

### Jane developed symptoms of depression after a series of stressful life events.

She was involved in an abusive marriage and a painful divorce. She was unable to cope at work and subsequently lost her job as an advertising executive. Without her routine of work, she began to spend more and more time at home, where she would dwell and ruminate on her failures in love and work. She became less active, tired most of the day and her mood deteriorated. She began to believe that her brain had changed irreversibly as a consequence of her depression and she started to avoid seeing her friends for fear that they would look down on her for not being able to cope. Her medical doctor prescribed antidepressants, which she felt 'took the edge off her depression' but her symptoms still prevented her from going out or returning to work.

The psychiatrist, Aaron T. Beck, developed cognitive therapy in the 1960s to treat depression.<sup>1</sup> Up until that time, most psychotherapy for depression had its origins in the psychodynamic approach inspired by the work of Sigmund Freud.<sup>2</sup> The first controlled outcome study of cognitive-behaviour therapy (CBT) for depression was conducted in 1977 and since then a great deal of research into the effectiveness of CBT, across a range of treatment settings and populations, has been conducted. Currently, CBT is in common use throughout the world, within public and private health care services, and particularly in the US, Canada, the UK, Australia and Northern Europe. CBT for depression is administered either on its own or in combination with medication.

### 1.0 The Content of the Therapy

CBT, as applied to depression, relies on all of the key principles of CBT, in that it is collaborative, present-oriented, and problem-focused. Typically, the treatment involves:

- Helping the person in treatment to establish daily activities to provide structure and direction in graduated steps;
- Encouraging the person to identify and challenge negative thoughts and assumptions characteristic of their depression and to consider evidence for more realistic views of their experience;
- Helping the person shift focus away from physical symptoms and negative mood associated with depression; and
- Helping the person return to a routine of pleasurable and productive activities, on a scheduled basis.

The treatment also typically involves psychoeducation about depression that normalizes the symptoms as part of an illness, which the person can do something about, rather than an indication of 'laziness' or 'a deficit in character'. In addition, it often involves learning techniques to solve problems and prevent relapse. Feelings of hopelessness are treated early on in treatment because they are associated with suicidality<sup>3</sup> and individuals do better in CBT when hopelessness is addressed effectively.<sup>4,5</sup>

CBT for depression has been successfully administered in individual, group and couples formats. Individuals who have a more chronic or recurring illness may often require repeated interventions, or a shift in focus, to address early life experiences as well as personality, interpersonal, and identity issues.

### Approximate Lifetime Prevalence: 7%

#### Diagnostic Criteria for a Depressive Episode:

For more than two weeks, five or more of the following symptoms are present (either depressed mood or decreased interest or pleasure must be one of the five).

- 1 For most of nearly every day, interest or pleasure is markedly decreased in nearly all activities
- 2 There is a marked loss or gain of weight or appetite is markedly decreased or increased nearly every day.
- 3 Nearly every day the patient sleeps excessively or not enough.
- 4 Nearly every day others can see that the patient's activity is agitated or compromised.
- 5 Nearly every day there is fatigue or loss of energy.
- 6 Nearly every day the patient feels worthless or inappropriately guilty.
- 7 Nearly every day the patient is indecisive or has trouble thinking or concentrating.
- 8 The patient has had repeated thoughts about death, suicide, or has made a suicide attempt.

In recent years, researchers have examined CBT in order to understand how, and with what symptoms and disorders, it works most effectively. For example, currently there is research looking at how to reduce ruminative thinking using CBT. Rumination, a common symptom in depression and anxiety disorders, is the process of thinking over and over about one's problems and their causes and consequences.<sup>1</sup> In

addition, a CBT technique called “behavioural activation”, a process that emphasizes the individual “do” things in a structured way, has been specifically investigated. Behavioural activation can help patients focus on commencing, or resuming, normal routines of behaviour.<sup>6</sup> Another recent innovation in the treatment of depression is “mindfulness-based cognitive therapy” which incorporates techniques from meditation, and is designed to help prevent relapses in people with recurrent depression.<sup>7</sup>

### 2.0 Effects on Symptoms in Different Patient Populations

There is accumulating evidence that CBT is effective for individuals with acute depression, chronic depression lasting two years or more, and for recurrent depression. CBT has been proven effective with children over ten years of age, adolescents, and older adults. Furthermore, CBT may prevent the development of depression in children and adolescents.<sup>8,9</sup> There is emerging evidence that CBT is effective in treating depressive symptoms in individuals with medical conditions such as rheumatoid arthritis, cancer, multiple sclerosis and brain injury.

### 3.0 Effects on Relapse Rates

During active treatment, the effects of CBT appear to be as effective as medication. However, several studies have shown that after treatment, relapse rates remain low for at least two years for people who have engaged in CBT (either on its own or after treatment with medication) as compared to those who have received medication alone. Interestingly, in one study that followed people for six years, individuals who received CBT had only a single relapse whereas those who received medication and were monitored by a psychiatrist had multiple relapses.<sup>10</sup> CBT that continues with monthly follow-up sessions can help to further reduce relapse rates<sup>11</sup>, particularly in people whose depression had an early onset, or whose depressive symptoms did not disappear by the end of active treatment.<sup>12, 13</sup>

### 4.0 Effects on Global Measures of Functioning

In addition to reducing symptoms, CBT for depression also appears to have an effect on broader aspects of functioning that are generally maintained when people are followed after treatment. Generally, functioning in a person's work, school, home and leisure activities improves in concert with reduction in depressive symptoms both during and following a course of CBT.

### 5.0 Combined CBT and Pharmacological Treatment

In practice, CBT is often used as an adjunct to medication. Studies have compared the effects of a combination of CBT and medication in comparison to either CBT or medication alone. Some, but not all, studies show the combination of CBT and medication works better only in the case of severe or chronic depression but that CBT alone works as well as the combined treatment for mild-to-moderate depression. The combined treatment may also be of greater benefit in treating depressed adolescents.<sup>14, 15</sup> It is thought that CBT and medication act differently on different subgroups of depressed individuals, although this proposal requires further testing.

### 6.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

There is evidence that CBT works better than other psychological treatments that are also used to treat depression.<sup>16</sup> However, the effectiveness of other psychological treatments has not been studied as extensively as has CBT. It is the strong evidence base for CBT that makes it a compelling treatment approach when provided by qualified CBT practitioners. It is also possible that several psychological treatments, including CBT, have specific and common active ingredients that help reduce symptoms, for example, a strong therapeutic relationship.

## 7.0 Brief Therapy and 'Rapid Responders'

Most studies have evaluated CBT for depression using between 12 and 20 treatment sessions. However, a considerable proportion of people respond to CBT within the first few sessions of therapy.<sup>17, 18</sup> People who respond rapidly to CBT (or "rapid responders") tend to accept the cognitive model of their depression early on<sup>17</sup> and show an early increase in hope for the future.<sup>5</sup> Because of the rapid change some people experience in CBT, and because shorter treatments are less expensive and allow for more people to be seen more quickly, brief forms of CBT have been evaluated. There is some evidence that 6 to 8 sessions can be effective.<sup>19, 20, 21, 22</sup> Although no studies appear to have directly compared brief and standard CBT for depression, it appears that longer courses of CBT are more beneficial to individuals with severe depression.<sup>23</sup> In addition, it appears that whereas brief CBT works for rapid responders, those whose symptoms persist even after a standard-length course of CBT has been tried, will benefit from longer courses of CBT.<sup>12</sup>

## 8.0 Self-Help and CBT

Depression is common and can improve with CBT, however most cases go untreated. CBT for depression has been successfully adapted and validated within a self-help format using a book, computer program, or the internet. Qualified CBT practitioners could help many more individuals by delegating some of the more straight-forward aspects of treatment and after session practice to effective computer guidance.<sup>24</sup> Only some individuals (usually those with milder severity of depression) would be suitable for self-directed CBT; qualified CBT practitioners should screen and assess whether self-help CBT would be suitable and for any given individual.

## 9.0 What Predicts a Better Response to CBT for Depression?

Studies have shown that there are several factors that predict what kinds of people will benefit from CBT. Most of these factors are associated with less severe illness. For example, individuals with less severe illness, shorter length of illness, later age of illness onset, and fewer previous episodes of illness tend to respond well to CBT. Among adult populations, demographic factors such as gender, age and education generally do not affect outcome for CBT, although married people have been shown generally to do better than unmarried people. There is evidence that children respond better to CBT for depression than adolescents.<sup>25</sup>

While it was once thought that people with longstanding interpersonal and personality problems, in addition to their depression, respond poorly to CBT, there are now indications that these individuals benefit to the same extent as those without associated problems. It appears that people with longstanding interpersonal and personality problems, in addition to their depression, may be less likely to be symptom-free at the end of a fixed number of CBT sessions because they had more symptoms initially. Also, there is evidence that it is the beliefs associated with some personality problems (for example, paranoid thinking), rather than the depression itself, that can interfere with treatment.<sup>26</sup> As is the case with other psychological treatments, a good alliance between the practitioner and the person seeking treatment makes for a better outcome. It is possible, however, that rapid response to therapy contributes to a better alliance rather than the other way around.<sup>27</sup> In addition, a good alliance seems related to how well a person gets along with others in general and that people who have better interpersonal relationships do better in therapy.<sup>28</sup> Addressing painful feelings or managing suicide ideation can make it difficult to engage in, or immediately benefit from CBT. However, it has been shown that approaching these feelings in a collaborative and exploratory way is linked to a better outcome of CBT.<sup>29</sup>

### 10.0 Role of the Family

Family participation in the treatment for someone with depression is important for a number of reasons. Often, a family history of depression exists. Also, family interactions may be strained or difficult if one family member is experiencing depression. It also may be important in the long-term for family members to recognize signs of relapse, so that timely treatment may be sought.<sup>30</sup>

### 11.0 Summary

- CBT has been widely validated by carefully designed research.
- CBT has been a widely used and successful intervention for depression.
- CBT requires specialized training to deliver.
- CBT helps prevent relapse and can be delivered in a range of formats to a wide variety of populations.
- CBT's effects on the symptoms of depression are comparable to the effects of medication in the short-term.
- At follow-up, CBT is superior to medication.
- More research needs to be done to establish whether CBT is superior to other available, but less researched, forms of psychological treatment, such as IPT.
- There is evidence that combining CBT with medication may enhance treatment effects for severe or chronic cases of depression.

Jane saw a qualified CBT practitioner for 16 sessions. The practitioner assessed her symptoms, such as tiredness and poor concentration, and explained to her that these were the symptoms of depression that would return to normal once she had recovered. She found this information a great relief. The practitioner and Jane agreed that her therapy would focus on developing a routine of daily activities that they hoped would alleviate her depression over time. Jane kept a daily diary of her activities and their effects on her mood. She soon discovered that keeping a routine of activities improved her mood and increased her confidence. She and her practitioner discussed situations that had worsened her mood. For example, she had met a previous work colleague in the street who seemed to recognize her but did not go over and talk to her. When talking about these situations, the practitioner discovered that Jane was generating very negative, personalized meanings from these situations (for example, “She thinks that I am inferior”) and then dwelling on them for long periods. The practitioner helped Jane to consider alternative explanations that were less self-blaming (for example, “She felt awkward”). By the end of therapy, Jane’s symptoms were reduced to the extent that she was seeing her friends again and was considering returning to work part-time.