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**A qualitative investigation into participant experiences of group  
person based cognitive therapy for chronic depression**

**15,468 Words**

Section A: The effectiveness of acute phase psychological therapies for chronic  
major depression: A literature review. (5491 words)

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Section B: Participant experiences of group person based cognitive  
therapy for chronic depression. (7995 words)

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Section C: Critical appraisal. (1982 words)

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Section D: Appendix of supporting material

Major research project submitted in partial fulfilment of the requirements of Canterbury Christ  
Church University for the degree of Doctorate in Clinical Psychology

Gemma Luke - July 2011

**Insert declaration**

### **Acknowledgements**

I would like to thank each of the participants who agreed to be interviewed about their experiences of this group psychotherapy, as without them this study would not have been possible. I would also like to thank both of my supervisors, who were a wonderful source of knowledge, guidance and support. Lastly, but by no means least, I would like to thank my husband who has been incredibly patient and considerate throughout the duration of this research process.

## **Summary of MPR Portfolio**

### **Section A: The effectiveness of acute phase psychological therapies for chronic major depression: A literature review.**

This review critically evaluates the literature pertaining to the use of psychotherapy for people experiencing moderate to severe chronic depression. It concludes that people with chronic major depression experience a greater reduction in depressive symptoms from extended periods of treatments and from combined therapy, both in the form of psychotherapy and pharmacotherapy, but also integrative therapies which combine different therapeutic models and modalities.

### **Section B: Participant experiences of group person based cognitive therapy for chronic depression.**

This study explored participants' experiences of group person based cognitive therapy for chronic major depression. Transcripts of 12 semi-structured interviews were analysed using Interpretative Phenomenological Analysis. The study concludes that PBCT may be a suitable intervention for adults with CMD, and it enhances previous findings which suggest that brief mindfulness practices may be acceptable to people experiencing current symptoms of depression.

### **Section C: Critical Appraisal.**

In a critical appraisal of the study described in section B, this section discusses the authors learning and reflections pertaining to research skills developed, applying the findings to clinical practice, and gives consideration to further research.

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## **SECTION A**

# **The effectiveness of acute phase psychological therapies for chronic major depression: A literature review**

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### **Abstract**

The detrimental effects of depression have been widely recognized, but for people with chronic depression, these effects are exacerbated. While the literature pertaining to psychotherapies for chronic depression is expanding, there has to date been no review exploring the effectiveness of psychological therapies with people experiencing chronic depression with moderate to severe symptoms. The purpose of this review is to critically evaluate the literature pertaining to the use of psychotherapy for people experiencing moderate to severe chronic depression. Literature searches identified 12 relevant studies: one case study, two case series, two open trials, one crossover trial, and six randomised clinical trials. These are reviewed according to psychotherapeutic modality, before a general critique of the literature is provided. This review concludes that people with chronic major depression experience a greater reduction in depressive symptoms from extended periods of treatments and from combined therapy, both in the form of psychotherapy and pharmacotherapy, but also integrative therapies which combine different therapeutic models and modalities. Clinical and research implications of the findings are considered.

## **Introduction**

### **The Extent of the Problem**

The National Institute of Clinical Excellence (NICE, 2010) guidelines highlight that the emotional, motivational and cognitive effects of depression can significantly reduce one's ability to work effectively, with subsequent losses in income, societal contribution, and greater dependence on welfare benefits. Furthermore, reduced self-esteem and self-confidence has repercussions, including difficulties sustaining personal relationships. Depression can also exacerbate physical illness (Rugulies, 2002), lead to an increase in health-risk behaviours such as physical inactivity (Katon, 2003), and in some cases, suicide (Chachamovich, Stefanello, Botega, & Turecki, 2009). It is therefore not surprising that depression is projected to rise to the second contributor of global burden of disease by 2020 (World Health Organisation, 2010).

Chronic depression is reported to account for between 10-33% of all cases of depression (Layard, 2006) and 47% of people treated by mental health services (Torpey & Klein, 2008). It is associated with greater social maladjustment, poorer social functioning (Friedman, 1995) and greater risk of suicide (Gilmer et al., 2005) than acute depression. However, the study of chronic depression is complicated by varying definitions, with some authors classifying chronicity as a period of six-months or more (e.g. Simpson, Corney, Fitzgerald, & Beecham, 2003), and others as two years or more (e.g. McCullough et al., 2003).

### **Classification**

The DSM-IV (American Psychiatric Association, 1994) recognises four categories of chronic depression:

- (i) Dysthymic Disorder: a depressed mood, lasting for most of the day, on more days than not, for two years or more, which does not meet the criteria for a Major Depressive Disorder (MDD).
- (ii) MDD, single episode: Continually meeting diagnostic criteria for Major Depressive Episode (MDE) for two years or more.
- (iii) MDD, recurrent, without full interepisode recovery: Meeting the criteria for MDD for two years or more, with periods of remission lasting no more than two months.
- (iv) MDD and Dysthymic Disorder: a MDE superimposed on pre-existing dysthymic disorder. Often termed “double depression” (Keller & Shapiro, 1982).

Controversy surrounds these categories, with some authors arguing against their use due to the belief that they may be hampering research (Parker, 2005) and that there is little evidence the distinctions between them are stable, etiologically meaningful, or indeed clinically useful (Klein, 2010). Furthermore, results from a large scale study by McCullough et al. (2003) suggested that the latter three subtypes represent a homogeneous group in terms of aetiology and treatment response. Developing this, and considering a 10-year naturalistic study by Klein, Shankman and Rose (2006), Gelenberg, Kocsis, McCullough, Ninan and Thase (2006) called for a two-by-two classification system consisting of mild versus moderate to severe depressive symptoms and acute versus chronic types (see Table 1). This introduced the position of considering treatment implications for chronic major depression (CMD) independent from episodic major depression or dysthymia. Due to its grounding in empirical support, this review will adopt a definition of CMD based on the “chronic moderate-severe” part of the Gelenberg et al. (2006) quadrant.

Table 1

The Gelenberg et al. (2006) classification system of uni-polar disorders.

<b>Course of illness</b>	<b>Mild</b>	<b>Moderate-Severe</b>
Acute	Minor depressive disorder	Episodic major depression
Chronic	Dysthymia	MDD MDD, recurrent, without full inter-episode recovery Double depression

### **Psychotherapy and Depression Chronicity**

Research has indicated important distinctions between chronic and non-chronic depression regarding the effectiveness of psychotherapy. For instance, Angst, Gamma, Rossler, Ajdacic and Klein (2009) found that people with chronic depression have an earlier age of onset and typically present with higher rates of co-morbid Axis I and Axis II disorders. A further important consideration is the role of childhood adversity, which is deemed a risk factor for chronic depression (Klein & Santiago, 2003) and a predictor of chronicity among chronically depressed samples (Klein et al., 2009). Given this complexity, it is unsurprising that research has indicated lower treatment response rates in chronically depressed clients (Blom et al., 2007; Cuijpers et al., 2010). Furthermore, people with CMD face barriers to treatment, including a pessimistic attitude from professionals and an in-coherent view on appropriate treatment (Koekkoek, van Meijel, Schene, & Hutschemaekers, 2008). However, interestingly, Fournier et al. (2009) found chronicity to be positively associated with treatment completion, which they attributed to participants being more motivated to achieve some relief from their

symptoms.

### **Psychotherapy and Depression Severity**

Much of the available research focuses on the effect of non-chronic depression severity on treatment outcome (Luyten, Blatt, van Houdenhove, & Corveleyn, 2006; Parker, 2005). For instance, Elkin et al. (1989) found cognitive therapy to be no more efficacious than placebo for severely depressed outpatients. However, subsequent research drew contrasting results (e.g. DeRubeis, Gelfand, Tang, & Simons, 1999). It was subsequently suggested that people with severe depression do respond to psychotherapy, but may require an increased focus on behavioural activation techniques (Scott & DeRubeis, 2001) and a longer course of therapy (Shapiro et al., 1994). Exploring the impact of severity in chronic depression, a recent meta-analysis by Cuijpers et al. (2010) also reported an association between effect size and number of treatment sessions and suggest that at least 18 sessions are required for an optimal treatment effect. Their findings also indicated that psychotherapy may be less effective for clients diagnosed with dysthymia than for those with CMD and called for further research to explore potential hypotheses. Therefore, even among those who are chronically depressed, symptom severity appears to result in further disparity in treatment response.

### **Rationale**

People with chronic depression have historically been considered difficult to treat, but it has been recognised that this population present a clinically different picture to people with acute depression and thus require more specialised treatments. There is a wealth of literature exploring psychotherapeutic interventions for acute episodic depression and relapse prevention (e.g. Scott, Palmer, Paykel, Teasdale, & Hayhurst, 2003). While literature pertaining to psychotherapy



efficacy for people with chronic depression is increasing, reviews to date have combined dysthymia with CMD (Arnou & Constantine, 2003; Cuijpers et al., 2010; Torpey & Klein, 2008), thereby potentially distorting their findings. A review specific to the efficacy of psychotherapy with people with CMD is therefore timely.

This review will explore the literature pertaining to the effectiveness of psychological therapies with people experiencing CMD. Theoretical underpinnings and key procedures of the psychotherapeutic approaches will be outlined, before the outcome literature pertaining to their use with this client group is reviewed. The focus on psychological approaches to chronic depression is not to negate the extensive literature on other treatment approaches; however, these are beyond the scope of this review. Furthermore, due to space constraints, where studies report a number of outcome measures only primary outcome measures will be discussed unless a different pattern is shown by the secondary measures.

### **Search Strategy**

Due to the varied terminology used by authors to denote CMD, the initial search was kept wide in order to ensure all relevant papers were identified. The electronic databases PsychInfo, Science Direct, Web of Science and Cochrane reviews were searched using the terms: chronic depress\* OR chronic major depress\* OR double depress\* OR persistent\* depress\* OR recurrent depress\* combined with a variety of terms denoting different psychotherapeutic models (see Appendix I). No date restrictions were applied but results were limited to the English language. Initial electronic searches retrieved a high volume of papers (PsychInfo=125; Science Direct=55; Web of Science=198; Cochrane reviews=18). Abstracts were manually searched and based on the following inclusion criteria, potentially relevant papers obtained.

The inclusion criteria required studies to:

- a) Evaluate a psychotherapeutic intervention with participants diagnosed with CMD, defined as: MDD, single episode; MDD, recurrent, without full inter-episode recovery; or MDD combined with dysthymic disorder (double depression, Keller & Shapiro, 1982) each characterised by a duration of at least two years.
- b) For studies exploring double depression, participants were required to be experiencing a MDE at the time of entry into the study. This was measured by baseline scores on the primary measure of depression indicating moderate to severe depression.
- c) In the case of unclear or mixed samples, a study was included where z-score calculations estimated that over 90% of the sample met parts a and b of the inclusion criteria.

Studies were excluded if:

- a) Insufficient data were provided to calculate z-scores for the duration and severity of the current episode.
- b) The primary diagnosis was not CMD, as defined in parts a and b of the inclusion criteria.
- c) The paper was not peer reviewed.

## **Results**

Following execution of the search strategy, 12 papers were included in this review: one case study, two case series, two open trials, one crossover trial, and six randomised clinical trials. No qualitative studies were identified. The reference lists of included studies were manually searched for additional studies, but none were identified.

## **Literature Review**

The following section will discuss the literature according to the psychotherapeutic approach in which they sit. In evaluating the quality of the papers, case studies were considered according to suggestions made by Yin (2009), such as the adequacy of measures, potential for replication, and consideration of threats to internal validity. The reporting of RCTs was evaluated according to the Consort Checklist 2010 (Schulz, Altman & Moher, 2010, See Appendix II). Due to many of the checklist items also being relevant to the reporting of other trials, the reporting of information for the open and cross-over trials was also considered according to the Consort Checklist 2010 (Schulz, Altman & Moher, 2010).

### **Cognitive-Behavioural Therapy (CBT)**

**Theoretical underpinning.** The cognitive model of depression (Beck, Rush, Shaw, & Emery, 1979) purports that an individual's interpretation of events alters their emotional response and subsequent behavioural reaction to that event. Those with a cognitive vulnerability to depression are believed to have latent negative schemas involving themes of loss, inadequacy, rejection and worthlessness. These can be activated by adverse life events and result in susceptibility to information processing distortions and habitual negative thinking known as negative automatic thoughts (NATs). NATs are believed to trigger low mood and inactivity, subsequently exacerbating the negative thoughts and depressive symptoms. Cognitive-behavioural therapy (CBT) aims to increase adaptive behaviour by re-engaging the depressed individual in constructive and rewarding activities, while bringing attention to and modifying dysfunctional cognitions (Beck et al., 1979). Utilising a combination of cognitive and

behavioural strategies the aims include reducing rumination, facilitating problem-solving and challenging NATs, in order to subsequently increase self-reward, counter helplessness and reduce associated symptoms.

**Outcome literature.** An early case report by Rush, Khatami and Beck (1975; case study 3) described five weekly CBT sessions for a 24-year-old male experiencing MDD without full inter-episode remission. The client's self-report Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) score dropped to within the 'mild' range by week two. Post-therapy this had reduced further to zero, and was maintained at 12-months follow-up. The client was also reported to have successfully re-engaged in his studies. While this case example demonstrated the potentially positive effects of CBT for one form of CMD, a major limitation was the lack of consideration given to exogenous variables, which may have contributed to the outcome. Furthermore, subsequent studies have not demonstrated comparable findings.

Barker, Scott, and Eccleston (1987) recruited 25 in-patients with MDD. Although primarily an investigation of a 12-week pharmacotherapy regime, participants were randomly assigned to 12-weeks of CBT that consisted of twice weekly sessions for three weeks followed by weekly sessions for the remaining nine weeks. Full data were reported for 20 participants, however, the number who received CBT is not stated. At week six, both the observer rated Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) and BDI scores were reported to have dropped significantly across the sample. However, participants continued to experience moderate symptoms of depression and no further change was reported in the subsequent six-weeks of treatment. The authors report no significant difference in outcomes for those receiving CBT, suggesting no additive benefit. Unfortunately, results pertaining to CBT were not

presented separately and given the small sample size one cannot be certain that the non-significant result was not due to a lack of power. Furthermore, no follow-up data were collected to explore longitudinal effects.

Similarly, Scott (1992; study 1) reports an open study involving eight participants who received pharmacotherapy combined with 15 sessions of standard CBT bi-weekly for three weeks, then weekly for nine weeks. At 12-weeks, HRSD and BDI scores had reduced significantly, however, participants continued to report symptoms indicative of moderate depression. Again, this study was limited by the small sample size and lack of follow-up data.

In summary, three studies have investigated the effects of standard CBT for chronic depression. Overall results indicated a significant reduction in depressive symptoms post-treatment, however, many participants remained symptomatic. Where CBT was added to pharmacotherapy (Barker et al., 1987), no additive benefit was found, although as highlighted, this study potentially lacked power, thus limiting this conclusion. There was also a general lack of exploration into follow-up effects by these studies and none utilised a control group. Therefore, evidence for the effectiveness of standard CBT for CMD is limited.

**Theoretical developments.** Moore and Garland (2003) argue that for people experiencing chronic depression, negative thoughts are not automatic, but habitual and reflect enduring beliefs of low self-worth, helplessness and hopelessness. They suggest that these beliefs result in pervasive low mood which underpins various behavioural, cognitive and emotional avoidance strategies and which are subtle and long-term, differentiating chronic from acute depression. Furthermore, maladaptive consequences, such as a restrictive range of activity and passive or acquiescent behaviours can perpetuate hopelessness and increase vulnerability to

persistent low mood. Additional difficulties recognised in chronic depressives include failure to recall specific memories, poor subjective awareness and failure to generalise learning (Scott, 1992). Indeed, Scott (1992) suggests that chronic depression requires an extended and more intensive course of therapy, with additional focus on engagement, secondary interpersonal consequences, the role of the family, and therapist factors.

**Modified CBT: Outcome literature.** Scott (1992; study 2) reports an open-trial with 16 participants who received combined pharmacotherapy and an adapted, intensive course of CBT. This involved 26 inpatient sessions with a prolonged initial emphasis on action-orientated behavioural techniques and attention to engagement, followed by outpatient treatment for six-months. Sessions were shorter and more frequent (20mins, three times a week) than in standard CBT, techniques were practiced in vivo on the ward, and included family sessions. At week 12, mean HRSD and BDI scores had reduced significantly, and indicated mild depressive symptoms. Furthermore, 11 of the 16 participants subjectively reported feeling much improved. Unfortunately, this study lacked any follow-up, and the use of combined psychotherapy and pharmacotherapy did not permit differentiation of treatment effects of each aspect individually.

Based on the premise that personality traits negatively influence prognosis, Bristow and Bright (1995; study 2) employed a model of therapy that placed greater emphasis on core beliefs (used in the treatment of personality disorders; Beck, Freeman and Associates, 1990). Of four starters, three participants completed group CBT, which consisted of weekly ninety-minute sessions for 28-weeks. Overall, scores on the symptomatic measures reduced, with percentage change ranging from 29%-39% on the BDI and 11%-43% on the HRSD. Furthermore, participants reported enhanced understanding of the roots of their difficulties. However, two of the three participants reported continued depressive symptoms of moderate severity and there

was little change in relation to scores of hopelessness and irritability. Furthermore, the small sample size limits ability to generalise the results.

Purporting that chronic depression is maintained by narrow self-representation and goal overestimation, Barton, Armstrong, Freeston and Twaddle (2008) report a clinical case series of five participants, utilising standard CBT procedures with added emphasis on current self-representations and goal engagement. CBT was adjunct to pharmacotherapy where treatment resistance or only partial response was evident. Therapy consisted of up to 20 sessions in a 16-week period, followed by up to six booster sessions over an eight-month period. Four participants completed treatment. Post-treatment clinician-rated scores indicated that three had responded to treatment, defined by an HRSD score of 12 or less, one of whom had achieved full remission, defined by an HRSD score of 7 or less. At 12-months follow-up the same three clients met the criteria for full remission. Intent-to-treat analysis of BDI scores demonstrated that all participants achieved reliable change (Jacobson & Traux, 1991) two of which were clinically significant, defined by a BDI score of 13 or less. At 12-months follow-up all participants were deemed to have maintained reliable change, three of which were clinically significant. These results suggest an additive benefit of CBT to pharmacotherapy, although the direction of this effect remains unknown. However, the authors acknowledge that replication with a larger sample is required.

Studies exploring modified CBT for CMD appear to demonstrate benefits regarding the use of psychotherapy to reduce symptoms of depression. However, considering that the studies span 1975-2008 there is a surprising lack of progressive research. Each of the studies were plagued by small, and therefore potentially underpowered, samples, and lacked control groups making it difficult to ascertain that observed effects are attributable to psychotherapy.

Furthermore, pharmacotherapy varied between studies, and Bristow and Bright (1995) do not indicate whether participants were currently using pharmacotherapy. Again, this makes it impossible to attribute positive effects to psychotherapy alone. Given these limitations, it seems reasonable to conclude that modified CBT appears to be more effective than standard CBT in reducing depressive symptoms, particularly when combined with pharmacotherapy. However, further research with larger samples is needed.

### **Interpersonal Therapy**

**Theoretical underpinning.** Rather than viewing depression primarily from an intrapsychic perspective, as in CBT, IPT frames depression as a medical illness occurring within a social context with interpersonal antecedents and sequelae (Klerman, Weissman, Rounsaville, & Chevron, 1984). Stuart and Robertson (2003) purport that psychological and interpersonal problems occur when one's need for attachment are unmet, either due to lack of effective communication or an inefficient social support network. Furthermore, due to the belief that events occurring over the past few months have little relevance in a chronic course of depression, it is believed that chronically depressed clients may have never learnt, or lost skills such as self-assertion, confrontation, effective expression of anger and taking social risks (Markowitz, 2003). The main aims of IPT are to support exploration of the link between interpersonal patterns and dysphoric mood and to facilitate the expression of need and emotion more effectively. The latter achieved through expanding one's interpersonal repertoire of behaviours, enhancing interpersonal flexibility, and developing shared responsibility in current relationships (Ravitz, 2004).



**Outcome literature.** De Mello, Myczcowisk and Menezes (2001) report a pilot study involving 35 Brazilian outpatients with dysthymic disorder (91% had double depression) who were randomised to receive pharmacotherapy combined with either routine clinical management or IPT. The authors describe the IPT as being modified for dysthymic disorder, however, they do not provide any further information regarding the content. This study suffered from a high drop-out rate, with 49% (n=17) participants withdrawing (combined=6, pharmacotherapy=11). Of these, seven participants (combined=1, pharmacotherapy=6) completed at least one outcome assessment and were included in the intent-to-treat analysis. Findings indicated a significant within-group reduction in scores on the HRSD and Montgomery-Asberg Depression Rating Scale (Montgomery & Asberg, 1979) for both treatment groups. This trend continued at the 24-week and 48-week assessments for the IPT group but was non-significant. No between-groups statistically significant results were found, however, this may be due to a possible lack of power due to the small sample size.

In a later study by Schramm et al. (2008) 45 inpatients were randomly assigned to receive pharmacotherapy combined with either IPT (modified for use in an inpatient setting, Schramm, 2001) or clinical management. The five-week IPT intervention consisted of three weekly individual sessions with optional family sessions, and eight group sessions with interpersonal and behavioural components. Clinical management was defined as an educative, supportive and empathic intervention of 15-20 minute duration, for three weekly sessions. Analysis revealed a significant post-therapy improvement for both treatment groups on both the HRSD and BDI. Between-group analysis indicated a significant benefit of IPT over clinical management in relation to the HRSD but not the BDI. Post-treatment response rates, defined as a reduction in symptom severity of 50% or more on the HRSD, were significantly higher for the IPT group.

With regards to post-treatment remission, defined as a score of seven or less on the HRSD, between-group difference only reached statistical significance in relation to treatment completers. Sustained response rate was significantly higher for the IPT group at both three and 12-months follow-up. There was a similar trend in relation to sustained remission rates, although this did not reach statistical significance.

Despite the growing evidence-base in relation to IPT for depression, this review has highlighted that limited research has been conducted in relation to IPT for CMD. Two studies have examined IPT combined with pharmacotherapy versus pharmacotherapy with clinical management, but with contrasting results. The positive results reported by Schramm et al. (2008) may have been linked to the markedly increased therapist time, to peer support obtained from the group therapy sessions, and also to the larger sample size. Unfortunately, as stated above, de Mello et al. (2001) do not provide any information regarding the content of their adapted IPT intervention. It is also of note that during the naturalistic follow-up in Schramm et al. (2008), the majority of participants continued to use pharmacotherapy and/or outpatient psychotherapy, therefore subsequent changes to symptoms of depression cannot be wholly attributed to the IPT intervention.

### **Integrative Approaches**

#### **Cognitive behavioural analysis system of psychotherapy (CBASP).**

Drawing on Piaget's (1926) model of cognitive-emotional development, CBASP views the aetiological basis of chronic depression as arrested maturational development. McCullough (2000) suggests that the inability to generate authentic empathic interpersonal behaviour results from a lack of awareness of the consequences of one's behaviour, and leads to maladaptive

interpretations of interpersonal situations, the development of dysfunctional world views, and the employment of maladaptive coping strategies. An additional preoperational feature that McCullough (2000) identifies in people with chronic depression is reaching conclusions without considering alternative hypothesis and remaining unresponsive to the logical reasoning of others. CBASP aims facilitate progression to a formal-operation level of functioning through targeting maladaptive cognitive and behavioural patterns, increasing awareness of interpersonal behaviour consequences, and addressing feelings of hopelessness and helplessness. The cornerstone technique used is situational analysis, with the primary motivating factor of behaviour modification being negative reinforcement through bringing the clients' attention to the undesirable consequences of their actions. The therapist can then model more adaptive social behaviours, promoting skill acquisition.

**CBASP Outcome literature.** Keller et al. (2000) randomised 681 outpatients with CMD to 12-weeks of pharmacotherapy, CBASP (16-20 sessions), or a combination of both. Remission was defined a priori as a HRSD score of eight or less at weeks 10 and 12, or at last follow-up for the intent-to-treat group. For non-remitters, a satisfactory response was determined by a minimum 50% reduction in the HRSD score, with a total score of between eight and 15, over the same time period. Intent-to-treat analysis (n=662) indicated a significant reduction in HRSD scores across all three groups. However, combined therapy was significantly more effective than either monotherapy, with 85% of treatment completers achieving 'satisfactory response' compared to 55% and 52% for the pharmacotherapy and psychotherapy groups respectively. The authors recognise that a major limitation of this study was the lack of control group. A further limitation was the sizeable exclusion criteria, which arguably reduced generalisability of results.

However, in terms of establishing effectiveness, based on the Consort Checklist 2010 (Schulz, Altman & Moher, 2010) this is the largest and highest quality study to date exploring the effects of psychotherapy for CMD. From these findings appears reasonable to conclude that combined therapy may be more effective than either monotherapy in the treatment of CMD.

A subsequent phase explored crossover treatment effects for non-responding monotherapy participants (Schatzberg et al., 2005). Improvement was reported for both groups. However, results only reached statistical significance in relation to the intent-to-treat sample, which indicated higher response rates for the participants switching from pharmacotherapy to CBASP. Considering these results in conjunction with those of Keller et al. (2000) raises interesting questions around the potential additive benefits of CBASP to pharmacotherapy over and above that of pharmacotherapy to CBASP. Retrospective re-analyses of Keller et al.'s (2000) data has provided interesting insight into potential mediating factors. For instance, the anti-depressant Nefazodone was found to result in significantly more rapid and greater ultimate relief of insomnia associated with chronic depression (Thase et al., 2002), and to reduce symptoms of a concurrent anxiety disorder, independent of depressive symptom reduction (Ninan et al., 2002). Therefore, participants receiving psychopharmacology may have experienced additive benefits that potentially contributed to the reduction and manageability of depressive symptoms. With regards to the combined therapy groups, Arnow et al. (2007) found that dropouts attributed to adverse effects of medication were significantly lower in the combination group than in the Nefazodone only group, which the authors attribute to the possible role of psychotherapy in increasing client willingness to persevere. Further exploring the separate and combined benefits of Nefazodone and CBASP, Blalock et al. (2008) suggest that each produced distinct changes in maladaptive cognitions and coping, and that the additive effects of both forms of treatment

partially accounted for the superiority of combined treatment. This supports previous findings that indicated stronger therapeutic alliance for participants in the combined therapy group than the CBASP alone group (Klein et al., 2003), and that early therapeutic alliance facilitated skill utilization and predicted change in depressive symptoms (Santiago et al., 2005).

Developing this, Kocsis et al. (2009) randomly assigned 491 non- or partial-responders to a 12-week pharmacological algorithm to a further 12-weeks of pharmacotherapy augmented with CBASP, pharmacotherapy augmented with Brief Supportive Psychotherapy (BSP), or optimized pharmacotherapy alone. BSP emphasised non-specific factors assumed to be important across psychotherapies, such as reflective listening and empathy. Specific interpersonal, cognitive, behavioural, and psychodynamic interventions were strictly proscribed within this group. Outcome was measured according response and remission rates, with the former defined as a HRSD score between eight and 16 which had decreased by at least 50% from baseline, in conjunction with Clinical Global Improvement (CGI) score of three or below, for a two-week period. Remission was defined as a HRSD score of less than 8, that had reduced by 50% or more from baseline, in conjunction with a CGI score of one or two, for a two-week period. Results indicated that 37.5% of participants experienced partial response with the additional 12-weeks of treatment. No statistically significant differences were found between the three treatment groups, putting these results in contrast to those of Keller et al. (2000). One possible explanation for this difference is that participants had less therapeutic contact time than reported by Keller et al. (2000).

These studies found that CBASP performed no better than pharmacotherapy in reducing depressive symptoms. There was some evidence that combined treatment produced better results, however, subsequent findings indicated no difference. One possibility for the differing results is

treatment preference: pharmacotherapy was guaranteed in each treatment condition of the Kocsis et al. (2009) study, thus potentially attracting participants with a pharmacotherapy preference. Supporting this hypothesis, research burden was a common reason for dropping out among psychotherapy non-completers.

**Relief of chronic of resistant depression (Re-ChORD).** Integrating treatment approaches across disciplines, Murray et al. (2010) describe the Re-ChORD programme as a multi-modal treatment programme addressing biological, psychological and social problems frequently associated with chronic depression. Components of this four-month outpatient intervention included weekly or bi-weekly medication management, 16 ninety-minute sessions of group IPT with monthly follow-up sessions, and 10-12 weekly sessions of group occupational therapy. The latter was aimed at addressing social and occupational dysfunction. 64 participants were randomised to receive either the ReChORD programme or treatment as usual (TAU), which consisted of any available community services. Remission rates, defined as a post-treatment HRSD score of seven or below, were significantly higher among the ReChORD treatment group, including for intent-to-treat analysis. While similar trends were apparent on the self-report measure (BDI-II, Beck, Steer, & Brown, 1996) these did not reach statistical significance. While the magnitude of remission rates reaching clinical significance for the ReChORD group should not be overlooked, they were based on a single time point and thus may not have been maintained. The paper would also have benefited from some consideration to the higher drop-out rate in the ReChORD group.

In summary, research exploring the effectiveness of integrative therapies for CMD has made an important contribution to the literature base. The studies were large and generally well-

designed, and findings have indicated a significant reduction in symptoms of depression where therapy has integrated different models and modalities. It remains unclear whether these effects are attributable to greater therapeutic alliance resulting from the intensive, multimodal treatment approach, or to the different therapeutic elements having distinct effects. However, the CBASP research team are making good headway in exploring this.

### **General Critique**

Following a detailed search for outcome literature pertaining to the use of psychotherapy for people with chronic depression, 12 studies were identified and included in this review. The strengths and limitations of this research base as a whole will now be discussed.

### **Study Designs**

RCTs have been deemed the “most credible evidence of intervention effects” (Littell, Campbell, Green, & Toews, 2009; p. 12), particularly when intent-to-treat analysis is employed. Six of the 12 studies reviewed employed randomisation techniques, but only Murray et al. (2010) utilised a TAU group. The study by Keller et al. (2000) was the largest and most empirically sound of the studies reviewed. However, it still lacked a control group. The authors acknowledge this, referencing research indicating that chronic depressives show a low rate of response to placebo trials (Kocsis et al., 1988) and that a placebo control group can impede recruitment, thus reducing the ability to generalise the findings (Rush et al., 1998). However, future research might benefit from a TAU waiting list design, which would permit control group comparison, exploration of naturalistic change over time, whilst not withholding treatment from any group.

## **Samples**

An important factor when considering the generalisability of findings is the characteristics of the population from which data has been gathered. Klein and Santiago (2003) highlight that chronic depression frequently co-occurs with other Axis-I and Axis-II disorders. Therefore, although arguably increasing internal validity through sample homogeneity, the restrictive inclusion criteria employed by the randomised studies reviewed here reduces the generalisability of results. A further important consideration regarding generalisability is the age of participants. Only studies from the CBASP research team included participants over the age of 65 years, but still had a cut off of 75 years. Therefore current findings cannot be generalised to the older adult population.

## **Outcome Measures**

Each study used validated measures, and most combined the clinician-rated HRSD with the self-report BDI, which correlate positively. Thase (2009) highlights that treatment guidelines for depression have adopted 'remission' as the optimal outcome, so it was positive that six of the reviewed studies employed this as an outcome measure. However, there was some difference in the definition of response and remission used by authors. For instance, Keller et al. (2000) required participants to have a 50% reduction pre to post-therapy and for this reduction to be stable over a period of two weeks. Murray et al. (2010) on the other had only required a reduction to below the clinical cut-off, based on a single point in time, which may not be a true measure of remission.



## **The Effectiveness of Psychotherapy for Chronic Major Depression**

Seligman (1995) highlights that efficacy studies should include random assignment to rigorous controlled conditions, which involve a group of participants receiving no treatment. Based on this definition, none of the reviewed studies established efficacy for psychotherapy for people with CMD. However, effectiveness studies are increasingly deemed credible empirical validation of psychotherapeutic interventions due to their focus on naturalistic over experimental conditions (Seligman, 1995). The literature reviewed here demonstrated some evidence for the effectiveness of psychotherapy for CMD. Furthermore, La Greca, Silverman and Lochman (2009) highlight that investigating mediators of treatment is critical in the development of evidenced-based interventions. In this respect, the progression made by the CBASP study group has undoubtedly contributed to the knowledge-base regarding psychotherapeutic interventions for people with CMD.

### **Conclusion**

The introduction highlighted that people experiencing severe acute depression benefited from combined psychotherapy and pharmacotherapy, and an increased duration of therapy. In considering the findings of literature reviewed and the limitations identified, it appears reasonable to conclude that people with CMD also experience a greater reduction in depressive symptoms from extended periods of treatments, from integrative therapies which combine different models and modalities, and from combining psychotherapy with pharmacotherapy over either monotherapy. The latter finding is in line with the recommendations of NICE guidelines (2010). However, Otto, Smits and Reese (2005) warn that combined treatment should not be

considered as a default treatment before further consideration has been paid to the complex relationship between psychotherapy and pharmacotherapy, and its cost-effectiveness. Therefore further research is justified.

### **Directions for Future Research**

Despite the array of psychotherapies available, few have been explored as potential interventions for CMD. The literature-base would therefore benefit from research exploring the effectiveness of different therapeutic modalities, in addition to directly comparing them against each other and considering the potential additive role of pharmacotherapy. Furthermore, as mentioned above, future research would benefit from using control groups to reduce the possibility of alternate explanations of findings.

The studies reviewed here demonstrate that residual symptoms are a reality for many clients with CMD, which merits further investigation due to its link to increased risk of relapse (Judd et al., 2000). An expanding research base is establishing the therapeutic benefits of third-wave therapies, such as Mindfulness-Based Cognitive Therapy (MBCT), for people experiencing acute (Finucane & Mercer, 2006) and protracted (Barnhoffer et al., 2009) symptoms of depression. MBCT focuses on facilitating an altered relationship with depressive symptoms rather than attempting, and failing, to ameliorate them, which could be an important area to explore in relation to people with CMD.

Furthermore, given the intrinsically personal experience of living with CMD, qualitative research would make an important contribution to the literature base as to date no studies have employed qualitative analysis to explore participants' own experiences of psychotherapy for CMD. The adoption of this methodology would enhance understanding of how therapy works

in addition to providing insight into potential behavioural changes which standardised measures are not sensitive too.

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## **SECTION B**

# **Participant experiences of group person based cognitive therapy for chronic major depression**

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### **Abstract**

This study explored participants' experiences of ways in which group person based cognitive therapy for people with chronic major depression facilitated or hindered therapeutic change. Qualitative methodology was used to explore the experiences of six participants who had completed the 12-week group. Transcripts of the semi-structured interviews were analysed using Interpretative Phenomenological Analysis. Five super-ordinate themes emerged: experiences of depression before the group; the group experience; perceived changes; role of external factors; desire for more. Participants reported a changing experience of depression with regard to the way in which they related to and managed their symptoms, viewed themselves, and managed challenging situations. This study indicates that PBCT may be a suitable intervention for adults with CMD, and enhances previous findings which suggest that briefer mindfulness practices may be more acceptable to people experiencing current symptoms of depression.

## Review of the Literature

The detrimental effects of depression are widely recognised and it is projected to rise to the second highest contributor of global burden of disease by 2020 (World Health Organization, 2010). Chronic depression is reported to account for between 10-33% of all cases of depression (Layard, 2006) and is associated with greater social maladjustment, poorer social functioning (Friedman, 1995), higher levels of service use (Howland, 1993) and greater risk of suicide (Gilmer et al., 2005) than acute depression.

The DSM-IV (American Psychiatric Association, 1994) recognises four categories of chronic depression: dysthymic disorder; major depressive disorder (MDD), single episode; MDD, recurrent, without full inter-episode recovery; and MDD combined with dysthymic disorder, often termed “double depression” (Keller & Shapiro, 1982). These are each characterised by a duration of at least two years. However, a large-scale empirical study suggested that the latter three subgroups actually represent a homogeneous group in terms of aetiology and treatment response (McCullough et al., 2003). Gelenberg, Kocsis, McCullough, Ninan and Thase (2006) subsequently called for a two-by-two classification system consisting of mild versus moderate to severe depressive symptoms and acute versus chronic types. Adopting this classification system, for the remainder of this paper the term chronic major depression (CMD) will be used to refer to people whose symptoms of depression locate them within the lower right hand part of the quadrant (see Table 2).

With regard to treatment implications, people with chronic depression have historically been considered difficult to treat, but it has been recognised that this population present a clinically different picture to people with acute depression. For instance, research has



demonstrated lower treatment response rates in people with chronic forms of depression (Blom et al., 2007; Thase, Reynolds, Frank, & Simons, 1994). Even among those who are chronically depressed, symptom severity appears to be result in further disparity in treatment response with findings of a recent meta-analysis indicating that psychotherapy may be less effective for clients diagnosed with dysthymia than for those with CMD (Cuijpers et al., 2010).

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Table 2

The Gelenberg et al. (2006) classification system of uni-polar disorders.

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<b>Course of illness</b>	<b>Mild</b>	<b>Moderate-Severe</b>
Acute	Minor depressive disorder	Episodic major depression
Chronic	Dysthymia	MDD MDD, recurrent, without full inter-episode recovery Double depression

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### **Current Treatment Approaches**

There are currently four psychotherapeutic approaches that have been robustly studied with people experiencing CMD. These are cognitive-behavioural therapy (CBT), interpersonal therapy (IPT), the cognitive behavioural analysis system of psychotherapy (CBASP), and the relief of chronic resistant depression program (Re-ChORD). These will now be briefly discussed in turn.

**Cognitive behavioural therapy.** Based on the theory that an individual's interpretation of events alters their emotional response and subsequent behavioural reaction, the cognitive model of depression (Beck, Rush, Shaw, & Emery, 1979) proposes that people who are depressed harbour negative beliefs about themselves, others and the world around them, making them susceptible to information processing distortions. CBT is a structured and collaborative process that facilitates recognition, exploration, examination and testing of negative beliefs, before aiming to develop alternative, more functional beliefs and adaptive behaviours.

A number of randomised control trials (RCTs) have shown CBT to be an effective psychological intervention for reducing both symptoms of depression and rates of relapse (see National Institute of Clinical Excellence; NICE, 2010 for a review). In relation to CMD, three studies have suggested a significant reduction in post-treatment depressive symptoms following CBT, however, the majority of participants remained symptomatic (e.g. Barker, Scott, & Eccleston, 1987; Scott, 1992). Furthermore, these studies had small sample sizes and only Rush, Khatami and Beck (1975; case study 3) obtained follow-up data, therefore limiting the conclusions that can be drawn about the effectiveness of CBT for CMD. Subsequent recommendations called for modifications to standard CBT, including extended and more intensive therapy in addition to considering interpersonal consequences and therapist and family factors (Scott, 1992). Empirical research has demonstrated greater support for modified CBT for CMD (Barton, Armstrong, Freeston & Twaddle, 2008; Bristow & Bright, 1995: study 2; Scott, 1992: study 2). However, there was a general lack of methodological progression as studies were underpowered and lacked control groups, again limiting validity of the results.

**Interpersonal therapy.** Rather than viewing depression primarily from an intra-psychic perspective, as in CBT, IPT frames depression as occurring within a social context with interpersonal antecedents and sequelae. It places emphasis on the relational aspects of individual experience and integrates psychological theories of attachment and interpersonal communication (Ravitz, 2004). The main aims of IPT are to facilitate the expression of needs and emotions more effectively, and to support exploration of the link between interpersonal patterns and dysphoric mood, relationship expectations, and empathic responsiveness.

To date, there are only two studies exploring the use of IPT with people with CMD. De Mello, Myczcowisk and Menezes (2001) found no significant differences between the treatment and non-treatment groups, although this study had high dropout rates and was potentially underpowered. In contrast, Schramm et al. (2008) found response rates for their IPT group to be significantly higher post-treatment and at 12-months follow-up, compared to their clinical management group. However, these results cannot be wholly attributed to the IPT intervention, as the majority of participants continued to use pharmacotherapy and/or outpatient psychotherapy during the naturalistic follow-up period.

**Cognitive behavioural analysis system of psychotherapy.** Drawing heavily on Piaget's (1926) model of cognitive-emotional development, McCullough's (2000) CBASP positions the aetiological basis of chronic depression as arrested maturational development, including egocentrism and "thinking in a prelogical and precausal manner" (p. 35). This is suggested to lead to maladaptive interpretations of interpersonal situations, the development of dysfunctional world views, and the employment of maladaptive coping strategies. CBASP aims to facilitate

progression to a formal-operation level of functioning through targeting maladaptive cognitive and behavioural patterns, increasing awareness of interpersonal behaviour consequences, and addressing feelings of hopelessness and helplessness.

In a widely cited study, Keller et al. (2000) randomised 681 outpatients with CMD to receive 12-weeks of pharmacotherapy, CBASP, or a combination of both. Although modified intent-to-treat analysis indicated a significant reduction in symptoms of depression across all three groups, combined therapy was significantly more effective than either monotherapy, with 85% of treatment completers achieving a 'satisfactory response' compared to 55% and 52% for the pharmacotherapy and psychotherapy groups respectively. A later study by Kocsis et al. (2009) produced contrasting results, with no significant differences being found between treatment groups. However, therapeutic contact time was substantially less than reported by Keller et al. (2000). Unfortunately, neither study included a treatment as usual (TAU) control group.

**Relief of chronic resistant depression program.** The Re-ChORD program is an integrative approach that addresses biological, psychological and social problems frequently associated with CMD (Murray et al., 2010). Key components include IPT, pharmacotherapy, and occupational therapy. Murray et al. (2010) report that remission rates for the randomly assigned ReChORD treatment group were significantly higher than for TAU. However, these were based on a clinician rated measure administered at a single time point, thus may not have been maintained. While similar trends were apparent on the self-report measure these did not reach statistical significance.

Therefore, despite the array of psychotherapies available, few have been robustly studied as potential interventions for CMD. From the literature available, it appears reasonable to conclude that people with CMD experience a greater reduction in symptoms of depression from extended periods of treatments, integrative approaches, and from combined psychotherapy and pharmacotherapy. However, even where studies demonstrated a reduction in depressive symptoms, it is clear that residual symptoms remain a reality for many people. Therefore, it may be important to consider the literature on mindfulness-based cognitive therapy (MBCT), which focuses on facilitating an altered relationship with depressive symptoms rather than attempting, and failing, to ameliorate them.

### **The Potential Role of Mindfulness Principles and Practice**

Based on the information-processing theory of depression, Teasdale et al. (2000) suggest that people who have experienced major depression show ruminative thinking patterns activated by dysphoria that resemble those previously present during their depressive episode (Segal, Gemar & Williams, 1999). MBCT was developed to address latent vulnerability between episodes of recurrent depression, through helping individuals alter their relationship to ruminative thoughts, feelings and bodily sensations, which are believed to contribute to relapse (Segal, Williams, & Teasdale, 2002). MBCT therefore aims to help people become more aware of negative thoughts and feelings, to respond to these in ways which allow them to disengage from habitual 'automatic' thoughts, and thereby preventing them from escalating into ruminative depressive states.

Early RCTs demonstrated MBCT to be effective at reducing relapse in people who were currently well but had a history of three or more episodes (Ma & Teesdale, 2004; Teesdale et al., 2000). NICE (2007) subsequently recommended MBCT for this client group. However, its use with people experiencing acute depression was initially discouraged due to the potential for negative content encountered during practices to become overwhelming (Barnhofer et al., 2009). However, a recent RCT indicated that MBCT was effective at significantly reducing symptoms of depression in currently symptomatic participants with a protracted course of depression, 68% of whom met the criteria for CMD (Barnhofer et al., 2009). Unfortunately, the sample size was small and there were significantly more participants with CMD in the control group than in the treatment group, therefore making conclusions tentative. However, the findings did corroborate previous uncontrolled studies (Eisendrath et al., 2008; Kenny & Williams, 2007), and therefore provide preliminary support for the use of MBCT with people experiencing active and possibly CMD.

Given the experiential element in MBCT, an important addition to the literature base has come from qualitative studies that have facilitated exploration into the underlying processes by which participants experience the intervention. To date, these have explored experiences of participants who are currently asymptomatic (Mason & Hargreaves, 2001; Ma, 2002), have mild residual symptoms (Allen, Bromley, Kuyken, & Sonnenberg, 2009), and those currently experiencing acute-phase moderate to severe symptoms (Finucane & Mercer, 2006). Employing a mixed-methods approach, Finucane and Mercer's (2006) findings interestingly highlighted chronicity and severity of problems to be a motivating factor for engagement with the course. Other themes included the group process providing a normalising and validating experience for participants, that the MBCT course was perceived as too short, and that follow-up sessions

would have been beneficial. Participants' views were mixed in relation to the mindfulness practices; some participants experienced practices as relaxing, but for others they elicited difficult experiences relating to traumatic past experiences. Overall, the majority of participants experienced some perceived benefits from MBCT, including an increased ability to relax, decreased tendency to jump to negative conclusions, learning new ways to deal with difficult emotions and increase self-acceptance.

In the discussion of their results, Finucane and Mercer (2006) highlight that a possible hindrance to the effectiveness of MBCT for people with long-standing symptoms is the absence of certain therapeutic elements, including behavioural activation, modifying unhelpful assumptions and schema work. An approach that has the potential to address this while incorporating mindfulness practice is person-based cognitive therapy (PBCT; Chadwick, 2006).

### **Person-Based Cognitive Therapy (PBCT)**

Placing the person at the centre of the therapeutic process, this model suggests that distress is not a direct consequence of symptoms, but of the meaning attributed to them. PBCT aims to facilitate a new relationship with negative self-beliefs through increasing experiential awareness, viewing them as emotionally charged experiences of the self, rather 'the self', and subsequently facilitating acceptance (Chadwick, 2006). The intention is to ease distress and disturbance, whilst eliciting and strengthening positive self-beliefs. Incorporating theory from cognitive therapy for psychosis, mindfulness and person-centred counselling (Rogers, 1961), PBCT highlights four domains of therapeutic change:

1. Symptomatic meaning - identifying, exploring and evaluating meanings attributed to symptoms.
2. Schemata - Identifying and evaluating negative self-beliefs, and identifying and strengthening positive self-beliefs.
3. Relationship with internal experience - Developing decentred awareness through the inclusion of mindfulness principles and practice.
4. Symbolic self - Developing a metacognitive awareness of experiences, and of the Self as a complex and changing process, which comes from developing self-acceptance and awareness of a diverse and contradictory range of experiences.

Therapeutic change across all four domains is seen to be facilitated by a collaborative therapeutic relationship, drawing on Rogerian principles. Within the therapeutic relationship, change is enabled through supporting the person to work within their 'zone of proximal development' (Vygotsky, 1978), whereby more change can occur within a collaborative relationship than can be achieved working in isolation. Group PBCT can further enhance the element of building relationships through making explicit the beliefs and metacognitive insights that are embedded in interpersonal relating, a theory central to group therapy (Yalom, 2005).

Therefore, integrating comprehensive behavioural and schematic elements with mindfulness principles and practice, PBCT offers alternative psychological understanding to alleviating distress. A number of factors indicate that it may be of value to explore the potential benefits of PBCT for people experiencing CMD. Firstly, aimed at people with current distress, although PBCT foregrounds mindfulness ideas and practice, the emphasis is on brief, ten-minute, in-session practice rather than 45-minute practices during and between group sessions, thereby potentially making them more manageable. Secondly, there is preliminary evidence regarding



the effectiveness of group PBCT with people who are actively hearing distressing voices (Dannahy et al., 2011), and a number of similarities have been identified between them and people with active depression. These include; negative core beliefs about the self (Close & Garety, 1998; Kinderman & Bentall, 1996; Trower & Chadwick, 1995), the role of social comparisons in accounting for the level of clients' distress (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000) and reflecting wider social relationships (Hayward, Denney, Vaughan, & Fowler, 2008). Furthermore, individual PBCT has been piloted with people experiencing CMD with positive results (P. Chadwick, personal communication, July 10, 2010). Therefore, research into transferability of PBCT to people with CMD is timely.

## **Rationale**

The advantages of employing qualitative methodology to facilitate the exploration of personal experiences of mental illness has been well documented (e.g. Messari & Hallam, 2003). Furthermore, qualitative methods can be essential in developing an understanding of the active ingredients of a new therapeutic approach (Maltrud, 2001). Therefore, given the originality of the application of PBCT to people with CMD, combined with the centrality of meaning, awareness and understanding in the model, this study aimed to enhance the findings of a concurrent quantitative outcome study by generating rich personal accounts from the participants. It was hoped that qualitative analysis would facilitate exploration of how participants experienced different aspects of the PBCT program, and allow exploration into their perception of the active ingredients of change regarding the way participants relate to their symptoms, the self and others.

## **Aims of the Study**

The overarching objective was to explore participants' experiences of a PBCT group for people with CMD, in order to understand some of the ways that the group may have facilitated or hindered change for individuals. The research questions were:

1. What are participants' perceptions of how, if at all, their experience of depression changed over the course of the intervention?
2. How, if at all, do the participants think the group PBCT facilitated change in their experience of their condition and life more generally?

## **Method**

### **Methodology**

A qualitative methodology was chosen as it enables complex and in-depth aspects of participant experience to be studied (Barker, Pistrang, & Elliott, 2002). The aim of this study was to develop an understanding of the individual experience of the participants rather than to build a theory or to explore the construction of their accounts. Therefore, the selected method of analysis was Interpretive Phenomenological Analysis (IPA). IPA aims to facilitate an understanding of how individuals subjectively view, experience, and make sense of the phenomena being investigated, whilst acknowledging the role of the researcher's own conceptions in making sense of participants' accounts (Smith, Flowers, & Larkin, 2009). In addition to eliciting the

idiosyncratic aspects of participant experiences, IPA also explores commonalities across participants, therefore allowing the development of themes.

Furthermore, IPA is deemed to be an effective method of analysis where existing theory is present (Smith et al., 2009). While PBCT has not been previously used with clients experiencing CMD, the model draws on aspects of both CBT and MBCT, providing some theoretical background.

## **Participants**

Participants consisted of a sub-sample from Strauss, Hayward and Chadwick (in preparation) in which 28 participants, recruited through secondary care Consultant Psychiatrists, were randomly assigned to either the PBCT for CMD group (n=14) or to TAU (n=14). Inclusion criteria for the current study were that the participants had completed a minimum of 8 out of 12 sessions of group PBCT for CMD and by necessity, had also met the inclusion/exclusion criteria for the group PBCT for CMD study. The inclusion criteria for participants to be eligible for group PBCT for CMD were:

- a) To be aged 18 years or older
- b) To have been assessed by the team psychiatrist as meeting the criteria for CMD
- c) To have a BDI-II score of at least 20 (equivalent to ‘moderate depression’)
- d) To have been stable on current antidepressant medication for at least three months with no planned changes to medication during the course of the study.

The exclusion criteria for group PBCT for CMD were:

- a) To be in current psychological therapy or planning to be in psychological therapy during the course of the study.
- b) To have been assessed by the team psychiatrist as meeting diagnostic criteria for: mania or hypomania, psychosis, obsessive compulsive disorder, eating disorder, pervasive developmental disorder, substance misuse, attention deficit hyperactivity disorder, post-traumatic stress disorder, generalised anxiety disorder, or learning disability
- c) To be currently habitually self-harming.

Smith et al. (2009) suggest between four and ten interviews to be an appropriate number for professional doctorate research using IPA. Participants for this study were six graduates from two PBCT intervention groups who, on completion of the group program, volunteered to be interviewed about their experience. Participant demographics are provided in Table 3.

### **Interview Schedule**

A semi-structured interview schedule (see Appendix III for final version) was developed using guidelines by Smith et al. (2009) pertaining to the use of interviews in IPA. The interview schedule was constructed with the aim of allowing the participant space to convey their personal perceptions, in order to capture the essence of their experience of PBCT, while also allowing the researcher to guide the topic of discussion to some extent. The content drew on Elliott, Slatick, and Urman's (2001) The Change Interview, insofar as it was deemed important to establish both the positive and negative changes perceived by participants, but also to explore their attributions

Table 3

Participant demographics.

<b>Group attended</b>	<b>Age</b>	<b>Gender</b>	<b>No. Sessions attended / 12</b>	<b>Age at first diagnosis</b>	<b>Current episode length in years</b>	<b>Current anti-depressant medication</b>	<b>Previous psychological therapy</b>
1	48	F	11	38	10	No	Yes
1	44	F	10	24	2	Yes	Yes
1	24	M	10	6	2	Yes	Yes
1	33	M	11	18	2	Yes	Yes
1	57	F	8	18	3	Yes	Yes
2	48	F	12	19	3.5	Yes	No

regarding what may have facilitated or hindered these changes. The interview was piloted with a colleague, following which minor alterations were made. No further alterations were made following participant interviews. To facilitate an environment in which participants felt able to express themselves openly, the author remained independent of the PBCT groups. Interviews lasted for between 25 and 75 minutes and were tape-recorded.

## Procedure

At the end of the 11th PBCT session, the author gave a short presentation on the current study. Participants were given copies of the participant information sheet (Appendix IV) and

consent form (Appendix V), and were invited to consider whether they would like to be interviewed about their experience of the group. It was emphasized that participation was voluntary and that declining to take part would not affect the care they receive. At the end of the 12th PBCT session, the group facilitator obtained contact details of those who consented to being contacted by the author. Interviews took place across three National Health Service (NHS) buildings that were accessible and familiar to the participants. At the beginning of the interview the author reiterated key information about the interview process and answered any questions the participant had about the study. Participants were asked to sign two copies of the consent form, one of which was retained by the researcher. Participants were reimbursed their travel expenses on the day of their interview.

### **Data Analysis**

Interviews were transcribed by a professional company which had signed a confidentiality agreement. Following transcription, the author listened to the interview recordings to amend the transcripts where necessary and immerse herself in the data. The subsequent data analysis followed IPA guidelines described by Smith et al. (2009). Each transcript was read repeatedly for close line-by-line examination of semantic content and language. Interpretive notes were made on the transcript, before emergent themes were developed. Patterns in themes were then identified to create super-ordinate themes. This process was repeated for each transcript, before patterns were identified across participants' accounts.

## **Ethics**

This study was approved by a NHS Research Ethics Committee and the relevant NHS Research and Development Department (see Appendix VI). Participants were made aware that they were under no obligation to take part in the study and had the opportunity to consider the consent form prior to agreeing to partake. Informed consent was then obtained prior to the commencement of the interview. The right to withdraw from the study at any point during or after the interview was made clear. Participants were also made aware that non-identifiable quotations would be reproduced in the academic submission and in any future publications or presentations of the research. The option of requesting that any part of their interview not be used was made clear.

Due to the sensitive nature of the material, consideration was given to the potential of the interview to cause distress. At the end of each interview, the participant was reminded that they could contact the group facilitator, a clinical psychologist, if they wanted to discuss any difficult feelings that arose following the interview. Furthermore, the author remained alert to potential risk to either the participant or another person, with the view to raise this with the participant and the group facilitator who would in turn inform the participant's care team.

## **Quality Assurance**

Throughout this study Elliott, Fischer and Rennie's (1999) guidelines for qualitative research were held in mind. For example, to facilitate owning my perspective, an early meeting with the head of the research department created a space in which I was encouraged to consider my previous experience in working with people with CMD. This pertained to an adult inpatient

setting where I had experienced the reliance on pharmacotherapy and electroconvulsive therapy as personally distressing, and which had the potential to bias my analysis of a study investigating psychotherapy for CMD. Written records were kept throughout the data collection and analysis process for the purpose of bracketing and reflecting on personal assumptions, and to detail why particular decisions were reached (see Research Diary, Appendix VII). A table of descriptive data for participants is provided as a way of situating the sample and thereby allowing the reader to consider the relevance of this study to other similar contexts. Attempts were made to ground the data in examples through the use of quotes in the results section and also in the Table of Themes (Appendix VIII) which details super-ordinate and sub-themes and contains example verbatim extracts for each relevant participant. It is hoped that this will facilitate appraisal of the fit between the data and my subsequent interpretation of it. An example annotated transcript (Appendix IX) is also provided to aid this process. Credibility checks were carried out through the use of supervision to discuss the coherence and plausibility of interpretation and theme development. Super-ordinate and sub-themes were then verified by two supervisors, following which the recommended amendments and elaborations were incorporated. Unfortunately, due to time constraints, it was not possible to establish respondent validation of my interpretation. However, this is not essential to IPA (Smith et al., 1999) and it is hoped that participants will feel able to comment following dissemination of the results.

## **Results**

### **Overview of Themes**

Participants' accounts of their experience of the PBCT for CMD group clustered around



five super-ordinate themes, each with between two and five sub-themes. These will now be systematically described, with illustrative verbatim extracts where appropriate. Table 4 details each super-ordinate and sub-theme, and highlights which participants experienced them.

### **Description of Super-Ordinate Themes**

**Experiences of depression before the group.** One of the powerful things that participants spoke about was their experience of depression prior to attending the group. Participants described their attempts to manage daily activities as a constant struggle, for reasons including reduced levels of motivation and energy, poor self-perception and the subsequent impact on their ability to relate to others:

*“...well it takes away any meaning or any purpose in life. And the worst is the days where I’m just a burden on everybody and want to kill myself. ...it’s a feeling, but it becomes a way of life, you’re just dragging yourself through it.*

(Participant F).

An important acknowledgement, made by five of the six participants concerned a loss of self. This sub-theme related to a loss of the self as previously known to the participant, but also, and perhaps pertinent to people who experience persistent and chronic forms of depression, a loss of expected self. For example, both participants B and D spoke of having to re-evaluate their career

Table 4

Table of themes illustrating participants' experience of the PBCT for CMD group.

<b>Super-ordinate themes</b>	<b>Sub-themes</b>	<b>Participants experiencing the sub-theme</b>
Experiences of depression before the group	Life as a constant struggle	A, B, D, E & F
	Loss of expected self	A, B, D, E & F
	Self in relation to others	A, D & F
	Depression as changing	B & F
The group experience	The group as a source of apprehension	B, C, D, E & F
	Desire to meet others with similar experiences	A, B, D & F
	Participation	B, C, D, E & F
	Normalising	A, B, C, D & E
	Supportive environment	A, D, E & F
Perceived changes	Increased awareness	A, B, C, D, E & F
	Acceptance	B, E & F
	Greater self-worth	A, D, E & F
	Responding differently	A, C, D, E & F
Role of external factors	Previous therapy	C & E
	Personal supports	C, D & E
	Health	A, B & F
Desire for more	Theoretical underpinning	A, B, C & D
	Follow-on support	A, B & F

paths in order to accommodate the persistent depression:

*“I think if, if my mood...uh...was generally better, well, not better, but if I was more functioning, I suppose I would have progressed further.” (Participant D).*

Participants also spoke of the impact that the depression had on the way in which they positioned themselves in relation to other people:

*“I was effectively setting myself up to fail ...I had a full time job, and two young children and I was comparing myself to my mum, who had a big house, three children, but didn't have any kind of job, so yes, she hoovered the house every day, and everything was always spotless ...And I was judging myself by her standards.” (Participant A).*

Furthermore, although only commented on by two of the six participants, the changing manifestation of depression appeared to make it harder for at least these two participants to know how best to respond to it.

*“...each day is different, I don't think there's any one thing ...It's just hit and miss, some days it will work, some days it won't.” (Participant F)*

Again, this is something that may be pertinent to chronic and recurrent forms of depression, which adapt and change over a person's lifetime.

**The group experience.** Unsurprisingly, a substantial sub-theme that emerged from the data concerned participants' apprehension prior to attending the group. However, despite this,

four participants, including three who had stated that it was a source of anxiety for them, reported a desire to meet others with similar experiences to their own. Group participation appeared to be an important factor for five of the six participants. With regards to participants from the first PBCT group, there was a clear divide between those who contributed and those who did not. This appeared to cause more tension for the ‘talkers’ than it did for the ‘non-talkers’, who spoke of being more introspective.

*“There were quite a few people that were happy just to sit back and let all of the others, um, sort of take the, the initiative and speak all the time. So sometimes it kind of felt that you’re almost pressurised to do that, because the others wouldn’t take it on.” (Participant E).*

*“[the facilitator] was coming around asking everybody questions, and I was thinking, please don’t ask me, because I knew I’d either have to walk out, or just wouldn’t be able to do it.” (Participant C).*

Interestingly, the one participant who attended the second PBCT for CMD group also raised the issue of group member participation, but from a perspective of unity:

*“...that made it a good group, because nobody just sat there. We all contributed....” (Participant F).*

The remaining two sub-themes pertaining to the group experience were normalising and the provision of a supportive environment. Five participants spoke of the group providing a normalising experience in terms of participants realising they were not alone, that other people experienced similar symptoms, and that other peoples symptoms fluctuated. Four participants

also spoke of the group providing a supportive environment, with two of them alluding to other group members being effective in challenging critical self-thoughts:

*“I had forgotten to do my daughter’s lunch, and I had felt absolutely useless and pathetic, ...several people said, oh, gosh, every parent must do that occasionally, ...it’s not because it’s you, it’s not because you’re depressed, it’s not because you’re useless ...since then, when a similar sort of thing has happened, I shrug it off, rather than letting myself get into a sort of downward spiral again.” (Participant A).*

But a perceived lack of support was also evident for one participant, during a session when she was the only female in the group:

*“I think the hardest group I found was probably, um, the one week ...it was all the men, and I was the only female there. ...not that I’m particularly anti-men or anything, but it was just quite hard being I was the only woman there, and there was no support” (Participant E).*

**Perceived changes.** The third super-ordinate theme concerned perceived changes since attending the course. All six participants reported ways in which their awareness had increased, with examples including renewed appreciation for their environment, noticing subjective negative thoughts and periods of rumination, and of an increased awareness of deep rooted core beliefs. Interestingly, this increased awareness was described as resulting from the application of principles and practices discussed in the group:

*“I just took the opportunity to sort of, do a Mindfulness exercise as I was strolling along, and found myself noticing, actively noticing things around me that I hadn’t noticed for a long time. ...And that then had a knock on effect, my enjoyment of what I was doing as well.” (Participant A).*

*“I didn’t realise how negatively I thought of myself. I mean, I’m not particularly confident and never have been. ...but I didn’t realise that was because I didn’t believe I was good enough, which was the core belief that I have. ...that I’ve always been...just a little bit not good enough. And that I don’t particularly like myself.” (Participant F).*

For three participants this increased awareness appeared to provide a platform for increased acceptance of the presence of depression in their lives:

*“I do realise there are no miracle cures ...some get better, some don’t, but if you try to do something positive for yourself, then maybe you’ll stand half a chance of managing your illnesses, more than being cured, but you’ll be able to cope with life” (Participant E).*

Four participants also spoke of developing a greater sense of self-worth, both in terms of how they see themselves as an individual and also in relation to others:

*“I do worry less about what people think of me ...and put myself slightly further forward rather than being at the bottom of the pile” (Participant D)*

Importantly, five of the six participants also reported noticing that they were better able to manage previously challenging situations by responding differently, both intra- and interpersonally:

*“...after four or five weeks, I was actually able to talk, ...and take part in the actual conversation, which was quite an achievement for me” (Participant C).*

*“I have the ability to say no to things, ah, which I suppose it was from the CBT point of view, sort of saying, look, what’s the worst that could happen if you say no.” (Participant D).*

**The role of external factors.** The three prominent sub-themes related to factors external to group PBCT for CMD, which participants believed to have contributed to perceived changes. Interestingly, the impact of previous therapy was only highlighted by two participants. This is perhaps surprising considering that five of the participants had previously engaged in therapy.

*“when I did the CBT ...we actually came out, and we had these huge folders, ...And a lot of it stays with you, I think.” (Participant E).*

Three participants also spoke of the importance of personal supports in their continued struggle with depression. These predominantly came in the form of friends, family and faith. Changes to participants’ physical health was also reported to have an important impact on their perceived

ability to manage their symptoms of depression, with two participants speaking of improved health, and one of deteriorating health:

*“...I’ve also been suffering from an auto-immune disease. ...I’ve been out of work and unable to do much for most of the last year and half. ...the last couple of months I’ve been being able to do more ...makes it quite a bit easier because it’s very difficult to fight depression if you’re just sat in your room staring at the wall all the time” (Participant B).*

*“...I’m limited physically now on what I can do. I mean, I can’t go for a nice long walk anymore, because of my back, ...I’d do the bare minimum that I needed to” (Participant F).*

**Desire for more.** The final super-ordinate theme concerned five participants wanting something more from the course. This was, in part, in terms of more theoretical underpinning throughout the course, particularly in relation to the cognitive component:

*“...the link between negative thoughts and negative moods was made very emphatically and very well, but I think some time could have been taken from that to explore other parts of CBT” (Participant B).*

A further desire reported by three of the six participants was for some form of follow on support after the group had completed, as the ending of the group appeared to be experienced as a loss



*“I really missed come, coming along, ...sometimes you’ve got to go something, like a course, and you think, oh no, it’s that time of the week again, I’ve got to go. With this, it was like, oh, great, you know...” (Participant A).*

*“But I do think there is some need for a follow up, especially when people find out things that they didn’t realise.” (Participant F).*

## **Discussion**

### **Findings**

This study aimed to explore participants’ experiences of a PBCT group for people with CMD through the consideration of two research questions. These will be discussed in turn in relation to the findings, before additional findings are considered.

The first research question concerned participants’ perceptions of how, if at all, their experience of depression changed over the course of the intervention. Participants provided detailed accounts of their personal history of depression from their initial episode to their subsequent experience of living with the illness. These accounts were in line with previous literature (Donahue, 2000; Stigsdotter Nystrom & Nystrom, 2007). However, as the interview progressed, all participants reported a changing experience of depression, not in relation to the presence of symptoms they experienced, but in the way in which they related to and managed their symptoms, viewed themselves, and managed challenging situations. The unfolding narrative of the identified themes suggested that increased awareness was central to a variety of

subsequent changes, including a greater acceptance of the presence of depression. This indicates a shift from a 'cure' model, and greater self-worth characterized by increased positive self-beliefs. Reported changes were not limited to participants' symptoms of depression, but included wider behavioural changes such as having more confidence to talk in the group and improved ability to self-manage in terms of not taking on excessive responsibilities.

The participants' accounts of change map closely to themes identified in previous qualitative studies exploring MBCT with people experiencing acute symptoms of depression (Allen et al., 2009; Finucane & Mercer, 2006). This suggests the possibility of similar treatment effects for these different clinical groups and that contrary to initial thoughts, some people experiencing CMD may be able to engage in and benefit from mindfulness practices.

The second research question concerned how, if at all, the participants thought that group PBCT facilitated change in their experience of depression and life more generally. The group environment provided participants with the opportunity to meet others who shared similar experiences. The way in which this was described by the majority of participants, positioned it as a central component of the overall intervention. In line with Yalom's (2005) theory of Universality, this appeared to lead to participants developing a group identity, which provided a sense of belonging following years of perceiving themselves as different. A second important function of the group, which also appeared to aid the therapeutic process, was the development of a mutually supportive environment in which group members felt able to both provide and hear challenges to critical self-thoughts from one another. This indicates that participants spontaneously challenged one another's negative thoughts by encouraging consideration of alternative views, mirroring techniques encouraged of clients in individual CBT (Greenberger & Padesky, 1995).

A further way in which group PBCT appeared to facilitate change in participants' experience of depression concerned the assimilation and application of principles and practices outside of the group setting. Participants' accounts centred on the cognitive and mindfulness components of the course, with little discussion of the behavioural element. Increased awareness and acceptance are well documented outcomes of MBCT (Kabat-Zinn, 1990). Furthermore, it has been suggested that acceptance creates change (Hayes, 2004; Teasdale, 1999). Therefore, it could be argued that the mindfulness component is an active ingredient of group PBCT. Interestingly, results from the quantitative paper (Strauss, Hayward & Chadwick, in preparation) found that an increase in scores on the Southampton Mindfulness Questionnaire (Chadwick et al., 2008) significantly predicted a reduction in self-reported symptoms of depression as measured by the BDI-II (Beck, Steer, Brown, 1996), accounting for one-third of the variance in outcome.

While the research questions were held in mind during the interview process, the semi-structured approach permitted exploration of additional areas brought by participants, with some important themes emerging. For instance, five of the six participants raised the issue of group member participation. This presented a challenge for four participants and although the fifth participant's comments were in contrast, they had experienced a different group. While this is not uncommon in the formation of groups (Yalom, 2005), it is an important factor to consider in order to enhance group coherence in future interventions.

A further important theme to emerge from participants' accounts concerned the external factors perceived as having had an important impact on the changes perceived. While there is little that can be controlled in relation to the health and family dynamics of participants, there is the potential to enhance therapeutic outcome through consideration of the importance of personal

supports. For instance, participants appeared to develop a group identity and four of the six participants perceived the group to provide a supportive environment. Therefore an ongoing maintenance support group could provide an important supportive element particularly for those who do not have this support externally. Not only was this explicitly requested by half of the participants interviewed, but is also in line with findings from Finucane and Mercer (2006). In addition to providing support, the function of such a group could also be to facilitate participants maintaining self-therapeutic activity. The importance of continued application of principles and practice after the completion of therapy through the development of the 'self-therapist' has been discussed in relation to long-term effectiveness of therapies (Glasman, Finlay & Brock, 2004). In the present study, despite five participants having previously engaged in psychotherapy, only two mentioned this in their interviews, suggesting that continued application of techniques was not routine. However, interestingly the group members demonstrated an ability to provide a supportive environment whilst effectively challenging one another. Therefore, a maintenance support group could potentially facilitate continued therapeutic activity.

A final important consideration raised in this study relates to the absence of any reported distressing experiences during the mindfulness practices. This is in contrast to findings from MBCT studies (Allen et al., 2009; Barnhofer et al., 2009; Finucane & Mercer, 2006). One possible explanation is that the significantly reduced duration of practices simply did not allow participants to become as fully immersed in them as they might have done in an MBCT group. However, given the nature of the themes highlighted in this study in addition to the quantitative finding that approximately one-third of BDI-II change was accounted for by improved self-reported mindfulness skills, this does not appear to have negatively impacted on the outcome.

This provides further support for the applicability of adapted mindfulness principles and practice for people experiencing CMD.

### **Theoretical Considerations**

Although qualitative research cannot be generalised, it is important to consider whether the experiences of participants in this study fit with existing literature. Of particular interest was that participants' accounts of change were consistent with PBCT's focal domains of therapeutic change. Through the application of an ABC framework, similar to that used in cognitive therapy (Beck et al., 1979), the meditational role of cognition in distress became apparent to some participants, who spoke of recognising the presence and impact of negative thoughts. Additionally, some participants spoke of the perceived benefits of mindfulness practices in alleviating distress through reducing adverse behaviours, such as rumination, thereby suggesting an altered relationship with their internal experience. Further support for the transferability of PBCT theory to people with CMD comes from participant discussions around schematic beliefs, which for some extended to being able to recognise and effectively challenge negative self-schema in other group members. This is not something currently highlighted in the literature and suggests the potential value of group over individual therapy for people with chronic conditions, who may be more prone to weakly held positive schemata. The final domain of therapeutic change highlighted by PBCT theory concerns developing a metacognitive understanding of self as complex, contradictory and changing. Some participants described the development of an observer self which was aware of experiences, such as negative self-schematic beliefs and periods of low motivation, but which accepted them as transitory rather than as defining the self.

This suggests some support for the fourth domain. However, these domains were not each apparent for all participants, nor did they appear to be linear.

### **Limitations of Current Study**

Qualitative methodologies do not aim to generate ‘truths’ but rather an understanding of a specific group of peoples’ experiences. Therefore, a limitation inherent in IPA is the lack of generalisability of the findings and caution should therefore be exercised when considering the findings of this study beyond the participants interviewed. However, if a sample is well situated, some of the findings may transfer (Elliott et al., 1999). Therefore, while tentative links have been made to existing theory, further research is warranted to see if subsequent findings resonate with the experiences of participants in this study. Furthermore, IPA requires homogeneous sampling (Smith et al., 1999), so these findings are potentially limited by the sample variation particularly concerning the participant who attended a different group. This latter issue came to light following personal communication with one of the group facilitators who stated that she experienced the two groups from which the participants were sampled as very different. However, IPA does allow for contradicting accounts, and this discrepancy did come across to an extent in the data, particularly in relation to sub-theme ‘Participation’. A further limitation pertaining to sampling, concerns the self-selection bias resulting from only interviewing participants who volunteered. It is possible that only participants who had a positive experience volunteered to speak about it, thereby potentially biasing the results. Finally, participants in this study were interviewed between three and six weeks after completing the group. Therefore, no

conclusions can be drawn regarding the longevity of engagement in PBCT principles and practice.

### **Clinical Implications**

Participants in this study noticed a variety of non-symptom specific ways in which the therapeutic intervention benefited them. This included the increased acceptance of and subsequently an altered relationship with their experience of depression, which resulted in reduced distress from their continued symptoms. It is clinically important that such changes are recognised by professionals working with this client group, particularly in light of research by Koekkoek, van Meijel, Schene and Hutschemaekers (2008), which highlighted that a major barrier faced by people with CMD is a pessimistic attitude from professions. A further implication to consider in light of the findings of the present study is the importance of holding in mind the powerful impact that psychotherapy can have for people, in terms of unearthing areas of the self which may have been dormant for a number of years. When interventions are brief and time-limited, it is important that an appropriate level of consideration is given to ensuring that clients are not left with residual negative or confused feelings that are perceived as unmanageable. Participant in this study spoke of the role of personal supports and also of wanting ongoing support after the group had ended. Both of these are potential ways in which residual feelings might be appropriately managed if incorporated into a treatment plan.

## **Direction for Future Research**

This study has demonstrated the value of employing qualitative methodology to enhance understanding of participant experiences of CMD and of the potential applicability of an innovative psychotherapeutic approach to its treatment. The exploration into the applicability of PBCT for people experiencing CMD is in its infancy, therefore, further research, adopting both qualitative and quantitative methodologies is required to corroborate or contradict current findings. With regards to developing the themes identified in this study, future research would benefit from attending to issues raised by participants. For instance, if maintenance support groups were implemented, would these increase continued application of principles and practices, and if so, what impact would they have on long-term outcomes? Furthermore, given that these groups are offered by the NHS, a cost-benefit analysis would be appropriate to ascertain an optimum duration.

## **Conclusion**

In exploring participant experiences of group PBCT for CMD using an interpretative phenomenological approach, the present study indicates that group PBCT may be an acceptable and beneficial therapeutic approach. Participants in this study had experienced chronic periods of depression throughout their adult lives, the impact of which was all encompassing. While participants reported continued symptoms of depression, there was a considerable shift in the way participants reported relating to these symptoms. Furthermore, this shift extended to include altered ways of relating to the self and others, and for some was supported by behavioural changes.



In addition, this study has demonstrated that the climate of caution and concern surrounding offering interventions that incorporate mindfulness practices to people who experience CMD is perhaps unjustified. Indeed, it enhances previous findings (Finucane & Mercer, 2006) which suggest that brief mindfulness practices may be more acceptable to people experiencing current symptoms of depression. However, the limitations of this study must be borne in mind, and further research is justified.

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**SECTION C**

**Critical Appraisal**

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**Word Count: 1982**

## Overview

This paper provides a critical appraisal of a qualitative study that utilised Interpretive Phenomenological Analysis to explore participants' experiences of group person based cognitive therapy for people with chronic depression. It is guided by four questions which will be addressed in turn.

### **Question 1: What research skills have you learnt and what research abilities have you developed from undertaking this project and what do you think you will need to learn further?**

My learning in relation to research skills started back with the conceptualisation of this study. While it was quickly decided that the most appropriate methodology for the research questions would be a qualitative one, much time was spent deliberating on the most appropriate form of analysis, particularly between grounded theory, thematic analysis and interpretative phenomenological analysis (IPA). As each of these methods were new to me, the extensive reading and numerous discussions gave me a much better understanding of how and when each of these forms of analysis should be applied.

The main skills that I believe have been developed throughout the course of this qualitative study are interviewing and conducting IPA. With regards to the former, the process of reading the interview transcripts highlighted the progression I had made over the course of the six interviews. For example, I felt that my ability to be with the participant and follow their dialogue whilst holding the interview questions in mind progressed with each interview. I feel that this permitted a richer level of data to emerge, which was more in line with participants'

experiences than with my interests as the researcher. With regards to the data analysis, again I noticed that the more I understood the analysis process, the more I was able to be led by the data. This was clearly evident in the difference between my first and second attempts of developing super-ordinate themes, which were initially grouped according to my research questions rather than by what emerged from the data.

However, I also feel that I have more to learn in regards to both of these areas. For instance, when interviewing participants at times I found it challenging to remain in the role of a researcher and not get pulled into the therapist role, particularly given the emotional nature of the content. To aid this process, I found it helpful to consider the motivation behind any questions that deviated from the semi-structured interview schedule. I had not personally had the experience of asking someone such detailed questions about their mental health difficulties outside of a therapy setting, and this is not something that became evident during the pilot interview, which was conducted with a fellow trainee. The realisation that the pilot interview did not evoke the level of emotion and meaning elicited in the actual interviews made me aware of the importance of piloting materials with the people you intent to use them with. I think that my concern around not recruiting enough participants blinded me to this fact, when in actuality I could have piloted the interview schedule with the first one or two participants and if appropriate still used the data.

In addition to the above, I feel that through the process of developing this study I have learnt a lot about conducting research within the NHS. This project formed part of a larger research study which provided me with the opportunity to be a part of the process from the planning and high level of competition involved in applying for funding, the initial joint REC application which was rejected, the subsequent discussions around how best to meet the

requested amendments, and finally re-submitting as separate studies. Having experienced this, I believe that I would be more confident in future research funding bids and ethics applications.

**Question 2: If you were able to do this project again, what would you do differently and why?**

The main thing that I would do differently relates to the groups from which I drew my sample. Five of the six participants interviewed had attended the first person based cognitive therapy (PBCT) group for chronic depression and the sixth had attended the second group. This was due to only one participant from the second group volunteering and the MRP deadline, which was prior to the time point at which recruitment from the third PBCT group would have been possible. After analysing my data, I met with one of the group facilitators to discuss my findings. She confirmed that they were in concordance with her experience of the group, which was a relief to me. However, she proceeded to inform me that her experience of the subsequent two groups had been very different. She attributed this difference to the facilitators having learnt from the first group and having developed a better understanding of the overall PBCT group experience which they were able to apply to groups two and three. As a result, she felt that some of the issues that had been raised by participants, particularly around the balance and quality of the core therapeutic components, were very specific to this group.

Although the transferability of qualitative findings always requires careful consideration, I had to consider that that majority of my findings had come from what essentially ended up being the pilot PBCT group. Given that the aim of this study was to explore participants' experiences of group PBCT in order to aid understanding of its applicability to people with

chronic depression, with hindsight I think the study would have benefited from recruiting participants from the more established second and third PBCT groups. However, the results of this study indicated that PBCT did appear to be transferable to people experiencing chronic major depression (CMD), therefore, one would hope that as the content of group sessions developed to become more tailored to this client group, participants would find the intervention even more acceptable.

During the interviews, I was aware that I, an employee of the NHS, was asking participants to feedback their experiences of group PBCT, a therapy offered by the NHS. While I endeavoured to stress to participants that it was important that they share, where applicable and comfortable, both positive and negative experiences, I did wonder whether there may have been an element of them holding back. Therefore, if I were to conduct this study again I think I would use focus groups rather than one-to-one interviews. The potential benefits of a focus group would be that I, the researcher and NHS employee, would be outnumbered by the participants. I would hope that this might empower participants to share experiences and opinions they may have been uncomfortable sharing in a one-to-one interview. However, focus groups are not without disadvantages and one of the themes to come out of the interviews concerned 'talkers' vs 'non-talkers'. Therefore there would be the potential for the 'non-talkers' voices to be overshadowed in a focus groups. Furthermore, in the current sample one participant had attended a different group. Therefore, had these participants engaged in a focus group, that participant may have felt uncomfortable discussing their experiences in a group where everybody else knew each other.

**Question 3: Clinically, as a consequence of doing this study, would you do anything differently and why?**

One of the themes that emerged from my analysis of the data concerned the role of external supports. This included participants' friends, family, and religion. While I believe that I do generally consider the role of such supports in my clinical practice, on reflection I feel that my clients would benefit if I held this more in mind. For example, by collaboratively considering how a client's personal supports might be incorporated into the treatment plan in order to facilitate both the process and maintenance of change.

Half of the participants that I interviewed for this study expressed a desire for ongoing support after the group had ended, which led me to consider whether this was also something experienced by people after individual therapy. This is something that I intend to hold in mind in my clinical practice, when coming towards the end of therapy either with groups or individual clients. Although in the constraints of the NHS there may be little I could offer to people personally, by establishing a good knowledge base of local services I would hope to be able to signpost clients to appropriate services should they wish to receive ongoing support.

Additionally, conducting this piece of research has drawn my attention to the imbalance between individual versus group therapies offered to outpatients on the NHS. On reflection I realised that throughout my three years of clinical training I have only facilitated one therapeutic group. All participants in this study had something positive to say regarding the perceived benefits of sharing the experience with other people who are experiencing similar difficulties. Although the group situation came with understandable anxieties, which may have deterred some people from engaging in group-based PBCT, the positives did appear to outweigh the negatives.



I believe that this may be particularly important for people diagnosed with chronic conditions, for whom a sense of physical or emotional isolation may be apparent. Therefore, in my future clinical practice I hope to hold this in mind and to consider the appropriateness of group therapy for clients rather than automatically seeing people individually. Furthermore, in terms of future groups that I run, I plan to take on board the issues that were raised in the interviews and pay particular attention to things like the balance of males and females, and where necessary bring underlying tensions such as the ‘talkers’ and ‘non-talkers’ into the room so that they can be addressed.

**Question 4: If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing that?**

As previously highlighted, I think this study may have benefitted from recruiting a sample of participants from more established PBCT groups. Given that the larger scale qualitative branch of the study is running three treatment groups and employed a control design, there is a large pool of potential participants who were not approached for the current study and who attended better established groups. Therefore, I would be interested in repeating this study, recruiting from this larger pool of participants, and comparing the results to the current study in order to see if they corroborate. Such a study would have important implications in terms of further establishing the transferability of the theoretical underpinning of PBCT, originally designed for people who hear distressing voices, to people who experience CMD.

I would also be keen to undertake further research that seeks to explore the longitudinal impact of group PBCT for chronic depression. I am aware that the concurrent quantitative study has a 12-month follow-up period, and I believe that it would be interesting to interview participants in order to explore if and how they continue to apply practices and principles from the group in their lives. In terms of recruitment, potential participants could be approached at the point of completing the follow-up measures for the quantitative study and could involve all group attendees, not just participants from this study. It is important to study the longitudinal impact of psychological therapies in order to establish overall cost-effectiveness. The longitudinal quantitative research will use standardised measures to assess change in relation to self-reported symptoms of depression. However, this will not establish whether any reported changes are attributable to PBCT or to external factors. A major benefit of conducting longitudinal qualitative research is that it would be able to explore: if and how participants continue to apply the principals and practices from group PBCT; if and how participants perceive these principles and practices to have facilitated the maintenance of any changes they had experienced; and what factors have made it easier or more difficult for participants to continue applying PBCT principles and practice in their daily living.

## Appendix I: Literature Review Full Search Criteria

chronic depress* OR double depress* OR persistent* depress* OR recurrent depress* OR chronic major depression	Combined with boolean  AND	cognitive behav* therapy OR cognitive behav* analysis system of psychotherapy OR behav* activation OR cognitive therapy OR mindfulness based cognitive therapy OR psychodynamic psychotherapy OR acceptance and commitment therapy OR dialectical behav* therapy OR functional analytic psychotherapy OR compassion focused therapy OR integrative behav* couples therapy OR cognitive behav* group therapy OR rational emotive therapy OR psychotherapy OR family therapy OR behav* therapy OR psychoanalytic OR brief psychotherapy OR brief supportive psychotherapy OR metacognitive therapy OR cognitive analytic therapy OR interpersonal psychotherapy OR counsel* OR systemic therapy OR narrative therapy OR
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Results limited to: adulthood <18+ years> and English and human

**Appendix II: CONSORT 2010 checklist of information to include  
when reporting a randomised trial**

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### **Appendix III: Semi-structured interview schedule**

#### **Allow up to 1 hour**

Thank you for agreeing to take part in this research by being interviewed. This interview will last for up to one hour, depending on how much you would like to talk about things.

I am interested to hear about your experiences of the PBCT group that you have recently completed. This includes both the good and the bad experiences and whether you liked it or not. It is also fine for you to not tell me about some of your experiences if you don't want to. I only want you to talk to me about the things you are comfortable talking about.

If you would like to stop the interview, at any point, just let me know. We can stop the interview and you don't have to tell me why.

Reconfirm confidentiality agreement.

For their own privacy, please try not to name any other group members during this interview.

Do you have any questions before we get started?

(Second level questions denote *possible* prompts)

#### **Introduction and expectations**

- 1) How did you feel about starting the PBCT group?
  - a) Did you experience any fears or anxiety?
  - b) How did you manage them?
- 2) What did you expect the group to be like?
  - a) What were you hoping to gain by attending the group?

**Changes: Symptom specific**

- 3) Can you tell me what depression means to you?
- 4) Have you noticed any changes in the way that you recognise and manage your symptoms of depression since participating in the PBCT group?
  - a) Are you doing anything, thinking, or feeling differently?
  - b) How is this different from how you might have recognised and managed them before?
    - Encourage examples
- 5) In your view, what led to these changes?
  - a) What leads you to believe that (*initial response*) lead to these changes?
  - b) Is there anything else that may have lead to these changes?
  - c) How likely do you think these changes would have occurred without the group?

**Changes: General**

- 6) Have you noticed any changes in the way that you manage difficult situations in your daily life, since participating in the PBCT group?
  - a) Are you doing anything, thinking, or feeling differently?
  - b) How is this different from how you might have recognised and managed them before?
    - Encourage examples
- 7) In your view, what led to these changes?
  - a) What leads you to believe that (*initial response*) lead to these changes?
  - b) Is there anything else that may have lead to these changes?
  - c) How likely do you think these changes would have occurred without the group?

**Perceptions of mindfulness practices**

- 8) What was your experience of the mindfulness practices that were used within the groups?
  - Remind participants of different practices
  - a) Did you notice any changes in the way you related to your thoughts, feelings, or bodily sensations?
- 9) Have you found these practices, or the ideas behind them, helpful in your day to day life?
  - a) If so, how?
    - Encourage examples

**Overall view of the group**

- 10) Were there any aspects of the PBCT group that you found unhelpful or disappointing?
- a) Has anything changed for the worse since joining the PBCT group?
  - b) Is there anything that you wanted to change but hasn't?
    - Encourage examples
- 11) Were there any aspects of the PBCT group that you found particularly helpful?
- a) Please can you say a bit more?
    - Encourage examples
- 12) Is there anything else you would like me to know about your overall experience of the PBCT group?

**Thank you for your time**

## Appendix IV: Participant Information Sheet



### **Participants' experiences of group person-based cognitive therapy for chronic depression**

#### **Participant Information Sheet**

You are being invited to take part in an *individual* interview that will follow the end of the therapy group you have been attending. Before you decide to take part in the individual interview, it is important for you to understand why the interview is being conducted and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Please take time, at least 24hours, before deciding whether or not you wish to take part.

#### ***What is the purpose of the study?***

This study is being led by Gemma Luke, who is a trainee clinical psychologist. The results will be submitted for evaluation as part of the course requirements for a doctoral qualification in clinical psychology.

The interview will try to explore your experience of the therapy group for people with longstanding depression. It is an opportunity for you to tell us what you thought about the group, and for the research team to learn from you.

#### ***Do I have to take part?***

No. Gemma hopes to interview between 8 and 10 people who attended the person-based cognitive therapy for depression group. All the people who took part in the therapy group will be



invited to an interview but it is up to you whether or not to take part. If you decide to take part you will be asked to sign a consent form. If you decide to take part you are free to withhold any personal information or to withdraw from the study at any time, without giving a reason. This will not affect the care you receive. Neither will a decision not to participate at all.

Please note that only the first 8 to 10 appropriate respondents will be able to take part in this study.

***What would I have to do?***

1. You will be asked to attend the interview at the same place you attended the therapy group. The cost of travelling to this place will be repaid.
2. The interview will take place approximately one or two weeks after the end of the therapy group. Gemma will ask you questions about your views of the therapy group, your experience of managing symptoms of depression since the therapy group and your experience of managing any difficult situations since the therapy group.
3. The interview will last for up to one hour and provide an opportunity to talk about your views of the therapy group. The interview will be tape recorded to allow the discussions to be fully remembered. Gemma will be leading the interview and is a member of the research team. Gemma is a Trainee Clinical Psychologist. You are free to stop the interview at any time without giving a reason.

***What are the disadvantages of taking part***

Taking part in the interview would require you to travel to the NHS location of the therapy group. This may be burdensome for you, and we hope to reduce this burden by paying your travel expenses.

There is a possibility that taking part in the interview may cause you some distress as Gemma will be asking you to think and talk about your experience of the therapy group, your experience of depression since leaving the group and your experience life in general since leaving the group. Should this occur, Gemma will discuss with you what support, if any, may be helpful (e.g. this could included speaking with the clinical team involved in your care).

***What are the benefits of taking part?***

Taking part in the interview will allow you space to think about different aspects of the therapy group such as what you found particularly helpful or unhelpful. This may help to strengthen and secure your personal learning.

***Who will hear/see what I have said?***

The interview will be tape-recorded and from this, a written transcript will be typed. A professional typing service will be used for this process and they will be required to sign a confidentiality agreement. All information on the transcript will be reported anonymously – different names will be used so it will not be possible to identify you. Gemma and her supervisor, [REDACTED], will have access to the original tape recordings.

Direct quotations from your interview may be anonymously written into Gemma's research and other articles that may be written about the study. If you don't want your comments included in the write-up please let Gemma know, and they will not be included.

What you say during the interview will be kept confidential, unless it is felt that there is a possible risk to yourself or others. If this occurs, Gemma will discuss this with you and make your care-coordinator aware.

***What will happen to the results of the study?***

The findings from the interviews will be written-up by Gemma for her research at Canterbury Christ Church University. Gemma will also help the research team to write-up and submit the findings to a national psychology journal. No participant will be identified in any part of the write-up or article.

***Who has reviewed the study?***

This study has been reviewed and approved by the Research and Development Department within your local NHS Trust. It has also been reviewed by a NHS Research Ethics Committee and an Independent Research Review Panel from the Department of Applied Psychology, Canterbury Christchurch University.

**Contact for further information**

If you have any questions or concerns about the interview, you should discuss them with the researcher leading the study:

Gemma Luke,  
Trainee Clinical Psychologist  
Dept. Of Applied Psychology  
Canterbury Christ Church University  
Broomhill Road,  
Tunbridge Wells  
TN3 0TG  
Tel: 01892 507673

**Who do I let know if I want to take part in this study?**

You are advised to wait for at least 24 hours before making your mind up as to whether or not you want to take part in this study. If after this time you decide you would like to, please let your group facilitator know so they can pass your preferred contact details to Gemma. Gemma will then contact you to arrange for you to be interviewed at a time that is convenient for you.

**What should I do if I want to make a complaint?**

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you. You may also wish to seek advice from the Patient Advice and Liaison Service (01323 446042 – [pals@sussexpartnership.nhs.uk](mailto:pals@sussexpartnership.nhs.uk)).

**Thank you for taking the time to read this.**

## Appendix V: Consent Form (original on one page)



Centre number:

Participant Identification Number:

### CONSENT FORM

**Title of Study:** Participants' experiences of group person-based cognitive therapy for chronic depression

**Name of Researchers leading the study:** Gemma Luke

- |   | <b>Please<br/>initial box</b> |
|---|-------------------------------|
| 1 I understand that my participation in the interview is voluntary and that I am free to withhold personal information or to stop the interview at any time. I do not have to give any reason for withdrawing, and my medical care or legal rights will not be affected.  | <input type="checkbox"/>      |
| 2 I understand that the interview will be tape recorded. A transcript of the interview will be written from the recording, in which all personal information will be anonymised. I understand that any third party involved in this process will be required to sign a confidentiality agreement.                           | <input type="checkbox"/>      |
| I understand that relevant sections of the data collected during the study, may be looked at by individuals from the research team, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information. | <input type="checkbox"/>      |
| 3   | <input type="checkbox"/>      |
| 4 I understand that Gemma Luke will be using the themes from the conversations at the individual interviews for her research at Canterbury Christ Church University   | <input type="checkbox"/>      |
| 5 I understand that quotations from my interview may be anonymously written into the research of Gemma Luke and other articles that may be written about the study. I understand that I have the right to ask for my quotations not to be used.   | <input type="checkbox"/>      |

- 6** I agree to participate in a one-off individual interview to explore my views of the therapy group. I have read the information sheet dated 1<sup>st</sup> October 2010 (version 4) and have had the opportunity to ask questions.
- 7** I agree to my care team being informed that I am taking part in this study.

Name of participant

\_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

\_\_\_\_\_

Researcher

Date

Signature

**Appendix VI: NHS Research Ethics Committee and Research and Development  
team approval documents**

**This had been removed to preserve anonymity**

### Appendix VII: Excerpt from Research Diary

Date	Diary Entry
16 January 2009	<p>Research Conference: There were a few studies that I quite liked the idea of, particularly the one presented by [REDACTED]. He spoke of an innovative psychotherapy intervention for people who hear voices. Definitely would be interested in this for three main reasons:</p> <ul style="list-style-type: none"> <li>• I really enjoyed facilitating a Hearing Voices group on an inpatient unit as an assistant psychologist.</li> <li>• My interest in working in a forensic setting post-qualification – and from my experience psychosis is quite predominant in this client group.</li> <li>• It would be a chance work with a large research team, who are based in the trust i would ideally like to work in post-qualification.</li> </ul> <p>Feeling pretty anxious about it all though as this whole process of having to ‘apply’ for the studies we are interested in and for supervisors feels so competitive. Hope not too many other people are interested in this one!</p>
30 January 2009	<p>Met with [REDACTED] to discuss joining the research team. Had attended the meeting with the understanding that I would be involved in the second stage of research regarding a new psychotherapeutic intervention for people who hear voices, however, [REDACTED] said that he would like me to be involved in a different arm of the research, which would involve investigating whether the PBCT model would transfer to people with treatment resistant depression. He wanted me to carry out a qualitative study alongside a quantitative one that was planned.</p> <p>Must admit I was initially disappointed with this, as I would have preferred to carry out my IRP in the area of psychosis due to greater personal interest. However, I also think that it would be an amazing opportunity to be a part of an established research team, and would particularly like the opportunity to work with [REDACTED] following having read and heard a lot about him while working as an assistant.</p> <p>[REDACTED] was asking me a lot about my previous experience in working with people with treatment resistant depression. I spoke about my most recent assistant post on an inpatient unit where there was a lady with severe depression who had not responded to various treatments. I recalled sitting in ward rounds where the psychiatrist stated that because this client had been refusing to take her prescribed medication, she had been investigating the possibility of getting it in soluble form and putting it in a drink against the client’s knowledge. The conversation then progressed to recommending ECT unless she took her medication. I had been absolutely disgusted at the thought of ‘slipping’ this client medication against her wishes and wondered why no-one appeared to be taking the time to talk to her and trying to understand why she had started to refuse meds. Over the following week, the client was booked in for ECT but sabotaged the first two occasions by saying that she needed the toilet and then having a drink of water from the bathroom tap.</p>

	<p>To me this indicated that she was very aware of what she was doing and gave even more reason for the need to understand her motivations. Instead she was placed under intense observation and subsequently restrained to be taken for ECT.</p> <p>█ and I discussed how such an experience might affect the way in which I approach qualitative analysis of data from people with treatment resistant depression. We agreed that I would need to hold in mind the possibility that:</p> <ul style="list-style-type: none"> <li>• Interviewees may become distressed if I ask them personal questions about depression, which may elicit similarly distressing experiences to that of the lady on the inpatient unit.</li> <li>• I might equally become distressed if interviewees recount distressing experiences.</li> <li>• While analysing the data I might be biased towards positive comments about psychotherapy over pharmacotherapy due to the latter holding negative connotations for me.</li> </ul> <p>In terms of supervision, █ said that █ would supervise me, so it is nice to have that sorted and not have to worry about trying to find an external supervisor.</p>
27 February 2009	<p>Having a nightmare with sorting out internal supervision. Both █ and █ have shown real interest in the study and I need to make a decision. Seeing as I am new to qualitative research it seems to make sense to go with █ who has expertise in this area. However, █ has published a lot in relation to depression. Need to decide soon.</p>
12 March 2009	<p>Decided to go with █ as an internal supervisor as █ has informed me that she is “somewhat novice” when it comes to qualitative methodologies.</p> <p>Choosing between IPA or grounded theory. Feeling rather clueless at the moment so lots of reading to do.</p>
20 March 2009	<p>In a meeting yesterday █ suggested that i might was to think about using thematic analysis to analyse my data, describing it as a “flexible and sophisticated” approach. - Now i’m even more confused!</p>
13 May 2009	<p>I have given a lot of thought to the relevance of my research questions, in terms of how they fit into both the literature and the service in which this study is being conducted. After further discussion with both █ and █, it was agreed that grounded theory was not suitable because although PBCT has not been used with this client group, it does draw on existing theory. We want to foreground participants experiences as there is currently limited literature in this area that does this, and given the experiential element of PBCT this seems very important. It was therefore finally decided that I will use IPA for my methodology because thematic analysis foregrounds theory over experiences.</p>



	<p>Definitely feels good to have reached this decision. While i appreciate that it is important to consider our options it has felt somewhat unnerving constantly chopping and changing.</p>
19 June 2009	<p>Meeting with [REDACTED] and [REDACTED] to discuss application for funding. We have decided to submit as one large study with two arms. She has offered to complete most of the form and would like me to prepare a piece of text that covers my part of the study. It is important that the qualitative part does not come across as an 'add-on' but is given serious weight.</p> <p>We also spent time thinking about the timeline of the study as the quantitative part will be continuing for longer than the qualitative part due to a 12-month follow-up phase, and the fact that mine needs to be submitted in July 2011!!</p> <p>Also discussed issues of consent – should consent be sought for the overall study or separately for the quantitative and qualitative parts. Agreed that separate would be better as not all participants who consent to taking part in the group will consent to being interviewed.</p>
10 July 2009	<p>Funding Meeting: A particularly scary experience for me. It was very formal with a panel of five important people. I was very glad that there were four of us. I was surprised to learn that there were six bids for the pot of money that would only stretch to funding two studies and realised that I have become very concerned that if we don't get funding I won't have an IRP and will need to start from scratch.</p>
15 July 2009	<p>Meeting with [REDACTED] and [REDACTED] re ethics application.</p> <p>Decided that it would be best if I waited until towards the end of the PBCT group before presenting my study to participants and gaining consent as if it is all presented to them at the beginning it might be overwhelming, and also they may feel obliged to say yes to both despite perhaps only really wanting to do the group.</p> <p>Depending on final numbers, I may be obtaining my sample from different groups, therefore i will need to be aware of the pros and cons of this.</p>
2 October 2009	<p>Independent Research Review Panel: Very nerve racking process, really didn't feel as though i was up to scratch and clear enough about what i was trying to say – a common problem i have in such situations! Overall they seemed happy with it, but have requested a few changes.</p>
14 December 2009	<p>Ethics Panel Meeting: Horrendous experience. Absolutely tore the study apart. I was really great to have the opportunity to observe [REDACTED] in this situation as she handled all the questioning so well. Think I would have cracked!! They have requested a huge amount of</p>

	changes, the main one being that we need to re-submit as two separate studies. I am absolutely dreading have to resubmit and go through this on my own!
23 December 2009	<p>Meeting with ██████ to discuss the outcome of the ethics review and think about the changes that need to be made in order to re-submit.</p> <p>We also discussed the pros and cons of re-submitting to the same panel versus going to a different one. I must admit that having spoke to other trainees about their experiences i was very much up for going to a different one so that i might avoid being torn apart! However, in the end ██████ and ██████ felt it would be best to go back to the same panel to show them all the ways in which we had taken on board their recommendations and improved the studies.</p>
8 March 2010	Confirmation received that my favourable IPR proposal review still stands following the major changes requested by the ethics panel.
24 March 2010	Re-submitted my ethics application.
19 April 2010	<p>Ethics Panel Meeting: Was dreading this so much! Was very thankful to ██████ for coming with me, however i knew that this time i would have to do all the talking.</p> <p>Couldn't believe it – in and out within five minutes!!! Three very minor alterations required, but just points of clarity.</p> <p>YES!!</p>
23 April 2010	While i am very please that everything is going ahead – i am very aware that we are now massively behind schedule. The original timelines planned for groups to be starting this month but the recruitment process has only just begun. I am now experiencing the downside of being part of a larger study and being completely reliant on them to get the groups off the ground in order for me to have a potential sample of participants.
23 June 2010	<p>More delays. Groups not looking to start until September now so i cant start recruiting until December!!! Have spoken with ██████ and if they get postponed again I may have to look for a different study due to the need for me to hand something in!</p> <p>That is an awful prospect.</p>
29 July	Heard from ██████ that recruitment is still going slowly. I should really be getting on

2010	with my Section A but part of me is thinking that i just don't want to put all that time and effort into a piece of work until i know for sure that i am going to need it. Really questioning my decision to do this study at the moment.
27 August 2010	<p>██████ has confirmed that the first group will go ahead in September, but it will be smaller than first hoped. This means that i am definitely going to need to approach the second group as well – and they don't finish until Feb 2011!!!</p> <p>Fingers crossed a reasonable number of volunteers from the first group so at least I can make a start with the analysis.</p>
10 October 2010	Given time constraints i have decided to have someone else transcribe the interviews. Have to complete 'Notice of Substantial Amendments' for ethics and amend most of my documents to account for this.
25 November 2010	Attended the 11 <sup>th</sup> session of the PBCT group to 'sell my study' to the participants. I was very aware that almost half the group looked extremely bored and barely made eye contact. Discussed with ██████ afterwards in case it was my pitch, but she felt i did a good job. Worried that that is a bad sign in terms of recruitment, but i also need to bear in mind that I went into the end of a 90-minute session so in reality they probably were tired and just wanted to go home. I really hope a decent amount agreed to be contacted.
29 December 2010	<p>Interviewed my first participant today. Feels great to have made a start on my data collection, however, I think that I need to improve my interviewing skills. On listening back to the interview I was shocked at how many times I said "um...". It was rather embarrassing!</p> <p>The interview was a very moving experience. I was immediately struck by her desire to join the group due to it being so difficult getting psychotherapy on the NHS due to the long waiting lists. I was also particularly struck by how depression had encompassed the majority of her adult life, and how she felt unable to manage certain interpersonal occurrences. In fact, it was a privilege to have this woman willing to share so much with me, as a researcher. I guess that meant i had managed to establish good rapport with her.</p> <p>It was also really nice to hear that she did appear to have benefitted from the group, but I am aware that i need to be careful about latching onto this!!</p> <p>With regards to my interviewing skills, nerves aside, I think that I can afford to be a little more flexible with the interview schedule next time in order to allow the participant space to expand on the areas important to them. And stop saying um so much!</p>
12 January	Interviewed participants 2 and 3 on the same day, within a short space of each

2011	<p>other. While this made sense on a practical level, due to the long drive and them both wanting to attend the same centre, on reflection i think that by doing this i lost something in terms of not affording each of them as much post-interview reflection space as i had for participant 1. In future i am going to stick to a max of one in a day, unless there is a large gap between for me to process and reflect.</p> <p>The first person i interviewed today was very reflective and had so much to say about his experience of depression and also of the group. He actually also seemed genuinely pleased to be taking part in the interview. However, i am concerned that the second interview was very short. It was a real challenge trying to give full answers to the question so i hope that i will be able to get enough from the analysis.</p>
3 February 2011	<p>Have now interviewed five people from the first PBCT group. Going to send the recordings off to be transcribed.</p> <p>Will be attending session 11 of the second group on 11<sup>th</sup> so fingers crossed i get a few more volunteers.</p>
24 February 2011	<p>Received transcripts. Checked the accuracy of the transcriptions for interviews D and B by listening to the recordings while reading the transcript. Unfortunately, there were still parts that i was unable to decipher. However, I found this to be a really great way of immersing myself in the data as it really took me back to the interviews and sitting with each of the participants. I found that this process allowed me to consider so much more than just the words on the page, but also recall the participants tone and non-verbal nuances.</p> <p>Although I have not begun the analysis yet, I have already noticed some common themes:</p> <ul style="list-style-type: none"> <li>• There had been a general air of anxiety around joining the group, but on the whole people have actually been really glad of the opportunity to meet others who have chronic depression.</li> <li>• The participants are still having to manage continued symptoms of depression despite having attended the group.</li> <li>• Participants accounts of their experience of depression has been all encompassing and life changing – to a much higher degree than i would have initially expected. The accounts have really moved me.</li> </ul> <p>It will be interesting to see if these are apparent in any of the other interviews, however, i must be careful not to get caught up on these and put them to the side for the time being.</p>
12 March 2011	<p>Realise that i have not begun analysing my data yet. Have been working hard on my other assignments that need to be handed in at the end of April, but i wonder if i am also putting it off a bit? I do feel a little like i don't really know where to start! On the other hand, maybe it is a good idea to get all of the interviews completed before</p>

	beginning the analysis so that i can be more confident that i am not leading the interviews to fit with identified themes?
31 March 2011	<p>Interviewed 6<sup>th</sup> participant today.... very chatty therefore very long interview!!!</p> <p>Unfortunately i have still not got hold of the other person to re-arranged the cancelled interview. Very aware that i don't want to pester her too much. Maybe her not responding is her way of saying no. I think i will leave if a couple of weeks, try once more and if i still have no luck, take that as withdrawn consent.</p>
7 <sup>th</sup> May 2011	<p>I have begun analysing my first interview. I have no idea if i am on the right lines or not but i hope so as it took hours!! I am pretty confident that i have stayed close to the participant's words in the transcript.</p> <p>The main thing that i have noticed is that while i generally have a lot to say in the right hand column, i have found it harder to draw themes. Smith says "reduce detail while maintaining complexity." This sounds like it requires more creativity that i feel i can give to it today. Also, I wonder if i have gone into a little too much detail, however, the example in the Smith book is pretty detailed also.</p>
8 May 2011	<p>Back to developing emergent themes. Much more progress made than yesterday, but there is a persistent voice in my head worrying about loosing the essence of what the participant has said. But, this is where i need to put myself into the data, after all, i did choose IPA!!</p> <p>.....Break!</p> <p>In developing super-ordinate themes, i have found it hard to discard themes that i have identified. Is this due to a fear of discarding something important. Or due to feeling guilty that i am moving away from the data?</p>
4 June 2011	<p>Spent a few hours trying to draw themes across the interviews. I have been holding in mind that each interview must be approached and analysed in its own merit by bracketing off what I have learnt from the previous ones. However, this has resulted in an abundance of themes!!</p> <p>I am concerned that lots of important data will get lost as each interview is in essence so unique. I am finding this process very daunting. I am concerned of becoming swamped by the data but i want to make sure that i am doing a good job and really doing justice to each of my participants. I think i am struggling to move from a more descriptive level to one that is more conceptual and that still encompasses the richness of the data. That is, i think i am struggling to apply the interpretive part of IPA!</p> <p>Also very away of keeping 'polarisation' in mind rather than trying to separate such themes into different themes.</p>

5 June 2011	<p>Given the expansive literature base on the therapeutic qualities of groups, i was not surprised to find themes pertaining to group members feeling anxious about starting the group and this is pretty well documented in psychological literature. Same applies for the function of the group as normalising.</p> <p>On the contrary, i had not expected to find themes such as people feeling able to challenge each other's negative thoughts within the group setting, or that some had been left with distressing feelings that they did not know where to take.</p>
9 June 2011	<p>Under the advice of the ever helpful Smith, i have compiled 53 tables consisting of the emergent theme and the relevant quotes listed under each emergent theme. On printing these out and re-carpeting the lounge floor, i have been able to re-configure the themes by identifying links and themes which could be discarded. The outcome is that themes have been re-clustered under six super-ordinate themes.</p> <p>Feel much more manageable!</p>
10 June 2011	<p>In preparing for supervision I have come to a horrible realisation that i may have made a big mistake. In re-organising my 51 themes into the six super-ordinate themes, i have been focusing on how i will write them up and clustered them largely around my research questions! Now, i am pretty sure this is not correct.</p> <p>.....</p> <p>Post supervision: Yeah, and back to the drawing board i go. Can't face it today so going to leave it for a bit.</p>
12 <sup>th</sup> June 2011	<p>Back to the lounge floor with my original 53 tables. Basically repeated what i had done the other day, however this time i ensured that I remained focussed very much on the themes i had in front of me and put aside any thought is the write up and my research questions.</p> <p>I am much happier with the final outcome. Lets hope [REDACTED] and [REDACTED] are too!</p>

**Appendix VIII: Summary Table of Themes detailing Super-ordinate and Sub-Themes with Example Verbatim Extracts**

**This had been removed to preserve anonymity**

### **Appendix IX: Example Annotated Transcript**

**This had been removed to preserve anonymity**