CHAPTER – 4

SUMMARY
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Clinical depression is a state of sadness that has advanced to the point of being disruptive to an individual's social functioning and daily activities requiring clinical intervention. Over the past several years, the prevalence of depression has been on the rise. According to World Health Organization, clinical depression which is currently the fourth leading illness, worldwide, is expected to become the second leading cause of disability by the year 2020 (Murray and Lopez, 1997; World Health Organisation, 2002).

FUNCTIONAL IMPAIRMENTS CAUSED BY DEPRESSION

Patients with depression appear to suffer from impairments in the following various spheres:

(A) Adjustment Impairment
   (a) Social Functioning Impairment
   (b) Work Functioning Impairment
   (c) Marital and Interpersonal Functioning Impairment

(B) Self Esteem Impairment

(C) Maladaptive Coping Skills

INTERVENTIONS FOR DEPRESSION

Depression is one of the most common and debilitating psychiatric disorder. Depending upon the severity and nature of depression, there are a wide range of effective treatments available (Donohue and Pincus, 2007) which are as follows:

(A) Biological Treatments
   (a) Electroconvulsive therapy (ECT)
   (b) Antidepressant Medication

(B) Psychological Interventions
   (a) Psychodynamic Therapy
   (b) Interpersonal Therapy
   (c) Cognitive Behavioural Therapy
Cognitive Behavioural Therapy (CBT) has been found to be the most promising psychosocial intervention over the past 50 years. CBT is one of the best supported treatments for depression and is the only psychotherapy to date that has demonstrated an enduring effect in the treatment of depression (Hollon et al., 2006; Dobson et al., 2006).

Cognitive Behavioural Therapy is a psychotherapeutic approach, which is used by psychologists and therapists to help promote positive change in individuals, to help alleviate emotional distress and to address a myriad of psychological, social and behavioural issues. CBT aims to alleviate distress by modifying cognitive content and process, realigning thinking with reality (Longmore and Worrell, 2008). Cognitive Behavioural therapists identify and treat difficulties arising from an individual's irrational thinking, misperceptions, dysfunctional thoughts and faulty learning. CBT is based on the scientific fact that our thoughts cause our feelings and behaviours, not external things like people, situations and events. The benefit of this fact is that we can change the way we think to feel and act better even if the situation does not change. The therapy can be conducted with individuals, families or groups. CBT includes cognitive techniques as well as behavioural components. The former emphasizes on recognizing and challenging negative thoughts and maladaptive beliefs while the latter involves graded task assignments, pleasant events scheduling as well as other skills training such as relaxation skills, communication skills, assertiveness skills and problem solving skills (Soloman & Haaga, 2004).

THE EFFECTIVENESS OF COGNITIVE BEHAVIOURAL THERAPY IN REDUCING THE FUNCTIONAL IMPAIRMENTS CAUSED BY DEPRESSION

In recent years, significant attention has been paid to understanding the mechanisms by which cognitive behavioural therapy produce symptom and functional change in patients suffering from major depressive disorder (Scott et al., 2000; Hirshfeld et al., 2002; Papakostas et al., 2004; Goldapple et al., 2004). Several researchers have found that CBT produces significant improvements in the areas of adjustment (i.e. social functioning, work functioning, marital and interpersonal functioning), self esteem and development of adaptive coping skills.
PRESENT STUDY

In the present study, an effort has been made to study the three treatment modalities (i.e. medication alone, a combination of CBT and medication as well as CBT alone) and to see whether these three treatment interventions can bring about a reduction in the level of depression and an improvement in the adjustment and self esteem level of depressed clients. This study has also seen whether the three treatment interventions help the depressed clients in reducing their maladaptive coping styles and developing more adaptive and rational coping strategies. It has also been seen which of the three treatment interventions show the greatest efficacy in reducing the level of depression as well as maladaptive coping skills and in improving the self esteem, adjustment and rational coping skills among depressed clients. In the present study an effort has also been made to see whether the age, gender, marital status, preferences, expectations and the motivation level of the clients affect the outcome of CBT.

OBJECTIVES

Keeping in view the significance of CBT as a mode of intervention the following objectives have been formulated:

1a. To study whether each of the three treatment interventions (i.e. Medication alone, a combination of CBT and medication as well as CBT alone) will show a significant reduction in the level of depression.

1b. To study whether there will be a significant difference in the effectiveness of the three treatment interventions (i.e. Medication alone, a combination of CBT and medication as well as CBT alone) in reducing the level of depression among depressed clients.

2a. To study whether each of the three treatment interventions will show a significant improvement in the level of self esteem.

2b. To study whether there will be a significant difference in the effectiveness of the three treatment interventions in improving the self esteem of depressed clients.
3a. To study whether each of the three treatment interventions will show a significant improvement in the level of adjustment.

3b. To study whether there will be a significant difference in the effectiveness of the three treatment interventions in improving the adjustment level of depressed clients.

4a. To study whether each of the three treatment interventions will show a significant reduction in the maladaptive coping skills of confrontive coping (hostile and aggressive behaviours), distancing (detachment and denial), self controlling (inhibition of feelings and actions), accepting responsibility (feelings of self blame and self criticism) and escape avoidance (wishful thinking and behavioural efforts to escape or avoid the problem).

4b. To study whether there will be a significant difference in the effectiveness of the three treatment interventions in reducing these maladaptive coping strategies among depressed clients.

5a. To study whether each of the three treatment interventions will show a significant improvement in the rational coping skills of seeking social support (emotional, instrumental and sometimes informational assistance or help), planful problem solving (active cognitive and behavioural attempts to manage stress) and positive reappraisal (reframing the situation to see it in a positive light).

5b. To study whether there will be a significant difference in the effectiveness of the three treatment interventions in improving these rational coping skills.

6. To study whether there will be a significant difference in the outcome of CBT with reference to the clients’ age, gender and marital status.

7. To study whether there will be a significant difference in the outcome of CBT with reference to the clients’ preferences, expectations and their motivation level.
HYPOTHESES

Keeping in view the objectives of the study, the following hypotheses have been framed:

1a. All the three treatment interventions (i.e. Medication alone, a combination of CBT and medication as well as CBT alone) will show a significant reduction in the level of depression.

1b. There will be a significant difference in the effectiveness of the three treatment interventions in reducing the level of depression among depressed clients.

1c. It is also hypothesized that CBT either in combination with medication or when applied alone will be more effective than medication alone in reducing the level of depression.

2a. All the three treatment interventions will show a significant improvement in the level of self esteem.

2b. There will be a significant difference in the effectiveness of the three treatment interventions in improving the self esteem of depressed clients.

2c. It is also hypothesized that CBT either in combination with medication or when applied alone will be more effective than medication alone in improving the self esteem of depressed clients.

3a. All the three treatment interventions will show a significant improvement in the level of adjustment.

3b. There will be a significant difference in the effectiveness of the three treatment interventions in improving the adjustment level of depressed clients.

3c. It is also hypothesized that CBT either in combination with medication or when applied alone will be more effective than medication alone in improving the adjustment level of depressed clients.
4a. All the three treatment interventions will show a significant reduction in the maladaptive coping skills of confrontive coping (hostile and aggressive behaviours), distancing (detachment and denial), self controlling (inhibition of feelings and actions), accepting responsibility (feelings of self blame and self criticism) and escape avoidance (wishful thinking and behavioural efforts to escape or avoid the problem).

4b. There will be a significant difference in the effectiveness of the three treatment interventions in reducing these maladaptive coping skills.

4c. It is also hypothesized that CBT either in combination with medication or when applied alone will be more effective than medication alone in reducing these maladaptive coping skills among depressed clients.

5a. All the three treatment interventions will show a significant improvement in the rational coping skills of seeking social support (emotional, instrumental and sometimes informational assistance or help), planful problem solving (active cognitive and behavioural attempts to manage stress) and positive reappraisal (reframing the situation to see it in a positive light).

5b. There will be a significant difference in the effectiveness of the three treatment interventions in improving these rational coping skills.

5c. It is also hypothesized that CBT either in combination with medication or when applied alone will be more effective than medication alone in improving these rational coping skills among depressed clients.

6. There will be no significant difference in the outcome of CBT with reference to the clients’ age, gender and marital status.

7. There will be no significant difference in the outcome of CBT with reference to the clients’ preferences, expectations and their motivation level.
METHODOLOGY

The aim of the current study is to explore and evaluate the effectiveness of cognitive behavioural therapy as a treatment modality for moderate depression. The present study has also attempted to investigate whether the three treatment interventions (i.e. Medication alone, a combination of CBT and medication as well as CBT alone) reduce the level of depression and improve the self esteem as well as the adjustment level of the depressed clients over the period of treatment. This study has also examined whether the three treatment modalities bring about a reduction in the maladaptive coping skills and an improvement in the rational coping skills of depressed clients during the course of treatment.

Another significant issue, which has been dealt within this study is to investigate whether there is a significant effect of certain moderators in the outcome of CBT i.e. age, gender, marital status, preferences, expectations and motivation of the clients.

Sample

This research was carried out by taking a total of 120 clients suffering from major depression of moderate severity from two renowned hospitals in Jalandhar, Punjab i.e. Ashoka Neuro Psychiatric Hospital and Lajwanti Hospital. The diagnosis of unipolar moderate depression was done by the psychiatrists and physicians of the above mentioned hospitals using standard psychological measures. After the formal diagnosis was made, the clients were referred for cognitive behavioural therapy.

Out of these 120 clients, the first group which is the control group consisted of 40 clients who were administered medication by the psychiatrists and physicians. The second group constituted of another 40 clients, who were given intervention in the form of CBT as well as medication. In both these groups, the clients were being administered antidepressants in the form of Selective serotonin reuptake inhibitors (SSRIs). In the third group, all the 40 clients were treated with CBT only (without any kind of medication). The selection of the clients was made as per the following criteria (inclusion criteria):

(a) Clients with moderate depression as per DSM-IV-TR criteria were included.
(b) Clients between the ages 25-45 years were included.
(c) Both male and female clients were included.
(d) The clients were not suffering from any kind of other mental illness.

DSM-IV-TR (American Psychiatric Association, 2000) classifies moderate depression as including 2 of the first three symptoms and at least 4 others.

1. Two weeks of an abnormal depressed mood
2. Loss of interest or pleasure in activities that used to be enjoyable
3. Reduced energy, or feeling tired
4. Loss of confidence and self-esteem
5. Feeling guilty and unworthy
6. Recurrent thoughts of death or suicide, or any suicidal/self-harming behaviour
7. Reduced ability to think or concentrate
8. Agitated or slow movements
9. Disturbed sleep (not enough/too much/poor quality)
10. Change in appetite (increase or decrease) with weight change
11. Decreased libido
12. Unexplained physical symptoms

Psychological Measures

The following psychological tests have been used in the present study:

(a) Beck Depression Inventory (Beck et al., 1961)
(b) Adjustment Scale (Asthana, 1968)
(c) Coopersmith Self Esteem Inventory (Coopersmith, 1981)
(d) Ways of Coping Questionnaire (Folkman & Lazarus, 1988b)

Procedure

The diagnosis of moderate depression for all the 120 clients was made by the psychiatrists and physicians of Ashoka Neuro Psychiatric Hospital, Jalandhar, Punjab and Lajwanti Hospital, Jalandhar, Punjab. These 120 clients were divided into three groups as follows:
The first group which is the control group comprised of 40 clients who were given only medication by the psychiatrists or physicians of the above mentioned hospitals.

The second group comprised of another 40 clients who were administered medication as well as cognitive behaviour therapy.

The third group consisted of still another 40 clients who were given only cognitive behaviour therapy as a treatment modality for depression.

The case history of all the clients in the three intervention groups were taken by the therapist. The clients’ demographic information (which included their name, date of birth, age, religion, current working status, current educational status and current family structure), personal history (developmental milestones, early medical history, adjustment to school, academic achievements and peer relation), family background (age of parents and siblings, upbringing and family relationships, parental marital history, parents’ occupation, socioeconomic status, family medical and psychiatric history and self marital history) and information about the presenting problem (description of the problem, onset and course of the problem, frequency of the symptoms, antecedents of the problem, automatic thoughts asserted with the problem and reaction to the triggers or life events, intensity and duration of the problem, previous treatment for the problem and any additional problems) was noted down carefully.

After the detailed case history was taken, all the clients were administered the different psychological measures (i.e. Beck Depression Inventory, Coopersmith Self Esteem Inventory, Adjustment Inventory and The Ways of Coping Questionnaire). The results obtained at this point constituted the pre test scores. The clients’ expectations from the therapy were assessed at the time of intake. The clients’ motivation level and references to engage in the treatment modality assigned to them was also assessed. The completion of the homework assignments between CBT sessions also gave us an indication into the motivational level of the clients in group II and group III. An additional effort has been made later in this study to investigate about the outcome efficacy of CBT on the basis of the clients’ age, gender, marital status, their preferences
to engage in the therapy, their expectations from the therapy and their motivation to engage in the therapy.

After this, the control group underwent only medication, the second group underwent both CBT as well as medication and the third group underwent only CBT for a period of 16 weeks.

Beck Depression Inventory, Self-Esteem Inventory, Adjustment Inventory and Ways of Coping Questionnaire were administered on all the 120 clients after 8 weeks and then after 16 weeks. The results obtained at this point of time constituted the post test scores.

(A) **Structure of Cognitive Behavioural Therapy in The Present Study**

In the present study, cognitive behavioural therapy was carried out as a treatment modality for moderately depressed patients. On the whole, 16 sessions were conducted. The patients received one session of cognitive behavioural therapy in a week and each session lasted for approximately 45 minutes. During the course of therapy, several cognitive and behavioural techniques were used so as to restore the patients’ cognitive and behavioural functioning.

(a) **Techniques Used in Cognitive Behavioural Therapy**

In this study, the following cognitive and behavioural techniques across various sessions were used to help patients uncover and examine their thoughts and change their behaviours:

- *Detection and Identification of Automatic Thoughts*
- *Validity Testing*
- *Recording Dysfunctional Thoughts*
- *Socratic Questioning*
- *Downward Arrow Technique*
- *Cognitive Rehearsal*
- *Behavioural Homework Assignments*
(b) Treatment Plan Across The Sessions

The major objectives of CBT include reasonably prompt relief of symptoms of the depressive syndrome and prevention of recurrence. These aims are implemented by training the patients to learn to identify and modify their faulty thinking and dysfunctional behaviour.

In the present study, a general plan for CBT was made while a specific plan for each individual session was developed depending upon the needs and requirements of the clients. CBT can be viewed in three phases: beginning, middle and termination.

In the beginning phase of treatment, a number of goals were accomplished. The main aim of this phase is to re-engage the clients in their daily activities and restore their functioning (Mor and Haran, 2009). A strong therapeutic alliance was built between the therapist and the clients by establishing trust and rapport. The patients were socialized into cognitive behavioural therapy and they were educated about moderate depression, the cognitive model and about the process of therapy. They were educated about how CBT would help them alleviating this depression and their difficulties were normalized. The clients were helped in identifying the problems and setting goals. The clients’ willingness to engage in the therapy and their expectations from the therapy were elicited. The motivation level of the clients was also assessed and efforts were made by the therapist to instill hope and positivity in the clients with low motivation level. The clients were helped in identifying the problems and were encouraged to set realistic short and long term goals and to delineate the steps needed to achieve these goals. Subsequently, the clients were successful in achieving their set goals by refuting their negative thoughts.
of incompetencies and incapabilities. During this phase, the clients were behaviourally activated by making use of various behavioural techniques such as monitoring and scheduling activities, problem solving skills, decision making skills, relaxation skills etc.

The main aim of the middle phase of treatment is to address cognitive changes (Mor and Haran, 2009). In this phase, more emphasis was laid on identifying automatic thoughts, evaluating and modifying these thoughts. The clients were helped in examining their thought patterns using Socratic questioning and guided discovery. The patients were helped in reformulating their goals and were taught the skills that were needed to accomplish them. Although work on cognitive coping skills had already begun in the early phase of treatment, it was in the middle phase that the therapist and the patients worked to solidify these skills. The patients worked between sessions to identify the situations and thoughts that brought about negative affect. They used dysfunctional thought record and began questioning their thoughts at the time of any disturbances. The patients’ DRDT were reviewed and they were helped in formulating rational responses to their negative automatic thoughts. It was also during this phase that patterns associated with schemata and underlying assumptions were identified. The therapist kept giving and reviewing homework assignments to the patients according to the goals which had to be accomplished.

In the final phase of therapy, the emphasis shifted to preparing for termination and prevention of relapse. By this time, the patients had become more active in therapy, taking the lead in setting the agenda, suggesting solutions to problems and devising homework assignments. The clients in this phase learnt to work on altering their core beliefs that usually triggered negative automatic thoughts. To achieve this goal, various cognitive techniques as well as behavioural experiments were used.

In the final sessions, the patients were made ready for the termination as well. The patients’ automatic thoughts about termination were elicited. Some patients were excited and hopeful while some were fearful about relapses. Most of them had mixed feelings. Though, the patients were pleased about their progress, they were concerned about relapse. In these sessions, the therapist discussed and reviewed with the patients all the important coping skills that they had learnt during therapy sessions and how they could
be used effectively in case any difficult situation arises in the future. Moreover, the patients were encouraged to compose some coping cards specifying what to do if a setback occurs after the therapy has ended. Thus, when the therapist and the patients felt confident that they knew how to be their own therapist, it was the right time to terminate the therapy. The patients were helped to have a clear view of what they had accomplished during the therapy and were also helped in setting realistic goals for the future. In the 16th session, the patients were encouraged and taught the importance of scheduling booster sessions once a month or once in two months as per the need. The patients were explained that booster sessions will offer them an opportunity to discuss how they have handled difficulties that might have arisen after termination and also to predict future difficulties that could arise.

RESULTS

The data obtained at intake and at two time intervals (after the completion of 8 weeks and after the completion of 16 weeks) were subjected to t-tests and ANCOVA. The t-tests were calculated to find out whether the three treatment interventions (i.e. Medication alone, a combination of CBT and medication as well as CBT alone) bring about a significant reduction in the level of depression as well as maladaptive coping skills and bring about a significant improvement in the level of self esteem, adjustment and rational coping skills. The Analysis of Covariance is used in the present study to ascertain the impact of three different treatment interventions in reducing the level of depression as well as maladaptive coping skills and in improving the level of self esteem, adjustment and rational coping skills.

The t-tests were also used to find out whether there is a significant difference in the outcome of CBT with reference to the clients’ age, gender, marital status, their preferences for therapy, expectations from the therapy and motivation to involve in the therapy.

On the basis of the results obtained, the following conclusions have been drawn:

1. All the three treatment interventions (i.e. Medication alone, a combination of CBT and Medication as well as CBT alone) have shown a significant reduction in the level of
depression. It is even found that there is a significant difference in the effectiveness of the three treatment interventions in reducing the level of depression. Still further it can be concluded that CBT either in combination with medication or when applied alone is more effective than medication alone in reducing the level of depression.

2. All the three treatment interventions have shown a significant improvement in the level of self esteem. It is even found that that there is a significant difference in the effectiveness of the three treatment interventions in improving the self esteem of depressed clients. Still further it can be concluded that CBT either in combination with medication or when applied alone is more effective than medication alone in improving the level of self esteem.

3. All the three treatment interventions have shown a significant improvement in the level of adjustment. It is even found that that there is a significant difference in the effectiveness of the three treatment interventions in improving the adjustment level of depressed clients. Still further it can be concluded that CBT either in combination with medication or when applied alone is more effective than medication alone in improving the level of adjustment.

4. All the three treatment interventions have shown a significant reduction in the maladaptive coping skills of confrontive coping, distancing, self controlling, accepting responsibility and escape avoidance among depressed clients. It is even found that that there is a significant difference in the effectiveness of the three treatment interventions in reducing these maladaptive coping skills. Still further it can be concluded that CBT either in combination with medication or when applied alone is more effective than medication alone in reducing these maladaptive coping skills.

5. All the three treatment interventions have shown a significant improvement in the problem solving skills and positive reappraisal among depressed clients. CBT either in combination with medication or alone has shown significant improvement in the coping skill of seeking social support but medication alone has not shown a significant improvement in the coping skill of seeking social support. It is even found that there is a significant difference in the effectiveness of the three treatment interventions in
improving the coping skills of seeking social support, planful problem solving and positive reappraisal. Still further it can be concluded that CBT either in combination with medication or when applied alone is more effective than medication alone in improving these rational and adaptive coping skills.

6. There is no significant difference in the outcome of CBT with reference to the clients’ age, gender and marital status.

7. There is no significant difference in the outcome of CBT with reference to the clients’ preferences, expectations and their motivation level.

Thus, from all the above conclusions we can say that CBT either in combination with medication or when applied alone is more effective than medication alone in improving the self esteem, adjustment, seeking social support, planful problem solving and positive reappraisal as well as in reducing depression, confrontive coping, distancing, self controlling, accepting responsibility and escape avoidance among depressed clients.

There are several research studies which support the findings and conclusions of the present investigation:

The findings of the present study that CBT either in combination with medication or when applied alone is more effective than medication alone has been supported by several researchers.

Pilling and Burbeck (2006) concluded that CBT is an effective treatment for moderate and severe depression when compared to the accepted standard treatment of antidepressant medication. Mor and Haran (2009) found that CBT is a family of empirically-based treatments aimed at changing dysfunctional thinking and behavior, in which clients learn to identify faulty beliefs and challenge them and to replace avoidant coping with active problem solving. CBT has been found to be superior to antidepressants and have more lasting effects.

Hollon et al. (1992) suggest that combined treatments may confer additive benefits because the strengths of each modality are promoted while the weaknesses of
each modality are minimized. Thus, response and remission rates for combined treatment should be superior to those of either treatment modality as a monotherapy. They argue that combined treatment increases the magnitude, probability and breadth of clinical response. Adding drug therapy to psychotherapy may bring about a more rapid relief of symptoms than psychotherapy alone, permitting the patient to participate more productively in psychotherapy (Thase and Howland, 1994). Conversely, adding psychotherapy to drug therapy may increase medication adherence, decrease the presence and risk of residual symptoms following drug discontinuation and facilitate the patient’s development of healthy coping skills (Paykel et al., 1995).

Fava et al. (2003) found that the neurobiological substrate of an individual’s depressive illness may be too severely disturbed to be responsive to psychotherapy alone. Likewise, psychosocial or interpersonal stressors may be so extensive that pharmacotherapy alone will not bring about full remission of an individual’s depressive episode. Investigators consistently demonstrate an increased recurrence risk for individuals who experience a partial remission, delayed response to acute treatment, or residual symptoms post treatment. For these individuals, combined psychotherapy and pharmacotherapy may be the best treatment modality.

Frank et al. (2006) states that the majority of private practitioners, still see combination as the ideal treatment and combination therapy is recommended in the treatment guidelines promulgated by the American Psychiatric Association.

March et al. (2007) found that the combination of CBT and an SSRI is particularly powerful because it provides a "one-two" punch against the powerful symptoms of depression. Medicines target brain chemistry problems that can impact mood. CBT steps in to provide a person with skills that they can use whenever and wherever they happen to be. These new skills can improve a current depressed mood, as well as help to prevent (or decrease the severity of) future depressive episodes.

Abernethy III et al. (2008) stated that though psychiatric medications are commonly considered the first line of treatment for a wide range of psychiatric disorders, pharmacotherapy may not produce a complete remission of symptoms and at times may be associated with a delayed effectiveness. CBT can complement, if not replace,
pharmacotherapy for various disorders. CBT can be offered to patients to control symptoms while awaiting a response to medications and to supplement or strengthen treatment response. Indeed, CBT has also been shown to be an effective treatment in addition to medication for depression. These findings seem to support the notion that two treatments (CBT plus pharmacotherapy) must be better than one.

Blanco et al. (2010) found that combination therapy may work better than either monotherapy because some patients may respond to psychotherapy and others to medication and so if patients receive both therapies, the probability of response is higher. The other, more likely, explanation is that the two treatments have an additive or synergistic effect. He said, "The average improvement in the combined treatment is better than the average improvement in one of the therapies, so it is not just a matter of probability responding to one or the other; it is actually that the effect of one adds to the effect of the other."

The present study also concludes that the depressed clients showed more improvement in the self esteem, adjustment, seeking social support, planful problem solving and positive reappraisal as well as more reduction in the scores of depression, conflontive coping, distancing, self controlling, accepting responsibility and escape avoidance after the completion of 16 sessions as compared to the scores after the completion of 8 sessions. Though there is a significant improvement on all the 11 variables after the completion of 8 sessions, yet the effect size of the improvement is less as compared to the effect size of improvement achieved after the completion of 16 sessions. These findings suggest that 8 sessions of CBT are not sufficient to produce the required change among depressed clients and as such 16 sessions of therapy is necessary to bring about the desired change in all the 11 variables.

These findings are supported by various empirical studies:

Several researchers have found that though brief CBT is effective in reducing depression but the effect sizes are low when compared to patients receiving these treatments over a longer duration, as for many patients brief treatments may not be sufficient (Butler et al., 2006; Ekers et al., 2008; Cape et al., 2010). Kennard et al. (2009)
found that the participants who had more than 9 CBT sessions were 2.5 times more likely to have adequate treatment response than those who had 9 or fewer sessions.

In the present study, an effort was also made for having an additional enquiry into the role of the clients’ age, gender, marital status, their preferences for therapy, expectations from the therapy and motivation to involve in the therapy on the outcome of CBT. From the sixth and seventh conclusion, it is very clear that there is no significant difference on all these variables in the outcome of CBT and hence it may not be correct to call them as moderators. However, a subsequent or additional enquiry in future studies may help us to shed light on the role of these variables in the outcome of CBT.