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Individuals' Long Term Use of Cognitive Behavioural Skills to Manage their Depression: A Qualitative Study

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Background: Cognitive Behavioural Therapy (CBT) aims to teach people skills to help them self-manage their depression. Trial evidence shows that CBT is an effective treatment for depression and individuals may experience benefits long-term. However, there is little research about individuals' continued use of CBT skills once treatment has finished. **Aims:** To explore whether individuals who had attended at least 12 sessions of CBT continued to use and value the CBT skills they had learnt during therapy. **Method:** Semi-structured interviews

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were held with participants from the CoBalT trial who had received CBT, approximately 4 years earlier. Interviews were audio-recorded, transcribed and analysed thematically. **Results:** 20 participants were interviewed. Analysis of the interviews suggested that individuals who viewed CBT as a learning process, at the time of treatment, recalled and used specific skills to manage their depression once treatment had finished. In contrast, individuals who viewed CBT only as an opportunity to talk about their problems did not appear to utilize any of the CBT skills they had been taught and reported struggling to manage their depression once treatment had ended. **Conclusions:** Our findings suggest individuals may value and use CBT skills if they engage with CBT as a learning opportunity at the time of treatment. Our findings underline the importance of the educational model in CBT and the need to emphasize this to individuals receiving treatment.

Keywords: Qualitative interviews, cognitive behavioural therapy, mental health, treatment resistant depression.

Introduction

Cognitive Behavioural Therapy (CBT) models explore the role of thoughts and behaviours in the development, maintenance and treatment of depression (Hundt, Mignogna,Underhill and Cully, 2013). Beck's cognitive model argues that depression arises as a response to dysfunctional thoughts, core beliefs, and information processing biases (Beck, Rush, Shaw and Emery, 1979). CBT aims to teach patients skills to help them change these dysfunctional assumptions in order to reduce depressive symptoms (Beck et al., 1979). Studies have shown CBT to be an effective treatment for depression at the time of treatment (Butler, Chapman, Forman and Beck, 2006; DeRubeis et al., 2005; Wiles et al., 2013).

Given the educational basis of CBT, it is assumed that CBT may confer a long-term benefit because clients continue to use the skills they learnt beyond therapy. The CoBalT trial (Figure 1) established that CBT, as an adjunct to usual care, was an effective treatment for primary care patients with treatment resistant depression (Wiles et al., 2013). A recent follow-up of this trial has shown CBT to reduce depressive symptoms and to improve patient's quality of life 46 months after they had been randomized into the trial (Wiles et al., 2016). However, despite evidence for the effectiveness of CBT at both the time of treatment and at follow-up, research that considers the processes and mechanisms by which CBT works is still in its infancy (Adler, Strunk and Fazio, 2015; Strunk, Hollars, Adler, Goldstein and Braun., 2014; Hundt et al., 2013). Also, it is not evident whether patients continue to use the CBT skills they have been taught in treatment to manage their depression long-term.

The only evidence to suggest CBT skill usage might be important for patients managing their depression, posttreatment, comes from a survey of older, formerly depressed patients. This survey showed patients with fewer depressive symptoms reported CBT skills to be useful to them (Powers, Thompson and Gallagher-Thompson, 2008). This is supported by a solitary qualitative study that interviewed nine individuals about their use of CBT skills, 10 months after their treatment had ended. It found that patients still continued to use a range of CBT skills once treatment had finished (Glasman, Finlay and Brock, 2004). However, these small studies may not be representative of all people who receive CBT; both studies used small samples and drew their findings from participants who had received a varying range of psychotherapeutic treatments and not necessarily CBT.

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The CoBalT trial, (Trial registration: ISRCTN 38231611) a randomized, multi-centred controlled trial examined the clinical and cost-effectiveness of CBT as an adjunct to usual care that included pharmacotherapy for patients whose depression had not responded to treatment with antidepressant medication alone. Participants were recruited to CoBalT through 73 GP practices in Bristol, Exeter and Glasgow. Each research centre employed 2–6 CBT therapists who were representative of those working in NHS psychological services. Therapists received additional training at the start of their employment to ensure consistency across the research sites, with additional expert input as necessary, and weekly supervision with an experienced CBT therapist throughout the trial. In total, 469 patients were randomized to either continue with usual care or receive Beckian CBT in addition to usual care. Ninety percent (n = 422) of participants were followed-up at 6 months and 84% (n = 396) at 12 months. The CoBalT trial found that CBT in addition to usual care was effective at reducing depressive symptoms. Ninety-five participants (46.1%) in the intervention group met criteria for "response" (at least a 50% reduction in depressive symptoms compared to baseline) at 6 months compared to 46 participants (21.6%) in the usual care group (odds ratio (OR): 3.26 (95%CI: 2.10, 5.06) $p < .001$). These effects were maintained over the 12-month follow-up period (Wiles et al., 2013). In the long-term follow-up (median 45.6 months after completing treatment) 275 individuals were followed-up. 149 participants in the intervention group had a mean BDI-II score of 19.2 (*SD* 13.8) compared with the mean BDI-II score of 23.4 (*SD* 13.2) for the usual care group (repeated measures analysis over 46 months: difference in means -4.7 (95%CI: -3.0 (p <.001). The findings suggested that CBT as an adjunct to usual care that includes antidepressants is clinically effective and cost-effective over the long-term for individuals whose depression has not responded to pharmacotherapy (Wiles et al., 2016).

Figure 1. CoBalT Trial and long-term follow-up

A review paper by Hollon, Stewart and Strunk (2006) suggests that patients may struggle to use the skills they have been taught in treatment when they initially start to manage depressive feelings, unless they remind themselves to do so. Hollon et al. (2006) conclude that only as these conscious efforts become more automatic will patients be less likely to jump to negative conclusions that may result in a subsequent decline in depressive symptoms. These findings are important as they suggest the prophylactic qualities, efficacy and cost-effectiveness of the CBT model rests, in part, on patients grasping the importance of learning CBT skills in treatment, in order to recall and use them to manage their depression after treatment. To date no research has shown whether patients do recall the CBT skills they have been taught and whether they continue to use them in the longer-term to manage their depression.

The aim of our study was to explore whether people who had attended at least 12 sessions of CBT continued to use and value the CBT skills they had learnt during therapy, about 4 years earlier, to manage their depression.

Method

Recruitment and sampling

An invitation letter, information sheet and consent form were sent to individuals who had completed a CoBalT long-term follow-up study questionnaire. These documents were sent to individuals who had been randomized to receive a full course of CBT (between 12–18

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one hour sessions) plus usual care, and to individuals who had been randomized to receive usual care only. The letter asked if they would be prepared to take part in a brief telephone interview about how they had continued to manage their depression since their long-term follow-up, 12 months after having taken part in the trial. Potential participants were also asked to complete a brief measure of depressive symptoms (PHQ-9) (Kroenke, Spitzer and Williams. 2001) in order to inform the sampling for these interviews. The PHQ-9 is a multipurpose instrument that uses 9 questions to measure severity of depression. Patients scoring 0–4 are considered not to have depression, 5–9 – minimal depression, 10–14 – moderate depression, 15–19 moderately severe depression, and 20–27 – severe depression. Participants who were willing to be interviewed were required to sign the consent form, complete the PHQ-9 and return the documents, in a stamped addressed envelope, to the research team. Individuals who did not respond to the invitation letter within 2 weeks, were sent a reminder letter. If no response was received, no further contact was made.

From the replies received, we purposefully sampled participants to ensure interviews were held with participants from all three trial sites (Glasgow, Exeter, Bristol), and with participants whose depression had varied in severity as identified by an increase or decrease in their PHQ-9 before starting therapy, in the trial and when approached for interview. Within this sampling strategy, maximum variation was aimed for in relation to socio-economic background, gender and age.

Data collection

Participants were interviewed by LF between November 2014 and January 2015. The interviews were held by telephone for both pragmatic and methodological reasons: conducting face-to-face interviews across all three sites would be costly in terms of time and money, and researchers have shown that well planned telephone interviews can gather the same material as those held face-to-face (Sturges and Hanrahan, 2004).

A topic guide was used to ensure consistency across the interviews. It was based on our understanding of the literature, the aims of the interview, and comments from formerly depressed patients who had received CBT and were invited to consult on the study design as part of the study's patient and public involvement (PPI). The topic guide asked participants what skills and techniques they had learnt and continued to use, how they continued to manage their mental health, whether they had sought any further CBT or other help for their depression, what if any events of life changes they had encountered since completing treatment, and how they viewed their current physical and mental health. All the interviews were audio-recorded and transcribed verbatim. Data collection continued until data saturation had been reached, i.e. no new themes emerged.

Qualitative analysis

The interviews were analysed thematically using the approach described by Braun and Clarke (2006). This approach entailed transcripts being independently read and re-read by LF and KT to familiarize themselves with the data, identify emerging themes and to develop a coding frame. Once the coding frame has been agreed, transcripts were imported into the software package NVivo to allow electronic coding a retrieval of data. Comparisons were then made within and across the interviews in order to identify thematic patterns and deviant cases.

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Table 1. Characteristics of participants interviewed

Name	PHQ-9 score before receiving CBT	PHQ-9 score at 46 mths	Gender	Location	Age	Education
Hannah	17	14	Female	Glasgow	64	NF
Claire	16	16	Female	Exeter	60	AL
Fred	12	7	Male	Glasgow	70	D
Georgia	17	4	Female	Bristol	32	AL
Kate	17	3	Female	Bristol	45	D
Phoebe	21	13	Female	Glasgow	36	AL
Susan	22	20	Female	Bristol	54	GCSE
Ben	22	25	Male	Bristol	56	GCSE
George	19	13	Male	Bristol	48	AL
Mark	23	11	Male	Exeter	63	GCSE
Oliver	12	5	Male	Exeter	54	GCSE
Angus	8	2	Male	Bristol	65	NF
Juliet	19	3	Female	Glasgow	59	HND
Mike	14	6	Male	Exeter	65	GCSE
Emma	12	5	Female	Bristol	56	GCSE
Rachel	7	0	Female	Exeter	49	GCSE
Nick	14	7	Male	Bristol	28	AL
Alec	25	0	Male	Glasgow	57	GCSE
Pippa	12	11	Female	Exeter	65	AL
Sally	18	1	Female	Bristol	64	GCSE

Participants

Of the 210 participants eligible to be contacted, 125 (60%) agreed to be contacted for interview (55 CBT; 70 Usual care), 19 declined, and 66 did not respond. Although we interviewed participants from both arms of the trial (20 CBT, 10 Usual care), here we only report data from the 20 participants interviewed who had been in the trial's intervention arm (Table 1), as the aim of this paper is consider how individuals used CBT skills following therapy. On average the interviews lasted around 30 minutes.

Results

Findings

All 20 participants mentioned that CBT had given them an opportunity to talk about their feelings. However, five participants spoke almost exclusively about the benefit of CBT as an opportunity to talk about their feelings, while the remaining 15 participants also described how CBT had been an opportunity for them to learn about their depression. In this regard, interviewees appeared to fall into one of two groups, which we have termed "talkers" and "learners". These two groups are described below under the theme "value of CBT". We then describe the participants' current use of CBT skills to manage their depression; their beliefs and behaviours following treatment, and how they coped with further challenges to their

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mental health. Whilst doing so, we highlight differences and similarities in the accounts of individuals in the two groups. All quotes have been anonymized and tagged with a pseudonym for the interviewee's name.

Value of CBT

All of the participants said CBT had helped them feel mentally better around the time they were receiving therapy. Participants described how CBT enabled them to release painful feelings that had been "bottled up" for years. For some individuals this meant revisiting suppressed experiences, such as historical sexual abuse, and for others it meant describing, confronting personal feelings of inadequacy and failure, or accepting feelings of loss, such as physical mobility due to other illnesses. Whilst painful, this was viewed as beneficial.

> Sometimes the sessions are a bit upsetting because it's forcing you to think about things that you just put to the back of your mind. But I always found them really helpful. I always felt better when I left. (Rachel)

Learners

While all of the participants described the benefits of being able to talk about their depression, many ($n = 15$) also described the benefits of being able to "learn" about their depression. This group of participants felt that through CBT they had learnt new ways to cope with their depression. They described being taught new skills and techniques, and spoke of learning and becoming aware of personal resources they could draw upon. This suggested that they had gained some sense of personal control and self-dependency in the management of their depression.

> Ok, at the risk of sounding a bit cheesy here, and forgive me, but it [CBT] really has changed a whole lot of how I live my life because of the fact that I found a whole set of tools there that I didn't know I had, that I didn't know I could use, I didn't know I could access … it gave me a sense of having a little bit more control over things than I had thought I had and it was a big relief because if there was something I could do about it [the depression] maybe things weren't quite so hopeless. (Kate)

Talkers

In contrast to the "learners", the "talkers" ($n = 5$) spoke only about the benefits of talking about their depression. These five individuals did not report learning new skills or discovering personal resources to draw upon. They also described wishing the therapist would "tell" them what to do and reported feeling frustrated that CBT had not given them an "answer" to their problems.

> Um … I think sometimes I wanted to ask questions where I wanted to get back an answer. Like there was a problem I had in day-to-day life, I wanted to go there and say "look this is the problem, what's the solution" and I never got that. (Hannah)

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This group also described the difficulty of treatment ending, with many participants in the group described feeling lost, suggesting that they still continued to rely on their therapist for help in the management of their depression and had not gained the same sense of self-dependency or sense of control that the first group had gained.

> The only thing I didn't really like was when it ended, because I was lost . . . I felt very, very lost, I didn't have no one to talk to you know about things then. (Ben)

Use of CBT skills

One of the most notable differences between the two groups related to their use of CBT skills once their therapy had finished.

Talkers. When participants were asked whether or not they thought the CBT skills they had been taught during treatment were useful or helpful, many of the talkers replied "yes" or "all of them". However, when talkers were asked which ones, or if they still used them, nearly all replied that they could not remember what they had been taught or that they did not use any of them now.

Only one participant from this group described writing worrying thoughts on a piece of paper, and another individual described reading a book to distract herself from negative thoughts. Furthermore, when it came to formally tracking their mental health, only a couple of the talkers mentioned they had done this in the first few months following treatment. One individual had continued to use the written assignments given in therapy as a tool for doing this, and the other participant had simply recollected thinking about his mental health day to day. Thus, there was very little evidence to suggest that individuals in this group were continuing to use the CBT skills they had been taught.

Learners. Conversely, nearly all the learners described how they were still using mood diaries and worksheets to track their mental health. As a consequence, learners appeared able to identify points of progress and change in their mental health over the preceding 46 months. They could also see that they had overcome feelings of low mood and were able to identify how they could better manage their mental health.

> When I looked back over the worksheets, I could see when I was getting better and when things were bad. It allowed me to work out the things I needed to change in my life so that I could avoid feeling bad and it showed me that things were getting better. (Oliver)

Learners were also able to recall many of the skills they were taught in therapy. They described regularly using the following skills: Black and white thinking; Breaking down problems; Challenging negative thoughts; Confronting and dealing with problems; Cycles of thought; Distraction; Going out and socializing; Hypothesis testing; Not taking things personally; Setting goals and meeting them; Thought catching; Thought triangle; and Writing things down.

Learners also described the ways in which they continued to remember to use the skills they had been taught. Two described writing brief messages to themselves, such as using sticky notes or writing on the bathroom mirror; others asked close family and friends to tell them to look at their course materials if they noticed they were looking down or seemed depressed.

While the majority of learners were very aware of using CBT skills, three participants from this group reported no longer using any of the skills they had been taught. It was only when these individuals were asked how they managed a "low day" that it was evident that they were unconsciously or automatically using CBT skills. Two learners also felt that they no longer considered that they had depression.

> Interviewer: Do you think that you continue to use any of the CBT skills you were taught in treatment?
> Interviewee: Um . . . I'm not sure. Yes, I suppose I do, I think it's just become a part of me, of who I am now. It's not something that I consciously apply. I don't know whether I do it anyway but it's not something I think about. I guess it's [depression] not something that bothers me anymore. (Fred)

Changes in beliefs and behaviour

Talkers. Many of the talkers reported being unwilling and unable to change their views. A couple of participants described being very stubborn and acknowledged the challenge their therapist must have felt in trying to get them to see things differently.

> The thing with me, I'm very stuck in my ways. It's difficult changing the way I think and do things. Even with the CoBalT, they were saying things I knew but it takes me time to put them into action and even then I'm . . . I'm just nervous to do something or change something. (Susan)

While one participant described taking small steps to change her behaviour after therapy, such as getting up in the morning and walking the dog in order to be more sociable, others described finding themselves back to the way things were before they received CBT, burdened by the same problems, unable to manage their mental health, and over-whelmed by new challenges that arose.

> I think it's got the better of me, to be honest with you, I don't know, I just . . . I can't at the moment I just can't see a way out of it, you know . . . Nothing has changed. I'm not good with problems you know, I don't cope very well with problems, if I get a new one, it tends to get on top of me a bit too much. (Ben)

Learners. In contrast, learners reported feeling that CBT had helped them to change their views and behaviour, to try new things, socialize more, and see things differently. Many felt CBT had helped them re-organize their problems, allowed them to see things more clearly and had given them a new perspective on their difficulties. This was particularly apparent for the three participants who appeared to be unaware of using the CBT skills they had been taught. Their accounts suggested that this lack of awareness reflected an important change in their views and beliefs.

> I see things very differently now. In fact it's hard to remember seeing them any other way. Perhaps I do still use the CBT techniques, the questions you've asked have made me realize I do, but I think when you are able to see things differently, you do things in a healthy way and all the CBT, CBT techniques just become who you are. (Fred)

Challenges to mental health and seeking further help

For some participants, the period since treatment ended appeared to have brought many challenges, such as the death of a loved one and the diagnosis of a serious medical condition. These significant events appeared to seriously challenge participants' mental health.

Talkers. When faced with challenges, the talkers tended not to describe using the materials they had been given in therapy and tended not to seek any further help for their depression other than trips to their GP to review their antidepressant medication. None reported using or referring to any online or self-help literature for their depression and almost felt getting any further help for their depression was very difficult. However, despite explaining that CBT had not helped them once treatment had finished, many did say it had been extremely valuable at the time and that they wanted more sessions of CBT.

> I'm grateful for the CBT treatment I received, it helped me hugely at the time but I needed more. As soon as the treatment ended I was back to square one with no one to talk too! (Ben)

Learners. In contrast many "learners" did seek further CBT related support for their depression. Many reported continuing to refer to the therapy materials they were given during the trial, two individuals joined online chatrooms for people to talk about their depression, many read self-help books about depression, and, notably, a number sought further CBT, either by joining a support group or by receiving top-up sessions of group CBT.

When asked why they had sought further support and had referred back to materials, many answered that they had learnt their depression could be managed using the CBT skills, so they had wanted to be reminded of them.

> I've been a bit wobbly because of what happened with my mum [mother died recently] but I'm doing as well as I can. It's not like it was. It's not a black pit and some days when it's really bad, I do my CBT and kit thing [booklet containing notes and worksheets from the therapy sessions], or my rescue kit or whatever they call it. I can't remember what they called it but it's very helpful. (Kate)

Discussion

The aim of the study was to explore whether people who had received CBT continued to use and value the skills they had learnt during therapy to manage their depression. All of the participants described how they felt CBT had been of help to them at the time of therapy but not all appeared to continue to use and value the CBT skills they had been taught. A minority of interviewees ($n = 5$) considered that CBT had not given them an answer to their problems and had not helped them once treatment had finished. This group did not recall any of the skills they had been taught and reported using very few CBT skills once therapy had finished. They did not provide any evidence to suggest they had changed their beliefs and behaviours, had not sought further help for their depression following the end of treatment in the trial, and described feeling unable to effectively manage their depression. In contrast, the majority of participants interviewed ($n = 15$) appeared to view CBT as an opportunity to learn new skills to manage their depression. They described becoming aware of their own personal resources they could draw upon, continuing to track their mental health, and consciously using many of the skills they had been taught, after treatment had ended. A few also reported

changing their beliefs to such an extent that their use of CBT skills had become automatic and unconscious. A few of these individuals reported feeling they no longer viewed themselves as having depression.

Strengths and limitations

To our knowledge this is the first qualitative study to explore how participants manage their depression over the long-term after receiving CBT, and it provides useful insights for quantitative studies that show that CBT is an effective treatment for depression over the longer term (Wiles et al., 2016).

Our study used purposive sampling to maximize the diversity of participants interviewed. However, sampling interviewees from those who agreed to be interviewed as part of a trial, and who had completed a long-term follow-up questionnaire and agreed to be interviewed, may limit the generalizability of the findings, as these participants may not be representative of other patients with treatment resistant depression or of individuals who have received CBT. Furthermore, the study included only individuals who had completed at least 12 sessions of CBT. Future research may want to explore how patients who drop out of CBT treatment continue to manage their depression in the long term. Or indeed explore the value of giving patients "booster sessions" of CBT following the termination of treatment in order to understand whether this improves the patient's recall of CBT skills and therein their use of CBT skills to manage their depression.

Comparison with existing literature

The findings support previous research suggesting that improvements in an individual's mental health may be sustained following treatment by continuing to use the CBT skills they have learned in therapy (Glasman et al., 2004). The findings also support previous suggestions that CBT leads to lasting change because patients learn skills that can be implemented after the treatment has ended (Hollon et al., 2006). They also highlight the importance of patients engaging with treatment as a learning process rather than simply viewing CBT as an opportunity to talk. This reflects the educational basis of the CBT approach (Beck et al., 1979; Williams and Morrison, 2010). The findings also support previous research by Barnes et al. (2013) that highlights the importance of emphasizing to patients, prior and during treatment, that CBT is a learning therapy in which the patient needs to actively engage, learn, recall and master CBT skills in order to help themselves independently manage their depression. Furthermore, the study demonstrates the value of what CBT therapists do, and how they use models and specific techniques that help the patient to manage their depression in the longer term, over and above what might be achieved simply by the therapeutic relationship alone.

It was apparent that some of our participants felt the CBT skills they have been taught had become automatic and unconscious once treatment had finished. This finding explains why previous studies, which have attempted to measure patients' use of CBT skills through self-report measures, may underestimate patients' CBT usage following treatment and therein the importance of CBT skills for patients' long term management of their depression.

Finally, the findings also highlight the importance of patients being able to recall the skills they have been taught in therapy in order to be able to practise them. Many of our participants wanted to receive further CBT sessions in order to recall CBT skills they had learnt or to learn

new ones in order to cope with adverse events that challenged their mental health. This finding lends support to previous studies that have suggested "booster sessions" may be key to CBT's enduring effects (Glasman et al., 2004; Kovacs, Rush, Beck and Hollon, 1981).

Conclusions

Patients who view CBT as both a talking and a learning therapy may actively learn CBT skills, which they can recall and utilize once treatment has ended. These individuals may also change previously held maladaptive beliefs and come to use the CBT skills automatically. These findings suggest for individuals to benefit from receiving CBT, in terms of managing their depression long-term, they must be encouraged to view and engage with this treatment as a learning process.

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The authors assert that all procedures contributing to this work comply with the ethical standards of the Helsinki Declaration of 1975, and its most recent revision.

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Contributors: NW, KT, WK, GL and CW conceived the original idea for this qualitative study. LF conducted all the qualitative interviews, analysed data (under the supervision of KT) and wrote the first draft of the paper. LT was the study co-ordinator. All authors contributed to, and approved, the final manuscript.

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Conflicts of interest: CW is the author of a range of CBT-based resources that address anxiety, depression and other disorders. These are available commercially as books, cCBT products and classes. He receives royalty, and is shareholder and director of a company (Five Areas Ltd) that commercializes these resources. WK is the co-author of the 2009 CBT book *Collaborative Case Conceptualization*, and receives royalties from its sales. The other authors have no conflicts to declare with respect to this publication.

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