijpers, 1997a; Dobson, 1989; Nietzel, Russel, Hemmings, & Gretter, 1987; Robinson et al., 1990; Steinbrueck, Maxwell, & Howard, 1983). In a meta-analysis it is assumed that each study estimates the real effect of an intervention. By combining several estimations, a better estimation of the real effect is obtained. In a meta-analysis the effect sizes that are found in the studies are converted into a measure that has no connection with the instrument used and can be compared to other measures (Glass, McGaw, & Smith, 1981; Smith, Glass, & Miller, 1980; Wolf, 1986). The effect size d is usually calculated by subtracting the average score of the control group (M_e) from the average score of the experimental group (M_c) and dividing the result by the average of the standard deviations of the experimental and control group (SD_{ec}; Schwarzer, 1989). An effect size of 0.5 thus indicates that the mean of the experimental group is half a standard deviation larger than the mean

of the control group. Lipsey (1990) has shown that an effect size of .56 to 1.2 can be assumed as large, while effect sizes of .33 to .55 are moderate, and effect sizes of 0 to .32 are small.

In the calculations of effect sizes, only those instruments were used that explicitly measure depression (Table 1). If more than one depression measure was used, the mean of the effect sizes was calculated so that each study (or contrast group) only had one effect size.

In one study (Manson & Brenneman, 1995), insufficient data were reported to calculate the effect size. In this case the significance level mentioned was used to estimate the effect size, according to the formula provided by Wolf (1986). All effect sizes were corrected for the small sample bias mentioned by Hedges and Olkin (1985).

The computer program used was Meta 5.3, developed for support in meta-analysis (Schwarzer, 1989). The statistical procedures in this program are mainly based on the work of Hedges and Olkin (1985). Several methods may be used to calculate the mean effect size. In our analysis we used the "random effects" model. In this model, a test for homogeneity is performed for each meta-analysis, which can be seen as an indication for systematic differences between the studies. Furthermore, Orwin's Fail-Safe N is calculated. This number indicates how many studies with an effect size of zero should be found in order to reduce the effect size that is found to a smaller value (for example, .20). A larger N indicates that the found effect size can be further generalized.

Results

In 3 of the 10 experimental studies, several versions of the Coping With Depression course were compared to a control group. Fourteen contrast groups (course versus control group) could be formed. These 14 groups included 295 participants; the 10 control groups included 193 subjects.

The mean effect size was 0.65, with a 95% reliability interval of 0.44 to 0.85 ($Z = 6.23$; $p < .001$). This is a large effect. A test for homogeneity showed that 80% of the variance is caused by fluctuations of the sample, which indicates that there are some systematic differences between the studies. The number of studies that should be found in order to reduce the effect size to 0.20 (Orwin's Fail-Safe N) is 31.

Because no control group was used in several studies, we also calculated the effect size on the basis of the improvement from pre- to posttest, where d_{impr} is calculated by substracting the average score of the experimental group at pretest (M_{pre}) from the average score of the experimental group at posttest (M_{post}) and dividing the result by the average of the standard deviations of the experimental group at pretest and posttest ($SD_{pre/post}$; Schwarzer, 1989).

The 27 contrast groups from which this effect size could be calculated

included 727 participants. The mean effect size was 1.21, with a 95% reliability interval of 1.05 to 1.36 ($Z = 14.89$; $p < .001$). Seventy-two percent of the variance is caused by fluctuations of the sample and the number of studies that should be found in order to reduce the effect size to 0.20 (Orwin's Fail-Safe N) is 136.

It was checked if the d_{impr} differed in the studies in which a control group was used and those without control group. For both groups a meta-analysis was performed, and it was checked if the 95% reliability intervals of the resulting effect sizes overlapped. There appeared to be hardly any difference between the two effect sizes (1.19 and 1.23), and this difference was not significant. It was also checked if the d_{impr} in the six studies with the highest methodological quality differed from the other studies. No significant difference was found between these groups either (the effect sizes were 1.18 and 1.23). Because the author of this paper was involved in several studies himself, it was also checked if the effect sizes of these four studies differed from the other effect sizes. A slight, nonsignificant difference was found (the effect sizes were 1.31 and 1.20).

The number of available studies was relatively small, and the set of studies has several limitations. Therefore, no analyses of relationships between effect sizes and characteristics of participants or the interventions were conducted.

In several studies, data were presented at 1 month, 6 months, 1 year, and 2-year follow-up. For each of these periods effect sizes from post-test to follow-up were calculated. The results, presented in Table 2, indicate that the effects remain stable for 1 to 6 months. After 1 year, participants showed further evidence of improvement. These results should be treated very cautiously, because of the small number of studies and because no control conditions were available at follow-up. In four of the five contrast groups for which follow-up data are available at 1- and 2-year follow-up, participants are adolescents. Consequently, it is not clear if the results can be generalized to other age groups.

Because no direct comparisons between the Coping With Depression course and other well-used interventions are available, no conclusion can be drawn about the relative efficacy of the course compared to other treatment

TABLE 2
EFFECT SIZES FROM POSTTEST TO FOLLOW-UP

	Studies	Contrast groups	N	d
1 month	6	10	322	−0.08
6 months	6	10	334	−0.08
1 year	2	4	109	0.31**
2 year	3	5	130	0.44**

** $p < .01$.

forms. Indirectly, however, we can compare the effect size we found with the effect sizes of other treatment modalities. We use the meta-analysis of Robinson, Berman, and Neimeyer (1990) for this comparison. Their paper contains the most comprehensive meta-analysis of psychotherapy for depression, in which 58 controlled studies of psychological treatment of depression and 15 comparisons of psychological and pharmacological treatments were reviewed. In this meta-analysis, an effect size of 0.73 was found for psychotherapies, which is a little larger than the effect size of the Coping With Depression course. This difference is small and can be explained by the differences in the method used and the selection of studies. If, for example, studies in which the two contrast groups used bibliotherapy as the intervention were not used in the meta-analysis (as in the meta-analysis of Robinson et al.), the mean effect size of the course increases to 0.69 (95% reliability interval of 0.47 to 0.92). It is also important to note that several of the variants of the course were designed for use with "difficult" target populations, for example, injection drug users (González, Muñoz, Pérez-Arce, & Batki, 1993) and caregivers of the elderly (Lovett & Gallagher, 1988). These are groups for whom it is known that interventions have only limited effects (Cuijpers, Hosman, & Munnichs, 1997; Muñoz & Ying, 1993). If we focus on the original Coping With Depression course for adults, which is examined in two controlled studies, we find an effect size of 0.84.

Another way to illustrate the effects of the course is to compare the scores on the Beck Depression Inventory (BDI) at pretest and posttest. The BDI is used in 22 studies of the meta-analysis of Robinson et al. (1990) and in 16 studies of the present meta-analysis. These data are presented in Figure 1. In the meta-analysis of Robinson et al., another 28 studies were found in which the BDI was administered to the general population. In addition, they found 12 studies in which individuals in the general population were screened on the absence of mental health problems ("nondistressed" persons). These data are also presented in Figure 1. It must be emphasized that Figure 1 can only give a general impression of the effects of psychotherapy and the Coping With Depression course because only one outcome measure (the BDI) is used. Besides, it is very well possible that there are structural differences between both populations.

Discussion

On the basis of the studies reviewed, it appears that the Coping With Depression course is an effective treatment modality for depression. This conclusion should be considered cautiously, however, because the set of the studies on which this conclusion is based is relatively small and has important limitations. Future research should compare the efficacy of the course with other psychotherapeutical and pharmacological interventions. It is also important in future studies to use other control groups than waiting

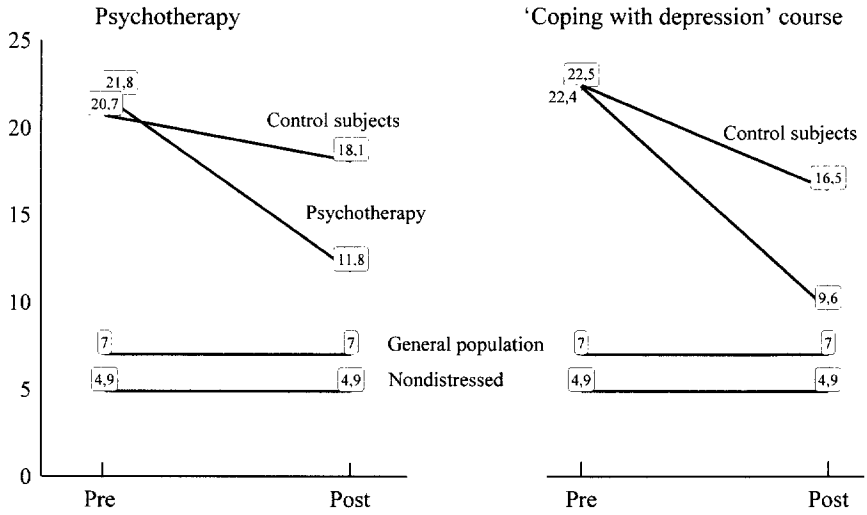

FIG. 1. The effects of psychotherapy and the "Coping With Depression" course, measured with the BDI.

lists. Furthermore, in this meta-analysis only measures of depression were used. It is necessary to examine the effects of the course on other aspects of the participants' functioning across social, interpersonal, and occupational spheres.

Because of the promising results of this meta-analysis, it is worthwhile to examine if it is possible through this course to reach depressed individuals who otherwise would not seek treatment. This is important, because a large percentage of the depressed population does not receive professional help (Cuijpers, 1995). The course's nonstigmatizing format and its active recruitment of participants could make reaching a greater number of depressed individuals a real possibility. As a large effect size of the course was found, it appears that large effect sizes can be realized outside the psychotherapist's office (e.g., in a classroom). This aspect needs further research before definite conclusions can be drawn.

Future research should try to determine which depressed persons can benefit from this intervention. Clinical experience indicates that not all patients benefit from a psychoeducational format. Clients with severe concentration problems, for instance, may need special attention.

As the results of this meta-analysis indicate, the Coping With Depression course is an effective treatment modality. It is worthwhile to examine the use of the course with other target groups—for example, people suffering from dysthymia or bipolar disorders—and people whose depression is comorbid with addiction problems.

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