In chronic depression, response rates significantly improve when psychotherapy and meds are combined.

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A Comparison of Nefazodone, the Cognitive Behavioral-Analysis System of Psychotherapy, and Their Combination for the Treatment of Chronic Depression

Background: Chronic forms of depression are significant sources of impairment. At any given time at least 3% of the U.S. population suffers from a chronic form of depression. Treatments for chronic depression have been varied and there have been few controlled clinical trials to examine treatment effects of psychotherapy or medications.

Aim: To compare the treatments of psychopharmacological management alone, with cognitive behavioral therapy alone, versus their combination in treatment of chronic depression.

Methods: A multi-center, clinical trial, where adults 18-75 years old were randomized to receive either nefazodone alone (not to exceed 600 mg per day); cognitive behavioral psychotherapy; or a combination of both therapies. For this study, chronic depressive disorder was defined as severe depressive symptoms for at least two years. The Hamilton Rating Scale for Depression (HRSD) was the primary outcome measured.

Main Findings: The overall response rate (both remission and satisfactory response) was 48% in both the nefazodone group and the psychotherapy group, as compared with 73% in the combined treatment group (P<0.0001). Nefazodone produced effects more rapidly than did psychotherapy with significant advantages evident in the first 4 weeks. However, psychotherapy had a greater effect during the second part of the trial and by week 12, the efficacy of the two approaches was similar. The combined treatments appeared to have an additive effect that became evident between week 4 and 5 and was sustained to the end of the 12-week trial. Adverse events were 14% of the Nefazodone group, 7% in the combined treatment group, and 1% in the psychotherapy group. The reasons for withdrawal from psychotherapy included the patient felt treatment was too time consuming, wanted medication, or did not want psychotherapy.

Conclusions: At the end of 12 weeks of outpatient treatment of patients with chronic depression, similar results were seen for monotherapies of nefazodone
or a form of cognitive behavioral therapy. The combination of these two treatments had significant benefit over either therapy alone.

Limitations: The lack of a placebo control might affect validity. A greater limitation, however, is the short duration of treatment (12 weeks) in a chronic disorder. Also, this study only involved patients with chronic depression and not those with depression of a shorter duration.

Impact on Internal Medicine: Chronic depression is a common debilitating illness seen in primary care. This study highlights the value of the combination of psychopharmacology and cognitive behavioral psychotherapy. It also suggests that in the chronic forms of depression, it is important to address underlying abnormal depressed cognitions and behaviors, perhaps consequences of years of depression, and not simply target the symptoms addressed with medications alone.

Related References:
Five-year course and outcome of dysthymic disorder: A prospective, naturalistic follow-up study.

In a longitudinal study, the estimated recovery rate for dysthymic disorder was 52.9%. The risk of relapse was 42.5% during a mean 2 year follow-up. This study confirms dysthymia is a chronic condition with a protracted course and a high rate of recurrence.

The efficacy of drug treatments for dysthymia: a systematic review and meta-analysis.

Drug treatment is effective in short-term trials of dysthymia (12 weeks or less). Similar results were obtained across different classes of antidepressants. Patients taking tricyclic antidepressants were most likely to report adverse events. Clinicians should consider drug treatment for dysthymia. The choice of drug should be guided by its side effect profile. How long antidepressant therapy should be continued requires further study.