Cognitive-Behavioral Therapy *and* Relapse Prevention *for* Depression and Anxiety

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ABSTRACT

Cognitive-behavioral methods have shown considerable promise both in promoting short-term improvement and in preventing relapse in emotionally distressed patients. There are, however, few comprehensive practical guidelines for the practitioner wishing to implement cognitive-behavioral strategies in an attempt to maximize therapeutic gains and prevent symptom recurrence in such patients. This book aims to fill the gap. It provides an overview of cognitive-behavior therapy and its relationship to maintenance and relapse. Relapse rates and predictors of relapse in the areas of depression and anxiety are reviewed. Practical procedures to facilitate maintenance and prevent relapse, which can be used at different points in therapy and in the after-care phase, are described in detail with several case examples. Specific difficulties encountered in working to maintain treatment gains and prevent relapse are outlined and possible solutions are explored. Finally, some general guidelines for therapists working with patients who have relapsed are offered.

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OVERVIEW OF COGNITIVE-BEHAVIORAL THERAPY (CBT) AND RELAPSE

In the last two decades there has been a virtual explosion of interest in effective short-term psychotherapies for use with emotionally distressed clients. Of these therapy approaches, cognitive-behavioral methods have received considerable attention (especially in the areas of depression, anxiety, and other related disorders) due to their apparent promise in promoting maintenance of treatment gains and preventing relapse. This introductory section will review the goals and strategies of cognitive-behavioral therapy (CBT) and how these relate to the objectives of relapse prevention.

Cognitive-behavioral approaches seem to have attracted clinicians from both behavioral and psychodynamic traditions. In fact, the theoretical basis of cognitive-behavioral therapy includes cognitive psychology (i.e., information processing and social psychology) as well as modern behaviorism and psychoanalysis. The principle theoretical assumptions of this model are:

1. Cognitions influence mood and behavior.
2. Perceptions and cognitions mediate the effects of situations on mood and behavior.
3. Cognition includes automatic thoughts, images, beliefs, underlying assumptions, and memories.

4. Different emotional disorders have distinct cognitive themes (i.e., specific automatic thoughts and beliefs).
5. In disorders of mood and behavior there are often underlying information-processing deficits or cognitive distortions.
6. Underlying thoughts and beliefs are often acquired as a result of early experience.
7. Modification of cognitions leads to emotional and behavioral change.

The goals of cognitive-behavioral therapy with emotional disorders are (a) to reduce depressive and anxious symptoms, (b) to help the patient develop self-management skills, and (c) to promote maintenance of treatment gains and facilitate relapse prevention.

These goals will be accomplished by the following means:

- Identify and challenge negative thoughts and maladaptive beliefs.
- Help the patient develop more adaptive beliefs and attitudes.
- Get the patient to practice and rehearse new cognitive and behavioral responses.

Specific procedures and strategies for accomplishing these objectives with depressed and anxious clients are well documented in A. T. Beck et al. (1979) and A. T. Beck and Emery (1985). The principle characteristics of the practice of cognitive therapy as outlined by A. T. Beck and Emery are as follows:

1. Cognitive therapy is based on a cognitive model of emotional disorders.
2. Cognitive therapy is brief and time limited.
3. A sound therapeutic relationship is a necessary condition for effective cognitive therapy.
4. Cognitive therapy is a collaborative effort between therapist and patient.
5. Cognitive therapy uses primarily a Socratic method of questioning.
6. Cognitive therapy is structured and directive.
7. Cognitive therapy is problem oriented and focused on the here-and-now.

8. Cognitive therapy is based on an educational model.
9. The theory and techniques of cognitive therapy rely on the inductive method (i.e., guided discovery).
10. Homework is a central feature of cognitive therapy.

In actual clinical practice, the cognitive-behavioral therapist may employ a variety of cognitive and behavioral techniques to alter the dysfunctional cognitions and behaviors that contribute to a patient's emotional distress. Cognitive techniques may include (a) identifying and monitoring dysfunctional automatic thoughts; (b) creating an awareness of the connection between thoughts, emotions, and behaviors; and (c) evaluating the reasonableness of automatic thoughts and substituting more adaptive thoughts. Behavioral techniques may involve (a) monitoring and scheduling activities, (b) graded assignments, (c) behavioral rehearsal, and (d) relaxation and attention-refocusing methods.

The emphasis throughout cognitive-behavioral therapy is on skill building. Patients are instructed to practice new cognitive and behavioral strategies through homework assignments between therapy sessions. In addition, patients have the opportunity to troubleshoot problems in applying these skills during therapy sessions. In this way, patients' progress toward becoming "their own therapist" is encouraged, and this shift is facilitated more and more as therapy progresses.

Cognitive-behavioral approaches tend to stress maintenance of change more than other theoretical schools. A number of therapy approaches assume that deep personality changes take place during therapy that allow the client to remain well without further efforts to sustain recovery (Shiffman, 1992).

Many of the arguments for using psychotherapy, in addition to or instead of pharmacotherapy, in the treatment of emotional disorders can also be used to support the role of psychotherapy in preventing relapse in these disorders. In the case of depression, for example, it has been found that although antidepressant medication is very effective in the acute treatment of depression, there is a high relapse rate. Weissman et al. (1974) have demonstrated that pharmacotherapy, without some form of structured psychotherapy, has a limited impact, especially in the long term, because symptom reduction does not necessarily bring with it social and interpersonal readjustment. Furthermore, although psychological factors are not addressed in

chemotherapy, they are an important focus of structured psychotherapies, especially interpersonal psychotherapy (Klerman et al., 1984) and cognitive therapy (A. T. Beck et al., 1979). Also, patients receiving chemotherapy may well attribute change to the medication rather than to their own efforts and, as a consequence, may see relapses or setbacks as beyond their control.

It is clear that emotional disorders are multifaceted and complex, and they involve a reciprocal interaction between cognition, behavior, biochemical events, and affect, as well as current and previous stressors. Thus, simultaneous or sequential interventions that address these many different psychological, biological, and environmental influences may be required. Any treatment plan that helps patients to modify dysfunctional attitudes, problematic behavioral patterns, and troublesome life situations, while also correcting any chemical imbalance, would seem most likely to prevent relapse.

More specifically, A. T. Beck (1976) predicts that because dysfunctional attitudes may predispose to depression and these attitudes are modified in cognitive therapy, then cognitive therapy patients will be inoculated to some extent against relapse. Similarly, Blackburn, Eunson, and Bishop (1986) make the point that cognitive-behavioral therapy is a sophisticated treatment that deals not only with negatively biased thought content but also with negative attitudes and information-processing deficits that are considered to be depressogenic. Therefore, it could be predicted logically that patients who undergo cognitive therapy will learn new skills that they can then apply in the future if disturbances of mood reoccur. From a theoretical standpoint, one would expect that the ability to correct thoughts and attitudes that exacerbate or maintain depression and anxiety would have an inoculating effect without the need for further therapy. To what extent this prediction has been borne out will be examined later.

Although most texts in the cognitive-behavioral area emphasize the importance of a maintenance and relapse-prevention focus, particularly in the later stages of therapy, there is no systematic body of work in the area of cognitive-behavioral treatment of emotional disorders comparable to that which now exists in the area of addictive behaviors (Chiauzzi, 1992; Marlatt & Gordon, 1985). The necessity for more practical guidelines on how to prevent relapse seems all the more important when one considers the research demonstrating that

different factors are often involved in the relapse process than in the initial episode of depression (Lewinsohn, Sullivan, & Grossup, 1982). Therapy aimed at relapse prevention will need to take this into account. In general, it might be argued that acute treatment may be very different from relapse-prevention work (Shiffman, 1992). It behooves clinicians not to assume that a standard course of cognitive-behavioral treatment automatically inoculates the client against relapse.

DEFINITIONS OF RELAPSE

As Brownell et al. (1986) have pointed out, there are two very different dictionary definitions of the word relapse, each reflecting a bias concerning its nature and severity. The first is "a recurrence of symptoms of a disease after a period of improvement" (Brownell et al., 1986, p. 765). This refers to a specific outcome and implies dichotomous categories of well versus ill. The second definition is "the act or instance of backsliding, worsening or subsiding" (Brownell et al., 1986, p. 766). This refers to a process rather than an outcome and implies that something less serious (e.g., a slip, mistake, or regression) has occurred which may or may not lead to a full relapse. Whether the process or outcome definition of relapse is chosen has obvious implications for the conceptualization, prevention, and treatment of relapse. Viewing relapse as a process and not as an outcome implies that there are choice points in the process where the therapist and client can intervene. Therefore, the initial stage may involve a lapse which might mean the reemergence of a previous habit or set of symptoms. This stage may or may not lead to a full relapse. Whether this occurs is related to the degree to which corrective action is taken and how successful this action is. Put simply, the patient's response to the initial lapse will determine whether relapse will occur.

The definition of relapse as a process is consistent with the theoretical underpinnings of cognitive-behavioral approaches, while the definition of relapse as a recurrence of a disease is more consistent with a medical model of emotional disorder. This framework helps to maximize treatment gains by focusing on the acquisition of self-management skills so that relapse can be prevented or at least attenuated.