Evidence-Based Psychotherapies

New Developments in Cognitive-Behavioural Therapy for Depression

Gilbert Pinard MD, FRCPC
Professor, Department of Psychiatry, McGill University, Montreal, Quebec

Key Words: depression, chronic, recurrent, cognitive-behavioural therapy, CBT, cognitive-behavioral analysis system of therapy, mindfulness training

Two aspects of the psychotherapy of depression appear most promising in terms of specific contributions of cognitive-behavioural interventions: first, the use of the therapy in combination with medication, particularly in patients with chronic or resistant conditions; and second, its role in the prevention of relapse or recurrence. Intuitively, it makes sense that the combination of psychotherapy and pharmacotherapy would be superior to either treatment alone. However, only a few studies of good methodological quality have demonstrated this.

One such study, published in the New England Journal of Medicine, was by Keller and collaborators from 12 major university health centres (1). This huge randomized controlled trial involved over 650 patients with chronic depression and had three treatment arms: medication alone, psychotherapy alone and the combination of the two. Chronic depression was defined as major depressive disorder (MDD) of at least two years’ duration, a current major depression superimposed on an existing dysthymia, or a recurrent MDD with incomplete remission. Unfortunately, the antidepressant used was nefazodone, which has recently been taken off the market because of hepatic toxicity. Nonetheless, the results are still empirically useful owing to its demonstrated efficacy. The psychotherapy arm was the cognitive-behavioral analysis system of psychotherapy (CBASP), an approach adapted from cognitive-behavioural therapy (CBT) by McCullough, with particular attention paid to interpersonal dimensions (2). I describe it in more detail later.

Results of the acute-treatment phase (the last 12 weeks of a long-term project) were dramatic. At the last visit in the intent-to-treat cohorts (the more conservative method of evaluating results), 48 per cent of depression patients receiving either of the two monotherapies were significantly improved. In comparison, 73 per cent of the combination treatment group had improved. (Of the three groups, 22 per cent, 24 per cent and 42 per cent, respectively, were considered to be in remission.) The group receiving medication alone and the group receiving combination treatment got better faster, compared with the group receiving psychotherapy alone, but because the effect of the combination appeared only after the first four weeks, the authors felt justified in writing that the two treatment effects were independent. The 25 per cent increment secondary to the combination represents a major therapeutic gain.

This form of psychotherapy targets depression, but symptoms of anxiety in these depression patients responded better to the combination of both treatments than to either monotherapy. However, the fact that patients suffering from comorbid anxiety disorders treated with CBASP alone did not show as much improvement in their anxiety symptoms as in their depression speaks to the specificity of this approach (3). (See the paper in this issue by Talbot and McMurray regarding CBT for anxiety disorders; 4.)

Standard CBT focuses on the link between one’s perspective on a situation, the emotions engendered and the resulting behaviours. Patient views of reality, their self-concept, their world view and their view of the future may be systematically distorted. Therapy aims to help patients modify maladaptive patterns of thought or behaviour through work during the sessions and at home in agreed-upon assignments.

In the CBASP approach, McCullough (2) integrates existing theoretical underpinnings from several sources: 1) postulated arrested maturational cognitive development from a Piagetian perspective, 2) the role of attachment and its different dimensions in the course of therapy, and 3) the patient’s habitual patterns of social interaction in the context of the therapeutic alliance. He also greatly elaborates the cognitive and behavioural analyses of patient interactions with the environment in terms of learning theory. I will describe two types of interventions to help clarify these techniques.

In situational analysis, patients are asked to describe a particular distressing event, how they appraised it, their reactions, the outcome of the discrete event and, finally, the desired outcome. Patients are then guided to realize how the meaning they assigned to the situation and their reactions influenced the results. They are then asked to consider whether alternative meanings and a different behavioural response might have led to a more desirable result.

(CPA Bulletin 2004;36[1]:23–24)
CBASP therapists also carefully use the therapeutic relationship to help patients recognize the difference between patterns of thinking, emotions and behaviours that are acquired most often through childhood experiences and current, in-session and out-of-session interactions. To do this, they employ exercises that ask patients to identify five or six significant others and to speculate as to how these people have influenced their present lives.

Therapists then help patients to discriminate between past and present in domains such as intimacy, expression of needs or negative affects, and failure. For example, a patient might recount that his father scolded him about his achievements in school, suggesting that he was never good enough. In such a case, the therapist could ask the patient whether he noticed how he expected negative comments regarding home assignments in therapy but was instead congratulated for his tremendous efforts.

The second development I address is the mindfulness training CBT approach described by Segal, Teasdale and collaborators (5). Relapse is a major problem in depression because of its frequency (it occurs in 50 per cent of patients after a first episode and in 70 per cent after a second episode) and also because of the now-accepted relation between recurrence and residual symptoms. In the mid-to-late 1990s, Fava (6) and Paykel (7) showed that standard CBT was advantageous in preventing relapse as well as in achieving full remission. Nonetheless, recurrence rates remain too high.

Mindfulness training CBT borrows from Kabat-Zinn and teaches post-treatment patients the rudiments of meditation based on oriental methods (8). The rationale behind this addition to CBT involves the idea that residual symptoms such as dysphoria reactivate negative thinking patterns learned during the acute phase of the disorder. These negative thinking patterns potentially produce feelings of increased hopelessness vis-à-vis the “inexorable” return of the feared depression.

As in Zen meditation, mindfulness teaches one to focus attention—to be aware of thoughts, emotions, and bodily sensations in the moment, not looking back or predicting future consequences. It encourages subjects to decenere, as if they were observers—to regard their experiences as something happening, not as what they are. As well, it fosters acceptance as opposed to an obligation to change the intrusive feeling or thought. Throughout the eight-week program, it is suggested that patients will learn to disengage from the ruminative process that facilitates relapse (“I’m sad, this must be the depression again. I’ll never get better”). Thought is thus construed as a mental event, not a fact (“This is only a thought; let it be”). In contrast to traditional CBT, the strategy is not to strive to change the content of thoughts but to “disengage from habitual dysfunctional cognitive routines” (9).

Initial results are encouraging. In a study of 145 individuals with recurrent depression who had recovered, mindfulness training CBT was added after medication had been stopped. Survival curves (that is, non-relapse occurrences) over a period of 60 weeks indicate a protective effect of these interventions. In subjects who had a minimum of three depressive episodes, the rate of recurrence decreased by approximately one-half, compared with patients undergoing treatment as usual. The authors underline that this treatment is specifically designed for patients who have recovered and not for people in the acute phase of the depression.

In conclusion, contemporary authors have borrowed from the literature on developmental cognitive theory, attachment theory and meditation practices to conceive of new interventions. These new developments, expanding on the standard methods of CBT, appear to increase treatment efficacy, particularly when combined with an antidepressant, and to help prevent recurrence or relapse in chronic depression. This holds promise for much-needed improved therapy outcomes.

Acknowledgements

I thank Dr. Gail Myhr for her comments on the first draft of this paper.

References


