

# Cognitive behavioural therapy treatment for severe depression



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The essay starts with a short definition of the term depression and continues with an abstract about the main basics of Cognitive Behavioural Therapy for the treatment of depression. The focus is on CBT as it is practised according to Aaron Beck. Due to the shortness of the essay I decided to focus on Beck, rather than on the behavioural approach of Albert Ellis, although Ellis contributed a lot to CBT as it is practised today. Beck is especially useful for the theme of the essay because the treatment of depression was a lifelong focus in his therapeutic work. Most authors refer to him rather than Ellis.

In the third part of the essay I want to discuss the benefits and limitations of CBT as a treatment for depression, comparing it with some ideas and strategies of Family Therapy and Hypnotherapy.

## **What is Depression?**

The terms “ Depression” and “ being depressed” are very common and frequently used. We use them in every day life to express that we are unhappy, in a low mood, disappointed or feel a lack of energy. It seems as though every human being gets to know feelings of depression during his life time and it is within the human range of experiences to get through times of deep disheartenment. So, when does “ Depression” becomes a serious

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disorder and reaches the state of an illness? The boundaries seem to be fluid, but the usual description of feelings, like being sad, anxious or desperate doesn't capture the depressive experience. It is often described as rather an absence of emotions, a total blankness. (Hell, 1992 p. 61)

Psychiatrists today mainly use the number of symptoms and the length of their appearance for the classification. According to the ICD-10 criteria, diagnosis of a depressive episode requires at least two, out of the following three core symptoms for most of the day, nearly every day, for a minimum of two weeks:[1]

- Low mood (feeling low, unhappy, sad or miserable)
- Fatigue (feeling tired or having little energy)
- Anhedonia (lack of interest or enjoyment in things)

Whether a depressive episode is classified as mild, moderate or severe depends on the number of associated symptoms:

- Sleep disturbance
- Change in appetite and weight
- Anxiety
- Poor concentration and irritability
- Suicidal thoughts
- Feelings of guilt and worthlessness

These symptoms may occur in a one-off episode (a major depressive episode), can recur more than once (a major depressive disorder) or be less severe but more persistent, which is then called dysthymia. The periodic appearance applies to 50% of the cases. (Hell, 2008 p. 49)

Depression is often associated with other disturbances such as addiction, anxiety, compulsive disorders or eating disorders. (Brunnhuber and Frauenknecht, 2005 p. 148) It can be masked by fatigue, insomnia, a burn out syndrome and can also appear in conjunction with a physical illness.

In addition to the clinical definition of depression I would like to mention Dorothy Rowe's assessment that people suffering from depression describe themselves as feeling trapped and isolated from the rest of the world. (1994, p. xxi) Not being in contact with others is in my eyes important because it has an major impact on therapy.

The number of people being diagnosed with depression is still increasing. It is said that about 15-20% of the population is likely to suffer from a diagnosable depression once during his life time. Women are two to three times more likely to be diagnosed with depression than men. 15% of the people who have been treated in hospital because of depression, later commit suicide. (Brunnhuber and Frauenknecht, 2005 p. 147)

Despite a great deal of research there is still no evidence of a single cause for depression. Early life experiences, hereditary factors, social risk factors, a chemical disturbance in the brain, all are still said to contribute to the development of a depressive episode. Although I do not intend to address these theories in detail in this essay, the question what causes depression is <https://assignbuster.com/cognitive-behavioural-therapy-treatment-for-severe-depression/>

vitaly important to every school of psychotherapy in dealing with the problem.

## **CBT as treatment for depression**

One reason for NHS to choose CBT as the favoured form of treatment is, that it has been subject to intensive scientific testing for many years and has been found “ as effective as antidepressant medication and other forms of therapy.” (Mulhern et al., 2004 p. 185) I don't want to challenge these results in my essay, instead want to understand how CBT works.

The CBT explanation of depression derives from the work of Aaron Beck and focuses on the relationship between unhelpful thinking, emotions and behaviour.

The proposition is, that negative early life experiences make some people vulnerable to depression, which can be activated later in life by stressful events. Our early experiences decide how we view ourselves, others and the world. The individual develops rules and compensatory assumptions, which have the function to prevent the activation of the negative and painful core beliefs. For example someone who grew up in a family without warmth and approval might have the core belief: “ I'm unlovable”. Over the years he might develop a rule, how to get the desired response from others: “ If I put the needs of others first, then they will love me.” Beck called that type the “ sociotropic personality style”, with a greater need to be accepted, placing their self-worth and individual needs after those of others.

In contrast “ autonomous personality types” place a greater value on independence and the achievement of individual goals. The autonomous  
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personality may experience depression as a result of failure in achieving goals and external stressors like unemployment, debt, a failed exam etc. The sociotropic style will be vulnerable to depression when interpersonal relationships are threatened or lost. (Mulhern et al, 2004 pp. 184-5)

The underlying psychological vulnerability is assessed by using different kinds of questions for detecting the core beliefs and negative automatic thoughts (e. g. "I'm not good enough"). Automatic thoughts are usually outside the conscious attention of a person, but so familiar that they seem to be the ultimate truth.

According to Beck it is not a negative event that causes depression, but the interpretation of the event, based on our core beliefs. After detecting the "wrong" beliefs the client learns to work out for himself, how these thoughts affect his feelings and behaviour. When insight in the mechanism is achieved, the therapist and client work collaboratively to change the dysfunctional thoughts.

It is an essential part of the session to clarify the difference between feelings and thoughts. For example the client learns to say "I think I am a bad person" instead of "I feel I am a bad person". CBT therapists have a circular understanding of the relationship between cognition, emotions and behaviour. For example cognitive processes can influence behaviour and feelings, and vice versa, changed behaviour can influence cognitions and feelings.

As in other schools of Psychotherapy, warmth, genuineness and empathy are important components of the therapeutic relationship. But cognitive therapy <https://assignbuster.com/cognitive-behavioural-therapy-treatment-for-severe-depression/>

does not use the relationship as the focus of therapy. The aim is to create a therapeutic milieu in which the specific cognitive techniques will be accepted by the client and can be applied most efficiently. (Beck et al, 1997 pp. 45-9)

The therapist explains all techniques, how they work and their purpose. Beck uses the picture of two scientists observing the presented problem. Therapist and client are partners in the process of problem-solving. The therapist is directive in the beginning of the process, but the client is supposed to take more and more responsibility for developing his own strategies. Nevertheless there is always a script which leads through the session.

The client shall remain emotionally independent from the therapist and the number of sessions is limited. NHS usually pays for 6-20 sessions of CBT, dependent on the severity of the depression. (NCHP, 2009 p. 182) Beck himself worked with an average number of 15 sessions over an 11-week period. (Beck et al., 1979 pp. 104-5)

The setting of homework is a key stage in CBT, which transfers the learning and changed behaviour into the clients every day life. It also activates the client and may give him first feelings of achieving something. Homework assignments are often presented in the form of behavioural experiments.

The activation of the depressed client is one of the most important tasks in CBT. The client is monitoring his activities and rating them as to the pleasure he gets from them. The usual idea of the depressive client of “ doing and enjoying nothing at all” can be altered into a more reasonable view. The patient becomes more sensitized to feelings of satisfaction and thus

experience and recalls more pleasurable sensations. (Beck et al., 1979 p. <https://assignbuster.com/cognitive-behavioural-therapy-treatment-for-severe-depression/>)

125) The technique of “ activity scheduling” is used to increase step by step the number of activities the client takes part in. Scheduling is also used for breaking down big tasks, which the client feels unable to work on, down into smaller bits and pieces.

Rather than ruminating on the cause for the depression, monitoring and later changing thoughts, feelings and behaviour is the goal of therapy. The more “ objective data” shall allow the client to get rid of his self-judgement and feelings of worthlessness.

## **Discussion**

In the beginning I was really reluctant to write about CBT. It was never very appealing to me and I have no personal experience with it. The books I read seemed to be very schematic and strict, written without empathy and inspiring ideas, a bit too educational and directive. It was the CBT-Weekend at NCHP with Jeannie Bruce, which encouraged me to delve a bit deeper into the subject. Being such an enthusiastic and empathetic therapist, she convinced me that the techniques of CBT are working for people suffering from psychological problems like depression or anxiety. She uses Hypnotherapy as well and I think most CBT-therapists today use additional techniques and borrow from other therapeutic schools. This is probably one of the advantages of CBT today: The openness to integrate with whatever technique is useful for the client.

To keep it manageable I want to stay close to the original theories of Aaron Beck about depression, when starting the discussion about the benefits and limitations.[2]

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CBT is not focusing on the cause of depression. The explanation why depression exists is more functional. " A kind of protection, when we are in a high-stress environment, like a safety switch or fuse on an electrical circuit environment" (Gilbert, 1993 p. 33) or evolutionary: " Go to the back of the cave and stay there until it is safe again" (Gilbert, 1993 p. 43)

People suffering from depression tend to have a low self-esteem and are very self-critical. The client is supposed to learn, that with his continuous self criticism he is constantly stimulating his natural threat system. Through this permanent stress he is maintaining the depressive state, getting deeper and deeper into exhaustion and inactivity. With that explanation CBT focuses on how the client is maintaining his depression, rather than what causes it. The idea is offered that the individual, who usually feels powerless against the almighty depression, might still have some influence on it. The individual is taking more responsibility for changing his behaviour and thoughts and works his own way out of depression. If you want to bring a change as quickly as possible, this is probably a very straightforward and good approach. As a family therapist I'm familiar and mostly agree, with the idea that for initiating a change, it is not necessary to go deeply into the causes of the pronounced problem. Problems are best solved in the here and now. In Hypnopsychotherapy we use this approach as well.

CBT assumes it is the clients thinking that produces his low feelings. Beck even calls it a " thinking disorder" (1979, p. 14) I think this is a very simplistic idea, maybe too simplistic for the complex human psyche.

Nevertheless it is true that the way we think can influence our feelings. And it is much easier to change willingly the way we think than the way we feel.  
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Gaining back control will be a big relief. CBT claims, that this is more helpful and longer lasting than the relief a client may get from expressing his feelings. (Beck 1979, p. 42)

I do have a problem with telling people that what they are thinking and feeling is “ wrong”. It sounds a bit contradictory to explain to someone that his belief that “ I’m not ok”, is not o. k. Can that unconsciously consolidate the core belief, “ I’m not ok”, despite consciously being trained to say “ I’m a good person”? Will stable self-esteem and valuation result from this message? Hypnotherapists believe that core beliefs exist mainly in the subconscious mind and need to be addressed there. Not in simply abandoning them, but in carefully changing them, displacing them step by step with new suggestions.

I have more sympathy with an approach that accepts all feelings and thoughts as a part of the individual, and tries to integrate them, rather than declaring them simply wrong.

I find CBT techniques helpful in breaking the vicious circle of withdrawal and inactivity, which maintains and even boost the low mood. Withdrawing from people, staying in bed and constantly ruminating would probably also depress a well balanced person. It is difficult to find a way out. With the direct approach to change behaviour CBT can be a useful emergency-tool to escape from the prison of depression. Nearly all experts agree that if client is suffering from a severe depression a therapeutic communication is quite difficult. To improve the mood in the first place is preferable.

A CBT session is well structured and follows a fixed script. The script may keep a secure distance between therapist and client. The so called “together as scientists” approach, signals that the client isn’t forced to engage deeply with the therapist. It might be wise not to focus on the therapeutic relationship if the client is deeply withdrawn and distrustful or scared of others.

There is another benefit for the therapist. In my experience, working with people who are depressed may easily lead to an atmosphere of emptiness and hopelessness during the session, which could easily infect the therapist as well. If you have a fixed script to follow and concentrate on it, you may be able to avoid being stuck in a problem-trance.[3]

From a more critical point of view I would like to ask what happens after the case of emergency is accommodated? The individual engages in activity again and is able to follow his everyday chores. Will the change last, if the underlying problems are not addressed? Is a long lasting effect possible without insight? Will the client be able to find more satisfaction in his relationships?

There is no answer to the question whether the “wrong thinking” is really causing the depression or whether it is just the other way round: because the individual is depressed, his thinking is negative and irrational. If you see it as circular not linear, it does not matter from which side you approach the problem and initiate change. But for the individual who’s looking for deeper insight into his problem this approach may be unsatisfying.

In the view of CBT, depression is an unwanted experience. It causes suffering and therefore is to be eliminated. Other Psychologists were asking: Is there any sense in depression? For example Dorothy Rowe criticizes CBT for ignoring the major questions of life, which deserve to concern us: Why am I here? What is the purpose of life? What happens after death? (1994 p. xviii) The thinking about these questions makes us human beings. It could help the client to talk these through in Psychotherapy.[4]An existential fear of death for example, which can appear after an important loss and lead to depression can not simply be rationalised. In my eyes it must be taken seriously and addressed with respect and time.

There may also be environmental or social circumstances, which may raise the question, whether it is not reasonable to be depressed and has nothing to do with wrong thinking at all. There is a strong connection between social problems like poverty, unemployment and social exclusion, and the appearance of depression.(Hell, 2008 pp. 33-34) Acknowledging that distressing incidences can legitimately cause depression doesn't stop us from looking for solutions.

I also have an objection to the way CBT deals with ambivalence. People are complex and able to think, feel and believe two opposite things at one and the same time. For example: " I'm a talented person" and " I'm a failure". CBT is labelling the negative thinking as wrong and simply tries to eliminate it with changed cognitions, reality testing and training. As a future Hypnotherapist I know that the unconscious mind has many possibilities to store something away, and it might come up with the next challenge or disappointment again. It makes sense for me to address the negative  
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thoughts directly in the unconscious state, rather than with rational techniques. Addressing the unconscious mind can be helpful, especially if we talk about the type of depression which seems to arise out of the nowhere, without an obvious cause. The unconscious mind might give us some answers about unfulfilled needs, hidden wishes and former painful experiences which may contribute to the state in which we are now.

Schmidt points out, that it is often the attempt to eliminate ambivalences that leads into depression. The black and white thinking of the depressive individual may cause the trouble. (2004, p. 284) Isn't the "good" and "wrong" labelling of thoughts and behaviour in CBT supporting this categorical thinking?

I'm a bit suspicious about the success rate in CBT, because depressed people are often described as being adaptive and well-behaving. (Linares and Campo, 2003 pp. 14-5) The moderate depressed client might follow the instructions and homework assignments willingly, holding back other feelings of anger and resistance. He is more likely to show guilt in case of a relapse and usually blames himself for it.

While reading the CBT manuals for depression I sometimes think: That sounds like "good parenting" to me. For example, scheduling the day with your depressed client, advising him in detail how to start the day, brushing teeth, take a shower, have some breakfast, go to work. Depression is also described as a kind of regression and maybe CBT meets the need of a client to have a "good and caring parent" in therapy, as compensation for neglect in childhood.[5] This can heal a wound, but can also provoke being a "good

child" again, pleasing others, adjusting to the tasks. Without question it depends on the quality of the therapist to recognize and address this.

Another thing could be missed if the depressed client is characterized solely as someone with low self-esteem and a negative self-perception. This part of the personality shows up first and is presented quickly. In my eyes it is only one side of the coin. Unipolar depression occurs often later in life, when we realize that we didn't live up to our expectations and we see no solution for that. It is a time when we may have to say goodbye to dreams, fantasies and wishes which helped us to survive as a child and young person. I would always carefully explore whether there are hidden feelings of self-aggrandisement. Between the two poles of devaluation and delusions of grandeur the individual may oscillate. In that case depression could make sense to him as a reason for retaining his delusions of grandeur, and even as an excuse for why he is not able to live up to his (unreasonable) expectations. Depression may also protect us from making further decisions and taking full responsibility for how we live.

It could also simply be a break, for getting some rest and protecting the individual from his own excessive demands. It can transfer information about legitimate and so far neglected needs. (Schmidt, 2004 p. 283-285)

If depression is a kind of protection, the question should not be how to get rid of it as quickly as possible, but how to protect oneself in different ways, which causes less suffering.

Another interesting idea I would carefully explore as a therapist is, whether the client has a problem with regulating closeness and distance. Depression  
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can be a tool in keeping at a distance from other people. It can be a form of withdrawal into one's inner self, if we do not feel allowed to leave an unbearable situation, or to express our needs. Family therapy is looking for the sense in "showing yourself depressed" in connection with our environment. The assumption is that all human behaviour makes sense and all behaviour is communication. Because it is impossible not to communicate, even a behaviour which consists of withdrawal and bleak silence (how the depressive person is often presenting himself) is communication. It is a message to the people around and provokes reactions. Depression arises in our relationships. It is not a process inside the individual, but a symptom in the communication between two or more people. Although it appears to be dysfunctional there is an underlying intention for the behaviour. Eliminating the depressive symptoms as quickly as possible could be overhasty, if you don't respect their meaning and function first. The development of other strategies and an improvement in communication would be the prior goals.

I find this approach helpful, when the depressed person is living in a constant relationship and obviously the depression interferes with the partner or the whole family.[6]

Depression is a very complex psychological problem and I hope I was able to show a variety of reasonable approaches and theories which are all based on practical therapeutic experiences and research. Probably no two depressions are the same and every case needs to be explored carefully. As it is such a complex theme, it is a loss that the NHS, mainly for economic reasons, decided to promote CBT as the only treatment of choice. "One suits all", <https://assignbuster.com/cognitive-behavioural-therapy-treatment-for-severe-depression/>

that is wishful thinking. There are much more helpful and interesting strategies which would be worth a try. One client may want a quick fix only, another may want to explore the underlying causes and a third may respond to hypnosis rather than to rational approaches. At this moment, we are far from having found the one and only treatment for depression. Working with depressed people is probably one of the biggest challenges as a therapist.

If we have in mind the high number of recurrent depressions it might be more economic to pay once for an individualised therapy than for the short term and relatively cheap CBT, as a treatment for all.

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