Effect of Cognitive Therapy With Antidepressant Medications vs Antidepressants Alone on the Rate of Recovery in Major Depressive Disorder
A Randomized Clinical Trial

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**IMPORTANCE** Antidepressant medication (ADM) is efficacious in the treatment of depression, but not all patients achieve remission and fewer still achieve recovery with ADM alone.

**OBJECTIVE** To determine the effects of combining cognitive therapy (CT) with ADM vs ADM alone on remission and recovery in major depressive disorder (MDD).

**DESIGN, SETTING, AND PARTICIPANTS** A total of 452 adult outpatients with chronic or recurrent MDD participated in a trial conducted in research clinics at 3 university medical centers in the United States. The patients were randomly assigned to ADM treatment alone or CT combined with ADM treatment. Treatment was continued for up to 42 months until recovery was achieved. Survival analyses based on subdistribution hazard models were used to model treatment outcomes.

**INTERVENTIONS** Antidepressant medication with or without CT.

**MAIN OUTCOMES AND MEASURES** Blind evaluations of recovery with a modified version of the 17-item Hamilton Rating Scale for Depression and the Longitudinal Interval Follow-up Evaluation.

**RESULTS** Of the 452 participants, 227 were randomized to the CT combined with ADM treatment group, and 225 to the ADM treatment alone group. Combined treatment enhanced the rate of recovery vs treatment with ADM alone (75.2% vs 65.6%; $t_{451} = 2.44; P = .02$; hazard ratio [HR], 1.32; 95% CI, 1.06-1.65; number needed to treat [NNT], 11; 95% CI, 6-91). This effect was conditioned on a statistically nonsignificant interaction with severity ($t_{451} = 1.67; P = .09$; NNT, 6) and a significant interaction with chronicity ($\chi^2 = 7.66; P = .02$; NNT, 6) such that the advantage for combined treatment was limited to patients with severe, nonchonic MDD (84.7% vs 57.7%; n = 147; $t_{451} = 3.88; P = .001$; HR, 2.21; 95% CI, 1.48-3.31; NNT, 4; 95% CI, 2-8). There was no difference in the number of patients who dropped out of combined treatment vs ADM treatment alone (18.1% vs 24.8%; $t_{451} = −1.77; P = .08$; HR, 0.70; 95% CI, 0.47-1.04). Remission rates did not differ significantly either as a main effect of treatment or as an interaction with severity or chronicity. Patients with comorbid Axis II disorders took longer to recover than did patients without comorbid Axis II disorders regardless of the condition ($P = .001$). There were no statistically significant differences in the numbers of serious adverse events in the 2 groups (41 in the ADM plus CT group vs 52 in the ADM-alone group; $\chi^2 = 1.76; P = .18$).

**CONCLUSIONS AND RELEVANCE** Cognitive therapy combined with ADM treatment enhances the rates of recovery from MDD relative to ADMs alone, with the effect limited to patients with severe, nonchonic depression.

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The sample comprised 452 adult outpatients. Inclusion criteria were (1) DSM-IV major depressive disorder (MDD)\(^\text{17}\) either chronic (episode duration ≥ 2 years) or recurrent (with an episode in the past 3 years if only the second episode), (2) 17-item Hamilton Rating Scale for Depression (HRSD) score of 14 or more, (3) age 18 years or older, (4) English speaking, and (5) willing and able to provide informed consent. Exclusion criteria were (1) history of bipolar disorder or nonaffective psychosis, (2) substance dependence in the past 3 months, (3) DSM-IV Axis I disorders requiring nonprotocol treatment, (4) DSM-IV Axis II disorders poorly suited to study treatments (antisocial, borderline, and schizotypal), (5) suicide risk requiring immediate hospitalization, (6) medical condition precluding the use of study medications (including pregnancy), (7) current medications that induce depression, or (8) mandated treatment or compensation issues.

Procedures

Figure 1 depicts the study design and patient flow. The sample size was set to detect differences of 15% or greater (\(\alpha = .05; \beta = 0.20\)) based on previous findings.\(^\text{18}\) A total of 2097 potential participants were screened in person or by telephone; 1718 were invited for diagnostic interviews. Of those, 452 patients met all entry criteria and were randomly assigned (1:1 ratio) to receive ADM alone (\(n = 225\)) or ADM plus CT (\(n = 227\)). The project statistician (R.G.) generated randomization schedules for each site stratified on sex, marital status, symptom severity, recurrence, chronicity, and comorbid Axis II disorder. Project coordinators at each site were able to access these assignments only after each patient was screened into the project and provided informed consent. Intake ran from July 24, 2002, through February 22, 2006; the last patient completed continuation treatment in July 2009. (A 3-year follow-up will be reported.)

Acute treatment lasted until the patient met the criteria for remission, defined as 4 consecutive weeks of minimal symptoms; continuation treatment lasted to the point of recovery, defined as another 26 consecutive weeks without relapse. Patients did not need to maintain the symptom levels required for remission to meet the criteria for recovery. Participants who experienced relapse during continuation were required to meet remission criteria again before they were eligible to meet the criteria for recovery. Patients who did not meet the symptomatic criteria for remission within 18 months of treatment were removed from the study and referred for other treatment, as were patients who did not meet criteria for recovery within 36 months. Patients who met only the symptomatic criterion for remission at month 18 (or recovery at month 36) continued treatment until it was determined whether they also met the temporal criteria. Thus, up to 19 months were allowed for remission and up to 42 months for recovery.

Measures

The 17-item HRSD,\(^\text{19}\) modified to include increases in sleep, appetite, and weight,\(^\text{20}\) was used to assess depression severity. The Longitudinal Interval Follow-up Evaluation (LIFE) was used to provide retrospective assessments of diagnostic status across time.\(^\text{21}\) Both instruments were conducted at least
biweekly through week 4, every 4 weeks through week 20 of acute treatment, and every 8 weeks thereafter through the end of continuation treatment. Trained interviewers blind to treatment condition conducted the evaluations. All evaluations were recorded, and a subset was rated across sites to establish interrater reliability. An intraclass correlation coefficient of 0.96 was obtained for the 17-item total HRSD score (n = 24); major depressive episode designation on the LIFE scale yielded a κ value of 0.80 (n = 12).

### Outcome Criteria

Full remission was defined as HRSD scores of 8 or less and LIFE ratings of 2 or less for 4 consecutive weeks. After month 12, these criteria were relaxed such that 4 weeks of HRSD scores of 12 or lower or LIFE ratings of 3 or lower were sufficient to meet the criteria for partial remission. Relapse was defined as 2 consecutive weeks of HRSD scores of 16 or more or LIFE scores of 5 or more. Serious adverse events (SAEs) were reported to the respective institutional review boards and to the data safety monitoring board as they occurred. Serious adverse events were defined as any untoward event that compromised the patient’s health including death for any reason, suicide attempt, psychiatric or medical hospitalization, and pregnancy or motor vehicle crash while receiving study medications.

### Treatment Procedures

**Pharmacotherapy**

A principle-based algorithm was implemented that could involve up to 4 different classes of ADMs and any of the augmenting or adjunctive agents commonly used in clinical practice. Dosages were raised as rapidly as possible and kept at maximum tolerated levels for at least 4 weeks. Treatment in patients who exhibited only a partial response was augmented with additional medications, and treatment in those who showed minimal response (or little additional response following augmentation) was switched to another ADM.

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**Figure 1. Consolidated Standards for Reporting of Trials Diagram of Patient Flow Through the Study**

MDD indicates major depressive disorder; SCID, Structured Clinical Interview for DSM-IV.

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Original Investigation Research

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patients were given multiple trials with easier-to-manage selective serotonin reuptake inhibitors or serotonin-norepinephrine reuptake inhibitors before treatment was switched to more difficult-to-manage tricyclic antidepressants or monoamine oxidase inhibitors. Patients who experienced remission usually received the same medications during treatment continuation, but the prescribing practitioners were free to adjust the doses and augment or switch medications as needed to forestall relapse. The goal was to provide personalized antidepressant therapy using the best clinical practice. These principles were followed in both treatment conditions. A detailed account of the medications used is beyond the scope of this article and will be subsequently reported.

The protocol called for patients to meet with their prescribing practitioner weekly for the first month, biweekly thereafter during acute treatment, and monthly during continuation. The initial session lasted 30 to 45 minutes, with subsequent sessions approximately 20 minutes. Ten board-certified psychiatrists and 7 psychiatric nurse practitioners with prescribing privileges provided pharmacotherapy (including J.D.A. and J.Z.). Sessions followed the protocol developed by Fawcett and colleagues for the Treatment of Depression Collaborative Research Program. Dr Fawcett oversaw the training and provided consultation throughout the study. Three of us served as the medical directors and provided supervision at the respective sites (J.D.A., R.C.S., and J.Z.). Pharmacotherapy sessions focused on (1) medication management including education about medications, dosage schedules, and adverse effects; and (2) clinical management, including a review of the patient’s functioning in major life spheres and brief supportive counseling.

Cognitive Therapy

Twelve doctoral-level psychologists, 1 psychiatrist, and 1 nurse practitioner provided CT (including P.R.Y.). The therapists met weekly for 90 minutes at each site to review cases, with on-site supervision provided by 3 of the authors (R.J.D., P.R.Y., and S.D.H.). The therapists followed the procedures outlined in the original treatment manual for CT of depression, augmented when indicated for patients with comorbid Axis II disorders. The protocol called for 50-minute sessions to be held twice weekly for at least the first 2 weeks, at least weekly thereafter during acute treatment, and then at least monthly during continuation. Therapists were free to vary the session frequency to meet the needs of the patient.

Statistical Analysis

Survival analyses were used to model treatment outcomes. In conventional survival analyses, censoring because of attrition is assumed to be unrelated to treatment or patient characteristics and therefore independent of time to the event. However, when attrition precludes the occurrence of the event, as it did in this trial, it is a competing risk that can bias estimates of the time to remission or recovery. We therefore adopted the subdistribution hazard model developed by Fine and Gray to account for the possible nonindependence of the censoring mechanism. The weighted partial likelihood estimation directly assesses the intervention and moderation effects for the target event even in the presence of a competing and possibly informative relationship between multiple competing events. The basic model included main effects for site, treatment, and their interaction. Main effects and treatment interactions for each of the stratification variables were estimated in the full models and retained in the final models only if significant. The resulting probabilities will not correspond exactly to the ratio between the actual number of patients recovered divided by the actual number of patients randomized but will provide a more valid estimate of the actual rates of attrition, remission, and recovery than the raw probabilities. All models were implemented in SAS, version 9.3 (SAS Institute Inc) using the algorithm developed by Zhang and Zhang for the subdistribution hazard model. Significance was determined using 2-tailed, unpaired t tests. To characterize the clinical significance of the findings, we computed the number needed to treat (NNT) ratio, a metric used in evidence-based medicine to estimate the number of persons who would need to receive the intervention to produce 1 additional positive outcome. Mantel-Haenszel $\chi^2$ analysis was used to test for treatment differences in the frequency of relapses and SAEs.

Results

Baseline Characteristics

A total of 452 patients were randomized: 151 at the University of Pennsylvania, 151 at Rush University, and 150 at Vanderbilt University. A total of 227 were randomized to the ADM plus CT group and 225 to the ADM-alone group. Baseline HRSD score means did not differ significantly as a function of treatment condition or site (overall mean [SD], 22.1 [4.2]; range, 14-33). The Table gives descriptive statistics for the baseline variables. No significant differences between the conditions were observed in these variables, but there were some significant between-site differences.

Attrition and Termination

Of the randomized patients, 97 (21.5%) did not complete treatment: 91 dropped out and 6 were withdrawn by the staff (excessive substance use, 4; manic episode, 2). Attrition was more than twice as likely to occur during acute treatment (n = 68) than during continuation (n = 29). Attrition rates were not significantly different in the ADM plus CT group vs the ADM-alone group (18.1% vs 24.8%; $t_{451} = -1.77; P = .08$; hazard ratio [HR], 0.70; 95% CI, 0.47-1.04). Patients with Axis II disorders were more likely to drop out irrespective of their condition (26.5% vs 16.6%; $t_{451} = 2.36; P = .02$). Patients who did not achieve remission by month 18 (n = 29) or recovery by month 36 (n = 8) were terminated from the study. Termination rates did not differ significantly by condition (ADM plus CT, 7.0%; ADM alone, 9.3%; $\chi^2 = 0.78; P = .38$).

Remission

Remission rates were high and did not differ significantly as a function of treatment (full remission of 63.7% for ADM plus CT vs 59.7% for ADM alone by month 12; $t_{451} = 1.02; P = .31$; and full or partial remission of 80.7% for ADM plus CT vs 76.1%...
Recovery rates were higher with ADM plus CT than with ADM alone (75.2% vs 65.6%; \( t_{452} = 2.44; P = .02 \); HR, 1.32; 95% CI, 1.06-1.65; NNT, 11; 95% CI, 6-91) and lower for patients with vs those without comorbid Axis II disorders irrespective of treatment condition (63.8% vs 77.0%; \( t_{451} = 3.26; P = .001 \); HR, 1.46; 95% CI, 1.16-1.84). The main effect of treatment on recovery was conditioned on a nonsignificant interaction with severity (\( t_{451} = 1.67; P = .09 \); NNT, 6) and a significant interaction with chronicity (\( \chi^2 = 7.66; P = .02 \); NNT, 6). There were no other main effects or treatment interactions with the other stratification variables or with site (all \( P > .10 \)).

Figure 2 displays the severity by treatment interaction. Recovery rates for patients with low-severity MDD (intake HRSD
Recovery was defined as 6 months without relapse following remission. A, High-severity chronic major depressive disorder (MDD), defined as an HRSD score of greater than 22 at intake and episode duration of 2 years or more. B, High-severity nonchronic MDD, defined as an HRSD score of 22 or greater at intake and episode duration of less than 2 years. ADM indicates antidepressant medication; CT, cognitive therapy; CT + ADM, cognitive therapy combined with ADM; HRSD, Hamilton Rating Scale for Depression; and dashed lines, median time to recovery (50th percentile).

*P < .001.

Figure 3. Time to Recovery as a Function of Chronicity by Condition Within High Severity

Recovery Rate, %

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A
- ADM (n = 42)
- CT + ADM (n = 43)

B
- ADM (n = 75)
- CT + ADM (n = 72)

Discussion

Combining CT with ADM enhanced the rate of recovery compared with ADM alone in a sample of patients with chronic or recurrent nonpsychotic MDD and minimal exclusions for other psychiatric and medical comorbidities. The modest (10%) increment observed is low in the range of comparable trials but similar to the one other study that also followed a more flexible medication algorithm. Doing so may leave little room for CT to enhance recovery.

The magnitude of this increment nearly doubled for patients with more severe depression or nonchronic MDD episodes, but there was little evidence of benefit for patients with less severe or chronic MDD. These findings are consistent with those from earlier trials. Thase and colleagues found that patients with severe recurrent depression were particularly likely to benefit from combined treatment relative to psychotherapy alone, and Kocsis and colleagues found no advantage for combined treatment relative to algorithm-guided treatment among patients with chronic depression. In the present study, exploratory analyses suggested that this increment was larger still (nearly tripled) in the one-third (32.5%) of the patients with MDD that was both more severe and nonchronic. Patients with chronic depression (38.1%) and those with non-
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Cognitive therapy combined with medication treatment enhanced rates of recovery relative to medications alone; this effect may be limited to patients with severe nonchronic depression.

Conclusions

The study has strengths and limitations. Treating MDD to a fixed outcome rather than for a fixed duration and following a principle-driven algorithm rather than limiting the medications used is more representative of clinical practice than the typical approach used in randomized clinical trials. Limitations include (1) the reliance on exploratory analyses to examine the joint effects of severity and chronicity given the lack of a significant interaction between recovery rate and severity; (2) the exclusion of patients with nonchronic first-episode MDD, which precluded the opportunity to test for interactions involving chronicity and recurrence; (3) the absence of another psychotherapy or psychotherapy control, in combination with medications, to test for the specificity of CT in accounting for the combined treatment advantage; (4) the absence of a psychotherapy-only condition, which limits the generalizability of the findings to patients receiving CT with concurrent ADM; (5) the lack of blinding for patients and treatment providers to the condition, which may have contributed to the superiority of combined treatment; and (6) the lack of a formal cost-benefit analysis.

Moderation always implies differential mediation. Our findings suggest that CT engages different mechanisms than ADM but that it likely does so only in some patients. Identifying these mechanisms may suggest ways to enhance treatment response. Future combinatorial trials should include comparisons with CT alone to examine the viability of each monotherapy, especially given evidence that CT effects persist beyond the end of treatment.

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Study concept and design: Hollon, DeRubeis, Fawcett, Amsterdam, Shelton, Zajecka.

Acquisition, analysis, or interpretation of data: Hollon, DeRubeis, Fawcett, Amsterdam, Shelton, Young, Gallop.

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Additional Information: Robert J. DeRubeis, PhD (University of Pennsylvania), Jan Fawcett, MD (University of New Mexico), and Steven D. Hollon, PhD (Vanderbilt University), were the principal investigators, and Jay D. Amsterdam, MD (University of Pennsylvania), John Zajecka, MD (Rush University), and Richard C. Shelton, MD (Vanderbilt University), were the coprincipal investigators. Drs DeRubeis and Hollon oversaw the implementation of CT at University of Pennsylvania and Vanderbilt University, respectively, and Dr Young did the same at Rush University. Dr Fawcett oversaw the implementation of pharmacotherapy across the study, and Drs Amsterdam, Zajecka, and Shelton supervised the implementation of pharmacotherapy at the respective sites.

Additional Contributions: Brent Freeman, BA, and Bernadette Koo, MS (University of Pennsylvania), Debra Kibbe, RN, and Matthew Marasco, BA (Rush University), and Margaret L. Lovett, MEd (Vanderbilt University), served as the study coordinators. Giampaolo Gallo, MD, Moira Molloy, MSN, Bobbie Posmontier, PhD, Nancy Rutherford,


