

Antidepressants plus cognitive therapy reduced relapse in residual depression

Paykel ES, Scott J, Teasdale JD, et al. Prevention of relapse in residual depression by cognitive therapy. A controlled trial. Arch Gen Psychiatry. 1999 Sep;56:829-35.

QUESTION

In patients with residual depressive symptoms who continue to receive maintenance antidepressant treatment, does cognitive therapy (CT) reduce relapse rates?

DESIGN

Randomized {allocation concealed*}†, blinded (outcome assessors),* controlled trial with 1-year follow-up.

SETTING

2 psychiatric outpatient clinics, Cambridge and Newcastle, England.

PATIENTS

158 patients between 21 and 65 years of age (mean age 43 y, 51% men) with unipolar depression, satisfying the *Diagnostic and Statistical Manual of Mental Disorders, 3d edition, Revised (DSM-III-R)* criteria for major depression within the previous 18 months but not in the previous 2 months, and who had residual symptoms (lasting 2 to 18 mo) reaching at least 8 on the 17-item Hamilton Depression Rating Scale and 9 on the Beck Depression Inventory. Exclusion criteria were history of bipolar disorders, cyclothymia, schizoaffective disorder, drug or alcohol dependence, persist-

ent antisocial behavior or repeated self-harm, *DSM-III-R* dysthymia with onset before 20 years of age, borderline personality disorder, learning disability, organic brain damage, current receipt of formal psychotherapy, or any other primary Axis I disorder. All patients had to have been taking antidepressant medication (mean doses equivalent to 185 mg/d of amitriptyline or 33 mg/d of fluoxetine) for the previous 8 weeks or more.

INTERVENTION

80 patients were allocated to clinical management plus CT for 16 sessions during 20 weeks with 2 subsequent booster sessions, and 78 were allocated to clinical management alone. Clinical management and antidepressant treatment continued for the entire 1-year follow-up period.

MAIN OUTCOME MEASURES

Relapse and symptom ratings.

Antidepressant treatment with clinical management plus cognitive therapy (CT) vs antidepressant treatment with clinical management alone (control) for residual depression†

Outcome at 68 weeks	CT	Control	RRR (95% CI)	NNT (CI)
Relapse	29%	47%	38% (5 to 61)	6 (4 to 42)

†Abbreviations defined in Glossary; RRR, NNT, and CI calculated from data in article.

MAIN RESULTS

Analysis was by intention to treat. The relapse rate for acute major depression and persistent severe residual symptoms at 68 weeks was 38% lower in the CT group than in the control group ($P = 0.02$) (Table). Groups did not differ for symptom ratings.

CONCLUSION

In patients with residual depressive symptoms who continued to receive maintenance antidepressant treatment, cognitive therapy reduced relapse rates.

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*See Glossary.

†Information provided by author.

COMMENTARY

CT has generally been associated with a lower degree of relapse than medication alone in the treatment of depression (1). Nevertheless, relapse remains an issue in CT, and one that has led to a recent focus on developing maintenance strategies for the treatment of depression (1). Earlier studies show that maintenance treatments seem to lower symptom relapse in patients with depression who receive acute treatment with either medication or CT. Specifically, maintenance CT or CT plus medication have lower rates of relapse than does maintenance medication alone (2).

Building on this literature, Paykel and colleagues have done a well-designed, randomized, controlled trial. Their results show that, for patients with residual symptoms of depression, those receiving maintenance CT relapsed less often than did patients who continued receiving medication (29% vs 47%). Results from this study are consistent with the literature and show an absolute risk reduction of 18% and a number needed to treat (NNT) of 6 (95% CI 4 to 42): For every 6 patients treated with CT, 1 relapse would be prevented. Secondly, although complete remission of depressive symptoms was infrequent in both groups, results showed that CT had higher remission rates at 20 weeks (24%) than did clinical management (11%) (NNT of 8).

In conclusion, CT may be beneficial as an additive treatment in

reducing relapse among patients who achieve a partial response to antidepressant treatment. A similar study that was published earlier and that used a smaller sample found that CT reduced relapse even when patients were tapered off medications (3). Considering that many patients are reluctant to remain on long-term medication treatment even when clinical wisdom dictates otherwise, it would have been interesting to replicate the findings of Fava and colleagues (3) in a larger sample, such as the one in the study by Paykel and colleagues. Nevertheless, the present findings are striking and call for a more closely allied working relationship between pharmacotherapists and cognitive therapists in clinical practice.

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