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The Role of CBT in Treating Depression

1. Introduction

This article outlines the nature of depression and how it is amenable to treatment using Cognitive Behavioural Therapy.

Depression is a very common mental disorder and can have many precipitants. Some people are born with neurological disorders that leave them predisposed to depression. However for many others, depression occurs as a consequence to changing life circumstances.

There are numerous medications that are prescribed to depressed people. However many people find these have unpleasant side effects and there is also a cultural distain in many sections of the general public for anti-depressant medications. Medication is also not recommended for pregnant women.

Given the above, another approach is needed. According to Beck et al. (1979) CBT can treat depression by attempting to modify how the client structures his view of the world. This makes CBT a very useful alternate for those people who won't or can't take the medication.

2. Definition of depression

The DSM-IV-TR (APA, 200a) suggests that between 10-25% of women and 5-12% of men will experience depression over their lifetime.

DSM-IV also tries to define depression in terms of symptoms displayed over a short period of time, i.e. two weeks. The key symptoms are depressed mood and diminished interest in many daily activities. DSM-IV also lists ancillary symptoms such as tiredness, change in appetite, change in sleeping patterns, poor concentration, low self-esteem and recurrent thoughts of death or suicide. Various combinations of the above dictate the degree of depression present.

While the DSM-IV definition lists these observable phenomena as though unconnected, Beck (1976) suggested that the characteristics of depression could be viewed as an underlying shift in the person's cognitive organization of his world. The person feels that he has lost something very special to him and this loss has left his personal domain diminished in some way. The loss can be varied such as loss of health, youth, professional status or loss of a

key relationship. The sense of loss can also be anticipatory, in that the person fears loosing something of value in the future.

Beck (1976) explains this all encompassing sense of loss in terms of ***the cognitive triad***. The cognitive triad is composed of:

1. A negative view of the world in general.
2. A person's negative view of themselves.
3. A negative view of the future.

This cognitive triad affects discrete but interconnected components of the person's life and that positively affecting one of these components would bring about a positive change in the others as well. These components are emotional, motivational, cognitive, behavioural and physiological.

Beck is not alone in seeing depression as a maladaptive cognitive shift. Ellis (1987) had his own version of the cognitive triad and suggested the main causative agents in depression are:

1. A devout belief in one's own personal inadequacy.
2. The "horror" of not having what one "needs".
3. The "awfulness" of the way things are.

While depression has largely been studied as a human characteristic, Seligman (2002) noted in his animal experiments that the phenomena of ***learned helplessness*** shared many of the characteristics of unipolar depression found in people. These characteristics (that can be viewed as a cognitive shift) are listed as passivity, learning difficulties, more pronounced sadness and anxiety. There are also similarities in the underlying brain chemistry of learned helplessness and depression. Further to this, the same medications that gives relief to the helplessness in animals also helps lift the depression in humans.

3: Contextual Factors Involved In Depression.

While depression can be observed in a person using either the characteristics as laid down by DSM-IV, or observing the person's behaviour along the lines of Beck's cognitive triad, the onset of depression and the course it takes is also heavily impacted by the environment the person finds themselves in.

Carr (2006) outlines predisposing, precipitating and maintaining factors involved in the likelihood of someone becoming diagnosed with depression. Predisposing factors include a family history of depression or anxiety, childhood adversity, poor parental care from both parents, loss of a parent, low intelligence and no unique talent.

Precipitating factors in depression are listed as major stressful life events in particular those relating to loss. Low levels of sunlight can also leave those predisposed to depression at greater risk. Segal et al. (2002) has also shown that if someone has already experienced depression due to a significant loss in their life, minor setbacks in the future can trigger depression again.

High levels of environmental stress are known to maintain depression. In this context the person sees the demands on them as exceeding their capacity to cope. Insufficient exercise and lack of meaningful social relations also mitigate against beating depression.

The opposite to the predisposing, precipitating and maintaining factors involved in stress are themselves factors in the eliminating and alleviating of stress. It can be seen as such that despite depression being viewed as an illness, better social support of individuals and families at risk might contribute towards the breaking of a depressive cycle in future generations.

Despite the above list of well documented factors that are seen as associated with depression, it should not be assumed that depression is a foregone conclusion if these factors exist. Seligman (2002) noticed that despite the predictability that about 66% of animals tested in the learned helplessness experiment would give up and adopt a depressed response, there always remained the 33% of animals that never gave up trying to break free from their uncomfortable environment. He further noticed that about 12% of the animals did not need any conditioning at all to become helpless. In later analysis of human patients, this same diversity of coping capacities was also noticeable. As such the cognitive shift model of depression may be somewhat more accurate than the disease model.

4: Course of Depression

Like Seligman, Beck (1976) also talks of those who are predisposed to depression to a greater or lesser degree. He suggests that early traumatic life events will leave a psychological mark on these people, and this mark will cause the person to over react when analogous situations happen later in life. Other people set very rigid standard for themselves and become depressed when they find that they can no longer maintain them.

For example, suppose a young boy looses contact with a parent through divorce and this has a big emotional impact on the child. Let us further suppose that from trying too hard to be the perfect husband, his own marriage breaks up and he becomes depressed. The extreme negative distortions associated with depression can conceivably drive the following train of thought:

- I loved her and she was the source of my happiness.
- I am nothing without her.
- If only I had been an even better husband, she would have stayed.
- All our friends will go to her.
- The children will want to be with her.
- How will I afford the support payments and have a life of my own.
- This is too much to bear.
- I will always be sad and lonely.

The above negative mindset will become a self-fulfilling reality and as the depression get deeper, attempts at change will be seen as doomed to failure. The man will see himself as worthless and as a consequence will start to take less care of himself and retreat from the company of others. This in turn will drive people away, thus confirming his catastrophic view of his life. Also every new slightly unfortunate event will be seen in the light of all the troubles gone through before.

5: Cognitive Behavioral Approach to Treating Depression.

Given the general congregation around the cognitive shift model of depression by all the major CBT players, it is obvious that altering the client's thinking habits along with encouraging the adoption of more functional behaviours would be the bedrock of the CBT solution.

The basic model can be formulated as follows:

- A = Activating Agent.
    - Something of perceived personal importance has happened in the person's environment.
- B = Belief.
    - The activating agent has been filtered through a deeply held belief and has caused an evaluated response.
    - This belief triggers a ***negative automatic thought***.
- C = Consequential Behaviour
    - Based on the results of the evaluation above, the person will adopt (what they see as) an appropriate behaviour.

During the sessions, the therapist helps the client frame the problems they present with in terms of the above.

Carr (2006) suggests the development of a case formulation that links predisposing, precipitating and maintaining factors of the person's depression, and offset these against any protective factors in his life. This will allow the bigger picture to be seen and will also allow the client to see the therapeutic interventions in terms of their own personal life.

Carr further suggests that the goal of therapy is to encourage the client to look for correlations between activating events (A) and mood changes (C). During sessions the client is taught to use "***thought catching***" to get at the underlying belief (B) and the accompanying negative automatic thought. These beliefs and the negative automatic thoughts can then be examined dispassionately.

A useful way to help the client distance themselves from their negative automatic thoughts is to get to them to keep a Record of Unhelpful Thoughts. This small chart allows the clients to write down their troubling thoughts and the emotions they gave rise to, along with a brief description of the triggering situation they found themselves in at the time. They can then consciously look for alternatives to the negative automatic thoughts. This can be done by

questioning the evidence that at first glance seems to support the negative automatic thought. When plausible alternatives are discovered, the client is then encouraged to reflect on the emotion induced by the more positive alternate thought.

A useful addition to the Record of Unhelpful Thoughts is the ***Cognitive Distortion List***. This list outlines a number of common cognitive distortions that many clients exhibit. Some of the distortions that depressed clients frequently exhibit are ***Jumping to Conclusions*** and ***Disqualifying the Positive***. Realizing that they are prone to these mistakes allows the client to make more productive searches for positive alternatives to their negative automatic thoughts.

Another tool in the fight against depression is the use of a ***graded activity schedule*** to map out ***homework assignments***. Homework assignments are the means by which the client gets to practice the more functional behavioural strategies identified during the session. Depressed people typically adopt an attitude that tasks will be too hard and even if they complete them, there won't be much personal reward. During therapy it is useful to ask the client to rate the degree of difficulty and also the degree of pleasure they anticipate completing a piece of homework. Then when the task is completed, ask the client to reappraise the degree of pleasure and difficulty. Very often the client is very pleasantly surprised to find that the task was not near as hard and yielded much more pleasure than anticipated.

Both of the above strategies, the Record of Unhelpful Thoughts and the Graded Activity Schedule, are very useful in challenging the negative disposition of the client. The progress that the client is making can be charted using tools such as Beck's Depression Inventory or Burn's Depression Checklist. These tools can be administered once per month and the variation in the scores achieved can be used to evaluate the effectiveness of the interventions suggested as homework.

6: Outcome Studies and Conclusions

Segal et al. (2002) show that 85% of people who experience major depression will on average relapse into depression for four episodes of twenty weeks over their lifetime. Combining this with the prevalence of depression in society today, it is imperative to know what effect the various approaches have to help solve the problem.

Carr (2006) notes that the relapse rates for people who have received both medication and CBT is between 20-35% as opposed to 50-80% for those on medication alone during follow-up studies.

Shipley and Fazio (1973) conducted studies that found there was little placebo effect in CBT treatment as beneficial effect was not determined by the initial expectancies of the participants. This makes CBT very useful to a

skeptical general public about using medication or those who have not benefited from other forms of psychotherapy in the past.

In a study on clinical patients as opposed to volunteers, Morris (1975) found that significant change can occur in patients in a very short time frame, so long as a critical number of sessions (six sessions in this study) are conducted. It is findings like these that make CBT very attractive to business.

This attractiveness to business was backed up very strongly by Lord Layard's (2006) report estimating that depression costs the British economy up to £12 billion per year. It was also estimated in this report that half of those suffering from depression could be cured using CBT for approximately £750 each. This is exactly the amount of money that these people will cost the economy each month while they are out sick.

Given the robustness of the CBT approach as outlined above, it seems clear that CBT needs to be part of the suite of tools that are used to tackle society's problem with depression.

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