A PROSPECTIVE STUDY OF BRIEF COGNITIVE BEHAVIOR THERAPY (CBT-B) IN THE TREATMENT OF DEPRESSIVE DISORDERS

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ABSTRACT

Background: Depression is emerging as leading cause of disability in low-income countries like India, however, a minimum number of patients only receives treatment. There is increased emergence of Briefer Psychotherapies like Cognitive Behavior Therapy (CBT) for mental illnesses to minimize the treatment burden; there is minimum utilization of the same due to lack of manpower and training. Thus a less time consuming Brief-CBT (CBT-B) may be more cost-effective treatment for depressive disorders.

Aim: To observe the efficacy of CBT-B in Depressive disorders and to find its impact on cognitive and interpersonal problems.

Study Design: Clinic based prospective repeated measures interventional study using Pre, Post and Follow-up design.

Materials and Methods: Fifteen adult patients with mild to moderate unipolar depressive episodes received 8 sessions of CBT-B. Patients were assessed for depressive symptoms on BDI-II, HAM-D, and for cognitive-interpersonal factors on ATQ, MCQ-30 and IIP-32 before initiation of CBT-B, after 8 sessions and at 6 months follow up.

Results: Patients improved significantly in symptom severity and also in negative thought process, negative metacognitive belief and interpersonal problems.

Conclusion: CBT-B should be considered as an independent or adjunct treatment option for overall management of mild to moderate depressive symptoms to reduce the disease burden of the community. This can be used effectively with minimum training even in rural population.

Keywords: depression, metacognition, interpersonal problems, brief cognitive behavior therapy, CBT-B, low-income country

Introduction
Depression is a major cause of disability worldwide; with the World Health Organization (WHO) estimating that by 2020 depressive disorders will become the leading cause of disability in low-income regions (WHO, 2001). An estimated 3-4% of India’s 100 crore plus population suffers from major mental disorders and about 7-10% of the population suffers from minor depressive disorders (Reddy, 2010). In a recent WHO report, over 5 crore Indians are suffering from Depression and this country is one of the major contributors of world suicide. A September, 2014, report by WHO found that India had the most deaths by suicide worldwide—258,000 of 804,000 deaths reported in 2012. The country’s suicide rate—21 suicide deaths per 100,000 people—is almost twice the world average. The high number of suicides is just one indicator of India’s mental health burden and poor state of mental health care.

The economic burdens associated with mental disorders exceed those associated with each of four other major categories of noncommunicable disease: diabetes, cardiovascular diseases, chronic respiratory diseases, and cancer (Bloom et al., 2011). The aggregate burden of Years Lost to Disability (YLDs) resulting from mental and behavioral disorders (22.7%) continues to be higher than that resulting from any other disease category, with an estimated contribution to the proportion of burden in 2010 that was similar to that in 1990 (Vos et al., 2012).
More than 75% of persons with serious mental illness in less-developed countries do not receive treatment for it (Demyttenaere et al., 2004). For the minority who do have access to mental health treatment in low- and middle-income countries, there are few data available to aid in the evaluation of the quality or effectiveness of the treatment.

Numerous randomized controlled trials in high income countries document the efficacy of psychotherapy based interventions like, Cognitive Behavior Therapy (CBT) in reducing depressive symptoms (Jane-Llopis et al., 2003) and also in preventing relapse. However, psychotherapy trials in middle and low income countries are sparse (Patel et al., 2009).

Poor adherence to treatment and high prevalence of psychosocial stressors are common factors for poor response to psychotherapy (Patel et al., 2010). With mental health treatment increasingly delivered in primary care, it is important to consider factors that affect adoption of evidence-based psychotherapies (EBPs). Traditional therapies such as Cognitive-Behavioral Therapies (CBT) for depression (NICE, 2009) are unlikely to be adopted in primary care (Funderburk et al., 2011) because of treatment length (12–20 sessions) and session duration (45–50 min). Additionally, traditional evidence-based approaches are often comprehensive, including detailed assessment, case conceptualization, and treatment focused on broad mental health outcomes. To address the emerging primary care mental health practice needs, abbreviated psychotherapies such as brief CBT (CBT-B) for depression have been developed.

Effectively treating depression in primary care patients is an important public health priority. Recent systematic review and meta-analyses found a moderate level of support for brief psychotherapies (Nieuwsma et al., 2011). Fewer sessions would mean that the same workforce could provide treatment to a larger number of patients, potentially more cost-effectively. In addition, clinicians from a variety of disciplines, if given adequate training and under appropriate supervision, may be able to provide brief therapies, further expanding access (Nieuwsma et al., 2011).

Cognitive Behaviour Therapy (CBT) focuses on the modification of biased information processing and dysfunctional beliefs associated with self, environment and future. Cognitive Behavioural Treatment is time-limited interventions and manualized brief version of the same therapy is also available that claim therapeutic progress in just 8 to 10 sessions (Munoz & Ying, 1993). There is lack of published research work that has tried to focus on application of brief evidence based psychological intervention in clinical population at tertiary care center in Eastern region of India. One randomized controlled trial study from Pakistan has rather suggested even CBT requires cultural adaptation in developing countries (Naeem et al., 2014). Moreover, exploration of the process involved in this treatment outcome in low and middle economic depressive population is relatively untouched area of research.

With this in the background the present study intended to find the efficacy of Brief Cognitive Behaviour Therapy (CBT-B) in post-treatment and 6 months follow-up outcome of depressive disorder in terms of severity of depressive symptoms. With this it also looked into if CBT-B could bring change in various cognitive and interpersonal factors with depression outcome.

Methods

Study Design: The study was a Prospective Experimental Study of one psychotherapy procedure based on Pre-Post and Follow-up Design

Sample: Fifteen (N=15) adult Patients diagnosed as having Mild or Moderate Depressive episodes with or without somatic syndromes as per ICD-10 Diagnostic Criteria for Research (DCR) were considered for this study if following inclusion and exclusion criteria were met.

Figure 1: Inclusion Criteria

- Single or recurrent depressive episode
- Mild or Moderate Depressive Episode with or without somatic syndromes
- Age: 18-40 years and both binary gender
- Minimum 8 years of formal education
- Gave consent for the study and was willing to come for follow-up
- On Antidepressant Psychopharmacological Treatment at least for 3 months if on medication
Measures:

**Beck Depression Inventory-II (BDI-II)** (Beck et al., 1996)

BDI is used to quantify levels of depression. The scale includes description of symptoms like mood, pessimism, self-dissatisfaction, sense of failure, guilt feeling, suicidal ideation, crying spell, irritability, social withdrawal, sleep disturbances, fatigue, change in appetite, weight loss. Test includes a 21 item four-point self-report scale. It has a coefficient alpha of 0.92 for outpatients whereas 0.93 for college student samples. The BDI-II positively correlated with the Hamilton Depression Rating Scale, \( r = 0.71 \), had high test–retest reliability \( r=0.93 \) and internal consistency \( \alpha=.91 \).

**Hamilton Rating Scale for Depression (HAM-D)** (Hamilton, 1960)

This is designed to measure the severity of depression in diagnosed depressed patients. Reliability estimates, in terms of coefficient alpha, ranged from a low of .41 to a high of .89. The 17-item Hamilton Depression Rating Scale (HAMD-17) is one of the most widely used instruments in depression assessment and research. Cronbach’s \( \alpha \) was 0.74, proving the internal consistency of the scale. Maximal discrimination between depressed and non-depressed was obtained at a cut-off score of 8/9 (sensitivity 0.93, specificity0.98), meaning that a score of 8 or less indicates the absence of depression and a score of 9 or higher is indicative for the presence of depression.

**The Inventory of Interpersonal Problems-32 (IIP-32)** (Barkham et al., 1996)

The IIP-32 is a 32-item measure with eight subscales reflecting different interpersonal problems. Ratings of the degree to which each a problem is distressing are made on a 5-point scale ranging from 0 (not at all) to 4 (extremely). The IIP-32 subscales have demonstrated adequate internal consistency in outpatient and non-clinical samples. Cronbach’s alphas for each scale demonstrated acceptable to excellent internal reliability for each subscale: Hard to be (H) sociable (.90), Hard to be assertive (.83), Hard to be involved( .78), Hard to be supportive (.81), Too (T) open (.79), Too caring (.73), Too aggressive (.86), Too dependent (.68).

**Metacognitive Questionnaire-30 (MCQ-30)** The metacognitions questionnaire (MCQ) measures individual differences in a selection of metacognitive beliefs, judgments and monitoring tendencies considered important in the metacognitive model of psychological disorders. Exploratory factor analysis suggested a five-factor structure and these five factors are cognitive confidence, cognitive self-consciousness, positive beliefs about worry, negative beliefs about uncontrollability of thoughts and danger, and belief about need to control thoughts. The MCQ-30 showed good internal consistency and convergent validity, and acceptable to good test-retest reliability (Wells & Cartwright, 2004)

**Automatic Thought Questionnaire (ATQ)** The ATQ is a 30-item questionnaire developed to identify and assess the frequency of automatic negative self-statements which are linked to depression. Each item is an example of negative thought and the subject needs to rate how often a negative thought has come in the past week on a scale from 1 (not at all) to 5 (all the time). (Holon, 1980)

Procedure:

The study had approval of both research and institutional ethical committee of University of Calcutta, Kolkata. Pre-diagnosed cases mostly referred by consultant psychiatrists in Kolkata were considered. Informed consent was taken from all patients.
clinical interview was conducted to confirm the diagnosis as per ICD-10 DCR and also to assess if patients had any exclusion criteria. All the tools (BDI-II, HAM-D, IIP-32, MCQ-30, ATQ) were administered before beginning of treatment to get baseline. All Patients received 8-10 session of brief cognitive therapy following the module by Munoz et al. (1996). Certain modifications were done in the module keeping in mind the cultural aspect. The focus of the sessions was on mood, activity and relations. All the outcome tools were readministered after end of 8 sessions. HAM-D score of 7 or less was considered as improvement. Initial phase was for 2 one hour sessions, followed by 5 middle phase sessions and 1 termination session. Sessions were conducted minimum once in a week for initial 5 sessions and then once in two week session was planned. Two booster sessions after 2 months and 4 months of termination were also taken up. Outcome tools were readministered after 6 months follow-up to see maintenance of the therapeutic gain.

For CBT-B, after giving psychoeducation about depression the initial session centered on establishing the ground rule of therapy (e.g. to come every week, to do homework, to tell when feeling unwell etc.) and how mood-thought-actions are related. The importance of breaking the 3 cycles, like, depression and low activities, depression and negative thoughts, depression and few contacts with people was emphasized. Patients were encouraged to take a more active role in the therapeutic process to bring change with continuous encouragement. In next 6 sessions these 3 cycles were addressed using cognitive behavioral principles. In the last session focus was on relapse prevention, unresolved problems and importance of continuing learned strategies.

Loss to follow up was 4. Two patients discontinued after 5 and 6th sessions respectively and another 2 during 6 months follow-up. Thus, a total 19 patients received complete or incomplete treatment; however, patients with incomplete treatment were not taken up for final analysis.

Results

SPSS for Windows Version 16 was used for data analysis. A p-value of 0.05 was considered as level of significance for all computation. Effect size was estimated by partial $\eta^2$.

Mean age and education of the patients was 30.20±5.51 and 15.00±1.73 years respectively. In the sample 53.3% were female and 40% were unmarried where as 53.3% were married. Most of the patients had single episode of depression and the mean duration of current depressive episode was 7.73±2.55 months. There was almost equal distribution of patients with Mild and Moderate Depressive Episodes (53.3% had Moderate Episode). Around 73.3% of patients were taking anti-depression medicines with mean duration of 6.82±3.63 months.

<table>
<thead>
<tr>
<th>Table 1: Repeated Measures for Depression Related Outcome Variables for CBT-B Group</th>
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<tr>
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</tr>
<tr>
<td>BDI-II</td>
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<tr>
<td>HAMD</td>
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</table>

*Sphericity was assumed

A one-way within subjects (or repeated measures) ANOVA was conducted to compare the effect of CBT-B on BDI-II score in Baseline, Post Treatment, and 6 months follow up conditions. As sphericity of the variances could not be assumed, Greenhouse Geisser correction score was used for F value (219.59) which was significant at p≤.001 with high effect size (partial $\eta^2=.94$). Finding suggests a significant effect of treatment on depression severity on BDI-II across 3 assessment conditions. Post hoc analyses using the Bonferroni criterion for significance indicated that severity of score decreased significantly during post therapy assessment and further at 6 months follow-up. Significant effect of CBT-B on HAM-D scores on repeated measures ANOVA was seen (F=190.92, p≤.001, partial $\eta^2=.93$). Post hoc analyses using the Bonferroni criterion for significance indicated that severity of score decreased significantly during post therapy assessment and further at 6 months follow-up. (Table 1)
A one-way within subjects (or repeated measures) ANOVA was conducted to compare the effect of CBT-B on MCQ score in Baseline, Post Treatment, and 6 months follow up conditions. As sphericity of the variances could not be assumed, Greenhouse Geisser correction score was used for F value (149.74) which was significant at p≤.001 with high effect size (partial η²=.91). Finding suggests a significant effect of treatment on MCQ total score across 3 assessment conditions. Post hoc analyses using the Bonferroni criterion for significance indicated that severity of score decreased significantly during post therapy assessment and further at 6 months follow-up. (Table 2)

MCQ has 5 sub-domains and Repeated measures ANOVA was significant all the domains to suggest significant effect on MCQ Cognitive Confidence (F= 141.02, p≤.001, partial η²=.91), MCQ Positive Belief (F= 5.91, p≤.001, partial η²=.30), MCQ Cognitive Self Consciousness (F= 119.73, p≤.001, partial η²=.90), MCQ Uncontrollability & Danger (F= 70.48, p≤.001, partial η²=.83) and MCQ Need to Control Thoughts (F= 116.40, p≤.001, partial η²=.91). Post hoc analyses using the Bonferroni criterion for significance indicated that severity of score decreased significantly during post therapy assessment and further at 6 months follow-up for all those domains except MCQ Positive Belief. For this variable though there was significant overall effect but phase wise comparison was non-significant (p=0.89 between baseline and post treatment. No follow up effect was observed). (Table 2)

Finding suggests a significant effect of treatment on ATQ score across 3 assessment conditions (F= 149.74, p≤.001, partial η²=.91). Post hoc analyses using the Bonferroni criterion for significance indicated that severity of ATQ score decreased significantly during post therapy assessment and further at 6 months follow-up. (Table 2)

Significant effect of CBT-B on Interpersonal Problems as represented by IIP Total score across 3 assessment conditions was observed (F= 508.52, p≤.001, partial η²=.98). Post hoc analyses using the Bonferroni criterion for significance indicated that IIP score decreased significantly during post therapy assessment and further at 6 months follow-up. Effect of CBT-B treatment was also observed in the sub-domains of IIP with significant difference across the phases of assessment (Table 2).

### Table 2: Repeated Measures for Cognitive and Interpersonal Outcome Variables for CBT-B Group

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Post-treatment</th>
<th>6 months Follow-up</th>
<th>Mauchly’s W/ Greenhouse Geisser (Sig.)</th>
<th>F (df=2,28)</th>
<th>p-value</th>
<th>partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCQ</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Confidence</td>
<td>68.07±12.01</td>
<td>44.40±6.83</td>
<td>36.60±3.27</td>
<td>.60 (.001)</td>
<td>149.74</td>
<td>.001</td>
<td>.91</td>
</tr>
<tr>
<td>Positive Belief</td>
<td>15.00±3.05</td>
<td>9.33±1.88</td>
<td>7.87±1.06</td>
<td>.63 (.003)</td>
<td>141.02</td>
<td>.001</td>
<td>.91</td>
</tr>
<tr>
<td>Cognitive Self Consciousness</td>
<td>6.47±74</td>
<td>6.00±0.00</td>
<td>6.00±0.00</td>
<td>.00*</td>
<td>5.91</td>
<td>.029</td>
<td>.30</td>
</tr>
<tr>
<td>Uncontrollability &amp; Danger</td>
<td>12.33±2.19</td>
<td>8.47±1.55</td>
<td>6.80±3.94</td>
<td>.66 (.068)*</td>
<td>119.73</td>
<td>.001</td>
<td>.90</td>
</tr>
<tr>
<td>Need to Control Thought</td>
<td>16.27±4.45</td>
<td>9.73±2.60</td>
<td>7.67±1.35</td>
<td>.68 (.016)</td>
<td>70.48</td>
<td>.001</td>
<td>.83</td>
</tr>
<tr>
<td>ATQ</td>
<td>18.00±3.27</td>
<td>10.87±2.56</td>
<td>8.27±3.80</td>
<td>.83 (.306)*</td>
<td>140.19</td>
<td>.001</td>
<td>.91</td>
</tr>
<tr>
<td>IIP Total</td>
<td>99.93±22.34</td>
<td>60.47±20.11</td>
<td>46.87±13.84</td>
<td>.69 (.022)</td>
<td>116.40</td>
<td>.001</td>
<td>.89</td>
</tr>
<tr>
<td>Hard to be Assertive</td>
<td>78.40±15.79</td>
<td>50.87±12.98</td>
<td>38.13±11.22</td>
<td>.66 (.009)</td>
<td>508.52</td>
<td>.001</td>
<td>.98</td>
</tr>
<tr>
<td>Sensitive</td>
<td>12.20±2.24</td>
<td>7.93±1.91</td>
<td>6.13±2.00</td>
<td>.59 (.001)</td>
<td>289.41</td>
<td>.001</td>
<td>.95</td>
</tr>
<tr>
<td>H to be Sociable</td>
<td>12.33±2.16</td>
<td>7.80±2.11</td>
<td>5.60±1.68</td>
<td>.99 (.914)*</td>
<td>279.89</td>
<td>.001</td>
<td>.95</td>
</tr>
<tr>
<td>H to be Supportive</td>
<td>10.07±2.31</td>
<td>6.13±2.33</td>
<td>4.53±1.64</td>
<td>.77 (.186)*</td>
<td>133.96</td>
<td>.001</td>
<td>.91</td>
</tr>
<tr>
<td>H to be Involved</td>
<td>12.93±2.87</td>
<td>7.60±2.13</td>
<td>5.13±1.88</td>
<td>.56 (.001)</td>
<td>288.30</td>
<td>.001</td>
<td>.95</td>
</tr>
<tr>
<td>Caring</td>
<td>7.33±1.63</td>
<td>5.53±1.41</td>
<td>5.07±1.53</td>
<td>.61 (.001)</td>
<td>38.35</td>
<td>.001</td>
<td>.73</td>
</tr>
<tr>
<td>Too Dependent</td>
<td>10.33±2.66</td>
<td>6.87±2.26</td>
<td>4.73±2.02</td>
<td>.82 (.268)*</td>
<td>304.39</td>
<td>.001</td>
<td>.96</td>
</tr>
<tr>
<td>Too Aggressive</td>
<td>7.80±3.10</td>
<td>4.47±2.29</td>
<td>3.00±1.60</td>
<td>.56 (.001)</td>
<td>87.16</td>
<td>.001</td>
<td>.86</td>
</tr>
<tr>
<td>Too Open</td>
<td>5.40±1.30</td>
<td>4.53±1.19</td>
<td>3.93±1.33</td>
<td>.94 (.650)*</td>
<td>22.05</td>
<td>.001</td>
<td>.61</td>
</tr>
</tbody>
</table>

* Sphericity was assumed
Figure 3: Outcome of Depression as assessed by HAM-D score

Keeping a cut-off score of less than 8 as significant recovery on HAM-D, 11 patients (73.3%) improved during post treatment, whereas, 13 patients (86.7%) during 6 months follow up (Figure 1).

Discussion

Brief Cognitive Behaviour Therapy (CBT-B) was introduced over the period of 8-10 sessions on a sample with mild to moderate depressive episodes. Post treatment assessment revealed a significant recovery rate (Figure-3, 73.3%-86.6%). Thus, it can be stated that this study is able to establish the efficacy of CBT-B in the outcome of depressive disorders. In a recent study, Cuijpers et al. (2014) compared the effects of 19 types of psychotherapy for depression to find that overall 66% of patients treated with CBT no longer met criteria for major depressive disorder at the end of treatment. Our study is able to get a comparable or even better recovery rate may be due to various factors like mild to moderate depression, continuation of medication, young age and may be better support system in Indian family structure. Above all, the recovery rate was observed to be maintained even after 6 months post treatment follow up. It was further established in Table 1 that significant positive change was observable between pre-treatment & post-treatment and also between post-treatment & 6 months follow-up for all depression measures viz. BDI-II and HAM-D. This is indicative that probably patients were able to continue with the learnt therapeutic skills even after termination of therapy to have further therapeutic gain at later follow-up. It is important to mention that the treatment gain had large effect size for all depression scores and across stages.

It is now a well established fact that Cognitive Behaviour Therapy (CBT) is among the best empirically validated psychotherapy techniques in the treatment of Depressive Disorders and prevention of relapse (Gloaguen et al., 1998). Whereas other researchers (e.g. Cuijpers et al., In Press) have pointed out that CBT has medium effect size in the treatment outcome, in the current study we are able to get a large effect size for CBT-B. This might be an interesting claim.

Way back in 1996, Wood et al. applied brief CBT in adolescent depression cases to establish that brief version of CBT (5-8 sessions) can bring desirable result in depression outcome in comparison to Relaxation training. In an Asian study Thapinta et al. (2014) treated depression with alcoholic disorder using 6 sessions CBT with 1 month Follow-up. Significant improvement was observed at all stages in comparison to the control treatment.

If we look at the process of CBT-B, it is intensive, highly focused treatment, building upon strength of the person with less emphasis on long lasting cognitive issues that is more typical of standard CBT and these might have some impact on the therapeutic gain. Although it may appear counterintuitive to believe that patients could attain the same degree of improvement from eight (brief) and 16 sessions (standard sessions) of therapy, researches have revealed that when the number of sessions is limited from the beginning, both patients and therapists are on pressure to make more efficient use of intervention (Reynolds et al., 1996). Moreover, there is dearth of empirical research linking increased therapeutic “dosage” with therapeutic outcome (Swartz et al., 2014). In addition to that, Swartz et al. (2002) rightly pointed out that some individuals with depression may not be able to attend more number of sessions of psychotherapy, even when it is free or in a handy location.

The current study identifies that CBT-B is able to bring significant and desirable change in the negative automatic thoughts and metacognitive belief associated with depression during post-treatment and at 6 months follow-up with large effect size (Table 2). All the factors associated with metacognitive belief were significant. Positive belief about worries had low effect size but rest others showed a large effect size. This finding is not unusual as the target of CBT-B is to identify the depressive negative thoughts to bring change in the depressive emotion. Though there is lack of studies for CBT-B, researchers have reported that automatic thought change occurs quickly as an outcome of standard CBT (Furlong & Oei, 2002). The above mentioned study has also highlighted that change in automatic thought was not due to the change in dysfunctional belief, rather the outcome of change in BDI cognitive scale scores. While quick changes in ATQ scores may lend support for its surface structure in depression, it is likely that these changes may not truly predict depression outcome scores. However, same study claimed that dysfunctional attitude was a better predictor of depressive outcome.

Studies are very limited to assess metacognitive changes as a result of Cognitive Therapy outcome. In a recent study by Fernie et al. (2016) metacognitive changes in all the domains of MCQ-30 was observed as an outcome of both CBT and Graded Exposure.
Therapy for severity of Chronic Fatigue Syndrome. In another unpublished work by Felberg (2012) change in metacognitive processes as a result of Depression was reported for Generalized Anxiety Disorder. It was interpreted that “the focus on reality testing and disproving worry content in CBT also leads to decrease in negative meta-cognitions as patients realize that worry can, in fact, be controlled”. One of the areas of focus in CBT is to remove the negative automatic thoughts or worries to internal and external triggers, and focus on this in CBT probably affect indirectly meta-beliefs about positive & negative thoughts, uncontrollability, need for controlling thoughts etc. as the patient gain more insight into adaptive responses. Future studies should focus on this area.

CBT-B is found to bring significant and desirable changes in interpersonal problems faced by the patients of the current study with large effect size (Table 2). Medium to large effect size is observed for all the factors. The primary focus of CBT or CBT-B is modification of negative cognitive vicious cycle by altering illogical or dysfunctional thought processes and changing maladaptive behavioural pattern. It is interesting to observe that positive outcome in interpersonal issues like improved assertiveness, increased socialization, better ability to nurture or empathy and increased independency was evident as a result CBT-B where there was no direct focus on those issues in the therapy. Surprisingly, this area is not much explored area yet; however, in a recent research Millstein et al. (2015) could see a significant change in interpersonal problems in GAD patients as a result of cognitive behavioural schools of therapy incorporating mindfulness strategies. Possible explanation might be that CBT based intervention probably impacted the interpersonal behaviour leading to an positive impact on interpersonal crisis (Fulton, 2013). Another possibility is that as the focus of CBT is to modify negative cognition, thus change in cognition can modify the appraisal of interpersonal problems resulting into change in interpersonal behaviour. However, further research on this might be able to give a proper understanding.

Despite having desirable result, the study is not out of limitations. Single group pre-post design may be a weak design in absence of a comparative group. The sample size was also on the lower side. In addition to these, no blind assessment was possible to minimize effect of therapist biasness. Effect of medicine was another interfering factor that could not be controlled due to ethical reason. However, this study is able to contribute positively that Brief version of CBT can be effectively utilized in Indian set-up for mild to moderate depression to reduce the treatment burden.

Conclusion

This study is able to establish the efficacy of Brief version of Cognitive Behavior Therapy (CBT-B) in the treatment of depression. The improvement was also maintained during 6 months follow-up to conclude that CBT-B can be helpful in preventing early relapse. It also can be concluded that with the depression severity change could be observed in negative automatic thought, negative metacognitive belief and interpersonal problems. It can be stated that change in all these factors might be the predictor of positive therapeutic outcome of depression severity or vice versa.

References


