way to conduct them. Patients cannot be blinded to whether they are receiving a proper psychotherapy, nor can therapists be blinded to what kind of therapy they are providing. The studies we quote relied either on blinded rater assessments or patient-reported assessments. We know of no evidence that patients try to please researchers by overstating their improvement; in fact, patient reports often result in smaller treatment effect sizes than clinician-rated measures. Certainly, psychotherapy trials suffer from therapist allegiance effects, but that is one of the reasons to compare the conclusions of trials with allegiance to different experimental treatments (see study bias ratings in eTable 5 in the Supplement).

The comments from Tong et al are largely about deviations from our 2015 protocol article. We acknowledge these deviations but point out that changes to the protocol were based on limitations of the literature and were undertaken before the statistical analyses were carried out. We provided extensive appendices to ensure that readers could view all of the subanalyses conducted. Most trials reported recurrence as a binary outcome rather than time to recurrence. Few of the cited 12-week trials was only used in the depression stabilization analyses are listed in eTable 5A in the Supplement. The cited 12-week trial was only used in the analyses of depression stabilization and attrition, and its exclusion would not have substantially changed the conclusions. We acknowledged the variability in instrumentation in the Discussion and recommended the use of standardized assessment batteries in future studies.

We focused our primary and secondary analyses on questions that we believed to be of greatest interest to the field. As stated, we cannot draw conclusions about the comparative effects of different types of psychotherapy or therapy ingredients in patients who vary in illness severity or polarity. We hope that our article will encourage others to examine these subsidiary questions. For the longer term, initiatives such as the Wellcome Mental Health program strategy, which emphasizes the collaboration of different scientific disciplines to identify effective treatment components, will advance the field further.

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Error in Results, Figures, and Tables: In the Original Investigation titled “Longitudinal Trends in Childhood Insulin Levels and Body Mass Index and Associations With Risks of Psychosis and Depression in Young Adults,” published online January 13, 2021, there were errors in the Abstract, Results, Figure 2, and Table 1. In all places, the 95% CI for the adjusted odds ratio of 3.22 was reported as “1.11-9.90.” The 95% CI should have been “1.29-8.02.” In addition, several table P-values were adjusted and 2 other 95% CIs in Figure 3 were adjusted. The supplement was also updated to correct 95% CIs in eTable 10. This article was corrected online.