CBT for Depression:
AN INTEGRATED APPROACH

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Introduction

Practitioner Guidance

If you have opened this book to find out if it will be useful to you, it will be helpful at the outset to be clear about its aims and intended readers. This is a clinically oriented book exploring how to provide Cognitive Behavioural Therapy (CBT) to clients suffering from Major Depressive Disorders (MDD). It is not a self-help book for people feeling depressed; there are several books of this kind already available (e.g. Gilbert, 2009). The main intended readership is CBT therapists working in clinical services, including students of CBT. It isn't written with any particular profession in mind; in fact one of the refreshing aspects of CBT is its multi-disciplinary nature. In recent years there has been an opening of routes into becoming a CBT practitioner; this book welcomes you and encourages your interest whatever path you are on. CBT interventions are also used widely by other practitioners and professionals, who would not consider themselves to be CBT therapists, but nevertheless find CBT a useful approach. This book will be helpful to you because it will provide a clear grasp of the theoretical frameworks and evidence base underpinning cognitive-behavioural interventions. For the same reasons, academics, researchers, psychologists, psychiatrists, psychiatric nurses, social workers, counsellors, occupational therapists and all students of mental health will find the book of interest.

Therapy manuals describe the essential components of a treatment but they sometimes fall short of explaining *how* that therapy should be delivered, particularly with more challenging presentations. In this book we aim to do both, and this is what we mean by practitioner guidance. Whilst one of the attractions of CBT, at least in its basic forms, is the relative ease with which practitioners and clients can grasp its fundamentals, it is a considerable challenge to provide CBT competently and responsively, particularly with complex or difficult-to-treat cases (Garland, 2015). Rich with

case studies and examples, this book marries treatment components with how to go about providing them. There is also an emphasis on trouble-shooting because not all CBT interventions work smoothly every time; methods that generally work well can be a poor fit for particular clients. So this book explores how to provide CBT that is *responsive to the needs of particular clients*, particularly in challenging cases. Most of the clinical examples are based on clients within healthcare settings, since this is where most CBT is provided, but the guidance can be applied in a range of other sectors such as education, forensic, social work, probation, occupational health and independent practice.

We want to be clear at the outset that the emphasis is on treating *major* depression, in particular those clients who have not responded to established CBT therapies. Major depression is a very common mental health problem and the leading cause of ill-health and disability worldwide, a surprising fact when one considers the range of other physical and mental health conditions that have a disabling effect on human wellbeing. According to World Health Organization estimates, more than 300 million people are now living with depression, an increase of more than 18% between 2005 and 2015 (WHO, 2017). Lack of support for people with mental disorders, coupled with a fear of stigma, prevent many from accessing the treatments they need to live healthy, productive lives. This is a very concerning situation. In contrast with mild depression, major depression is associated with significant impairment to social and occupational functioning and huge personal, relational and economic costs when it is left untreated. It is heartening that evidence-based therapies, such as CBT, can make such a positive difference (Driessen & Hollon, 2010), but they are not yet effective for all clients and more research and development is needed.

For readers unfamiliar with the difference between major depression and milder mood disturbances, we have listed the criteria for Major Depression published in the tenth edition of the International Classification of Diseases (ICD-10; World Health Organization, 1992), in Table 1.1. To reach criteria for Major Depression the client must have two of the first three core symptoms (depressed mood, loss of interest in everyday activities, reduction in energy) plus at least two of the remaining seven symptoms.

These symptoms must be present for at least 2 weeks, but in clinical practice many clients will have experienced them for several months or even years. It is worth noting that severity is not only determined by symptoms: it is also their *impact* on occupational and social functioning. In relation to this, common distinctions between moderate and severe depression, and their typical impacts, are listed in Table 1.2. The presentation of clients varies considerably: some people's functioning reduces markedly with mild symptoms while others maintain surprisingly good functioning in spite of severe symptoms.

Table 1.1 Diagnostic symptoms of Major Depression listed in ICD-10

	Symptom
1	Depressed mood*
2	Loss of interest*
3	Reduction in energy*
4	Loss of confidence or self-esteem
5	Unreasonable feelings of self-reproach or inappropriate guilt
6	Recurrent thoughts of death or suicide
7	Diminished ability to think/concentrate or indecisiveness
8	Change in psychomotor activity with agitation or retardation
9	Sleep disturbance
10	Change in appetite with weight change

ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th Revision (see WHO, 1992).

CBT Model of Depressed Mood

CBT is usually provided through 16–24 treatment sessions over a 3- to 6-month period using an individualized formulation, or case conceptualization (DeRubeis et al., 2005). Later in the book we will review CBT's evidence base and explore several opportunities for its further development. However, we should be clear at the outset this book does not directly address brief or low-intensity cognitive-behavioural interventions for milder depression, such as guided self-help or computer-assisted CBT. Readers are encouraged to access other specialist texts devoted to this important area (Hughes, Herron & Younge, 2014; Papworth, Marrinan & Martin, 2013).

Table 1.2 Common functional impairments in moderate and severe depression

Functional domain	Moderate impairment	Severe impairment
Family relationships	Quiet, negative, passive	Withdrawn, disengaged, reluctant to talk
Education and work	Sometimes absent, less consistent effort (or more effort to maintain performance)	Often absent, reduced performance, lack of concern about consequences
Peer relationships	Decreased socializing, more isolated pursuits	Very isolated, socializing discontinued
Stress level and anxiety	Difficulties minimized or worried about privately	Feelings withheld, fears minimized by withdrawing
Suicidal ideation	Vague, occasional thoughts	Plan or method actively considered
Other self-harm	Occasional thoughts but no plans or attempts to harm	Self-neglect, possible cutting or other self-injury

To provide an orientation to some of the main issues, a CBT model of depressed mood is presented in Figure 1.1. This applies a generic 'hot-cross bun' model to the specific phenomena of depression. In this model a number of links are made that constitute a depressed mood: negative thinking, reduced activity, negative emotions and unpleasant body states. People who have not experienced severe depression sometimes struggle to understand why it cannot be shaken off or overcome more easily. In fact, clients with major depression experience a *much* greater intensity of negative emotions and distressing thoughts compared with 'normal' dysphoric moods.

For two linked reasons it is helpful to start with this basic model. Firstly, in many respects depression can be understood as a spectrum from normal dysphoria through to severe depression, and some of the phenomena observed in dysphoric moods, such as negative thinking and reduced activity, are also observed in severe depression. We will return to the relationship between normal and abnormal moods in Part II of the book. Secondly, Figure 1.1 neatly illustrates one of the fundamentals of CBT: emotional problems do not *persist* on their own. They are *maintained* by the cognitions and behaviours linked to them (Beck, 2011; Beck, Rush, Shaw & Emery, 1979; Martell, Addis & Jacobsen, 2001). Attempting to feel differently through choice or effort, without engaging with other parts of the model, usually leads to no change, or just adds frustration into the mix. In contrast, it is usually more effective to change a behaviour or test out a belief to find out if it is accurate or helpful. This is at the heart of CBT.

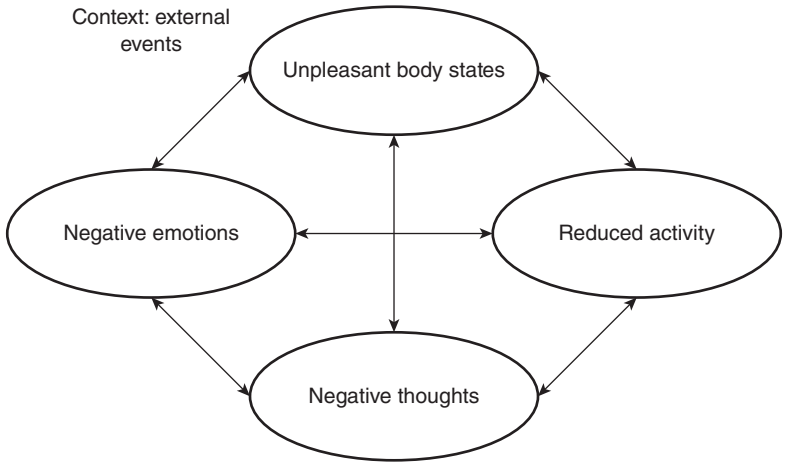

Figure 1.1 CBT model of depressed mood

Notice also that moods are not just emotions. Emotions can be quite short-lasting experiences triggered by specific events, whereas a mood tends to be a longer-lasting affective state. Although it is strongly affective in nature, there is usually more than one emotion involved, such as sadness, guilt or shame (Beck, 1976). Cognitive and behavioural aspects are fundamental in shaping how moods affect an individual. Moods colour how we perceive and think about the world; they orient our actions towards and away from different possibilities. We can be in the mood for doing X, but not Y, and so on.

This speaks to two other principles within CBT: firstly, we can believe something is true and feel sure about it, but we are actually mistaken; secondly, we can do what is helpful or necessary at one point in time, but later it develops into an unhelpful habit. There is good evidence that major depression is associated with unhelpful thinking and self-defeating behaviours. Inaccurate beliefs can *feel* true and unhelpful behaviours can *feel* helpful, because of their short-term effects. The general principle of testing out beliefs and experimenting with new behaviours is woven into the fabric of CBT. Of course, these principles are straightforward to understand intellectually, but they are less easy to apply in practice, particularly with challenging cases. This is one of the reasons for writing this book. As the book progresses we will see that CBT is not usually so simple as explaining to clients the benefits of thinking less negatively and becoming more active. Cognitive and behavioural changes need to be subtly and carefully targeted, particularly when working with clients with moderate or severe impairments.

Challenges for Therapists

This book engages with concrete experiences, not just theories or ideas, and we will focus on therapists' experiences, as well as clients'. We'd like to start that now by exploring your experience of working with depressed clients. This is a task we've used to good effect many times in training workshops because it helps to explore the sorts of challenges therapists face working with depression. If you're not a therapist, bring to mind a time you've been supporting a friend or family member who has been feeling very down.

Memory Task

Bring to mind a particular depressed client you have worked with in the past. Try to remember your first meeting, then subsequent sessions. Across the course of treatment, what *feelings* did you experience during your work together? Try to remember as many feelings as possible, not just information about the case. Take a few minutes to do this and list the feelings in a notebook before you read on.

When we first did this task we were surprised by the responses and we repeated it with different groups in various settings, finding the same pattern time and again. It is this: most therapists recall significantly more negative than positive feelings from their work with depressed clients. If this fits with your recollections, that is very normal. Table 1.3 lists common responses from our workshops: positive feelings are reported but they are consistently less common.

Could this be some kind of recollection bias? Perhaps therapists tend to remember experiences with more challenging clients? This may be true, but we don't believe it is the whole story. Encountering depressed moods in another person can be difficult, triggering a range of responses whether in a partner, friend, colleague or therapist. Being given permission to acknowledge and express difficult feelings can help therapists feel relieved that they aren't the only one who finds this work challenging. It can be de-shaming to 'fess up' to feelings of pessimism, frustration or even dread. But then there is a potential problem: if it is normal for therapists to experience negative feelings, how can they respond mindfully to those emotions so they form part of a creative understanding of their clients' experience, rather than react to them unreflectively?

In fact, this is a fundamentally hopeful situation because it demonstrates that therapists are *engaging* with the emotional world of their clients. Such engagement is essential

Table 1.3 Feelings commonly experienced by therapists working with major depression

Negative emotions	Positive emotions
Anxious	Comfortable
Disappointed	Empathic
Discomfort	Hopeful
Down	Rewarded
Drained	Satisfied
Dread	Sympathetic
Frustrated	
Heavy	
Helpless	
Hopeless	
Irritated	
Low	
Overawed	
Overwhelmed	
Panicky	

for the client to be supported, understood and taken seriously. Negative emotions are not bad: as long as they are noticed, reflected on and directed in a helpful way. It is when they go un-noticed or un-reflected that unhelpful behaviours result. To enable meaningful cognitive and behavioural change it is essential to have emotions and moods at the centre of CBT, not the periphery. This means that therapists need to be sufficiently aware of the impact of therapy on their own moods, and use supervision and reflective practice to make sense of them in the therapeutic process.

Follow-up Task

Choose one of the negative emotions from Table 1.3, preferably one you have experienced during your work with a depressed client. Consider the therapist behaviours that could result if this feeling was not noticed or was reacted to in an un-reflective way. Then consider possible therapist behaviours if the feeling is noticed and reflected on, for example in clinical supervision.

This task reveals a key challenge for therapists: while paying attention to their emotions, and the emotions of their clients, how to facilitate a process of *change*? Like all evidence-based psychotherapies, CBT requires therapists to balance support with change, and this is illustrated in Figure 1.2 (Webb, DeRubeis, Dimidjian, Hollon, Amsterdam & Shelton, 2012). When supportive elements are over-emphasized, therapists are over-concerned with building and maintaining a strong personal bond. They are empathic about their client's predicament, but if there is insufficient attention to change, that predicament is likely to be maintained rather than improved.

Conversely, if change-oriented techniques are over-emphasized, without building a sufficiently strong personal bond, the negative emotions reported by therapists in Table 1.3 are prone to recur. It can be frustrating and unsatisfying for therapists when depressed clients don't engage in the treatment as it has been outlined to them, for example, cancelling sessions, not doing homework, struggling to contribute to agenda setting, forgetting what was discussed in previous sessions, and so on. Therapists can experience this as thwarting, uncooperative, ungrateful or even sabotaging. In those same moments clients can experience their therapists as remote, business-like and safely distanced from the despair of depression. The aim is to balance and integrate bond and tasks, a theme we will return to throughout the book.

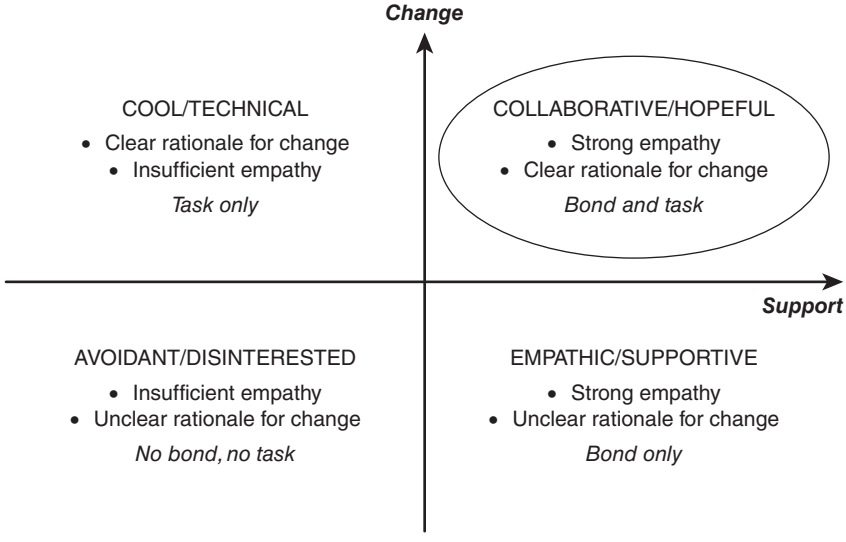

Figure 1.2 Balancing support and change in CBT for depression

Evidence-Based Practice

How can therapists learn to respond to these various challenges? The answer lies partly in a further theme: follow the evidence. All therapists want their treatment to be effective, and most recognize the need to ground it in an approach that isn't only personally satisfying, but also has empirical support. CBT for depression has a strong evidence base from randomized controlled trials (RCTs) and other types of evidence: therapy process studies, practice-based evidence, experimental studies of cognitive and behavioural processes, and so on. Clinical guidance tends to emphasize RCTs above other types of evidence and this is understandable to establish which treatments work for which disorders (NICE, 2009, 2017). Even when a breadth of evidence is considered, an awkward fact cannot be avoided: there is often a gap between the evidence base and its translation into clinical practice.

CBT for depression has a strong evidence base but there are several gaps, anomalies and ambiguities regarding its translation (Driessen & Hollon, 2010). For example, treatment manuals can be simultaneously supportive and frustrating. If the treatment components specified in manuals are empirically supported, it makes sense that this is what therapists should be doing. However, this overlooks two key points. Firstly, most manuals have a greater emphasis on *what* should be done than *how* to do it. How to deliver the therapy tends to be left to trainers and supervisors, and if training and supervision are not adequate, therapists can be left under-supported: the manual tells them what to do but falls short of explaining how (Roth & Pilling, 2007). Some manuals are also heavily task-focused. Rather than establishing a *balance* of bond and tasks they create the impression of therapy as a mainly technical exercise. In fact, all CBT skills are interpersonal skills. There is no way of setting an agenda or agreeing a homework task without a client present. Everything is done together. It is vital that therapists deliver the treatment components known to be effective, rather than drifting into an unstructured personal bond; but it is also important they are encouraged to be creative in delivering those components in a personalized and interpersonally-sensitive way (Waller & Turner, 2016).

Secondly, manuals are not always updated after RCTs have been completed and subsequent research becomes available. Not all treatment components are equally potent, so if manuals are not updated, therapists can be adherent to treatment procedures that are not strictly necessary and may be wasteful of treatment time. There have been 40 years of research since the inception of CBT for depression, but the lag-time for those findings entering routine clinical practice has been surprisingly long, especially when guidance, training and supervision have not been updated in a timely way. Alongside other influences, this book has grown out of a synthesis of that evidence, woven into the results of our own research and experience of provid-

ing therapy, supervision and training. The integrated approach that has resulted is introduced in detail in Part II.

We have learned a great deal from RCTs, but just as much from conducting single case analyses with our own clients. The reason is simple: clients with major depression *vary* a great deal. RCTs report average effects across large numbers of clients. The average effect of a treatment is important to know, but it creates the impression that most clients are average, as if they are drawn from an underlying normal distribution. The average client is a myth. All clients are unique, and the task of treatment is to apply the models and methods of CBT in a way that responds to individual need, not to apply what works for most people most of the time. For that reason our research and development strategy has been to take learning from RCTs and focus it on single case analysis. By recognizing the uniqueness of each individual we have learned a lot about what works for whom, and this is reflected in the case examples presented throughout the book.

The Heterogeneity of Major Depression

The *heterogeneity* of major depression is a huge challenge for CBT therapists. By this we mean multiple variations in the presentation of depressed clients. CBT provides a coherent framework to understand and treat depression, but this needs to be applied responsively to clients who often have very different needs. Heterogeneity can be encountered within the depression itself: some clients are in their first onset of major depression, others are in a pattern of repeated recurrences. Others have chronic and persistent depression that rarely, if ever, fully remits. The heterogeneity may be expressed in interactions with other mental health problems. Many have comorbid disorders such as Generalized Anxiety Disorder (GAD), Social Anxiety Disorder, Obsessive Compulsive Disorder (OCD) or Post-Traumatic Stress Disorder (PTSD). There is also the heterogeneity of clients' life circumstances: some are struggling with poverty, inadequate housing, unemployment or abusive relationships; others with physical health problems, such as illness or chronic pain. The varieties can be daunting and at times overwhelming, for client and therapist.

To respond to this breadth, our experience has taught us the importance of being *flexible* and *hopeful*. This will also be a recurring theme throughout the book. If you want to treat major depression, develop your capacity for hopefulness and expand your imagination to find flexible ways of delivering the therapy. Hope is not simply optimism or looking on the bright side. It is embodying and enacting the belief that no matter how bad a client's situation, there will be a way of improving it. With the above examples, none of the problems are *sufficient causes* of depression. An

individual's depression is not an inevitable consequence of comorbid disorders, social disadvantage, trauma or abuse. People can experience these problems and *not* fall into depression. When depression does occur its causal path usually involves multiple factors. Even for clients with traumatic histories, personality problems, social problems or chronic depression, the problem – at least in part – is the impact of those experiences on *how that individual thinks and behaves*. To follow through that logic, anyone can become depressed and everyone can recover or, at least, they can learn how to respond to depressed moods in ways that reduce their suffering. This book is an exploration of how to be hopeful and flexible working within the parameters of CBT, particularly when clients' depression is complex or difficult to treat. To do this effectively, heterogeneity has to be accepted and explored, not overlooked or over-simplified.

When therapist hopefulness and flexibility increases, the usual consequence is greater empathy, reward and satisfaction doing this therapeutic work. This has been our experience over an extended period, and a significant motivator to share our enthusiasm in this book. Of course, enthusiasm and hopefulness need to be harnessed with interventions that have the *potency* to respond to the types of challenges we've outlined. So how can CBT respond to these challenges? How can therapists adapt treatment to the needs of different clients?

The Heterogeneity of CBT

Beck et al.'s (1979) *Cognitive therapy* was the pioneering CBT treatment for depression and it is still the most widely researched and best-established work. We introduce it in detail in Chapter 2. Compared with before the turn of the millennium, CBT therapists now have multiple other options with the development of various other standalone treatments: Behavioural Activation, Rumination-Focused CBT, Mindfulness-Based CT and other third-wave approaches such as Compassion Focused Therapy and Acceptance and Commitment Therapy. These are welcome developments because, as we have outlined, depression is a multi-factorial problem. But, perversely, in clinical practice it is not always easy to know which model to adopt. Should I focus exclusively on a favoured approach and become familiar with it, at the risk of ignoring other models? Should I diversify and learn about new approaches, at the risk of losing fidelity and increasing confusion? Are third-wave therapies as effective as established approaches? These are the sorts of questions we've been asked many times at training workshops, and this book is partly the product of our endeavours to answer them.

Multiple approaches create therapeutic possibilities, and the field now has great breadth and depth, but in our view it lacks *coherence*. Competition between models

is inevitable, and useful if it helps to find out which approach works best for particular clients. The downside is that shared treatment processes tend to be overlooked and differences magnified. An unintended consequence is confusion in the minds of therapists, and our approach has been to seek *integration*. We believe CBT therapies relate to each other on a spectrum, though we are not implying this was the intention of their developers. Different models attend to different phenomena, and since depression is such a heterogeneous disorder, there are a lot of phenomena to consider. We have illustrated these relationships in Figure 1.3.

- *Cognitive Therapy/Cognitive Behavioural Therapy (CT/CBT)*. CT/CBT's main concern is to develop functional beliefs and cultivate realistic thinking. A key way of doing this is scheduling enjoyable activities and conducting behavioural experiments; engaging in activities to test out predictions and put beliefs to the test. Cognitive change is the primary aim (Beck et al., 1979; Beck, 2011; DeRubeis et al., 2005).
- *Behavioural Activation (BA)*. BA considers behaviours in detail through functional analysis of their antecedents and consequences, the aim being to increase positive reinforcement and encourage engagement with rewarding aspects of the environment. This is guided by idiosyncratic personal values; behavioural change is the primary aim (Kanter, Busch & Rusch, 2009; Martell et al., 2001; Martell, Dimidjian & Herman-Dunn, 2010; Richards et al., 2016).

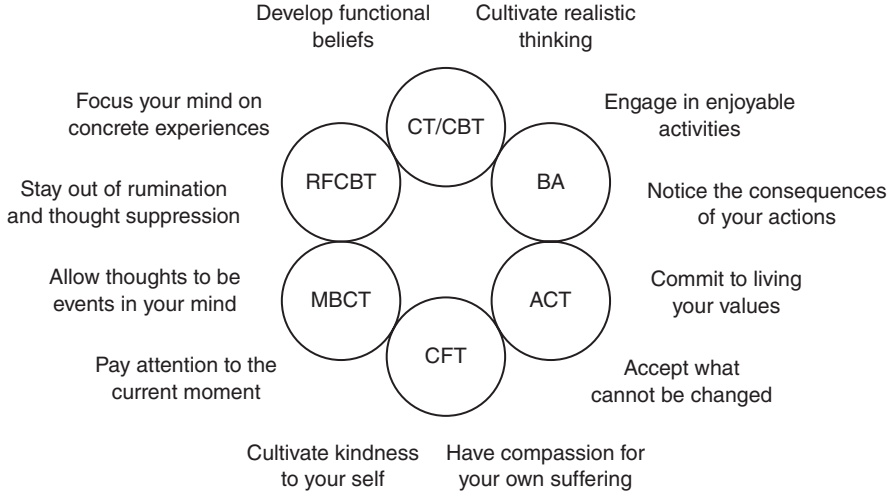

Figure 1.3 A spectrum of CBT therapies for major depression

- *Acceptance and Commitment Therapy (ACT)*. ACT encourages commitment to personal values, increasing contact with valuable experiences, maximizing what can be changed and accepting what cannot: this can otherwise become a source of conflict, pain and suffering. Behavioural change is essential to establish a different relationship to one's experience (Hayes, 2004; Zettle, 2007).
- *Compassion Focused Therapy (CFT)*. CFT cultivates compassion for one's own suffering and seeks to develop internal capacities for kindness. Many depressed people are compassionate to others but critical and judgemental of themselves; the challenge is learning how to be compassionate to oneself. In relation to depression, cultivating a compassionate self-to-self relationship is primary (Gilbert, Baldwin, Iron, Baccus & Palmer, 2006; Gilbert & Procter, 2006).[1]
- *Mindfulness-Based Cognitive Therapy (MBCT)*. MBCT encourages a non-judgemental acceptance of experience and helps clients learn how to pay attention to the current moment, including bodily experience; in this way thoughts and other mental events are experienced as events in the mind, rather than distressing truths. This helps to disrupt unhelpful processes such as cognitive rumination and emotional suppression (Ma & Teasdale, 2004; Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau, 2000). Cultivating mindful awareness is the primary aim.
- *Rumination-Focused Cognitive Behavioural Therapy (RFCBT)*. RFCBT targets unhelpful repetitive thinking and helps clients to learn more effective ways of information processing, such as concrete/experiential processes in preference to abstract/conceptual thinking. This enables greater 'flow' between mind and experience, which helps to maintain realistic and helpful thinking, returning full circle to the original aims of CT/CBT (Watkins et al., 2007, 2011).

These therapies contain a lot of wisdom, some of it shared, some of it unique – but at this point it is not clear what is specific and what is common to all. Our strategy has been to prioritize the *psychological processes that maintain depression*, rather than work within the parameters of one model. The challenge has been the large number of maintenance processes, and as we have tackled each one, we have experimented with various treatment components from the above therapies. In following this method, we have discovered that CBT can have a broad range of effects: reality-orienting, activating, problem-solving, engaging, accepting, self-compassionate, mindful, mentally freeing, and so on. Clients need these, and benefit from them, to different degrees. They do not necessarily need separate types and courses of CBT to experience these benefits; a single course of integrated CBT can be sufficient, at least for some clients.

[1]The proponents of CFT do not view it as a Cognitive Behavioural Therapy but its theory and techniques can be used to augment CBT. This is the approach we take in this book.

Integrated Approach

Psychotherapy integration is usually *between* therapy schools such as cognitive-behavioural, systemic, interpersonal or cognitive-analytic. This book seeks integration *within* the field of CBT. Our approach does not capture all aspects of the therapies illustrated in Figure 1.3. They each have their own integrity, and this book is not intended to undermine that. Rather, we have sought to maximize points of contact between them, to develop a CBT treatment that is sufficiently potent to treat complex and difficult-to-treat cases. Depending on the needs of the client, therapy can have a reality-orienting, activating, problem-solving, engaging, accepting, self-compassionate, mindful or mentally freeing effect. The resulting treatment is strongly process-oriented and described in detail from Part II onwards. In developing this approach, we have sought to make a virtue out of a necessity. For the past 20 years our clinical base has been the Newcastle CBT Centre, a specialist CBT service providing therapy at Step 4/5 in the English stepped care system (NICE, 2009, 2017). All depressed clients referred to our service have recurrent, complex or chronic difficulties. They have all received previous courses of CBT, and/or other psychotherapies, and these have either been ineffective or not had a lasting effect. The question that has repeatedly confronted us, is: what treatment should we offer when established CBT has not been effective, or not had a sustained effect?

In fact, this question is not unique to specialist services. In Part I of the book we introduce the best-established CBT therapies for depression, Beck's CBT and Jacobson and Martell's BA, and we review their evidence bases. At the present time these therapies produce a *sustained recovery* in approximately two-fifths of clients (Driessen & Hollon, 2010). This is the best available evidence from RCTs, where the treatment effects tend to be larger than routine practice. A proportion of clients drop out or do not respond to CBT, and some who respond are vulnerable to relapse in the post-treatment period. These rates are comparable with other evidence-based treatments: drop-out, non-response and relapse are challenges for all treatments, not just CBT. CBT is at least as effective as other therapies, and may be more effective under certain conditions. Nevertheless, three-fifths of clients remain depressed or have a significant vulnerability to depression after a course of established CBT.

We have illustrated this situation in Figure 1.4, showing the transition from Step 3 to Step 4 in the English stepped care system. For every five clients presenting with major depression at Step 3, two will need more specialist or intensive therapy at Step 4/5 and one of the others is likely to be re-referred, having suffered a relapse or recurrence at some point in the future. This book describes our response to what can be offered when established CBT has not worked, or not had a lasting effect. It explores how

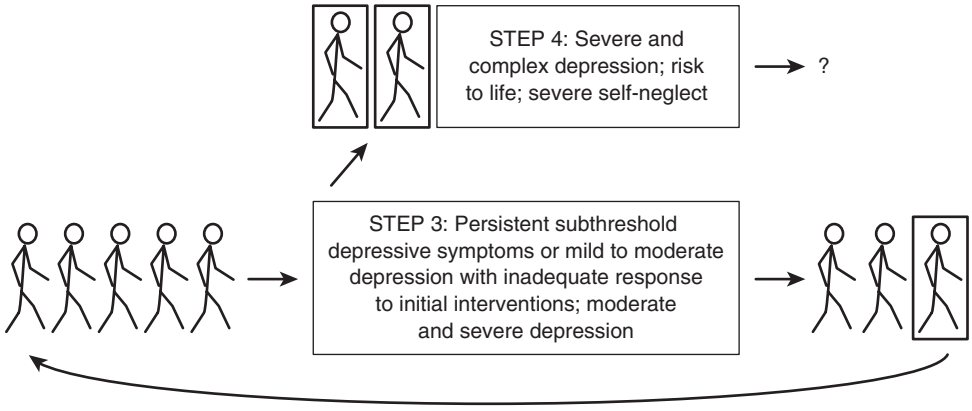

Figure 1.4 Outcomes from established CBT projected onto stepped care pathways

treatment can be adapted, adjusted or intensified for clients stepping up to Step 4/5 or recurrently presenting at Step 3. It also explores the factors that enable established courses of treatment, such as CBT or BA, to be delivered successfully.

We want to be unambiguous at this stage that *clients should receive an established course of CBT or BA as the first-line intervention*, exactly as recommended by current clinical guidance (NICE, 2009, 2017). We actively encourage therapists to deliver high-quality established CBT or BA in the first instance. When CBT or BA are effective they do an excellent job in bringing clients out of depression and helping them stay well in the future. For this reason, we devote Part I of the book to established CBT protocols including relapse prevention, where CBT has a stronger evidence base than most other therapies. The integrated approach that follows, from Part II onwards, has been developed for clients who do not currently achieve a sustained recovery: for those recurrently presenting at Steps 3 or 4/5.

The integrated approach is not a new brand of therapy; it is a way of organizing treatment components from existing CBT therapies. As will become apparent, a lot has been learned about how to prioritize and target CBT interventions for different types of clients. An analogy would be attempting to complete a jigsaw puzzle without the picture-board: the last 20 years has generated a lot of new pieces from various models, evidence and clinical techniques. A bigger picture is starting to emerge. This book integrates the pieces in a particular way, with the aim of creating an accessible up-to-date treatment that makes sense clinically, has theoretical coherence and is also evidence-based. The strategy underpinning the integration is three-pronged, and it is illustrated in Figure 1.5.

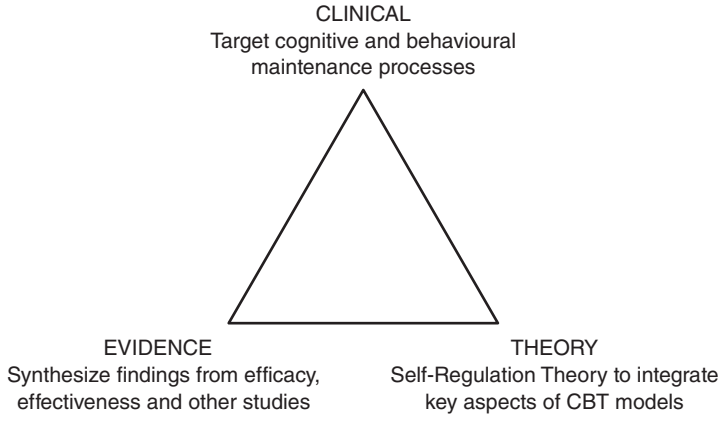

Figure 1.5 Rationale for an integrated CBT model

- *Clinical Integration*. Rather than work within a single CBT model, we have sought to incorporate the full range of *cognitive and behavioural processes that maintain depressed moods*. We have then experimented with treatment components from established therapies to respond to those various maintenance cycles. The main contributing therapies are CT/CBT, BA, ACT, CFT, MBCT and RFCBT. Additionally, we have drawn on Continuation Cognitive Therapy to support relapse prevention (C-CT: Jarrett et al., 1998, 2001; Jarrett & Thase, 2010).
- *Theoretical Integration*. Therapy should always be guided by an explicit cognitive-behavioural model. We have developed a model that uses Self-Regulation Theory (SRT; Carver & Scheier, 1999) together with several of the *principles* underpinning Interacting Cognitive Subsystems (ICS; Teasdale & Barnard, 1993). SRT is concerned with self-identity, affect, motivation and goal-directed behaviour. ICS views depression as an interaction of multiple cognitive subsystems. SRT has added to our understanding of suppressed motivation, reduced goal-directed behaviour and self-devaluation. The principles underpinning ICS have added to our understanding of over-generalization, memory processes and rumination. Additionally, the model has drawn from the Differential Activation Hypothesis (Teasdale, 1988), Retrieval Competition Hypothesis (Brewin, 2006) and Dynamic Systems Theory (Hayes, Yasinski, Barnes & Bockting, 2015).
- *Empirical Integration*. Various sources of evidence have been synthesized and they are broadly convergent: in other words, they point towards a generalizable picture of CBT's mechanisms and effects. Different types of evidence include clinical trials (open, randomized), single case research, case series, practice-based evidence, meta-analyses, epidemiological and cohort studies, experimental and observational studies. Within the book, the proposals we put forward have three 'levels' of evidence

and, as far as possible, without disrupting the flow, we try to make it clear which level applies at each point:

- Level 1: Claims that are already empirically supported in the field
- Level 2: Proposals that are consistent with the evidence base, but are our interpretation of it
- Level 3: New hypotheses that need further empirical tests

Of course, readers will be wondering: at this point in time, writing in 2018, what evidence is there for this integrated approach? There are three answers.

- *Treatment components*. The various treatment components are all derived from the existing CBT evidence base; Parts II, III and IV of the book set these out in detail.
- *Therapy research*. Some years ago we conducted a case series with an earlier version of this approach (Barton, Armstrong, Freeston & Twaddle, 2008). The post-treatment and follow-up data for those cases are presented in Figure 1.6. They were Step 4 cases with complex difficulties, and the outcomes were comparable to established CBT. What encouraged us was the follow-up data: one year after the end of therapy clients were continuing to improve, rather than relapsing back into depression.
- *Practice-based evidence*. Over the past 10 years, we have developed this approach with more than one hundred depressed clients, all with recurrent, chronic or complex depression that has either not responded to established CBT, or the CBT has not had a lasting effect. The book describes eleven of those clients in detail, as case illustrations. We have selected cases using the following criteria: (a) clients who illustrate a particular sub-type, complexity or clinical issue; (b) clients who had a full course of treatment; (c) clients who were willing to be included in the book. It is not a random sample, for example, treatment drop-outs are not included, and there is no comparator group. However, we have selected challenging cases, not the most successful cases, and the pre–post changes on their standardized measures demonstrate how effective this approach can be, particularly with difficult-to-treat depression.

In Chapter 13 we provide a synthesis of the cases and the various themes within the practitioner guidance across the chapters. We re-visit the issue of empirical tests and discuss different strategies for treatment development and ways of extending the evidence base with this client group.

From Beginners to Experts

This book has been written with different readers in mind. If you have no basic knowledge of CBT then it will be probably be too advanced. We recommend you read a more general introduction to CBT first, such as Kennerley, Kirk & Westbrook (2016).

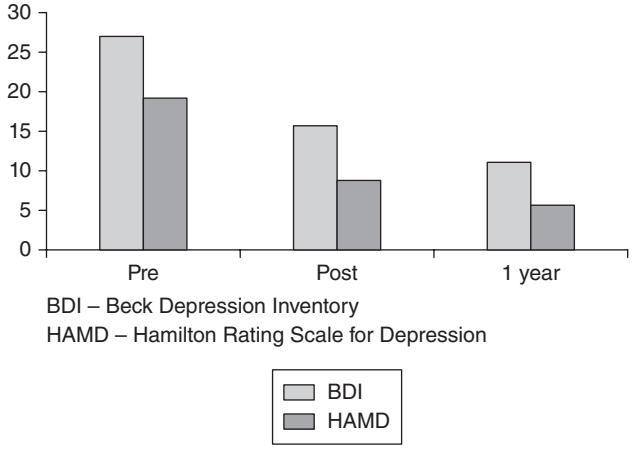

Figure 1.6 Post-treatment and 1-year follow-up outcomes from Barton et al. (2008)

In what follows a lot of general knowledge of CBT is assumed, such as: treatment structures, goal setting, agenda setting, activity scheduling, collaboration, Socratic guidance, thought challenging, behavioural experiments, and so on. If you're not sure what these are, it is best to start elsewhere. Otherwise, the book has been written for everyone, from therapists beginning to work with depression, to experts in the field and all points in between.

As Figure 1.5 suggests there is a triangle of knowledge in CBT that appeals to phenomenology, evidence and theory and each will be given equal weight. Sometimes our focus needs to emphasize our client's experience, which can be full of surprises. At other times we need to emphasize the evidence base; the different types of evidence mentioned above, and your own evidence collected as treatment progresses. At other times we need to emphasize the theoretical principles of CBT, and invoke models that capture the processes maintaining a particular client's difficulties. Over a course of therapy we need to triangulate experience, evidence and theory as we approach each problem, question or issue. This is the method we will follow, as far as possible, throughout the book.

We should acknowledge, however, that there has been inevitable selectivity on our part. CBT for depression is such a vast field that to do it justice with a comprehensive synthesis of evidence and theory would create a very different book. It would be a scholarly work of primary interest to academics, not practitioners. So there have been several compromises in developing this line of work and writing the book. To keep it useful, accessible and up-to-date we've kept the focus on what is most relevant

to clinical practice, and consequently certain theories and evidence bases are touched upon rather than given the space they fully deserve.

Developing therapists are recommended to work through each chapter in turn. Part I focuses on established CBT protocols, and there are various reasons for including these. To understand integration, one needs to understand the components that are being integrated. As we have already stated, the integrated approach is for clients who have already received a standard course of CBT and it has either not been effective, or not had a lasting effect. We want to be explicit about the treatment components clients have already received. If a standard course of treatment has not been sufficient, we need to be curious why not and consider what else can be provided. The integrated model is an *evolution* of established protocols, not a competitor brand; it builds on these interventions and augments them. By introducing them in Part I, we are able to address questions of the relationship between different CBT models in an explicit way.

In Chapter 2 we introduce Beck's CBT, illustrated with a clinical case. The client, like all case illustrations in the book, has consented for her anonymized treatment to be included. We review and synthesize the current evidence base, including rates of drop-out, treatment response, relapse and treatment mechanisms. In Chapter 3 we introduce behavioural therapies, most prominently Jacobson and Martell's Behavioural Activation (BA). In a similar format to Chapter 2, we review its evidence base and provide a case illustration. In Chapter 4 we focus on relapse prevention, including Continuation Cognitive Therapy (C-CT) and Mindfulness-Based Cognitive Therapy (MBCT). A synthesis of techniques, models and evidence is the basis for the integrated approach that follows in Part II.

Part II introduces the integrated approach. In Chapter 5 we describe the *self-regulation model* used to understand how depression is triggered and maintained, particularly for cases that have been unresponsive to established treatments. We provide a case example and discuss various cognitive and behavioural maintenance processes. In Chapter 6 we describe the treatment components and processes that help to reverse depressed moods and overcome major episodes. We explain the sequence of treatment and the different evidence-based components, some of which are essential for all clients, and others that are optional depending on need.

Part III applies the integrated approach to challenging sub-types of depression associated with non-response, relapse or recurrence. These create various challenges for therapists; some emotional and personal, others technical and practical. Adjustments need to be made to treatment parameters such as the balance of support and change, the therapeutic dose, the pace of change and treatment focus. As before, there are case examples in each chapter. Chapter 7 focuses on early-onset depression that occurs in adolescence and early adulthood. Young people who suffer major depression are at heightened risk of lifetime recurrences, and early intervention is a particular focus. Chapter 8 considers highly recurrent depression, a common presentation in clinical services. Compared with early onsets, similar cognitive and

behavioural processes apply but a different emphasis and focus is needed. Chapter 9 explores chronic and persistent depression where clients have experienced symptoms and functional impairment over an extended period of at least 2 years, although in many cases the duration is several years, or lifelong. We explore adjustments needed to treat clients with chronic presentations, some of whom can be helped to a full recovery, while others need a more acceptance-based approach, learning how to respond differently to depressed moods.

Part IV considers how to treat complex depression, often associated with comorbidities and other complexity factors. Chapter 10 develops an understanding of complexity based on the *interaction* of depression with a range of biopsychosocial factors. This differentiates complexity from severity, recurrence and chronicity, phenomena with which it is frequently (and unhelpfully) confused. The majority of clients with major depression have at least one comorbid disorder – often an anxiety disorder – and although this is a well-known fact, guidance for therapists under these conditions is remarkably sparse. In Chapter 11, guidance is offered for practitioners working with comorbid anxiety and depression, and clinical cases are used to illustrate the approach. Chapter 12 applies these principles to trauma and Post-Traumatic Stress Disorder (PTSD) including the impact of early trauma, abuse and neglect. Theories of psychopathology vary in the weight they give to early experiences. A happy childhood is not insurance against depression, and for some clients early experience is not the appropriate focus. Nevertheless, early adverse experiences such as trauma, abuse and neglect increase the *risk* of adult depression and for that reason we give it due prominence in this part of the book. The final chapter, Chapter 13, provides an overview and synthesis of the main themes of the book, in light of the integrated approach. We revisit what we have learned about the heterogeneity of depression and CBT; how the integrated approach differs from established therapies, and next steps in the development of this work.

As far as possible it is best to use this book in conjunction with supervised clinical practice. Because the emphasis is on therapeutic skills and treatment processes, most new learning will be found in applying the ideas in practice, rather than just abstract consideration. At no point do we shirk from how difficult this work can be, but we hope to communicate the tremendous satisfaction we've gained from treating hundreds of clients over the past 20 years. For complex, unresponsive or difficult-to-treat cases, successful therapy seems to be 'against the odds' – but over time our learning from clients, supervision, training and research has radically improved those odds. Depression is treatable: even complex and difficult-to-treat cases can be helped, and this is the learning we want to share in this book.

Summary

This chapter has introduced the overall aim of the book: to provide guidance to CBT practitioners working with major depression, particularly complex or difficult-to-treat cases.

This book:

- Requires a basic prior working knowledge of what CBT is and how it is used in clinical practice
- Is best used in conjunction with supervised clinical practice
- Will be useful for trainees, specialists and expert therapists – each will learn different things from it
- Explores the challenges CBT therapists face treating major depression, including effects on their own mood
- Helps therapists balance support and change within the therapy they provide
- Explores the heterogeneity of depression, in other words the wide variety of clinical presentations that meet criteria for major depression
- Maintains a balanced emphasis on different types of knowledge within the field: experiential, theoretical and empirical
- Draws on different types of evidence including RCTs, single case research, practice-based evidence, cohort and experimental studies
- Encourages therapist hopefulness and flexibility – not to drift from evidence-based protocols, but to deliver CBT responsively and imaginatively
- Focuses on which treatment components need to be prioritized for different clinical presentations
- Introduces an integrated CBT approach that harnesses techniques and treatment components from different evidence-based therapies
- Explores treatment adaptations for difficult-to-treat cases that have not had a sustained recovery following established CBT; these include complex cases with comorbidities, developmental factors, biological processes, social processes and healthcare complications.