Efficacy of cognative behavioural therapy for depression

\n[toc title="Table of Contents"]\n

\n \t

\n[/toc]\n \n

World Health Organisation estimated that by the year 2020 depression will be the leading cause of illness in developed countries. Furthermore, clinical depression at present = 3% to 16% of the total population (as cited in Grant et al., 2010). Symptoms of depression found in the DSM-IV. According to the Dictionary of Psychology, depression can be defined as a “ mood state characterised by a sense of inadequacy, a feeling of despondency, a decrease in activity or reactivity, pessimism, sadness and related symptoms.” This essay will evaluate the strengths and weaknesses of CBT and IPT in dealing with depression in a thematic structure. It will be concluded that evidence shows that while IPT is an effective therapy for depression, CBT is better used in mild-to-moderate and severe depression.

What is CBT (Cognitive Behavioural Therapy)?

Based on Beck’s theory of Cognitive Distortions (overgeneralisation, dichotonomous thinking), Cognitive Triad (distorted feelings of self, world

and future: unworthy, inadequate, flawed, world too demanding, negative future anticipations. Focus: rejection, deprivation and failure inevitable) and Beck Depression Inventory (Coolican, 2007).

CBT focus is on links between what the person thinks about themselves/situation and how it affects the way they feel and behave. CBT is: structured, goal-orientated (use of homework), with use of Socratic questioning. Short-term therapy with 8 – 12 sessions, lasting 3 – 6 months.

Strengths of CBT for Depression:

Has been shown to be effective in: mild-to-moderate depression: prominent therapy in NHS (primary care, tertiary care, computerised CBT) and recommended by NICE (guidelines). Shown to be effective in 2001 Department of Health Guidelines.

Used for severe depression with medication:

Blackburn and Moore (1997) compared CBT with antidepressants and found them to be as effective as medication. Further studies by Fava et al. (1998) found that adding CBT to medication can have a lasting change of several years (as cited in Holland & Ponniah, 2010).

Cornwall and Scott (1999) conducted a study on major depression with medication and hospitalisation. Suggest that CBT helps patients by alleviating symptoms of depression through the behavioural interventions while addressing beliefs (as cited in Whitfield & Williams, 2003).

Unlike medication, CBT has no side effects and therefore is an effective way to manage depressive symptoms. Appropriate to those who want to have insight into problems, but find psychotherapies that delve deeper, conflicting.

However, weaknesses of CBT:

While therapy is usually 12 – 16 sessions, Barkham et al. (1996) found CBT is most beneficial within first 8 sessions. Scott (2001) concludes that that there is little evidence to support offering more in mild-to-moderate depression (as cited in Whitfield & Williams, 2003).

CBT may be offered in NHS but offered to select number of people, therefore long waiting lists and limited access to treatment. Lovell and Richards (2000) argue that there are less than 800 practitioners trained in CBT in the UK. While CBT offers a maximum gains for minimum expenditure as a therapy, it should be offered to a far more inclusive range of people especially since large evidence base for CBT and depression (as cited in Whitfield & Williams, 2003).

CBT deals with cognitive processes, but not the cause. Depression may be a natural response to cause (e. g.: Abusive relationship) and not “ faulty thinking” as proposed by CBT.

What is IPT (Interpersonal Psychotherapy?)

Based on manual by Klerman where assumption is that social roles and interpersonal relations associated with onset of depression are reflected in behaviour and attitude. Assessed via interaction between: persons, defining

of roles and affects they have (mood/feelings relevant to role) with Interpersonal Inventory.

Two main goals of IPT: reduce symptoms and understand symptoms of four common problems (grief, role disputes, role transitions or interpersonal deficits) (Luty et al., 2007).

IPT is short-term and goal orientated with sessions between 12 – 16 weeks. It is tailor designed to fit each individual.

Strengths of IPT for depression:

IPT is also currently used in NHS and recommended by NICE (guidelines) and has been shown to be influential in depression studies.

E. g.: In one of largest and most influential studies of its time, (Elkin et al., 1989) the NIMH in placebo-controlled Treatment of Depression Collaborative Research Project (TDCRP) found that patients who were severely depressed fared better with IPT and medication than those who had pill-placebo. It also suggested that IPT fared better than CBT in severely depressed patients, but no significant difference in mild-to-moderately depressed.

Rosello and Bernal (1999), study on Puerto Rican adolescents, noted that IPT and CBT fared better than the waitlist control, however IPT was superior in terms of self-concept and social adaption.

However this could be because culturally, they place emphasis on family over self.

In the study by Markowitz et al. conducted a study in 1998 on HIV patients over a period of 16 weeks. Found that IPT was superior to CBT (as cited in Parker et al., 2006)

However IPT may be better at connecting life events as it is an interactional therapy.

IPT is interactional therapy, but has more structure than Psychoanalysis (Hollon & Ponniah, 2010). While being a " talking therapy" it is not based solely on cognitions and looks at identifying key interactional aspects of person's life.

Weaknesses of IPT:

In a study to compare IPT and CBT in outpatients who suffer from depression, Luty et al. (2007) found that only 20% of patients responded to IPT while 57% responded to CBT in severe depression. This compares well with hat of CBT and IPT in mild-to-moderate depression, of 55%.

However this contradicts that of Elkin et al. (1989) that reported a better response to IPT than CBT.

A study by Joyce et al. conducted in New Zealand in 2007 found that patients with severe depression fared better with CT than IPT (as cited in Hollon & Ponniah, 2010). This study favours that of Luty et al. in the findings.

Synthesis & Conclusion:

While both IPT and CBT can be used for depression, they are quite similar in therapies. According to Whitfield and Williams (2001), some therapies have

strong factors that overlap (structure, focus of problems and relationship of client-therapist). However, there are some differences between IPT and CBT, despite the similarities (time-limited, based on structure and inventories), IPT is focussed on the client's effects of depression, and not solely the cognitions. Social networks play a bigger part of IPT with depressed persons, while distorted thinking is the focus. Both use homework, however not all IPT may do so in order to overcome depressive symptoms. In both cases, brief therapy may not be suited to all persons.

While there has been extensive research into CBT for depression, there has been less so for IPT. In the studies for IPT, they have shown that CBT fares better for more severely depressed people. For this reason, the continued use of CBT for depressed people of all types (mild to severe) is highly supported in the NHS, while further research is needed into the efficacy in IPT for depression.