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Effective of Cognitive Behavior Therapy for the Treatment of Major Depression

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The study examines the effectiveness of cognitive behavior therapy for the treatment of patients suffering from major depressive episodes without psychotic features. The cognitive behavior therapy was given for a month which helped the patients to recover from the major symptoms of depression. A post treatment following at two, six and twelve months revealed the persistence of positive changes in the patients.

اثربخشی درمان شناختی رفتاری در درمان افسردگی اساسی

اس. ان دوبای و مدهوریما پارادهام

در این مطالعه اثر بخشی درمان رفتاری شناختی در درمان بیماران مبتلا به افسردگی اساسی بدون سیمای ÷سیکوتیک مورد آزمون قرار گرفته است.درمان رفتاری شناختی به مدت یک ماه، برای کاهش علایم افسردگی ارایه شد.پیگیری درمان در ۲، ۶ و ۱۲ ماه تغییرات پایداری را در بیماران آشکار کرد.

Introduction

Modem age is termed as the age of anxiety, stress and strain. Due to fast growing technological advancements in every sphere of life, the spiritual values that have been the center of our life style are pushed behind by the material values. This has caused the people to go beyond human capacities to work for material gain. The resulting continuous strain on their physical, psychological and social resources has led to the development of various psychological disorders. Depression, the so called “common cold” of mental health is one of the prominent disorders that the people are suffering now-a-days.

Depression has been recognized as a mood disorder in DSM III - R (1987) classification. The major depression (included under depression) is an unipolar disorder because the patient never experiences manic episode. It is an emotional state characterized by extreme dejection, gloomy ruminations, feelings of worthlessness and loss of hope and apprehension. Apart from this poor appetite, insomnia, psychomotor retardation, decreased sex drive, fatigue, inability to concentrate and thoughts of death or suicide are the main symptoms of major depression. Psychotic features such as delusions,

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hallucinations or depressive stupor (the patient is mute and unresponsive) may or may not accompany these symptoms.
We say, that some people look at the world through "rose-colored glasses." Aaron Beck's cognitive view of depression assumes that the depressive's glasses are of a somewhat more dusky hue (Beck, Rush, shaw & Emery, 1979). Beck holds that the symptoms of depression are the result of client's cognitions about the world. A cognitive triad characterizes the depressive's thinking: a negative view of himself (low self esteem), a negative view of his personal future and a negative view of his current experiences. In addition faulty information processing, tendency to over generalization and selective abstraction contribute to their negative perceptions. They tend to magnify negative things and minimize positive things.
The Cognitive-Behavior Therapy (CBT), as designed by Beck is a time limited, systematic, structured problem-solving approach to treat depression and also a wide range of other disorders (Emery, Hollon, & Bedrosian, 1981). The ultimate goal of this therapy is to identify dysfunctional cognitions, see how they trigger and generate depressive feelings and behavior, and learn to modify them.
Researches have shown that cognitive behavior therapy was found to be most effective intervention technique for the treatment of unipolar depression (Schoisser, Kavanagh and Wilson, 1988; Becker and Heimberg, 1985; Williams, 1984). Therapy groups showed greater improvements than control group (Wilson, Goldin and Charbonneau Bowis, 1983) or than only relaxation training group (Mc Lean and Hakstian, 1979). In addition this therapy has been found to be as effective as antidepressant medication (Murphy, simons, Wetzel and Lustman, 1984) but without any side effect. The objective of the study was to apply the cognitive behavior therapy for the treatment of patients suffering from major depressive episode without psychotic features.

Method

*Sample:*The study refers to a sample of 5 cases of major depression treated during July 1996 to April 1999. The subjects belonged to the urban middle income group. Their education ranged from 10th standard to graduation with age ranging from 30 to 37 years. The duration of their illness ranged from 3 to 7 years. The patients had received the treatment for sleeplessness and were advised to doses of antidepressants Chiorpromazin (100 mg) and Larazepam (1 mg) - twice a day. Four of the subjects had also been treated by some indigenous methods such as prayers and visit to some holy places.

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All of them had not received any psychological treatment before coming to us.

Evaluation of the Severity of Depression: The Beck's Rating scale, an inventory for measuring depression BDI (Beck, Ward, Mendelson Mock and Erbaugh, 1961) has been used to evaluate the severity of depression. The patients were assessed prior to the treatment, at the termination of treatment, and at two, six and twelve months intervals after the treatment. The pre-treatment evaluation revealed a mean score of 41 on BDI showing a severe level of depression. The BDI can be used as a diagnostic instrument of the severity of a patient's condition. The patients did not exhibit any psychotic symptom during the interview which confirmed the criteria of DSM-II1-R major depressive episode without psychotic features.

Technique of Treatment: In the present study, cognitive behavior technique was used for the treatment of patients. This technique is based on cognitive behavior therapy procedure developed by Beck, Rush, Shaw and Emery (1979). The CB assumes that depression results from the patient's illogical thinking about themselves, the world they live in and their future. These illogical ideas -e maintained even in the presence of self-defeating and self-fulfilling behaviors in which they selectively perceive the world as harmful. Beck attempts to help the clients to treat these dysfunctional cognitive as hypotheses rather than facts and then to test them against the evidence. This enables the patient to recognize his errors in processing of ideas and information and to integrate not only negative but positive data also (Beck 1995). In severe cases the therapist can get the patient to begin to test his! her dysfunctional cognitions while engaging in the behavioral activities. As these interventions gradually help to lift the depression, the client becomes open to cognitive interventions.

The technique of treatment used in the present study was aimed at identifying the depressogenic conditions and irrational beliefs, to subject these conditions and beliefs to logical analysis and empirical testing and to help the patients to think more positively and realistically. In other words, the cognitive behavior therapy helped the patients to:

(a) Identify negative thoughts

(b) Seek evidence to determine how much they represent reality and

(c) Modify underlying dysfunctional assumptions.

Procedure of Treatment: The treatment process consisted of following steps.

1- A warm, empathic and genuine therapeutic relationship was established with the patient to reinforce learning. Care was taken not to be judgmental or

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moralizing as it might reinforce the primitive judgmental thoughts of the patients. The case was formulated and Beck Depression Inventory (BDI) was administered to measure the seventy of depression. (1-3 sessions).

2- Progressive relaxation (Jacobson, 1938) training (4-9 sessions but continued till last session).

3- Home assignment to keep a daily record of activities at an hourly basis and to make an assessment of his sense of mastery and pleasure which he derived in those activities on a five point scale. During therapy session his ratings were discussed with the help of questions to uncover the positive and negative aspects of his activities. He was given graduated task assignments and/or cognitive rehearsal practice to follow at home. (4-7 sessions).

4- When the mastery and pleasure ratings began to improve the patient was given home assignment to keep a daily record of automatic thoughts. Whenever, he felt depressed, he had to record the objective situation, the thought he had and feelings they led to (6-9 sessions).

5- Patient was asked to write down alternative less dysfunctional ways of perceiving the situation. It was done to help the patient realize that he had been locked into one way of seeing the situation and that there were other ways. In this way he challenged the specific irrational thoughts and beliefs and developed hypothesis testing attitude. (6-20 sessions).

6- The patient was helped to increase the frequency and quality of positive thoughts and beliefs and thereby improving his sense of mastery and pleasure derived from different behaviors. (2 1-25 sessions).

7- Patient was encouraged to improve the frequency and quality of social interactions (25 to 30 sessions).

The procedure of treatment continued for 30 days. Each session was for at least an hour. At the termination of the therapy the subjects were assessed on BDI. The mean BDI score was decreased by 28 points. The patients had recovered significantly from the major symptoms of depression. Now they could sleep six hours in the night without the help of any medicine. They were guided to continue the relaxation practice and keep on enjoyable activities and indulge in social interactions. The patients were followed up at 2, 6 and 12 months after the therapy to monitor the effectiveness of the treatment. There were booster sessions in which the content of the original sessions, were reviewed, patients were praised for their attempts to apply

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themselves to the conditions and their remaining and/or new problems and negative cognitions were assessed on BDI.

Results

The inspection of BDI scores (Table-I) reveals that the patients have shown clinically significant improvement at the termination of the treatment and during follow-up sessions. These scores are in consistence with the scores (M=12.41) reported in a study by Neitzel, Russell, Hemmings, and Gretter (1998) in which cognitive behavior therapy was delivered in a group. Baker and Wilson (1985) have also reported a post- treatment score of 14.1. The foillow-up BDI scores of this study has been much less than that reported by Beck, Ward, Mendelson, Mock and Erbaugh (1961) and Ley (1984). Schlosser, Kavanagh and Wilson (1988) in a brief intensive programme of cognitive behavior therapy among a group of 4 patients reported a drop of a 10 scores on BDI. For reducing cognitive distortions and for improving the self control of the patients, cognitive behavior therapy followed by biofeedback was found to be most-effective (Biswas, Biswas and Chattopadhyaya, 1995).

Table 1. The BDI scores of the patients.

Subjects	Pre-treatment	At the termination of treatment	follow up Sessions		
			2 months	6 months	12 months
1.	40.0	13.0	13.0	12.0	12.0
2.	36.0	11.0	11.0	10.0	10.0
3.	43.0	14.0	13.0	13.0	12.0
4.	42.0	12.0	12.0	11.0	11.0
5.	44.0	15.0	14.0	14.0	13.0
Mean	41.0	13.0	12.6	12.0	11.6
SD	2.82	1.41	1.01	1.41	1.21

In the present study a reduction of 28 points on BDI could be achieved with the help of cognitive behavior therapy in one month period of treatment. It is much higher in the other referred studies. But the finding of this study has its own limitations. Since it has been carried out on only five patients, its findings can not be generalized. Therefore, to facilitate the generalization regarding the effectiveness of cognitive behavior therapy, further researches should be done with a large number of patients suffering from depression.

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