Cognitive Behavioural Therapy for Depression

Eoin Stephens, M.A.
Director of Education & Training
PCI College
& Centre for Sexual Addictions

1. Introduction.

Depression could be said to be both a common experience and a common illness. As an experience, we have all sometimes felt 'low' and found it hard to enjoy things. As an illness, it is so widespread that Seligman (1975) called it the common cold of psychiatry - though Gilbert (1992a, p. 3) suggests that 'This comparison is unfortunate, for it conveys the impression of a frequent but mild complaint.' In fact, severe depression can lead to tearfulness, irritability, feelings of guilt, emotional numbness, loss of enjoyment, lack of energy, poor concentration, disruption of sleep/appetite/sexual functioning, negative rumination, hopelessness and, in some cases, suicidal ideation/attempts (Fennell, 1989). It is therefore a potentially fatal illness.

Estimates of lifetime risk for severe depression vary from 5% to over 12 % (Paykel, 1989, quoted in Gilbert, 1992a; Fennell, 1989). According to Fennell (ibid.) '…depression has been estimated to account for 75% of psychiatric hospitalisations.' Gilbert (1992b) also points out that depression is frequently a factor in other disorders (e.g. anxiety, eating disorders, addictions, schizophrenia etc).

Many forms of treatment have been tried for depression, including a variety of drugs, ECT, and many psychotherapeutic approaches. This essay describes and evaluates the Cognitive Behavioural approach developed by Aaron Beck and his colleagues.

2. Definition, Classification & DSM-IV Criteria.

Defining depression is not a straightforward matter. In practice, clients rarely seem to present with a single 'unadulterated' difficulty (depression or otherwise). On the other hand, '… descriptions of behavioural, emotional, physiological and cognitive factors which may be found together can help the therapist to identify the general ground she is working on.' (Wills & Sanders, 1997, p. 114).

The most widely used definitions are those found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994), otherwise known as the DSM-IV.

In the DSM-IV, depression is dealt with in the chapter entitled Mood Disorders. First of all, the Depressive Disorders are distinguished from the Bipolar Disorders by their lack of any Manic component. The further distinction is then made between Major Depressive Disorder and Dysthymic Disorder on the basis of severity/intensity (as the word 'Major' would suggest). Major Depressive Disorder (defined as the presence of one or more Major Depressive Episodes; see over) is closest to what is normally described by the word 'depression', both in everyday usage and in counselling practice.

Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** in children, consider failure to make expected weight gains.
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode (see p. 335)

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms or not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Such a classification addresses our need to be able to approach problems in a systematic way. Orme (1984, p. 68) contends that '…anyone thinking he can help someone who is in psychological difficulties, who cannot at the same time systematically label those difficulties, is going to be as much use as a surgeon trying to set a broken limb with no knowledge of anatomy.' Similarly, research into a particular disorder requires mutually agreed definitions. On the other hand, psychological difficulties may be less objective, and more socially constructed, than are anatomical distinctions. Young points out that diagnostic technologies such as the DSM-IV '… are an integral part of the historical formation of some of the disorders … that they now identify and represent.' (1995, p. 107).

Psychiatric definitions, being medical, tend to assume that there are relatively discrete disease entities, each having a specific etiology and a preferred treatment regime (Beck, 1967). However, Gilbert (1992a) suggests that this *disease-centred,* "Platonic" approach, pioneered by Kraepelin in the early 20th century, is only one type of medical approach (which sees disorders such as depression as being *qualitative* variations from the normal). The alternative *person-centred* or *biopsychosocial* approach Gilbert traces back to Hippocrates; here, disorders are seen as *quantitative* variations.

CBT conceptualises clinical depression as distinct from, for instance, healthy grief by virtue of differences in cognitive content and style of information processing[1] (Fennell, 1989; Burns, 1999; Padesky and Greenberger, 1995). Lack of explicit reference to this cognitive aspect of depression is the strongest criticism of the DSM-IV criteria from a CBT perspective. Named symptoms such as low mood, diminished pleasure, feelings of worthlessness, loss of energy, agitation/sloth, disruptions of appetite/sleep, can be classified as affective, behavioural or physiological. Negative thinking is only mentioned in the specific context of suicidal thoughts or thoughts of death. Biased information processing is dealt with only in terms of 'diminished ability to think or concentrate.'

3a. CBT of Depression – Theory.

The conceptualisation of depression was the first to be attempted in CBT (Beck et al, 1979) and is based on the Cognitive Model of emotional disorders, namely, that cognitions play a central role in maintaining dysfunctional emotion, behaviour and physiology.

[1] This is addressed in more detail in section 3a.

The general form of a CBT case conceptualisation can be illustrated as in figure 1 below:

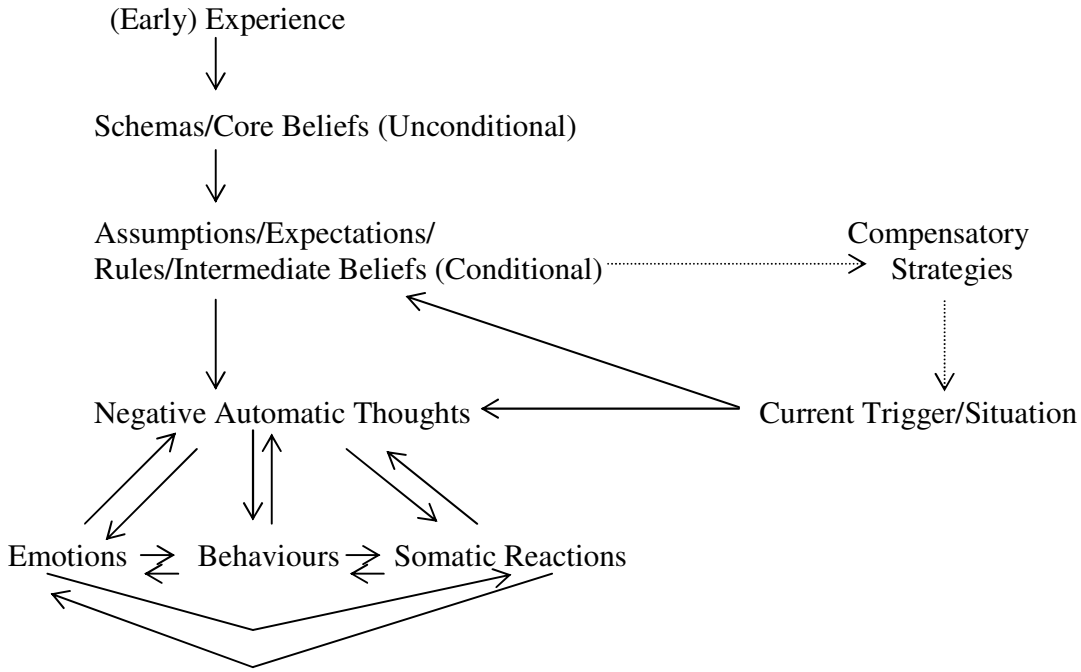

Figure 1. - Adapted from J. Beck (1995) and Fennell (1989)

Figure 2 applies this approach to a depressed client:

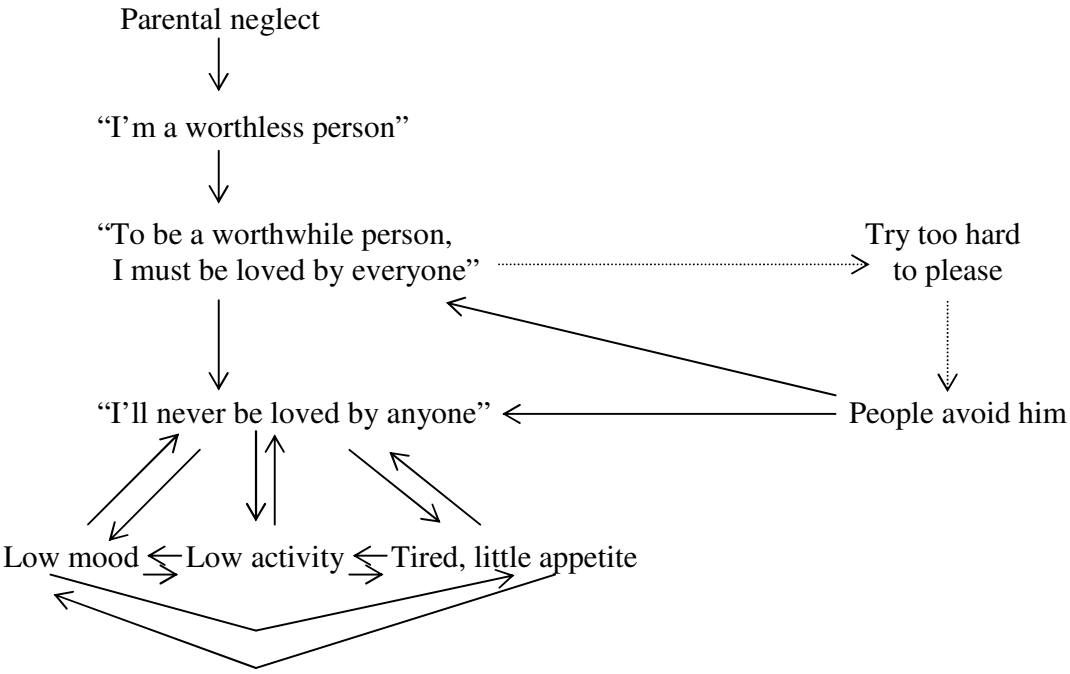

Figure 2.

People develop core beliefs based on their experiences, especially in childhood. In fig. 2 the client's awareness of being neglected led him to develop the core belief "I'm a worthless person", also described as a Worthlessness Schema. The term 'schema' refers to the idea that 'Relatively stable cognitive patterns form the basis for the regularity of interpretations of a particular set of situations.' (Beck et al, 1979, p. 12).

Beck et al (1979) suggested that the schemas of depressed people fall into three categories (the Negative Cognitive Triad):

1. The patient's negative view of himself. "He sees himself as defective, inadequate, diseased or deprived." (p. 11). Fig. 2 offers a good example.
2. The patient's negative view of his world. "He sees the world as making exorbitant demands on him and/or presenting insuperable obstacles to reaching his life goals." (p. 11).
3. The patient's negative view of the future. "As the depressed person makes long-range projections, he anticipates that his current difficulties or suffering will continue indefinitely." (p. 11). This is also apparent in fig.2 ('I'll never be loved by anyone').

'These negative concepts (schemas) may be latent but can be activated by specific circumstances which are analogous to experiences initially responsible for embedding the negative attitude.' (ibid. p. 16); thus a person can be seen as having a cognitive vulnerability to depression. Beck (1983) hypothesised that some people are more vulnerable to losses in the domain of relationships (sociotropic type), others to losses in the domain of achievements/independence (autonomous type).

Generally, what are *directly* activated are the conditional rules/assumptions (Fennell, 1989; J. Beck, 1995) e.g. 'To be a worthwhile person, I must be loved by everyone.' This means that if someone ignores or avoids the client (as they sometimes will, for a variety of reasons, some of them quite unconnected with him) he will see it as evidence for his worthlessness. This will lead to a variety of self-perpetuating cycles, as illustrated in Fig. 2.

One cycle arises from attempts at compensation: the harder the client tries to please, the more people avoid him; the more they avoid him, the harder he tries to please.

Other cycles involve interactions between the various symptoms of depression, centring on the Negative Automatic Thoughts (NATs) which are triggered when the client perceives himself as being ignored/avoided (circumstances analogous to being neglected by his parents). Negative thoughts lead to depressed feelings, lack of activity, and tiredness/loss of appetite, and are in turn reinforced by each of these symptoms. The symptoms on the bottom line also interact with each other in vicious cycles e.g. feelings of depression can lead to loss of appetite, while lack of proper nutrition is likely to leave the client more vulnerable to feelings of depression.

These cycles are also perpetuated by general information-processing biases, or 'distorted thinking' (Beck et al, 1979; Mathews, 1997). Examples of these are over-generalisation, magnification/minimisation, personalisation, black-and-white thinking (Burns, 1999; Williams, 1997). Teasdale (1997, p. 82) calls this 'cognitive imperialism' (which maintains the depressive 'mind-in-place'):

> '…the tendency of depressogenic schematic models to set processing priorities for access to limited processing resources so that information that is likely to maintain depression is given preferential treatment to the exclusion of information related to other minds competing for the same cognitive resources.'

The negative cognitive bias of a severely depressed client can be very strong, and a therapist faced with this can easily fall either into colluding with the client's negative view of things, or trying too quickly too challenge this view (Fennell, 1989; Scott et al, 1995). CBT practice aims to avoid both of these extremes.

3b. CBT of depression – Practice.

The CBT approach to depression is grounded in the following general CBT principles, many of which were first clearly described in Beck et al (1979):

- Collaborative empiricism (p. 6)
- Use of experiments (p. 56)
- Acknowledging the patient's 'personal paradigm' (p. 61)
- Emphasis on questions (p. 66)
- Providing the patient with a rationale (p. 72)
- Formulating a plan for each session (p. 75)
- Establishing an agenda (p. 77)
- Formulating and testing concrete hypotheses (p. 78)
- Getting feedback from the patient (p. 81)
- Use of homework (pp. 56-7)

Another important innovation in Beck et al (1979) is the Beck Depression Inventory, a 21-item self-report inventory which can be used to set a baseline regarding a client's emotional, physiological and cognitive symptoms, and to monitor progress (Wills & Sanders 1997). My own clinical experience is that different clients react quite differently to this initial 'quantifying' of their problem. Some find it a relief; others take it as something else to be depressed about. (This would of course provide some clues to be used in the initial case conceptualisation.)

According to Beck (1976, p. 265), 'Conceivably, the therapist could start with any of the symptoms – emotional, motivational, cognitive, behavioural, or physiological – and concentrate his efforts on changing that symptom cluster.' However, Beck et al (1979) focus on working with the *behaviours* and *cognitions* that are typically symptomatic of depression. As Fennell (1989, p. 170) points out, this was a radical departure:

> Until the mid-1970s, psychiatric conceptualisations of the disorder viewed behavioural and cognitive deficits present in depression as consequences of a primary disturbance in mood, and not as appropriate targets for treatment in their own right.

After initial socialisation of the client to the cognitive model of depression, treatment proper usually begins with behavioural activation[2]. This gives the client some initial lift in mood (Beck et al, 1979; Blackburn and Davidson, 1995), *and* a cognitive shift from 'Nothing can change in my situation' towards 'Change is possible, at least in small steps'. Wills and Sanders (1997, p. 18) put it like this: 'The aim of using these behavioural tasks is to promote the overall therapeutic goal of loosening the grip of depressogenic thinking on the client's mood and functioning.' In the case in fig. 2, *social* tasks were the main focus, as he had become isolated.

The main techniques used in this phase are as follows (Beck, 1976; Beck et al, 1979; Blackburn & Davidson, 1990; Fennell, 1989; Trower et al, 1998):

- Scheduling/monitoring.
  The activities of each day are planned on an hour-by-hour basis. Beck et al (1979, p. 120) suggest that 'The use of activity schedules serves to counteract the patient's loss of motivation, inactivity, and his preoccupation with depressive ideas.' Monitoring can serve to make this a 'no-lose' assignment; the client's task is to *observe* how he gets on, rather than to achieve any particular level of success.

- Mastery & pleasure ratings.
  The client records the degree of Mastery and/or Pleasure associated with activities, having predicted in advance the ratings he expected to give. Clients usually underestimate, and so are pleasantly surprised (Blackburn & Davidson, 1990).

- Graded task assignments.
  This is '…the practice of maximising the chances of success by breaking tasks down into small, manageable steps, each of which is reinforced in its own right.' (Fennell, 1989, p. 189). The tasks should be small enough to be achievable, otherwise the client's sense of failure is reinforced (Beck et al, 1979). I have found that the *pacing* of this technique is very important. Clients don't want to feel rushed, but they also want to see themselves moving on once they have mastered a task.

[2] Fennell (1989), however, begins with cognitive strategies such as distraction and counting.

The next phase uses cognitive techniques (Beck, 1976; Beck et al, 1979; Blackburn & Davidson, 1990; Fennell, 1989; Burns, 1989, 1999; Gilbert, 1992b, 1997).

First, there are some simple cognitive strategies which '…do not produce fundamental cognitive change but, by reducing the frequency of depressing thoughts, lead to improvements in mood which can then be used to facilitate problem-solving.' (Fennell, 1989, p. 186):

- Distraction (Blackburn & Davidson, 1990; Fennell, 1989).
  This involves focusing on objects, pleasant memories/fantasies, sensory awareness, mental exercises or physical activities so as to alleviate depressed mood.

- Counting/decentring (Beck et al 1979; Burns, 1999; Fennell, 1989).
  Keeping track of NATs (using an automatic counter) can help to create distance from these thoughts. However, there is also a danger of the client becoming '…increasingly aware of thoughts without having the skills to modify them.' (Fennell, 1989, p. 188), leading to further lowering of mood.

The heart of the CBT approach, however, lies in working directly to modify cognitions (Beck, 1976). NATs are addressed first:

- Monitoring and reality-testing NATs, and generating alternatives (Beck et al 1979; Fennell, 1989; Blackburn and Davidson, 1995).
  First of all, the client must be helped to become familiar with his own NATs, and the role they play in the generation of his emotions and behaviours. The main technique used here is that of 'guided discovery' (Beck and Young, 1985; J. Beck, 1995; Wills and Sanders, 1997).
  This can be facilitated by the use of the Dysfunctional Thought Record (DTR) (Bates, 1993; Beck et al, 1979; Blackburn & Davidson, 1990; Fennell, 1989; Burns, 1999; Gilbert, 1997); see figure 3 (below).

Date.	Situation.	NATs. Strength of beliefs (%).	Emotions. Strength of feelings (%).	Alternatives to NATs. Strength of beliefs (%).	New emotions. Strength of new beliefs and feelings (%).
Saturday.	Friend doesn't phone.	He hates me (80%). Everyone hates me (70%). I'm horrible (90%).	Depression (70%). Loneliness (80%). Anger (60%).	He's away for the weekend (60%). I do have friends who phone (60%).	Less anger (20%) and depression (40%). I'm likeable (30%). Relief (40%).

Figure 3: Dysfunctional Thought Record

As can be seen from figure 3, the next step is to assist the client in generating more helpful and realistic alternatives to his NATs, and again to note the impact on his feelings and behaviours. Percentage ratings can be used to quantify both negative and positive feelings, so that progress can be clearly seen.
Among the techniques used to help the client in challenging NATs (and assumptions/schemas; see below) are the following (Beck et al 1979; Burns, 1989; Blackburn & Davidson, 1990; Fennell, 1989):

- **Identifying distortions**. The client can be educated about the likely distortions in his processing of information (as described above).
- **Examining the evidence**. The client is encouraged to clarify for himself what exactly would count as evidence for or against his thinking. For example, the client in fig. 2 examined the evidence for or against people disliking him (e.g. not phoning him this week, not specifically saying that they like him, etc).
- **Re-attribution**. The client investigates all the possible factors contributing to his situation, rather than putting all the blame on himself (e.g. other reasons why someone might not phone him, in the client case above).

Other techniques are: Devising experimental tests of beliefs; Polling of friends and acquaintances; Cost-benefit analysis; Continuum thinking.

The final phase focuses on relapse prevention, and therefore works to change dysfunctional assumptions and schemas (Beck et al, 1979; Blackburn and Davidson, 1995; Fennell, 1989). This work uses many of the techniques already described, but may also make use of other techniques such as positive data logs, imagery, non-verbal interventions, role-plays and focusing on the dynamics of the therapeutic relationship (Scott et al, 1995; Wills and Sanders, 1997; Young, 1994). Learning from current setbacks and planning how to deal with future ones are also essential elements of this phase (Fennell, 1989).

4. Discussion – Strengths, criticisms, controversies etc.

A major strength of the CBT approach to depression is its grounding in empirical research. Weishaar refers to a meta-analysis of 28 outcome studies (Dobson, 1989) which '…demonstrates its superiority or equivalence to other treatments…' (1993, p. 60). Its particular strength, however, may be relapse prevention (Evans et al, 1992). Elkin et al (1989), for instance, found CBT to be equivalent to other psychological approaches, but there was some evidence that it produced lower relapse rates after one year (Shea et al, 1992). However, one of the most fundamental criticisms of the approach is that it adds nothing to a purely behavioural approach. A component analysis study by Jacobson et al (1996) suggested that the behavioural component of CBT produced change equivalent to that produced by the full CBT package.

There is some empirical support for the concept of the negative cognitive triad, according to a review by Haaga, Dyck and Ernst (1991). However, other aspects of the theory are less well supported. The notion of cognitive distortion in depression remains controversial, despite much research. Haaga, Dyck and Ernst (1991) suggest that the pessimism of depressed people may be realistic rather than distorted, but there is some evidence that depressed people display a negative bias in autobiographical memory (Williams, 1997; Williams et al, 1997). Beck (1991) proposes that nondepressed people have a positive cognitive bias and depressed people a negative one.

The concept of schemas has been criticised for lack of clear definition (Weishaar, 1993; Williams et al, 1997) and for the idea that latent schemas contribute to the etiology of depression, rather than just operating in a maintaining role after the depression has started. Williams et al (1997) suggest that:

> One of the major ambiguities in Beck's theory has been whether particular emotion-related schemata come into operation only when a person is in the relevant emotional state or whether they are present beforehand and contribute to the development of the emotional condition. In fact, the evidence for dysfunctional schemata being present *before* someone becomes anxious or depressed is not at all good. [Italics in the original]

The notion of a cognitive vulnerability to depression has therefore remained controversial. Weishaar (1993, p. 101) proposes that the concept '… continues to be key to the theory and elusive to demonstration at this point.'

Another criticism of the CBT approach is that it ignores the role of life events and the environment, especially the social environment (Gilbert 1992a; Safran & Segal, 1990; Weishaar, 1993). Barton (2000, p. 3) responds to this:

> Re-reading Beck et al. (1979) reveals a wealth of clinical examples in which *inferences about precipitating events* form the focus of therapeutic change, and this is something we need to rediscover and refine…[Italics in the original]

In the evolutionary perspective taken by Gilbert, Price, Stevens and others (Gilbert, 1992a; Price et al, 1997; Stevens and Price, 1996), depression is seen as partly a phylogenetically ancient response to perceived social failure; an involuntary subordinate/defeat routine is activated. This view, according to Gilbert (1992a, p. 409) '…places less emphasis on the person as responsible for their own distress…' He fears that 'In the hands of less skilled therapists a "cognitive errors therapy" can easily be turned into an "it's your fault" approach.' (ibid., p. 411).

This particular evolutionary approach seems to be different from Beck's 'energy conservation' one (Beck, 1987). Despite Beck's addition of the sociotropic/autonomous personality distinction to his theory (Beck, 1983), Gilbert (1992a, p. 407) insists that '…cognitive therapy is not really a social cognition theory.' He is particularly concerned that CBT does not pay sufficient attention to the role of such loss-related phenomena as envy, shame and anger in depression.

5. Conclusion.

The contribution of CBT to the treatment of distinct, unipolar depression is clear at this stage. What remain less clear are (1) its theoretical foundations (see above) and (2) its ability to adapt to the complex clinical pictures presented by most clients.

Gilbert (1992a, p. 476) proposes that 'Basically, to treat depression you can't be a "one-club golfer".' Safran and Segal (1996) emphasise that, despite impressive research outcomes, CBT has only been shown to be effective for *some* depressed clients. In other words, there is no simple one-to-one match between disorder and treatment.

Beck (1987) has responded to criticisms by expanding his theory to include six models of depression: cross-sectional, structural, stressor-vulnerability, reciprocal-interaction, psychobiological and evolutionary (Weishaar, 1993).

Themes of loss and of being a 'loser' have been central to the CBT view of depression at least as early as Beck (1976). However, integration of this approach with Bowlby's (1980) more developmentally based approach to loss is still at a relatively early stage (Weishaar, 1993).

Phillips (1999) writes of the importance of becoming 'good losers' (p. 127) and of losing as 'an art' (p. 120). In a similar vein, Gilbert (1997, p. 251) suggests that 'the secret of success is the ability to fail.' Perhaps this is why recovery from depression remains such a difficult challenge.

References

APA (American Psychiatric Association) (1994) *Diagnostic and Statistical Manual of Mental Disorders.* 4th edn. APA, Washington, DC.

Barton, S.B. (2000) New Possibilities in Cognitive Therapy for Depression? *Behavioural and Cognitive Psychotherapy*, 28: 1-4.

Bates, A. (1993) Cognitive-Behavioural Therapy. In Boyne, E. (ed) *Psychotherapy in Ireland.* Dublin: Columba Press.

Beck, A.T. (1967) *Depression: Clinical, Experimental and Theoretical Aspects.* New York: Harper and Row.

Beck, A.T. (1976) *Cognitive Therapy and the Emotional Disorders.* New York: International Universities Press.

Beck, A.T. (1983) Cognitive Therapy of Depression: New Perspectives. In P.J. Clayton and J.E. Barrett (eds), *Treatment of Depression: Old Controversies and New Approaches.* New York: Raven Press. pp. 265-84.

Beck, A.T. (1987) Cognitive Models of Depression. *Journal of Cognitive Psychotherapy: An International Quarterly.* 1 (1): 5-37.

Beck, A.T. (1991) Cognitive Therapy: A 30-year retrospective. *American Psychologist,* 46 (4): 368-375.

Beck, A.T., Rush, A.J., Shaw, B.F. and Emery, G. (1979) *Cognitive Therapy of Depression.* New York: Guilford Press.

Beck, A.T. and Young, J.E. (1985) Depression. In D.H. Barlow (ed), *Clinical Handbook of Psychological Disorders.* New York: Guilford Press. pp. 206-244.

Beck, J. (1995) *Cognitive Therapy: Basics and Beyond.* New York: Guilford Press.

Blackburn, I.M. and Davidson, K. (1995) *Cognitive Therapy for Depression and Anxiety*. 2nd edn. Oxford: Blackwell Science.

Bowlby, J. (1980) *Attachment and Loss: Volume III: Loss, Sadness, and Depression.* New York: Basic Books.

Burns, D.D. (1989) *The Feeling Good Handbook.* New York: Plume.

Burns, D.D. (1999) *Feeling Good: The New Mood Therapy.* Revised edn. New York: Avon.

Dobson, K.S. (1989) A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology.* 57 (3): 414-419.

Elkin, I., Shea, M.T., Watkins, J.T., lmber, S., Sotsky, S.M., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.R., Docherty, J.P., Fiester, S.J. and Parloff, M.B. (1989) National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Arcbives of General Psycbiatry.* 46: 971-983.

Evans, M.D., Hollon, S.D., DeRubeis, R.J., Piasecki, J.M., Grove, W.M., Garvey, M.J. and Tuason, V.B. (1992) Differential relapse following cognitive therapy and pharmacotherapy for depression. *Archives of General Psychiatry.* 49: 802-808.

Fennell, M.J.V. (1989) Depression. In K. Hawton, P.M. Salkovskis, J. Kirk and D.M. Clark (eds), *Cognitive Behaviour Therapy for Psychiatric Problems.* Oxford: Oxford University Press. pp. 169-234.

Gilbert, P. (1992a) *Depression: The Evolution of Powerlessness.* Hove: Erlbaum.

Gilbert, P. (1992b) *Counselling for Depression.* London: Sage.

Gilbert, P. (1997) *Overcoming Depression: A self-help guide using Cognitive Behavioural Techniques.* London: BCA.

Haaga, D.A.F., Dyck, M.J. and Ernst, D. (1991) Empirical status of cognitive therapy of depression. *Psychological Bulletin.* 110 (2): 215-236.

Jacobson, N. S., Dobson, K. S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K., Gortner, E., & Prince, S. E. (1996) A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology.* 64: 295-304.

Mathews, A. (1997) Information-processing biases in emotional disorders. In D.M. Clark and C.G. Fairburn (eds), *Science and Practice of Cognitive Behaviour Therapy.* Oxford: Oxford University Press. pp. 47-66.

Orme, J. E. (1984) *Abnormal and Clinical Psychology: An Introductory Text.* London: Croom Helm.

Padesky, C.A.& Greenberger, D. (1995) *A Clinician's Guide to Mind Over Mood.* New York: Guilford Press.

Phillips, A. (1999) *Darwin's Worms.* London: Faber and Faber.

Price, J., Sloman, L., Gardner, R., Gilbert, P. and Rohde, P. (1997) The Social Competition Hypothesis of Depression. In Baron-Cohen, S. *The Maladapted Mind: Classic Readings in Evolutionary Psychopathology.* Hove: Psychology Press. pp. 241-253.

Safran, J.D. and Segal, Z.V. (1990) *Interpersonal Process in Cognitive Therapy.* New York: Basic Books.

Scott, M.J., Stradling, S.G. and Dryden, W. (1995) *Developing Cognitive-Behavioural Counselling.* London: Sage.

Shea, M.T., Elkin, I., Imber, S.D., Sotsky, S.M., Watkins, J.T., Collins, J.F., Pilkonis, P.A., Beckham, E., Glass, D.R., Dolan, R.T. and Parloff, M.B. (1992) Course of depressive symptoms over follow-up: Findings from the National Institute of Mental Health treatment of depression collaborative research program. *Archives of General Psychiatry.* 49: 782-787.

Stevens, A. & Price, J. (1996) *Evolutionary Psychiatry: A New Beginning.* London: Routledge.

Teasdale, J.D. (1997) The relationship between cognition and emotion: the mind-in-place in mood disorders disorders. In D.M. Clark and C.G. Fairburn (eds), *Science and Practice of Cognitive Behaviour Therapy.* Oxford: Oxford University Press. pp. 67-93.

Trower, P., Casey, A. and Dryden, W. (1998) *Cognitive-Behavioural Counselling in Action.* London: Sage.

Weishaar, M.E. (1993) *Aaron T. Beck.* London: Sage.

Williams, J.M.G. (1997) Depression. In D.M. Clark and C.G. Fairburn (eds), *Science and Practice of Cognitive Behaviour Therapy.* Oxford: Oxford University Press. pp. 259-283.

Williams, J.M.G., Watts, F.N., MacLeod, C. and Mathews, A. (1997) *Cognitive Psychology and Emotional Disorders.* 2nd edn. Chichester: Wiley.

Wills, F. and Sanders, D. (1997) *Cognitive Therapy: Transforming the Image.* London: Sage.

Young, A. (1995) *The Harmony of Illusions: Inventing PTSD.* Princeton: Princeton University Press

Young, J.E. (1994) *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach.* 2nd edn. Sarasota, FL: Personal Resource Exchange.