

Cognitive Behaviour Therapy for Depression

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Cognitive behaviour therapy (CBT) is a form of brief psychotherapy, which over twenty controlled trials have found to be as effective as antidepressant medication in unipolar depression (Dobson, 1989). CBT has been developed over the past 20 years by Professor Aaron Beck in the USA (Beck, 1979). Rational Emotive Therapy, which was developed by Albert Ellis, is a closely related psychotherapy but has not been so extensively evaluated. One of the most exciting developments in CBT is the finding that this form of treatment

may reduce the risk of future relapse (Blackburn et al., 1986; Simons et al., 1986). CBT is also currently being evaluated for the treatment of personality disorders which often complicate chronic or treatment-resistant cases of depression. The therapy can be used with or without medication, but has not yet been evaluated in controlled trials in bipolar depression where it must still be used in conjunction with antidepressants.

CBT differs from psychoanalysis by being problem orientated. It deals with the 'here and now' and not with unconscious conflicts derived from childhood. The relationship between therapist and patient is a collaborative one akin to that of a teacher and student. It is also brief therapy – the average number of sessions for out-patient treatment is between 8 and 12 sessions.

What does 'cognitive' mean in CBT?

Cognitions are the way a person interprets events, as well as his images, thoughts and attitudes. Put simply, a person's mood reflects the way he thinks. By changing the way he thinks, he can change his mood.

CBT aims to change cognitions. It does not mean thinking 'positively' when a bad event occurs – but thinking and acting realistically; self-defeating beliefs are challenged. For example, a patient believed that he was worthless and pitied himself as a result of being rejected by his spouse. He became withdrawn, and felt hurt and depressed. During CBT, he learnt to accept that rejection occurred because the mix between himself and his spouse had deteriorated and also because his partner had changed. He decided that he had both positive and negative attributes as well as neutral ones, and he learnt the futility of damning himself as being totally worthless. As a result he felt sad at the loss of his relationship but was able to plan for the future.

Challenging self-defeating beliefs is a skill that can be learnt and much emphasis is placed on homework tasks for the patient

to complete between the sessions. Therapy is based on a structured programme of self-help with the therapist acting as a guide. Patients are asked to monitor the effects of the tasks or experiments in a diary, and these notes are always reviewed at the beginning of the following session.

What is the 'behavioural' component in CBT?

For some problems, such as phobias and obsessions, the most powerful way of changing beliefs is to act directly against them. The emphasis is therefore on helping patients to change the way they act by repeatedly facing up to their fears on their own until the anxiety disappears or is substantially reduced. Patients are usually taught how to use alternative coping strategies to help them face up to their fears and reinterpret their symptoms of anxiety.

For most depressed patients, cognitive and behavioural tasks are closely integrated from the beginning of therapy. A patient is taught how to conduct experiments to test out whether predictions are true or not. For example, a depressed patient is often inactive and socially withdrawn. This in turn causes him to criticise himself, to feel guilty, and to invite criticism from others – all of which reinforces his depressed mood. Breaking this circle did not mean telling him 'to pull his socks up' (he was already telling himself this), but getting him to identify his self-defeating beliefs and test out his predictions. In this example the patient predicted that completing a number of tasks would be too difficult and that he wouldn't enjoy any of them. He was helped to timetable his activities and before an activity he was asked to predict on a rating scale how much pleasure and satisfaction he would obtain; after he had completed the activity he was asked to re-rate it in accordance with the pleasure he had *actually* obtained. He was surprised by the discrepancy between the two ratings and this helped him to challenge his self-defeating beliefs and to continue timetabling his tasks over the coming weeks.

Cognitive behaviour therapy in the UK

Services in CBT for depression are regrettably still patchy in the UK. There are relatively few psychologists, psychiatrists or nurse therapists who have had trained supervision in this form of treatment. Consultant psychotherapists tend to be trained in psychodynamic therapy which is not indicated in depression.

There are two excellent self-help books based on cognitive therapy that I recommend for anyone suffering from depression: 1. *Coping with Depression* by Ivy Blackburn, published by Chambers, Edinburgh and 2. *Feeling Good – The New Mood Therapy* by David Burns, published by Signet.

Grovelands Priory Hospital in London is a private psychiatric hospital, which introduced a CBT programme for out-patients, day-patients or in-patients. The programme for day-patients and in-patients is more intensive as therapy is provided by individual and daily group therapy. It is combined with recreational exercise and occupational therapy. The groups are held like a class in which patients learn to identify their beliefs and to help one another generate more rational alternatives and solutions. Patients have a workbook in which to monitor their thoughts and practise answering back. Severely depressed patients will have a more structured timetable of activities before entering the group therapy. The programme will be audited and patients followed up to determine the risk of relapse.

References

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