Combining pharmacotherapy and psychotherapy or monotherapy for major depression? A meta-analysis on the long-term effects

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ABSTRACT

Background: The present meta-analysis aimed to examine to what extent combined pharmacotherapy with psychotherapy results in a different response to treatment compared to psychotherapy or pharmacotherapy alone in adults with major depression at six months or longer post-randomization.

Methods: A systematic literature search resulted in 23 randomized controlled trials with 2184 participants. Combined treatment was compared to either psychotherapy or anti-depressant medication alone in both the acute phase and the maintenance phase. Odds ratios of a positive outcome were calculated for all comparisons.

Results: In acute phase treatment, combined psychotherapy with antidepressants outperformed anti-depressants alone at six months or longer post-randomization in patients with major depressive disorder (OR=2.93, 95%CI 2.15–3.99, p < 0.001). Heterogeneity was zero (95%CI 0–57%, p > 0.05). However, combined therapy resulted in equal response to treatment compared to psychotherapy alone at six months or longer post-randomization. As for the maintenance treatment, combined maintenance psychotherapy with antidepressants resulted in better-sustained treatment response compared to antidepressants at six months or longer post-randomization (OR=1.61, 95%CI 1.14–2.27, p < 0.05). Heterogeneity was zero (95%CI 0–68%, p > 0.05).

Conclusions: Combined therapy results in a superior enduring effect compared to antidepressants alone at six months or longer post-randomization in patients with major depression. Psychotherapy is an adequate alternative for combined treatment in the acute phase as it is as effective as combined treatment in the long-term.

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1. Introduction

Depression is a highly prevalent disorder and one of the leading causes of disability worldwide. According to the World Health Organization (WHO), depression is currently the fourth largest contributor to the global burden of disease and is expected to become the second cause of disability by 2020. This is a result of the recurring nature of depression and its excessive economic costs, mortality, and morbidity rates (Reddy, 2010). Therefore, it is crucial for clinical decision making to identify which therapeutic strategies should be employed to produce the most favorable outcome in the treatment of depression in both the short and the long term.

There is ample evidence for the short-term effects of psychotherapies and pharmacological treatments for depression in the acute stage at alleviating the symptoms of an active depression (see Figure 1 for definitions and the results cannot be generalized to other types of psychotherapy. To our knowledge, no systematic review has examined the effects of combined treatment in the long term; such knowledge will provide insight into which therapy we should consider as first line treatment for major depression. The present meta-analysis aimed to examine what extent combined pharmacotherapy with psychotherapy results in a different response to treatment compared to psychotherapy and pharmacotherapy alone in adults with major depression at six months or longer follow-up.

2. Methods

We conducted the present meta-analysis with a filter for systematic reviews provided by PubMed (http://www.nlm.nih.gov/bsd/pubmed_subsets/sysreviews_strategy.html) and a filter for RCTs as recommended in the Cochrane Handbook (Higgins and Green, 2011). Search strategies for other databases were built accordingly.

In addition to the systematic literature search, we included all main psychotherapy interventions that have been identified in an expert taxonomy of psychotherapy for adults (≥ 18 years of age) depression (Cuijpers et al., 2008a). Here, psychotherapy was classified into seven different types: behavioral activation, cognitive-behavioral therapy, interpersonal therapy, problem-solving therapy, psychodynamic therapy, social skills training, and supportive counseling. Operational definitions of each type of psychotherapy are given elsewhere (Cuijpers et al., 2008a, 2008b). We considered for inclusion acute phase treatments as well as maintenance treatments (definitions are given in Table 1) and distinguished these throughout the analyses. The selected interventions were main psychotherapy interventions combined with antidepressive agents compared to main psychotherapy intervention or antidepressants alone.
The primary outcomes of the present meta-analysis were treatment response and sustained response. Treatment response was defined as every positive outcome achieved, such as whether a patient met criteria for remission or was free from relapse or recurrence. Moreover, sustained response was defined as a treatment response that was continued during and after maintenance treatment. Other outcomes were condition-related outcomes (depression rating scales).

Only outcomes at six months or longer after randomization were considered for inclusion. This cut off was chosen because remission is defined as the absence of a depressive disorder three months after the end of therapy, and because anti-depressant medication needs to be provided for at least six months (American Psychiatric Association, 2000). Additionally, a later time point for the cut off did not seem feasible as few studies have a longer follow up period. Outcomes were extracted for different time periods (six months and one year or longer).

2.3. Quality assessment

Two reviewers assessed study quality independently (EK and YS) based on the criteria of the Cochrane Risk of Bias tool (Higgins and Green, 2011). Disagreement was resolved through discussion and, if needed, the opinion of a third researcher (PC) was sought.

2.3.1. Data extraction

The following data were extracted from the included RCTs: patient characteristics, type of psychotherapy, treatment format, number of treatment sessions, type of pharmacotherapy, type of control and data on the follow up period. In some studies, outcome data were only reported for patients who responded to treatment in the acute treatment phase, while others report outcomes for the full, intention-to-treat sample. When available, intention-to-treat data were selected. One reviewer (EK) extracted data; a second reviewer (PC) checked the extracted data.

2.4. Description of the analysis

The primary focus was on dichotomous outcomes. We calculated for each comparison the odds ratio (OR) of a positive outcome, based on dichotomous results, such as remission and response, or the proportion of patients that no longer met criteria for a depressive disorder according to a diagnostic interview. The OR shows the odds that an event (e.g. treatment response) will occur in the treatment group (e.g. combined therapy) compared to the odds of the same event occurring in the control group (e.g. psychotherapy or antidepressants alone). An OR > 1 increases the odds that an event will occur in the treatment group. Reversely, an OR < 1 decreases the odds that an event will occur in the treatment group (Deeks et al., 2008). Generally, an OR of 1.5 is considered a small effect size, while an OR of 2.5 and OR of 4 represent a medium and a high effect size respectively (Rosenthal, 1996).

Where more than one dichotomous outcome was reported, we calculated the mean of the effect sizes according to Borenstein et al. (2009) procedures. Thus, each comparison resulted in only one effect. If no dichotomous outcomes were reported, the standardized mean difference (SMD) was calculated as the difference in mean scores divided by the pooled standard deviation. The SMD was converted into the OR according to the procedures given by Borenstein et al. (2009). For dichotomous outcomes all randomized patients were taken as the denominator, and reported outcomes in completers were taken as the numerator. To calculate pooled relative risks, we used the computer program Comprehensive Meta-Analysis (version 2.2.021). Because we expected considerable heterogeneity among the studies, we used the random effects model in order to pool the studies.

2.5. Heterogeneity

As a test of homogeneity of effect sizes, the $I^2$-statistic was calculated which is an indicator of heterogeneity in percentages. A value of 0% indicates no observed heterogeneity, and larger values indicate increasing heterogeneity, with 25% as low, 50% as moderate, and 75% as high heterogeneity (Higgins et al., 2003). 95% confidence intervals (CI) were calculated around $I^2$ (Ioannidis et al., 2007) using the non-central chi-squared-based approach within the hetero module for Stata (Orsini et al., 2005). The Q-statistic was calculated, and reported when significant.

2.6. Additional analyses

Publication bias was tested by inspecting the funnel plot on primary outcome measures and by Duval and Tweedie (2000) trim and fill procedure (as implemented in Comprehensive Meta-analysis, version 2.2.021). Duval and Tweedie's test estimates the number of missing studies that might exist in a meta-analysis due to publication bias. Trim and fill corrects for the resulting asymmetry in the funnel plot by adjusting the effect size for missing studies (Duval and Tweedie, 2000). Egger's test of the intercept was conducted in order to quantify the bias captured by the funnel plot and test whether it was significant (Egger et al., 1997).

Researcher allegiance for psychotherapy was examined for all the included RCTs. We evaluated a study as at high risk of researcher allegiance when any of the authors was also involved in the development of the treatment manual of the psychotherapy involved. The involvement of a researcher in developing the treatment under investigation is regarded as a valid indicator of researcher allegiance, while the validity of other indicators in reprint measures has been questioned (Munder et al., 2013)

Moderator and subgroup analyses were planned when sufficient studies (at least 3 studies per sub-group) were available.

3. Results

After removal of duplicates, we examined 11145 references on titles and abstracts. This process resulted in 2897 articles being retrieved for possible inclusion in the present meta-analysis. In the 23 RCTs that met inclusion criteria, a total of 2184 individuals suffering from MDD participated in the relevant comparisons combined therapy, psychological and pharmacological interventions. We identified 15 RCTs on acute phase treatment and 8 RCTs on maintenance treatment. Fig. 1 presents the studies selection process.
The majority of the included studies recruited their participants through clinical samples, such as general practitioners, outpatient psychiatric clinics and mental health institutes. One RCT recruited patients through both clinical and community referrals, one through community samples, and one did not report the manner of recruitment. Twenty-one of the 23 trials recruited outpatients, while two studies included inpatients. The examined RCTs were conducted across six different countries: Germany ($n=1$), Italy ($n=2$), China ($n=1$), the Netherlands ($n=2$), the United Kingdom ($n=5$) and the United States ($n=12$).

Regarding trials on acute phase treatment, the duration of follow up ranged from six to 48 months after randomization. As for the maintenance studies, patients entered into either maintenance psychotherapy combined with antidepressants or into maintenance antidepressant medication groups and were followed from six to 24 months.

The types of psychotherapy examined across the included trials were: CBT, interpersonal psychotherapy, problem solving therapy, psychodynamic supportive therapy, and social skills training. Acute phase treatment had a duration ranging from six to 29 sessions, while the maintenance psychotherapeutic interventions consisted of six to 20 sessions that were conducted either weekly/biweekly or monthly. The antidepressant agents used were the following: amitriptyline hydrochloride, fluoxetine, fluvoxamine, imipramine hydrochloride, nortriptyline, or sertraline. Study characteristics are given in Table 2.

### 3.1. Differences between combined psychotherapy and antidepressants vs. psychotherapy alone or antidepressants alone, acute phase treatment

Acute phase combined therapy did not differ significantly in patients’ response to treatment, compared to acute phase psychotherapy at six months ($OR=1.42, 95\% CI 0.97–2.07, p > 0.05$) and one year or longer postrandomization ($OR=1.33, 95\% CI 0.88–2.14, p > 0.05$). Heterogeneity between studies was zero ($95\% CI 0–71\%, p > 0.05$). There were no indications for publication bias (Table 3). However, combined psychotherapy with antidepressants (acute phase) resulted in a better treatment response compared to acute phase antidepressants after six months or longer postrandomization ($OR=2.93, 95\% CI 2.15–3.99, p < 0.001$). Heterogeneity between studies was zero ($95\% CI 0–57\%, p > 0.05$). There was some indication of publication bias. Duval and Tweedie’s Trim and Fill procedure indicated that two studies were missing. The imputed estimate was 2.71 ($95\% CI 1.95–3.74$). Nevertheless, Egger’s Test was not significant ($p > 0.05$). Similar results were observed for the same comparisons after one year or longer post-randomization. Combined therapy outperformed antidepressants in treatment response of outpatients with MDD ($OR=2.23, 95\% CI 1.43–3.41$). Heterogeneity was zero ($95\% CI 0–68\%, p > 0.05$). Duval and Tweedie’s Trim and Fill procedure indicated a possibility for publication bias and produced an imputed estimate of 1.97 ($95\% CI 1.29–3.01$), however, Egger’s test was not significant (Table 4). The main outcomes are summarized in Fig. 2.

### 3.1.1. Sensitivity and subgroup analyses

Two studies on inpatients were excluded in a sensitivity analysis. Acute phase combined psychotherapy with antidepressants resulted in better response to treatment compared to acute phase antidepressants at six months or longer postrandomization in outpatients with MDD ($OR=2.98, 95\% CI 2.07–4.29, p < 0.001$). Heterogeneity was low ($I^2=8\%, 95\% CI 0–63\%, p > 0.05$). There was some indication of publication bias. Using Trim and Fill the imputed value estimate was 2.80 ($95\% CI 1.89–4.14$) while Egger’s test was not significant. A similar pattern of results was observed at one year or longer postrandomization (Table 3). Sub-group
<table>
<thead>
<tr>
<th>Studies</th>
<th>Recruitment</th>
<th>Design</th>
<th>Any AXIS-Il Diagnosis (%/ Total N)</th>
<th>PT</th>
<th>N patients</th>
<th>Comparison</th>
<th>N patients</th>
<th>FU (months)</th>
<th>Outcome</th>
<th>Type of treatment</th>
<th>RA</th>
<th>Risk of bias&lt;sub&gt;a&lt;/sub&gt;</th>
<th>Country</th>
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</thead>
<tbody>
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<td>Beck et al., 1985</td>
<td>CS</td>
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<td>CBT</td>
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<td>6, 12</td>
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<td>Remission (HRSD scores reduction ≥ 40%)</td>
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<td>5</td>
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<td>IPT &amp; SSRI</td>
<td>20</td>
<td>SSRI</td>
<td>19</td>
<td>6</td>
<td>Response (HRSD &lt; 8; BDI &lt; 9)</td>
<td>Acute</td>
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<td>3</td>
<td>IT</td>
</tr>
<tr>
<td>Blackburn et al., 1986</td>
<td>CS</td>
<td>RCT/nat.FU</td>
<td>NR</td>
<td>CBT &amp; TCA</td>
<td>16</td>
<td>TCA</td>
<td>10</td>
<td>6, 12, 18, 24</td>
<td>Remission (HRSD ≤ 7)</td>
<td>Acute</td>
<td>0</td>
<td>5</td>
<td>UK</td>
</tr>
<tr>
<td>De Jonghe et al., 2001</td>
<td>CS</td>
<td>RCT</td>
<td>NR</td>
<td>PDST &amp; SSRI</td>
<td>83</td>
<td>SSRI</td>
<td>84</td>
<td>6</td>
<td>Remission (HRSD ≤ 7)</td>
<td>Acute</td>
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<td>4</td>
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<td>RCT</td>
<td>NR</td>
<td>PDST &amp; TCA/SSRI</td>
<td>101</td>
<td>PDST</td>
<td>107</td>
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<td>Acute</td>
<td>0</td>
<td>3</td>
<td>NL</td>
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<td>NR</td>
<td>IPT &amp; TCA</td>
<td>25</td>
<td>TCA</td>
<td>28</td>
<td>12, 24, 36</td>
<td>Recurrence (HRSD ≥ 15); survivors (HRSD &lt; 15; Raskin &lt; 7)</td>
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<td>Hersen et al., 1984</td>
<td>Com. S</td>
<td>RCT</td>
<td>NR</td>
<td>SS &amp; TCA</td>
<td>21</td>
<td>TCA</td>
<td>14</td>
<td>6</td>
<td>Depression symptoms (BDI; HRSD; REDS)</td>
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<td>TCA</td>
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<td>24</td>
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<td>Recovery (&gt; 26 consecutive weeks without relapse)</td>
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<td>RET &amp; TCA</td>
<td>10</td>
<td>TCA</td>
<td>10</td>
<td>6</td>
<td>HRSD; BDI</td>
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<td>Maina et al., 2009</td>
<td>CS</td>
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<td>NR</td>
<td>BDT &amp; SSRI</td>
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<td>SSRI</td>
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<td>48</td>
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<td>SSRI</td>
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<td>66</td>
<td>6</td>
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<td>NR</td>
<td>IPT &amp; TCA</td>
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<td>TCA</td>
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<td>Recovery (DSM-IV)</td>
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<td>65</td>
<td>TCA</td>
<td>65</td>
<td>12</td>
<td>Response (HRSD scores reduction ≥ 50%); Recovery (HRSD ≤ 7)</td>
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<td>3</td>
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<td>RCT</td>
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<td>TCA</td>
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<td>Response (BDI &lt; 10)</td>
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<td>CBT &amp; SSRI</td>
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<td>NR</td>
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<td>SSRI or TCA</td>
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<td>6, 12</td>
<td>Recovery (MADRS ≥ 10; BDI ≥ 12)</td>
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<td>RCT</td>
<td>NR</td>
<td>CBT &amp; SSRI</td>
<td>60</td>
<td>SSRI</td>
<td>60</td>
<td>6</td>
<td>Remission QIDS &lt; 5</td>
<td>Maintenance</td>
<td>0</td>
<td>4</td>
<td>CH</td>
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</table>

ADM: Antidepressant Medication; BDI: Beck Depression Inventory; BDT: Brief Dynamic Therapy; CBT: Cognitive Behavioral Therapy; CH: China; CIDI: Composite International Clinical Interview; Com. S: Community Sample CS: Clinical Sample; CP: General Practitioner; DE: Germany; DSM: Diagnostic and Statistical Manual of Mental Disorders; FU: Follow Up postrandomization; GP: General Practitioner; HRSD: Hamilton Rating Scale for Depression; IPT: Interpersonal Psychotherapy; IT: Italy; M: month(s); MADRS: Montgomery Asberg Depression Rating Scale; N: number; NL: Netherlands; NR: Not Reported; NS: Not Specified; PDST: Psychodynamic Supportive Therapy; PST: Problem Solving Therapy; PT: Psychotherapy; QIDS: Quick Inventory of Depressive Symptomatology-Self-Report; RA: Research Allegiance; RCT: Randomized Controlled Trial; RCT/nat. FU: Randomized Controlled Trial/Naturalistic Follow Up; SSRI: Selective Serotonin Reuptake Inhibitor; TCA: Tricyclic antidepressant; UK: United Kingdom; US: United States; W: week(s).

<sup>a</sup> One (1) is given when the study was evaluated as at high risk of researcher allegiance and zero (0) when the study was evaluated as at low risk of researcher allegiance.

<sup>b</sup> Sum of ‘unclear or high risk of bias’ of the individual quality criteria. The sum is derived after assigning a zero (low risk of bias) or one (unclear or high risk of bias) to each one of the following quality criteria: allocation sequence, allocation concealment, blinding of participants and personnel, blinding of assessors, incomplete outcome data, selective reporting, and other sources of bias.
Subgroup analyses were conducted only in the cases where at least three comparisons were available per group. N: Number of comparisons.

Table 4

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>N</th>
<th>OR</th>
<th>95%CI</th>
<th>( \hat{t} )</th>
<th>95%CI</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response at 6 months or longer postrandomization</td>
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<td>2.93</td>
<td>2.15–3.99</td>
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<td>0–57</td>
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<td>Subgroups</td>
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<td>CBT vs.</td>
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<td>SSRI</td>
<td>6</td>
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<td>1.70–4.11</td>
<td>19</td>
<td>0–64</td>
<td>0.51</td>
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<td>TCA</td>
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<td>1.90–5.99</td>
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<td>0–75</td>
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<tr>
<td>Response at 1 year or longer postrandomization</td>
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<td>2.23</td>
<td>1.43–3.41</td>
<td>0</td>
<td>0–68</td>
<td></td>
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</table>

Subgroup analyses were conducted only in the cases where at least three comparisons were available per group. N: Number of comparisons.

4. Discussion

The aim of the present meta-analysis was to examine to what extent combined pharmacotherapy with psychotherapy results in a different long-term response to treatment compared to psychotherapy and pharmacotherapy alone in adults with major depression. Results indicated that combined psychotherapy with antidepressants resulted in an equal acute phase treatment response compared to psychotherapy at six months or longer postrandomization, in adult patients with MDD. Further, combined psychotherapy with antidepressants resulted in a better acute phase treatment response compared to antidepressants alone, at six months or longer postrandomization. As for the maintenance studies, there was evidence that maintenance-combined psychotherapy with antidepressants resulted in a better-sustained response compared to maintenance antidepressants alone, at six months or longer postrandomization.

The results of the comparison between combined therapies versus antidepressants alone (acute phase treatment) may have been somewhat overestimated due to publication bias. This indication of publication bias is in accordance with previous meta-analyses on the same comparison (Cuijpers et al., 2014). However, the point estimate remained high and significant after the adjustment for publication bias.

The results of the present meta-analysis are in line with previous research, which compared the effects of combined therapy against antidepressants in patients with depression and anxiety disorders in the short term (Cuijpers and Dekker, 2005; Cuijpers et al., 2009, 2014, 2012; Khan et al., 2012; Pampallona et al., 2004). A recent meta-analysis by Cuijpers et al. (2014) showed that adding psychotherapy to antidepressants results in overall superior short-term effects compared to antidepressants alone in patients with MDD, panic disorder and obsessive compulsive

3.2. Differences between combined psychotherapy with antidepressants vs. psychotherapy alone or antidepressants alone in adults who have had MDD, maintenance treatment

Only one study (Frank et al. 1990) examined the comparison between combined maintenance psychotherapy with antidepressants and maintenance psychotherapy at six months or longer post-randomization. Thus, we could not examine this comparison.

Table 5 shows the results of the comparison between maintenance combined psychotherapy and antidepressants at six months or longer post-randomization. Combined maintenance psychotherapy with antidepressants resulted in a better treatment-sustained response compared to antidepressants at six months or longer post-randomization (OR = 1.61, 95%CI 1.14–2.27, \( p < 0.05 \)). Heterogeneity was zero (95%CI 0–68%, \( p < 0.05 \)). There was no indication of publication bias. Six studies compared the outcomes of combined maintenance psychotherapy with antidepressants versus antidepressants at one year or longer post-randomization. Combined maintenance psychotherapy with antidepressants resulted in a better-sustained response to treatment in comparison with antidepressants (OR = 1.73, 95%CI 1.20–2.49, \( p < 0.05 \)) after one year or longer post-randomization. Heterogeneity between the studies was zero (95%CI 0–75%, \( p > 0.05 \)). There was no indication of publication bias. Finally, subgroup analyses (studies with high vs. studies with low risk of bias, CBT vs. other types of therapy, SSRI vs. TCA antidepressants, and researcher allegiance vs. no researcher allegiance for psychotherapy) did not result in statistically significant differences.

The main outcomes of our analyses are summarized in Fig. 2. The forest plots of the main outcomes can be found in Appendix B.
Comparisons were available per group. Subgroup analyses were conducted only in the cases where at least three contained during 2 years follow-up (Cuijpers et al., 2014). The present adults with MDD.

Effect sizes maintenance psychotherapy with antidepressants vs. antidepressants in Table 5 depression (Barber et al., 2013). Moreover, the remission rates compared to antidepressants alone in adults with dynamic therapy combined with antidepressants results in higher dynamic therapy. The authors found that in the long-term dy-
tation due to several limitations. Most of the included trials used CBT as a psychotherapeutic intervention, therefore, differences between different types of psychotherapy could not be examined and the generalizability of the present findings to all types of psychotherapy is restricted. Similarly, a distinction between depression severities was not possible because there were no specific studies with a distinction between mild, moderate and severe MDD. The outcome was specified to treatment response since the included studies did not provide enough information on outcomes assessed by clinical interview. Furthermore, we identified only one trial on the comparison between maintenance combined therapy and psychotherapy alone (Frank et al., 1990). Thus, we could not analyze this comparison and we limited our analysis to the comparison between maintenance-combined therapy against maintenance antidepressants. Finally, a limitation that should be acknowledged is that the sample at randomization is typically not the same as the one at long-term follow-up, in spite of using advanced statistics to model missing data.

With respect to researcher allegiance, a bias of concern in psychotherapy research (Munder et al., 2013), we did not find evidence that studies at a high risk of researcher allegiance for psychotherapy favored psychotherapy more than did studies at a low risk of researcher bias. However, the number of studies in each subgroup was small, and we did not examine more subtle forms of researcher allegiance for psychotherapy such as whether authors advocated the psychotherapy or the mix of research teams (including methodologists and/or psychiatrists). As for our own researcher allegiance, we have carried out in the past a series of meta-analyses of several different types of psychotherapy and pharmacotherapy and we do not prefer one treatment to another. Additionally, we believe that out team is well balanced as it consists of researchers in clinical psychology as well as experts in evidence-based medicine.

The results of this meta-analysis raise several clinical possibilities. Currently, antidepressants are widely used as first option in treating major depression in primary and secondary mental health care (Geddes et al., 2003). Given the high risk of relapse (Keller, 1994), alternative treatment options should also be proposed. The present findings highlight that the combination of psychotherapy with antidepressants provides clinical gains in terms of long-term sustainability of the treatment response. Thus, in light of the enduring effects, combined therapy may be preferred over monotherapy with antidepressants in treatment of major depression. However, while combined therapy enhanced response rates relative to antidepressant alone, the present results failed to demonstrate a superiority of combined treatment compared to psychotherapy alone, after acute phase treatment. This might be due to the limited number of trials on the comparison between combined therapy and psychotherapy alone and it remains to be confirmed by future studies. However, it could also indicate that psychotherapy is in fact a viable alternative for combined treatment, which is important to note for several reasons. Psychotherapy in contrast to medication is not related to side effects (National Collaborating Centre for Mental Health, 2010) and

![Fig. 2. Main outcomes of combined psychotherapy and antidepressant medications (PT&ADM) in Odds ratio (OR) and 95% Confidence intervals (95%CI).](image-url)

### Table 5

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>N</th>
<th>OR</th>
<th>95%CI†</th>
<th>I²</th>
<th>95%CI</th>
<th>p*</th>
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<tr>
<td>Sustained response at 6 months or longer postrandomization</td>
<td>8</td>
<td>1.61</td>
<td>1.14–2.27</td>
<td>0</td>
<td>0–68</td>
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<td><strong>Subgroups</strong></td>
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<td><strong>Type of psychotherapy</strong></td>
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<td>CBT vs.</td>
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<td>1.79</td>
<td>1.19–2.70</td>
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<td>0–85</td>
<td>0.32</td>
</tr>
<tr>
<td>Other</td>
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<td>0.64–2.33</td>
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<td>0–85</td>
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<td>No</td>
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<td>0</td>
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<td>0.55–2.30</td>
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<td>0–90</td>
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<td><strong>Types of antidepressants</strong></td>
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<td></td>
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<td>SSRI</td>
<td>3</td>
<td>1.26</td>
<td>0.60–2.64</td>
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<td>TCA</td>
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<tr>
<td>Sustained response at 1 year or longer postrandomization</td>
<td>6</td>
<td>1.73</td>
<td>1.20–2.49</td>
<td>0</td>
<td>0–75</td>
<td></td>
</tr>
</tbody>
</table>

Subgroup analyses were conducted only in the cases where at least three comparisons were available per group. N: Number of comparisons.

† p < 0.05.

‡ 95%CI: 95% Confidence Intervals; OR: Odds Ratio; p: p-value.

* p-value between groups.

disorder. The authors also reported that these effects were sus-
tained during 2 years follow-up (Cuijpers et al., 2014). The present findings are also in line with the results of Barber et al. (2013) on dynamic therapy. The authors found that in the long-term dy-
namic therapy combined with antidepressants results in higher remission rates compared to antidepressants alone in adults with depression (Barber et al., 2013). Moreover, the finding that acute phase combined therapy results in no differences in treatment response compared to acute psychotherapy in longer than 6 months post-randomization is in accordance with Cuijpers et al. (2009) meta-analysis. Cuijpers et al. (2009) showed that there are no differences between the effects of combined therapy and psychotherapy at longer than 1 month follow up in patients with depression (Cuijpers et al., 2009). To the best of our knowledge there is no systematic review examining the effects of main-
tenance combined therapy.

The present study has several strengths. The included studies targeted outpatients with MDD and thus, the results of the present review refer to a highly homogeneous population. Additionally, our results are based on a direct comparison between acute/maintenance phase combined treatment and acute phase anti-
depressants/psychotherapy or maintenance antidepressants.

However, the present results should be interpreted with caution due to several limitations. Most of the included trials used CBT as a psychotherapeutic intervention, therefore, differences between different types of psychotherapy could not be examined and the generalizability of the present findings to all types of psychotherapy is restricted. Similarly, a distinction between depression severities was not possible because there were no specific studies with a distinction between mild, moderate and severe MDD. The outcome was specified to treatment response since the included studies did not provide enough information on outcomes assessed by clinical interview. Furthermore, we identified only one trial on the comparison between maintenance combined therapy and psychotherapy alone (Frank et al., 1990). Thus, we could not analyze this comparison and we limited our analysis to the comparison between maintenance-combined therapy against maintenance antidepressants. Finally, a limitation that should be acknowledged is that the sample at randomization is typically not the same as the one at long-term follow-up, in spite of using advanced statistics to model missing data.

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teaches patients a set of skills and coping mechanisms, which they can employ and use to sustain their improvement after the treatment phase is over. Furthermore, in evidence based practice the decision-making is based on both treatment effectiveness and patient preferences. Considering that combined therapy and psychotherapy alone result in equivalent outcomes over the long-term, patients’ preferences is an important factor when choosing treatment modality. Previous research has shown that some patients prefer psychotherapy to taking medication (van Schaik et al., 2004); thus, access to both psychotherapy and pharmacotherapy in primary and secondary mental health care may increase the chance of patients following their preferred treatment (Winter and Barber, 2013).

Further research is warranted to address outcomes such as quality of life or adverse events, and to examine more types of psychotherapy. To conclude, the present results suggest that combined treatment is the best available option both as acute and as maintenance therapy for treating major depression in the long term. In addition, if a patient does not prefer the combined treatment, acute phase psychotherapy could also be a treatment option as it is as effective as acute phase combined treatment in the long term.

Appendix A. Supplementary material

Supplementary data associated with this article can be found in the online version at [http://dx.doi.org/10.1016/j.jad.2016.01.036](http://dx.doi.org/10.1016/j.jad.2016.01.036).

References


