

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

Randomised [allocation concealed*]†, blinded (outcome assessors)*, controlled trial with 1 year of follow up.

*See glossary.

†Information provided by author.

Setting

2 psychiatric outpatient clinics, Cambridge and Newcastle, UK.

Patients

158 patients between 21 and 65 years of age (mean age 43 y, 51% men) with unipolar depression, satisfying *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 2–18 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, persistent antisocial behaviour or repeated self harm, *DSM-III-R* dysthymia with onset before 20 years of age, borderline personality disorder, learning disability, organic brain damage, currently receiving formal psychotherapy, or any other primary Axis I disorder. All patients had to be taking antidepressant medication (mean daily doses equivalent to 185 mg of amitriptyline or 33 mg of fluoxetine) for at least the previous 8 weeks.

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.

Main results

Analysis was by intention to treat. The relapse rate for acute major depression and persistent severe residual symptoms at 68 weeks was lower in the CT group compared with the control group ($p = 0.02$) (table). No differences existed between the groups for symptom ratings.

Conclusion

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

Antidepressant treatment with clinical management plus cognitive therapy (CT) v antidepressant treatment with clinical management alone (control) for residual depression at 68 weeks of follow up†.

Outcome	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.

COMMENTARY

CT has generally been associated with a lower degree of relapse compared with medications in the treatment of depression.¹ Nevertheless, relapse remains an issue even 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 appear to lower symptom relapse in patients with depression acutely treated with either medications or CT. Specifically, maintenance CT or CT plus medication have lower rates of relapse compared with maintenance medication alone.²

Building on this literature, Paykel *et al* have conducted a well designed, randomised controlled trial. Their results show that for patients with residual symptoms of depression, those receiving maintenance CT relapsed less often than patients who were continued on medication (29% v 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), indicating that for every 6 patients treated with CT, you would prevent 1 relapse. Secondly, although complete remission of depressive symptoms was infrequent in both groups, results showed that CT had higher remission rates at 20 weeks (24%) compared with 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 published earlier using 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 treatments even when clinical wisdom dictates otherwise, it may have been interesting to replicate findings of Fava *et al* in a larger sample such as the one in this study. 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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