### Supplemental Material 3: Data extraction form & Codebook

<table>
<thead>
<tr>
<th>category</th>
<th>variable</th>
<th>details</th>
<th>type</th>
<th>allowed_values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ID</td>
<td>id_study</td>
<td>unique study identifier (author, year)</td>
<td>character</td>
<td></td>
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<tr>
<td>2. Effect sizes</td>
<td>outcome_type</td>
<td>smd = standardized mean difference = Hedges g; dich = dichotomous; change = change scores based on m, sd, n variable, t-values, p-values</td>
<td>character</td>
<td>smd, dich, change, tval, pval</td>
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<tr>
<td>2. Effect sizes</td>
<td>outcome_measure</td>
<td>standardized instrument used</td>
<td>character</td>
<td></td>
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<tr>
<td>2. Effect sizes</td>
<td>sr_clinician</td>
<td>self-report measure or clinician-rated</td>
<td>factor</td>
<td>sr, cr</td>
</tr>
<tr>
<td>2. Effect sizes</td>
<td>time</td>
<td>time of assessment (baseline, post, fu1, fu2, ... fu8)</td>
<td>factor</td>
<td>baseline, post, fu1, fu2, fu3, fu4, f,</td>
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<tr>
<td>2. Effect sizes</td>
<td>time_weeks</td>
<td>time in weeks since randomization</td>
<td>character</td>
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<tr>
<td>2. Effect sizes</td>
<td>m</td>
<td>mean</td>
<td>numeric</td>
<td></td>
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<tr>
<td>2. Effect sizes</td>
<td>sd</td>
<td>standard deviation</td>
<td>numeric</td>
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<tr>
<td>2. Effect sizes</td>
<td>n</td>
<td>sample size</td>
<td>numeric</td>
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<tr>
<td>2. Effect sizes</td>
<td>dich</td>
<td>broad categories of dich outcomes (response, remission based on a cut-off, remission based on diagnosis, reliable change)</td>
<td>character</td>
<td>response, remission, other</td>
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<td>2. Effect sizes</td>
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<td>specific type of dich outcomes as defined in the study (response, remission, other)</td>
<td>character</td>
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<tr>
<td>2. Effect sizes</td>
<td>n_improved</td>
<td>for dichotomous outcomes</td>
<td>numeric</td>
<td></td>
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<tr>
<td>2. Effect sizes</td>
<td>n_randomized</td>
<td>n randomized</td>
<td>numeric</td>
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<tr>
<td>2. Effect sizes</td>
<td>change</td>
<td>measure used to calculate change</td>
<td>character</td>
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<tr>
<td>2. Effect sizes</td>
<td>change_m</td>
<td>change mean from baseline</td>
<td>numeric</td>
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<tr>
<td>2. Effect sizes</td>
<td>change_sd</td>
<td>change sd from baseline</td>
<td>numeric</td>
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<td>2. Effect sizes</td>
<td>change_n</td>
<td>change n</td>
<td>numeric</td>
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<tr>
<td>2. Effect sizes</td>
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<td>other reported statistics</td>
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<tr>
<td>3. Moderators</td>
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<td>year of publication</td>
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<tr>
<td>3. Moderators</td>
<td>comorbid_mental</td>
<td>if all the participants are recruited based on meeting criteria for a comorbid mental health disorder (e.g. anxiety and depression) 0 = no, 1 = yes</td>
<td>factor</td>
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<tr>
<td>3. Moderators</td>
<td>format</td>
<td>1= individual; 2= group; 3= guided self-help; 4= telephone; 5= couple therapy; 6= other (mixed formats)</td>
<td>factor</td>
<td>1, 2, 3, 4, 5, 6</td>
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<tr>
<td>3. Moderators</td>
<td>n_sessions</td>
<td>average number of sessions received</td>
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<tr>
<td>3. Moderators</td>
<td>country</td>
<td>1= usa; 2= uk; 3= eu; 4= canada; 5= australia; 6= east asia; 7= other</td>
<td>factor</td>
<td>1, 2, 3, 4, 5, 6, 7</td>
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<tr>
<td>3. Moderators</td>
<td>age_group</td>
<td>1= children; 2= adolescents; 3= young adults; 4= adults; 5= older adults (≥55 years); 6= older old adults (≥75 years)</td>
<td>factor</td>
<td>1, 2, 3, 4, 5, 6</td>
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<tr>
<td>3. Moderators</td>
<td>mean_age</td>
<td>average age</td>
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<tr>
<td>3. Moderators</td>
<td>percent_women</td>
<td>% of women at baseline</td>
<td>numeric</td>
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<tr>
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<td>recruitment</td>
<td>1= community; 2= clinical; 3= other</td>
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<tr>
<td>3. Moderators</td>
<td>diagnosis</td>
<td>1= major depression; 2= mood disorder; 3= cut-off score; 4= subclinical depression; 5= chronic depression</td>
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<tr>
<td>3. Moderators</td>
<td>target_group</td>
<td>1= adults; 2= older adults; 3= student population; 4= women with perinatal depression; 5= comorbid somatic disorder; 6= other</td>
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<tr>
<td>3. Moderators</td>
<td>ac</td>
<td>allocation concealment (0= high risk; 1= low risk)</td>
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<td>3. Moderators</td>
<td>ba</td>
<td>blinding of assessors (0= high risk; 1= low risk; sr= self-report)</td>
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<td>intention-to-treat analyses (0= high risk; 1= low risk)</td>
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<td>sg</td>
<td>sequence generation (0= high risk; 1= low risk)</td>
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<td>3. Moderators</td>
<td>sor</td>
<td>selective outcome reporting (0= high risk; 1= low risk; nr/rr= not registered or retrospectively registered)</td>
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<td>3. Moderators</td>
<td>rob_overall</td>
<td>overall risk of bias score, ranging from 0 (high risk) to 5 (low risk)</td>
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<td>4. Meta Data</td>
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<td>character</td>
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<td>4. Meta Data</td>
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<tr>
<td>4. Meta Data</td>
<td>protocol</td>
<td>link to protocol</td>
<td>character</td>
<td>NA</td>
</tr>
<tr>
<td>4. Meta Data</td>
<td>registry</td>
<td>link to registry</td>
<td>character</td>
<td>NA</td>
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<tr>
<td>4. Meta Data</td>
<td>ipd_available</td>
<td>whether individual participant data is available at the vu</td>
<td>factor</td>
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</tr>
</tbody>
</table>
## Description of variables of included studies, version 5/5/2019

<table>
<thead>
<tr>
<th>PARTICIPANTS</th>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>1. Community</td>
<td>If (a part of) the participants are recruited through announcements in newspapers, radio, tv, social media, flyers, etc., and participate as volunteers in the study, the study is rated as “community recruitment”. Basically, people have to take action themselves for participating in the study. This type of recruitment can be conducted in the general population, but also in more selected populations, such as university students, or patient groups.</td>
</tr>
<tr>
<td>2. Clinical</td>
<td>Participants are exclusively recruited from patients samples with mental disorders for which they have sought treatment. They can be recruited from primary care or outpatient centers. Participants actively seek help for depression. Recruitment of other, general medical patient groups do not fall into this category.</td>
<td></td>
</tr>
<tr>
<td>3. Other</td>
<td>Other recruitment methods (which are not community or clinical recruitment), such as systematic screening, recruitment from known patients in general medical settings, etc. If the recruitment method is not described in the paper (which happens occasionally) that is also rated as “other”</td>
<td></td>
</tr>
</tbody>
</table>

| Diagnosis    | 1. Major depression | MDD according to DSM-V criteria, DSM-IV criteria, DSM-III-R criteria, DSM-III criteria, Research Diagnostic Criteria (RDC) for major depression, of Feighner criteria for depressive disorder. |
|--------------| 2. Mood disorder    | MDD, or other diagnosed disorders (e.g., dysthymia; depression NOS; minor depression according to Research Diagnostic Criteria, etc.). |
|              | 3. Cut-off score     | Participants score above a cut-off score on a self-rating depression questionnaire, such as the PHQ-9 or the CES-D. This also includes studies where participants score in a specific range of the questionnaire (so there is a lower and an upper limit). If some participants meet diagnostic criteria for a mood disorder, and others only score above a cut-off, then this is also rated as (3) |
|              | 4. Subclinical depression | Participants score above a cut-off on a self-rating scale, but do not meet criteria for a depressive disorder according to a diagnostic interview (such as the MINI, CIDI or SCID). Studies are also rated in this category if participants meet criteria for minor depression according to the DSM-IV. |
|              | 5. Chronic depression | Participants meet criteria for chronic or treatment-resistant depression, according to any definition given by the authors of the study. |

| Target group | 1. Adults | The study is aimed at adults in general with no specific demographic characteristic. |
|             | 2. Older adults | The study is aimed at older adults according to any lower age limit above 50 years. Older adults with general medical disorders (these studies would also fit into category 5) are classified as “older adults”. |
|             | 3. Student population | The study is aimed at student populations from universities and colleges. |
|             | 4. Women with PPD | The study is aimed at women with perinatal depression. Mothers with young children were also included in this category, as well as pregnant women. |
5. General medical
The study is aimed at people with depression and any general medical disorder. Physical disability was also included in this category.

6. Other
Studies aimed at any other specific target group, not included in the other categories, were included in this category.

7. Children and adolescents
8. Adolescents
9. Young people

Age group
1. Children
the mean age is lower than 13
2. Adolescents
the mean age is between 13 and 18
3. Young adults
studies in college students and studies with a mean age between 18 and 24
4. Adults
all studies in adults (with or without an upper limit)
5. Older adults
all studies indicating that they work with older adults and with a mean age of 55 or higher.
6. Older old adults
all studies with a mean age of 75 or higher

Comorbid mental disorder
Yes (1) or No (0)
This includes any comorbid mental or substance use disorder, including insomnia

INTERVENTIONS
Type of psychotherapy
See Table 2

Format
1. Individual
The standard format is individual therapy in which the patients have therapy sessions with one therapist. If the format is not reported in the paper, it is assumed that the therapy is using an individual format.
2. Group
Patients are treated in groups by one or more therapists. We do not use an lower or upper limit for the size of the groups, but virtually all groups have 4 to 15 members.
3. Guided self-help
The patients works through a standardized treatment at home, with support (e.g., email, telephone) from a therapist. The treatment can be written down in a book, on the internet or any other medium.
4. Telephone
The treatment is conducted through telephone, skype, or any other distant connection.
5. Couple therapy
The treatment is conducted by the therapist, the patient and the partner of the patient.
6. Other
Some interventions use mixed formats (partly individual and partly in groups; or partly as guided self-help and partly individual). These are rated as “other”.

N Sessions
Continuous variable
The number of sessions is the number of planned sessions, but when the realized number of sessions is given this is preferred. Only full numbers are given (no decimals).

Pharmacotherapy
1. TCA
Tricyclic antidepressants.
2. SSRI
Selective serotonin reuptake inhibitor.
3. SNRI
Selective serotonin and norepinephrine reuptake inhibitors.
4. Other
Any other antidepressant were placed in this category. Other drugs that do not have an antidepressant effect, such as tranquilizers are not considered pharmacotherapy.

Control conditions
1. Waiting list
In this control group, respondents receive the intervention after termination of the intervention in the experimental group.
2. Care-as-usual
In this control group, respondents have access to regular routine care. In trials were no intervention is provided in the control group it is assumed that respondents have access to routine care.
3. Other
These are other control conditions, such as pill placebo and psychological placebo (please note that supportive therapy or counseling cannot be considered psychological placebo even if the authors indicate this).

OTHER
<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>2. UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>3. EU</td>
<td>Any country in Europe.</td>
</tr>
<tr>
<td>6. East Asia</td>
<td>China (plus Hong Kong and Macau), Japan, North Korea, South Korea, Taiwan, Mongolia.</td>
</tr>
<tr>
<td>7. Other</td>
<td>Any other country. This also includes studies in which participants from multiple countries (from 1 to 6) are included</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year of publication</th>
<th>Continuous variable</th>
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</thead>
</table>
## Definitions of Psychological Treatments of Depression

<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>Description/definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavior Therapy (CBT)</td>
<td>In CBT the therapists focus on the impact that a patient’s present dysfunctional thoughts have on current behavior and future functioning. CBT is aimed at evaluating, challenging and modifying a patient’s dysfunctional beliefs (cognitive restructuring). In this form of treatment the therapist mostly emphasizes homework assignments and outside-of-session activities. Therapists exert an active influence over therapeutic interactions and topics of discussion, use a psycho educational approach, and teach patients new ways of coping with stressful situations. The most used subtypes are CBT according to Beck’s manual (Beck et al., 1979) and the “Coping with Depression” course (Lewinsohn et al., 1984).</td>
</tr>
<tr>
<td>Behavioral activation therapy (BAT)</td>
<td>We considered an intervention to be behavioral activation when the registration of pleasant activities and the increase of positive interactions between a person and his or her environment were the core elements of the treatment. Social skills training could be a part of the intervention. There are several subtypes of behavioral activation (Mazzucchelli et al. 2009).</td>
</tr>
<tr>
<td>Problem-solving therapy (PST)</td>
<td>We defined PST as a psychological intervention in which the following elements had to be included: definition of personal problems, generation of multiple solutions to each problem, selection of the best solution, the working out of a systematic plan for this solution, and evaluation as to whether the solution has resolved the problem. Subtypes of PST are described elsewhere (Cuijpers et al., 2018).</td>
</tr>
<tr>
<td>Interpersonal psychotherapy (IPT)</td>
<td>IPT is a brief and highly structured manual based psychotherapy that addresses interpersonal issues in depression, to the exclusion of all other foci of clinical attention. IPT has no specific theoretical origin although its theoretical basis can be seen as coming from the work of Sullivan, Meyer and Bowlby. The current form of the treatment was developed by the late Gerald Klerman and Myrna Weissman in the 1980s (Klerman et al., 1984). There is a brief version of IPT, called Interpersonal counseling.</td>
</tr>
<tr>
<td>Third wave cognitive behavioral therapies</td>
<td>Third wave therapies are a heterogeneous group of therapies that introduce several new techniques to cognitive behavior therapies. They have in common that they abandon or only cautiously use content-oriented cognitive interventions, and the use of skills deficit models to delineate the core maintaining mechanisms of the addressed disorders (Kahl, Winter, &amp; Schweiger, 2012). Well-known therapies that we clustered in this category include Acceptance and Commitment Therapy, Mindfulness-based CBT, and meta-cognitive therapy.</td>
</tr>
<tr>
<td>Psychodynamic Therapy</td>
<td>The primary objective in (short-term) psychodynamic therapy is to enhance the patient’s understanding, awareness and insight about repetitive conflicts (intra psychic and intrapersonal). An assumption in psychodynamic therapy is that a patient’s childhood experiences, past unresolved conflicts, and historical relationships significantly affect a person’s present life situation. In this form of treatment, the therapist concentrates on the patient’s past, unresolved conflicts, historical relationships and the impact these have on a patient’s present functioning. Furthermore, in psychodynamic therapy the therapists explore a patient’s wishes, dreams, and fantasies. The time limitations and the focal explorations of the patient’s life and emotions distinguish psychodynamic therapy from psychoanalytic psychotherapy.</td>
</tr>
<tr>
<td>Non-directive supportive therapy</td>
<td>We defined non-directive therapy as any unstructured therapy without specific psychological techniques other than those common to all approaches such as helping people to ventilate their experiences and emotions and offering empathy. It is not aimed at solutions, or acquiring new skills. It assumes that relief from personal problems may be achieved through discussion with others. These non-directive therapies are commonly described in the literature as either counseling or supportive therapy.</td>
</tr>
<tr>
<td>Life review therapy</td>
<td>Reminiscence is a naturally occurring process of recalling the past, that is hypothesized to resolve conflicts from the past and make up the balance of one’s life (Bohlmeijer, Smit, &amp; Cuijpers, 2003; Butler, 1963). Since the beginning of the 1970s, reminiscence has been used by therapists as a specific treatment of depression in older adults. In these “life review” therapies the patients work through the memories of all phases in their life with the aim of re-evaluation of their life, resolving conflicts or assessing adaptive coping-responses. We defined life review therapies as all therapies that are aimed at the systematic evaluation of the lives of participants.</td>
</tr>
</tbody>
</table>