*International Journal Of*

**Recent Scientific Research**

**ISSN: 0976-3031**

**Volume: 7(2) February -2016**

# COGNITIVE BEHAVIOR THERAPY FOR DEPRESSION

**Abdulkarim Alzayyat RN., Aldwoha Mohammed Aldwoha RN and Malek Mohammad Khalil**

THE OFFICIAL PUBLICATION OF
INTERNATIONAL JOURNAL OF RECENT SCIENTIFIC RESEARCH (IJRSR)
http://www.recentscientific.com/ recentscientific@gmail.com

ISSN: 0976-3031

Available Online at http://www.recentscientific.com

*International Journal of Recent Scientific Research*
*Vol. 7, Issue, 2, pp. 8730-8735, February, 2016*

***International Journal of Recent Scientific Research***

**RESEARCH ARTICLE**

# COGNITIVE BEHAVIOR THERAPY FOR DEPRESSION

**Abdulkarim Alzayyat RN[1]., Aldwoha Mohammed Aldwoha RN[2] and Malek Mohammad Khalil[3]**

[1]Department of Nursing Al-Ghad International Colleges for Applied Medical Sciences Al-Madina Al-Monawara, Kingdom of Saudi Arabia
[2]Department of Nursing Al-Ghad International Colleges for Applied Medical Sciences Abha, Kingdom of Saudi Arabia
[3]Department of Nursing Zarqa University, Jordan

**ARTICLE INFO**

***Article History:***

Received 15th November, 2015
Received in revised form 21st December, 2015
Accepted 06th January, 2015
Published online 28th February, 2016

***Key words:***

Cognitive-behavior therapy, depression, psychotherapy.

**ABSTRACT**

**Background:** Cognitive Behavior Therapy (CBT) is acknowledged as the most empirically supported psychotherapy treatment for depression. CBT for depression was first developed by Aaron Beck in the 1960s, and since then it has been expanded and studied extensively.
**Purpose:** This paper provides a brief overview of depression and summarizes evidence supporting the effectiveness of CBT for depression management.
**Findings:** At present, treatments for depression incorporate antidepressant medications, psychotherapies such as CBT, electroconvulsive therapy, support groups, and counseling in outpatient clinic. Nevertheless, there is emerging evidence that CBT is effective on treating depression in diverse patient groups. Furthermore, CBT's effects on the symptoms of depression are similar to the effects of medication in the short-term. More research needs to be done to establish whether CBT is superior to other available, but less researched, forms of psychotherapy.
**Implications For Nursing Practice:** Psychiatric nurses have an important role in providing CBT as a means of satisfying patient expectations and quality improvement. Offering proper CBT training programmes for the psychiatric nurses is imperative. Moreover, nursing education programmes should make steps towards integration of CBT into nursing curriculum.



## INTRODUCTION

Depression represent a major mental health problem at the present time (Driessen, *et al*., 2007). Depression has been acknowledged as the most disabling sickness distressing about 17% of the people throughout their lifetime (Brent *et al*., 2008). According to the World Health Organization (WHO), in the year 2000 depression was the chief cause of worldwide disability and the fourth chief contributor to the universal burden of disease (WHO, 2012). Moreover, it is expected that by the year 2020 depression will be considered the world's second largest disease burden, immediately after coronary heart disease (Paradis, Reinherz, Giaconia, & Fitzmaurice, 2006). If untreated, depression can lead to impaired social functioning, poor quality of life, and even death (Penninx, Milaneschi, Lamers, & Vogelzangs, 2013). Nevertheless, with the proper management, depression can be effectively treated in most individuals (Boyd, 2012).

The second half of the 20th century has witnessed the emergence of two of the most innovative treatment modalities in relation to depression (Oei, Bullbeck, & Campbell, 2006). First: the emergence of antidepressant medications that successfully control depressive symptoms (Sidor & MacQueen, 2011). Second: the development of the cognitive behavior therapy (CBT) which has been considered as the most contemporary innovation in treatment of depression (Beck, 2011). CBT is a psychotherapy treatment that targets the interactions that occurs between how the individual think, feel and behave (Marian & Filimon, 2010). CBT is acknowledged as the most empirically supported psychotherapy treatment for depression (Cuijpers, Straten, Andersson, & Oppen, 2008). Furthermore, currently, CBT for depression is in common use throughout the world, within public and private health care

**Corresponding author:* **Abdulkarim Alzayyat RN**
Department of Nursing Al-Ghad International Colleges for Applied Medical Sciences Al-Madina Al-Monawara, Kingdom of Saudi Arabia

services, and it has been successfully administered on individuals, couples, and groups formats (Andersson & Cuijpers, 2009).

This paper provides a brief overview of depression and summarizes evidence supporting the effectiveness of CBT for depression management. The author assembled this paper for the benefit of health care providers (including psychiatric nurses) especially those who are interested in using CBT for depression. Therefore, the important implications for the psychiatric nursing practice are provided, in an attempt to incorporate the CBT with in the nuses daily practices.

### *Overview of Depression*

Depression is defined as a general mental state distinguished by sadness, loss of interest or pleasure, feelings of guilt and low confidence, change in appetite, troubled sleep pattern, poor concentration, and low energy (WHO, 2010). Depression is usually a normal adaptive response to a loss, change or a failure; however, it is considered pathological when adaptation is ineffective (Paradis *et al*., 2006). Depression disorders are a specific subset of mood disorders consisting of major depression, persistent depressive disorder (or dysthymia), and unspecified dipressive disorder (Boyd, 2012). The diagnosis of depressive disorders is based on the patient's self-reported experiences, behavior reported by relatives or friends, and a mental status examination (Kneisl & Trigoboff, 2009).

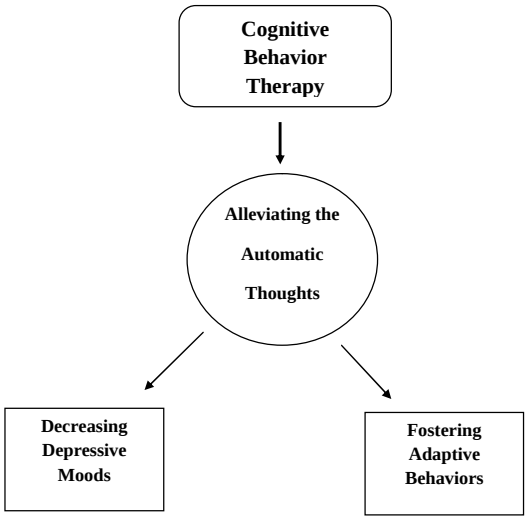


**Figure 1** Impact of Cognitive Behavioral Therapy

One of the most widely used criteria for diagnosing depressive conditions are found in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association [APA], 2013). According to DSM-V, there are two main depressive symptoms—depressed mood and anhedonia (i.e., lack of pleasure almost all activities). At least one of these must be present for at least two weeks to make a diagnosis of major depressive disorder.

Moreover, five of the subsequent symptoms should be evident: significant alteration in the body weight or changes in apetite, sleep disturbance, lack of energy, feelings of guilt or sense of worthlessness, psychomotor agiataion or retardation, decreased in ablity to concentrate or think, and recurring thoughts of death or suicide. These symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning. Persistent depressive disorder is milder but more chronic and is diagnosed when the depressed mood is present most of the days for at least two years for the adults (APA, 2013). The category unspecified dipressive disorder is diagnosed if the depressive episode's manifestation does not meet the full criteria for any of the disorders in the depressive disorders diagnostic class (APA, 2013).

At present, treatments for depression incorporate antidepressant medications, psychotherapies such as CBT, electroconvulsive therapy, support groups, and counseling in outpatient clinics (Boyd, 2012). Nevertheless, research reports that merely 35% of patients respond to antidepressant treatment, leaving the majority of the patients with ongoing depressive symptoms (Chen, Lu, Chang, Chu, & Chou, 2006). Recent literature indicates that CBT is effective in controlling the symptoms of depression and decreasing the relapce rate (Cuijpers *et al*., 2013). Further details about the effectiveness of the CBT will be presented in the following sections.

**Table 1** Examples of Socratic Questioning (Beck, 2011)

| |
|---|
| What do you mean when you say that? |
| Why do you say that? |
| Can you say that another way? |
| Why do you think you act in this way? |
| How did you come to this conclusion? |
| What else could we assume? |
| How can you verify or disprove that assumption? |
| If this happened to a friend or family member would you have the same thoughts about them? |
| Are these the only explanations? |
| What evidence is there to support what you are saying? |
| Has anyone in your life ever expressed a different opinion? Why do you think that is? |
| What alternative ways of looking at this are there? |
| What does it do for you to continue to think this way? |
| Who benefits from this? |
| What is the difference between…(this perspective) and …(that perspective)? |
| Why is this perspective better than that perspective? |
| What are the strengths and weaknesses of …? |
| What are the positive and negative consequences of that assumption or belief? |
| How does your belief affect your life (e.g. relationships, daily functioning, job, etc)? |
| How does this belief fit with what we've learned in session before? |
| What would it mean if you gave up that belief? |
| How would you benefit by changing this belief? |

### *Cognitive Behavior Therapy*

### *Theoretical Perspective*

The origin of CBT for depression goes back to the 1960s which was developed by Aaron Beck, since then it has been studied extensively and expanded (Grant, Townend, Mulhern, & Short, 2010). Beck's cognitive theory (1967) hypothesized that people's explanation of negative life incidents have an important role in their depression experience. Beck assumed that depressed peoples had negative or beliefs. These schemas are developed in the early days of childhood and included themes of inadequacy, worthlessness, interpersonal rejection and loss. In Beck's model, these beliefs constitute a cognitive vulnerability (dia-thesis) to depression. The schemas are

triggered by unfavorable life incidents (stressors) to generate negative (or automatic) beliefs about the life events. In particular, depressed individuals have a negative beliefs about themselves (viewing themselves as deficient, inadequate, unlovable, and worthless), their environment (viewing it as devastating, filled with setbacks and barriers), and their future (viewing it as discouraging, hopeless, and doomed to failure). This negative style of thinking directs one's interpretation, perception, and reminiscence of personally related experiences, thus producing negatively predisposed explanation of one's private world, and eventually, the emergence of depressive mood and symptoms. For instance, the depression-prone peoples are more probably to remember and notice conditions in which they did not achieve their personal standards or failed and ignore or discount those successful conditions. Based on this theory, CBT intends to change individual's thought styles so as to make possible mood improvements and enhance individual's adaptation with stressful life events (see figure 1).

***Implementation of Therapy***

The standards of CBT for depression are clearly reported in the literature (Dobson, 2009; Grant *et al*., 2010; Steven, 2011). According to these literature, CBT continues between 10 to 20 sessions. From the beginning, CBT practioners work to establish a therapeutic relationship with their patients, who are fostered to be an active praticipant in the therapeutic process. CBT session usually starts with a psychoeducational part in which the chrachteristics of depression and its predisposing factors (i.e., negative thinking patterns) are discussed. CBT practioners and patients mutually put goals for the treatment and collaboratively concur on the outline of the sessions. Moreover, CBT practioners give the patients inter-sessions "assignements" that helps in practicing those strategies that acquainted in the therapy sessions and in implementing essential behavioral and cognitive techneques outside the therapeutic milieu. The standard program of CBT for depression includes three consecutive stages; intial stage, middle stage, and the last stag (Mor & Haran, 2009).

***Intial Stage***

The first stage of CBT concentrates on behavioral change or symptom relief. The intent of this stage is to re-engage the patinets in their life activity and to support regain functioning. This stage is usually called as "behavioral scheduling". At the outset, patients learn to observe their experiences (i.e., daily activities). The patients are requested to carry on a log of daily activities that helps them in monitoring the association between their mood and thier behavior. The author provides examples of these logs in appendix A. The patients collect data on activities that improve their mood as well as those that deteriorate it. Utilizing the activity log, CBT practioner and patients work mutually on detrmining behavioral goals in vital life areas such as education, employment, social, health, leisure, etc. Consequently, patients gradually track the advancement in the direction of their goals, and prize themselves for their accomplishments.

***Middle Stage***

When the patients become more active and involved in their daily activies, the attention of the CBT move toward cognitive apprasial and restructuring. Initially, CBT practioners assist patintes to evaluate their thought patterns by the Socratic questioning (Beck, 2011). Table 1 provides examples of these questioning. In this stage, a thought record is usually utilized. Using the thought record, the patients write down the happening of perceived undesirable events and recognize depressing feelings in addition to negative thoughts resulted from these events. Beck (2009) has adressed that thoughts experienced by depressed patients predominantly include many cognitive distortions. Illustration of these distortion is presented in Table 2. Patients are taught about these distortions and are guided to identify them in their way of thinking. Then, they are trained to use alternative and more successful ways of connecting to the world and to themselves. The author provides examples of thought records in appendix B.

***Last Stage***

The last stage of CBT is called " a relapse prevention stage". This stage focuses on maintaing the outcomes of treatment as well as avoiding relapse. It usually incorporate two components; cognitive and behavioral. In the cognitive field, patients practiced on changing core beliefs that may generate automatic or negative thoughts. To realize this goal, they carry out a number of experiments. These are deliberated experiential activities planned to acquire new information to help in examining the acurracy of the patinets beliefs and substituting them with more helpeful ones. In the behavioral field, patients conduct a behavioral investigation of ineffective coping methods and alternate them with the problem solving methods. Lastly, they define future goals, predict barriers and think about successful approaches to overcome these barriers.

***Impacts on Depression in Diverse Patient Groups***

There is emerging evidence that CBT is successful for patients with acute depression, chronic depression persisting two years or more, and for recurrent depression (Hollon, Stewart, & Strunk, 2006). CBT has been confirmed to be effective with children, adolescents, adults, and older adults (Lynch, Laws, & McKenna, 2010). CBT can also prevent the emergence of depression in children and adolescents (Abela & Hankin, 2008). Furthermore, there is promising evidence that CBT is successful in treating depressive symptoms in individuals with somatic medical conditions such as heart ischemic disease, cancer, Acquired Immune Deficiency Syndrome (AIDS), multiple sclerosis, and stroke (Beltman, Voshaar, & Speckens, 2010). To conclude, it has been reported that CBT is effective treatement for depression across age groups and different health conditions.

***Impacts on Relapse Rates***

During active treatment, CBT is as effective as antidepressants (Cuijpers *et al*., 2013). On the other hand, literature indicated that after treatment, relapse rates remain low for at least two years for patients who have undergone CBT (either on its own

or after treatment with medication) compared to those who have been treated by medication alone (Hollon *et al*., 2006). In addition, CBT that persists with monthly follow-up meetings can aid in decreasing relapse rates, mainly in those patients whose depression had an early onset, or whose depressive symptoms did not fade away by the end of active treatment (Beck & Alford, 2009). Accordingly, CBT should be incorportated in the current treatement plans of depression toguarantee the successful management of possible relapses.

***Jointly CBT and Psycho-Pharmacological Treatment***

In the clinical context, CBT is commonly used as an adjunct to antidepressants (Butler, Chapman, Forman, & Beck, 2006). Studies have compared the outcomes of combining medication and CBT in comparsion to using either medication or CBT alone (Imel, Malterer, McKay, & Wampold, 2008). Some studies illustrate that combination of CBT and medication can result in better outcomes if used on severe or chronic depression, however, CBT alone works as the combined treatment (CBT & medication) for mild-to-moderate depression (De Maat, Dekker, Schoevers, & De Jonghe, 2006; Imel *et al*., 2008). The combined treatment may have a promising effect in managing depression in adolescents (Beck & Alford, 2009; Grant *et al*., 2010). There is a believe that CBT and antidepressant may act differently on diverse subgroups of patients with depression, although this notion needs further testing (De Maat *et al*., 2006).

***Comparison With Other Forms of Psychotherapies***

Some studies indicate that CBT is better than other forms of psychotherapy in terms of depression treatment (Tolin, 2010). Nevertheless, the impact of other forms of psychotherapy has not been studied extensively as CBT has (Cuijpers *et al*., 2013). There is a strong evidence base for CBT that makes it a convincing treatment modality when provided by qualified CBT practitioners (Beck, 2011; Beck & Alford, 2009). Moreover, many psychotherapy forms, (including CBT) have particular and general active features that assist in reducing symptoms, for instance, the therapist- client therapeutic relationship (Corey, 2009). Therefore, the author of this paper addresses the need of carefully controlled studies to control the effect of these confounding variables when making comparasion between CBT and other psychotherapy forms.

***Implications for Psychiatric/Mental Health Nursing Practice***

During the past 20 years, CBT has obtained substantial momentum in Psychiatric/Mental Health Nursing (PMHN) field (Currid, Nikc˘evic, & Spada, 2011). While contemporary PMHN practice includes delivering high quality care to the patients, evidence-based practice necessitates practitioners to provide the most helpful type of treatments available (Boyd, 2012). Taking into consideration that CBT has a broad evidence base for the management of depression problem, it is expected that psychiatric nurses will have an important role in providing CBT as a means of satisfying patient expectations, quality improvement, cost-reasonable care and increased effectiveness (Fortinash & Holsay- Worret, 2012).

CBT is favorable, advisable and patients imply high degrees of satisfaction Chen, Lu, Chang, Chu, & Chou, 2006). Høifødt *et al*. (2013) reported a high satisfaction rate of 89% from sample of 65 depression patients. Similarly, of a sample of 6 HIV patients with depression, Himelhoch *et al*. (2011) found that the mean satisfaction scores at post CBT treatment was 5.7 out of 6. This is indicate high level of satisfaction. Accordingly, it is probably that upcoming patients will request CBT exclusively or as a complementary to other treatment approaches (Tutty, Spangler, Poppleton, Ludman, & Simon, 2010). Although this does not indicate that all psychiatric nurses will be requested to train as competent CBT providers, it does necessitate that nurses to think about utilizing non-classical interventions in the constant advancement of biological treatment innovations for depression (Crowe *et al*., 2012). Moreover, it challenges practicing nurses to conceptualize patients' depression presentations and its negative effects in an individual manner that considers Beck's cognitive (1967) model. It has been reported that undergraduate nurse curricula do not address CBT principles adequately, despite a growing evidence base for its usefulness and acknowledgment that nurses can participate in promoting access to such psychosocial therapy (Stevenson & Sloan, 2012). Consequently, the nursing education programmes should make steps towards integration of CBT into nursing curriculum (Fortinash & Holsay- Worret, 2012). Furthermore, PMHN educators, researchers and practitioners should work together to modify the nursing curricula to satisfy the objectives of CBT in treatment of depression (Boyd, 2012). Nursing students should be taught about the essential steps of CBT during their PMHN course (Stevenson & Sloan, 2012).

Assuming that nursing students have adequate concerning principles of CBT for managing depression, another barrier that nurses (who already graduated) may face is the gap between knowledge and skills of applying CBT principles to meet the needs of patients with depression (Currid, Nikc˘evic, & Spada, 2011). The literature (Herschell, Kolko, Baumann, & Davis, 2010; Pinninti, Fisher, Thompson, & Steer, 2010; Redhead, Bradshaw, Braynion, & Doyle, 2011) that that lack of training is the most important factors that prevent CBT being delivered. Offering proper training programmes for the psychiatric nurses to engage in CBT activities is suggested by the author of this paper. This training possibly will bring about improvements in attitude, knowledge, and practice of the psychoitric nurses working with depressed patient in faclilities.

***Limitations of CBT for Depression***

Although there are great supports for CBT in the literature (Andersson & Cuijpers, 2009; Cuijpers *et al*., 2008), several aspects of CBT are exposed to a number of critiques (Dobson & Dobson, 2009). Firstly, the basics on which CBT depends are not as strong as some of its advocates would have us consider (Longmore & Worrell, 2007). CBT is relying on the client's ability in achieving a clear understanding of his or her belief system and the foundation of that system; therefore, CBT is not effective with clients who don't have an insight about their depression (Boyd, 2012). Secondly, there is ongoing doubt about the effectiveness of CBT (i.e., their benefits in the

clinical context) as compared to their efficacy (i.e., their benefits under "laboratory" conditions) (Longmore & Worrell, 2007). CBT works better in university based - trials with participants recruited from advertisements (Hamdan-Mansour, Puskar & Bandak, 2009), but the evidence about CBT effectiveness in the real clinical context is less imperative (Dobson & Dobson, 2009).

Lastly, there are indications that even remarkable cognitive behaviour practitioners themselves are beginning to doubt aspects of their CBT practices and becoming aware about some of their limitations. For example, Kuyken *et al*. (2008) doubting the "challenging the negative cognitions" approach in major depressive disorder, supposing that "mindfulness techniques" such as meditation are required as well, to assist clients disconnect themselves from their emotional pain.

## CONCLUSION

Given the alarming statistics of depression prevalence around the world, there is an urgent need to understand, treat, and even prevent depression. One of the most empirically supported treatment modality of depression is CBT. CBT is a type of psychotherapy treatments aimed at changing dysfunctional thinking and behavior, in which clients learn to identify faulty beliefs and challenge them, and to replace avoidant coping with active problem solving. Thus, CBT encourages people to identify and challenge negative thoughts and assumptions characteristic of their depression and to consider evidence that help them develop a more realistic view of their experience. CBT helps in preventipn of depression relapse and can be delivered in a range of formats to a wide variety of populations.

It has been reported that CBT's effects on the symptoms of depression are similar to the effects of medication in the short-term. Moreover, at follow-up, CBT has shown to be superior on antidepressants when used on indviduals with chronic depression. There is evidence that combining CBT with medication may enhance treatment effects for severe or chronic cases of depression. More research needs to be done to establish whether CBT is superior to other available, but less researched, forms of psychotherapy such as interpersonal psychotherapy. Finally, CBT approach faced a considerable critique in the literature (Dobson & Dobson, 2009), and maybe it is difficult to escape the notion that CBT seems so far ahead of the field in part because of its research and marketing strategy rather than its intrinsic effectiveness.

## References


Abela, J. R., & Hankin, B. L. (2008). *Handbook of depression in children and adolescents*. The New York: Guilford Press.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders.* (5nd ed.). Washington, DC: American Psychiatric Publisher.

Andersson, G., & Cuijpers, P. (2009). Internet-based and other computerized psychological treatments for adult depression: a meta-analysis. *Cognitive behaviour therapy*, *38*(4), 196-205.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper & Row.

Beck, A. T., & Alford, B. A. (2009). *Depression: Causes and Treatments* (2nd ed.). Philadelphia: University of Pennsylvania Press.

Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond* (2nd ed.). New York: Guilford Press.

Beltman, M. W., Voshaar, R. C. O., & Speckens, A. E. (2010). Cognitive–behavioural therapy for depression in people with a somatic disease: meta-analysis of randomised controlled trials. *The British journal of psychiatry*, *197*(1), 11-19.

Brent, D., Emslie, G., Clarke, G., Wagner, K. D., Asarnow, J. R., Keller, M., ... & Zelazny, J. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression. *JAMA: the journal of the American Medical Association*, *299*(8), 901-913.

Boyd, M. (2012). *Psychiatric Nursing: Contemporary Practice*. (5th ed.). Philadelphia, PA: Lippicott.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical psychology review*, *26*(1), 17-31.

Chen, T. H., Lu, R. B., Chang, A. J., Chu, D. M., & Chou, K. R. (2006). The evaluation of cognitive–behavioral group therapy on patient depression and self-esteem. *Archives of psychiatric nursing*, *20*(1), 3-11.

Corey, G. (2009). *Theory and practice of counseling and psychotherapy* (8th ed.). Pacific Grove, CA: Brooks/Cole.

Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). In Review A Meta-Analysis of Cognitive-Behavioural Therapy for Adult Depression, Alone and in Comparison With Other Treatments. *Canadian journal of psychiatry*, *58*(7), 376–385

Cuijpers, P., Straten, A., Andersson, G., & Oppen, P. (2008). Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. *Journal of consulting and clinical psychology*, *76*(6), 909-922.

Currid, T. J., Nikc˘evic, A. V., & Spada, M. M. (2011). Cognitive behavioural therapy and its relevance to nursing. *British Journal of Nursing*, *20*(22), 1443-1447.

Crowe, M., Whitehead, L., Carlyle, D., McIntosh, V., Jordan, J., Joyce, P., & Carter, J. (2012). The process of change in psychotherapy for depression: helping clients to reformulate the problem. *Journal of psychiatric and mental health nursing*, *19*(8), 681-689.

De Maat, S., Dekker, J., Schoevers, R., & De Jonghe, F. (2006). Relative efficacy of psychotherapy and pharmacotherapy in the treatment of depression: A meta- analysis. *Psychotherapy Research*, *16*(5), 566-578.

Dobson, D. J. G., & Dobson, K. S. (2009). *Evidence-based Practice of Cognitive-Behavioral Therapy*. New York: Guilford Press.

Dobson, K. S. (2009). *Handbook of Cognitive-Behavioral Therapies* (3rd ed.). New York: Guilford Press.

Driessen, E., Van, H. L., Schoevers, R. A., Cuijpers, P., van Aalst, G., Don, F. J., ... & Dekker, J. J. (2007).

Cognitive Behavioral Therapy versus Short Psychodynamic Supportive Psychotherapy in the outpatient treatment of depression: a randomized controlled trial. *BMC psychiatry*, *7*(1), 58.

Fortinash, K. M., & Holsay- Worret, P. A. (2012). *Psychiatric- Mental Health Nursing*. (5th ed.). Mosby: Missouri.

Grant, A., Townend, M., Mulhern, R., & Short, N. (2010). *Cognitive Behavioural Therapy in Mental Health Care* (2nd ed.). UK: Sage.

Herschell, A. D., Kolko, D. J., Baumann, B. L., & Davis, A. C. (2010). The role of therapist training in the implementation of psychosocial treatments: A review and critique with recommendations. *Clinical psychology review*, *30*(4), 448-466.

Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology*, *57*, 285-315.

Houghton, S., & Saxon, D. (2007). An evaluation of large group CBT psycho-education for anxiety disorders delivered in routine practice. *Patient education and counseling*, *68*(1), 107-110.

Imel, Z. E., Malterer, M. B., McKay, K. M., & Wampold, B. E. (2008). A meta-analysis of psychotherapy and medication in unipolar depression and dysthymia. *Journal of Affective Disorders*, *110*(3), 197-206.

Hamdan-Mansour, A. M., Puskar, K., & Bandak, A. G. (2009). Effectiveness of cognitive-behavioral therapy on depressive symptomatology, stress and coping strategies among Jordanian university students. *Issues in mental health nursing*, *30*(3), 188-196.

Himelhoch, S., Mohr, D., Maxfield, J., Clayton, S., Weber, E., Medoff, D., & Dixon, L. (2011). Feasibility of telephone-based cognitive behavioral therapy targeting major depression among urban dwelling African-American people with co-occurring HIV. *Psychology, health & medicine*, *16*(2), 156-165.

Høifødt, R. S., Lillevoll, K. R., Griffiths, K. M., Wilsgaard, T., Eisemann, M., Waterloo, K., & Kolstrup, N. (2013). The Clinical Effectiveness of Web-Based Cognitive Behavioral Therapy With Face-to-Face Therapist Support for Depressed Primary Care Patients: Randomized Controlled Trial. *Journal of medical Internet research*, *15*(8), e153.

Kneisl, C. & Trigoboff, E. (2009). *Contemporary Psychiatric-Mental Health Nursing.* (2nd ed.). New Jersey: Person, Prentice Hall.

Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., ... & Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *Journal of consulting and clinical psychology*, *76*(6), 966-978.

Longmore, R. J., & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behavior therapy?. *Clinical psychology review*, *27*(2), 173-187.

Lynch, D., Laws, K. R., & McKenna, P. J. (2010). Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. *Psychological Medicine*, *40*(01), 9-24.

Marian, M., & Filimon, L. (2010). Cognitive restructuring and improvement of symptoms with cognitive-behavioural therapy and pharmacotherapy in patients with depression. *Annals of General Psychiatry*, *9*, S173.

Mor, N., & Haran, D. (2009). Cognitive-behavioral therapy for depression. *Israel Journal of Psychiatry and Related Sciences*, *46*(4), 269- 273.

Oei, T. P., Bullbeck, K., & Campbell, J. M. (2006). Cognitive change process during group cognitive behaviour therapy for depression. *Journal of affective disorders*, *92*(2), 231-241.

Paradis, A. D., Reinherz, H. Z., Giaconia, R. M., & Fitzmaurice, G. (2006). Major depression in the transition to adulthood: The impact of active and past depression on young adult functioning. *The Journal of nervous and mental disease*, *194*(5), 318-323.

Penninx, B. W., Milaneschi, Y., Lamers, F., & Vogelzangs, N. (2013). Understanding the somatic consequences of depression: biological mechanisms and the role of depression symptom profile. *BMC medicine*, *11*(1), 129.

Pinninti, N. R., Fisher, J., Thompson, K., & Steer, R. (2010). Feasibility and usefulness of training assertive community treatment team in cognitive behavioral therapy. *Community mental health journal*, *46*(4), 337-341.

Redhead, K., Bradshaw, T., Braynion, P., & Doyle, M. (2011). An evaluation of the outcomes of psychosocial intervention training for qualified and unqualified nursing staff working in a low-secure mental health unit. *Journal of psychiatric and mental health nursing*, *18*(1), 59- 66.

Sidor, M. M., & MacQueen, G. M. (2011). Antidepressants for the acute treatment of bipolar depression: a systematic review and meta-analysis. *Journal of Clinical Psychiatry*, *72*(2), e1-e12.

Steven, D. (2011). Cognitive and behavior therapy in the treatment and prevention of depression. *Depression and Anxiety*, *28*(4), 263-266.

Stevenson, V., & Sloan, G. (2012). Developing staff competency in delivering cognitive behavioural interventions to service users: Val Stevenson and Graham Sloan discuss how a training programme is helping nurses increase patient access to talking therapies in Scotland. *Mental Health Practice*, *15*(7), 26-30.

Tolin, D. F. (2010). Is cognitive–behavioral therapy more effective than other therapies?: A meta-analytic review. *Clinical psychology review*, *30*(6), 710-720.

Tutty, S., Spangler, D. L., Poppleton, L. E., Ludman, E. J., & Simon, G. E. (2010). Evaluating the effectiveness of cognitive-behavioral teletherapy in depressed adults. *Behavior therapy*, *41*(2), 229-236.

World Health Organization. (2010). *Depression.* Retrieved march 22, 2013, from http://www.who.int/mental_health/management/depression/en/

World Health Organization. (2012). *Fact Sheet On Depression.* Retrieved march 20, 2013, from http://www.who.int/mediacentre/factsheets/fs369/en/Index.html

TSSN 0976-3031