The effects of group cognitive behavior therapy (GCBT) on suicidal thoughts in patients with major depression

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Abstract

Introduction: Depression is one of the common mood disorders. According to the World Health Organization depression disorders will become the second most frequent disorder throughout the world in 2020. So, the present study was designed due to the serious social, economic and familial consequences of depression and to assess the effects of group cognitive behavioral therapy (GCBT) in the major depressive patient.

Methods: Forty patients in Shahid Rajaee hospital were selected, randomly, in the present study as a clinical trial investigation. Major depression was confirmed in them by Beck Depression Inventory and DSM V criteria. The subjects were divided by Control and experimental groups. GCBT sessions were planned for four continuous weeks and there were two 90 minutes sessions every week. Data acquisition consisted of demographic, Beck's suicidal ideation, Beck's depression questionnaires. Beck's suicidal questionnaire (including 19 multiple choice questions) assessed attitude, behavior and planning for suicide in the patients. Data collection by the mentioned tools was established one week and one month after the GCBT. Furthermore, all the patients in the control and experimental groups did not give up their routine antidepressant drug therapy. Finally, the results in both steps of the experiment (pre-& post- GCBT) were analyzed in both groups by unpaired t-test using SPSS software.

Results: This investigation showed that there was a significant reduction between suicidal ideation score in control and experimental groups one week after GCBT, ($p<0.0001$). Moreover, the results demonstrated that one month after GCBT the suicidal ideation score in the experimental group was markedly reduced in comparison with the control, ($p<0.0001$).

Conclusion: Although routine antidepressants can reduce suicidal ideation during hospitalization, cognitive behavioral group therapy accompanied by drug therapy may be more effective to prevent suicidal thoughts and be considered as a complementary treatment beside the usual health care for major depression.

Key words: Major Depressive,
Group cognitive behavioral therapy,
Suicidal Ideation, Beck's suicidal ideation

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Introduction

Depression is one of the common types of mood disorders. According to the World Health Organization prediction, depressive disorders will be the second most common disease in the world by 2020. Also, based on existing studies, depressive disorders account for 75% of cases admitted to psychiatric hospitals (Yaeghoobi Nasrabadi et al., 2003, Kenny and Williams, 2007). According to a national survey, the rate of depression risk has been reported to be 21% in Iran (Noorbala et al., 2004). Major depressive disorder is the most common disorder among depressive disorders (Kenny and Williams, 2007). Diagnostic criteria for major depression are defined based on at least 5 cases of clinical manifestations for two weeks or more than two weeks that include at least one of the symptoms of low mood, lack of pleasure, as well as the occurrence of at least four symptoms of overall appetite change, loss of body weight by 5% or more, sleep disturbances, feeling of weakness and lethargy, loss of physical strength or fatigue, feelings of worthlessness, low self-esteem, permanent feelings of guilt, inability to concentrate thoughts of death and suicide (Association, 2013). In general, mood disorders, including major depression and low self-esteem are introduced as the most important predisposing factors for suicidal thoughts (Edalati Shateri et al., 2009). Basically, suicidal thoughts are one of the diagnostic criteria for depression (Kleiman et al., 2014) that is defined as the thoughts associated with death or destruction by planning about the time, place and method of committing suicide as well as its impact on others (Alizadeh et al., 2011). In addition, a range of risk factors of suicidal thoughts or suicide attempts have been proposed, including frustration, negativity, pessimism towards oneself and others (Reinecke et al., 2001), inheritance, family dynamics, communication networks, substance abuse, depression, schizophrenia, personality factors (King et al., 2001, Bearman and Moody, 2004, Gutierrez et al., 2000, Canapary et al., 2002, Zare and Sayadi, 2009, Troister et al., 2008). Assessment of suicide thoughts is not only considered a priority in the prevention process in patients with major depression, but also is a psychiatric emergency in the treatment phase (KaplanHI, 1995). Surveys indicate that about 7% of men and 4% of women with major depression lose their lives due to suicide (Nordentoft and Mortensen, 2011). Also, out of 95% of people with a history of suicide attempts, 80% had depression and 20% of them were diagnosed with major depression (AHMADIAN et al., 2009, Esmaeilnia et al., 2005). Although the exact statistics of suicides associated with affective disorders of major depression has not been reported in Iran, the suicide rate is higher compared to other Middle Eastern countries (MORADI, 2002). Considering that suicide causes a significant challenge for families and society and may result in the loss of active and productive forces of society; also, evaluation and identification of risk factors of suicidal ideation and suicide prevention in patients with major depression, are regarded as priorities in this regard (Vuorilehto et al., 2014). So, in addition to medical and pharmaceutical measures, scholars and researchers focus their attention on non-pharmacological and support approaches so that they can enhance one's flexibility, resistance, compatibility, stability and self-esteem against suicidal thoughts (Brezo et al., 2006). Considering the various biological, psychological and sociological factors in the etiology of depression and suicidal thoughts, different therapeutic methods have also been suggested such as individual psychotherapy, family interventions, problem-solving treatment training and hospitalization (Shokhmgar and Pakdaman, 2012). In addition to drug therapy, non-pharmacological methods such as cognitive-behavioral method have been of interest for treatment of depression since 1970 (Ghamari et al., 2012). Although this method, whether individual or group, emphasizes on active participation in problem-solving process on the part of the patient, venturesome presence in the environment and improvement of one's ability to interpret events and taking appropriate approach (NAVABIFAR et al., 2008, sotodeh asl et al., 2011), the group method is preferred over the individual method in terms of time, cost and feedback in the treatment group, (Ghamari et al., 2012, Aghaei et al., 2009). Cognitive behavioral approach is a supportive therapy and group psychotherapy for the treatment of mood disorders such as depression, and patients undergo the treatment process during a group process with clear, organized and planned objectives (Noorian et al., 2004). The studies indicate that the effect of this method in the field of depression has been more noteworthy rather than that of suicide thoughts. For example, the effect of this method has been reported in several studies on non-psychiatric patients, including epileptic patients with depression, epileptic patients (Salehzadeh et al., 2010, Macrodimitris et al., 2011), cancer patients (Khodai et al., 2011) and patients with type II diabetes and recovery from depression recurrence (Jacobson and Weinger, 1998) and patients with opioid dependence disorder and major depressive disorder (Rasouli et al., 2009). Therefore, considering the foregoing and the fact that suicide imposes heavy socio-familial and social burden on society, there is a need for low-cost health interventions to reduce suicidal thoughts predicting one's suicidal behavior in the future; so the aim of the present research was to investigate the GCBT impact on suicidal thoughts of patients with major depression The efficiency of this method regarding suicidal ideation in patients with major depression was studied.

Materials and Methods

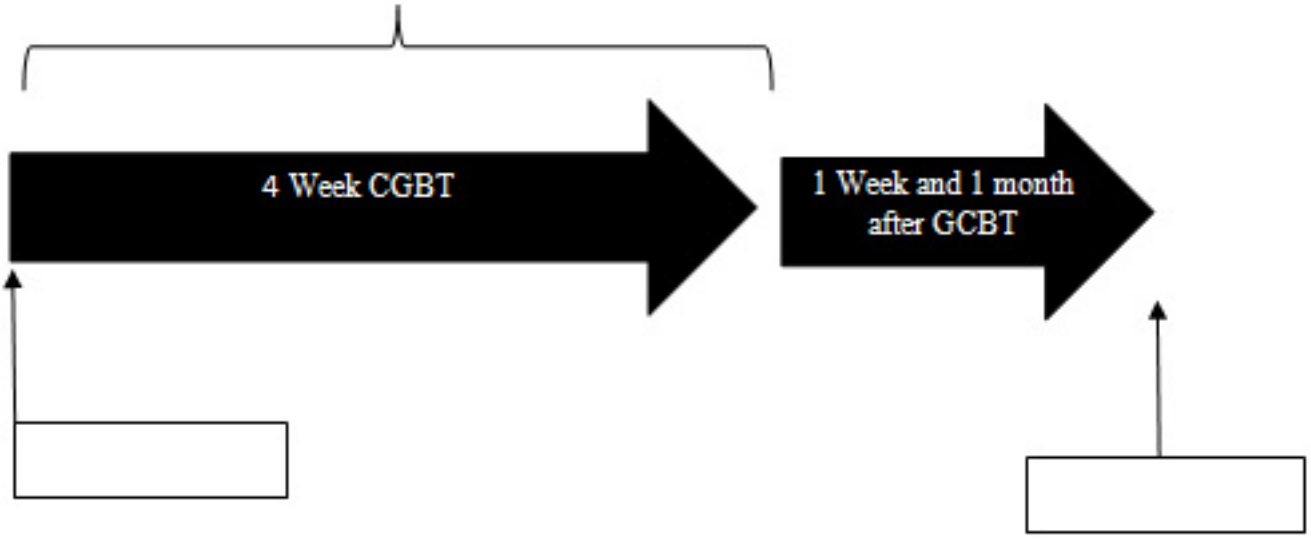
This study is a clinical intervention, the study population of which included all patients diagnosed with major depression who referred to the Psychiatric Clinic and Hospital of Shahid Rajaie, Yasouj, Iran. Due to limitation of the studied population and lack of computational formula based on probability sampling, available and eligible subjects were used to estimate the sample size. Samples were later divided into two groups, including experimental and control using random allocation. Inclusion criteria included a diagnosis of major depression by a psychiatrist based on the latest version of the Diagnostic and Statistical Manual of Mental Disorders, having a score higher than 29 on the Beck Depression Inventory, the age range of 18-45 years, the ability to be trained, having the physical

and cognitive ability to participate in intervention sessions, obtaining informed consent to participate in the study, obtaining a score higher than 12 for having suicidal thoughts based on Beck Scale for Suicidal ideations (BSSI) and lack of previous participation in similar studies. Exclusion criteria included acute psychiatric condition diagnosed by the psychiatrist, lack of cooperation and willingness to continue the study, incomplete questionnaires or transfer to other treatment centers. Before intervention, the informed consent letter was obtained from the participants after a full explanation about the study's goal. In addition, emphasis was placed on the confidentiality of the collected information, use of the information on the purpose of the study, complete voluntary participation in the study and free withdrawal from the study at any stage. In this research, 40 patients with major depression were studied and no participant withdrew from the study. However, since the above intervention is a GCBT intervention; and thus the experimental group was divided into two groups, 10 participants in each, and both groups were again evaluated one week and one month after intervention in terms of suicidal thoughts. With the start of the study, GCBT sessions began in the experimental group. The intervention protocol was based on the guideline proposed in the literature by a therapist for 8 sessions of 90 minutes twice per week for 4 weeks (Masoudi et al., 2009) (Figure 1). Details of the intervention sessions are listed in Table A (Kith. SD, 2006, Wright.Turkington.Kingdon.Basco, 1st. Ed. Arjamand. 2010). But the control group received no GCBT training but the prescribed medications were administered at the doses ordered by the psychiatrist in both groups. As the intervention protocol was previously mentioned in details, data were collected again and were compared with data before the intervention in both groups after the end of treatment. In this study, in addition to demographic data, data collection tools included Beck's Self-Rating Scale for Suicidal Ideation and the Beck Depression Inventory. Beck's Self-Rating Scale for Suicidal Ideation contains 19 questions with three choices scale (0, 1 & 2), which has been set for measurement of the intensity of attitudes, behaviors and (also) planning for reliance on suicide. The overall score ranges from 0 to 38 and scores 12-38 indicate high level of suicidal thoughts. Validity and reliability of the Persian version has been evaluated and confirmed (Esfahani et al., 2015). Beck Depression Inventory with 21 multiple-choice questions has been designed to measure feedback and symptoms of depression. The inventory statements are basically prepared on the basis of observation and summarization of attitudes and common symptoms in patients diagnosed with depression. Although the content of this questionnaire is comprehensively dedicated to depression symptomatology, it focuses more on the cognitive content. Beck Depression Inventory is a self-assessment test that is completed within 5 to 10 minutes. It also consists of 21 statements related to various symptoms, 2, 11, 2, 5 and statements of which are dedicated to affective, cognitive, obvious behaviors, physical symptoms among and intra-individual symptomatology, respectively. According to this scale, depression severity ranges from mild to very severe. Also, the total score is obtained by adding the scores of each of the above statements and minimum and maximum scores are equal to 0 and 63, respectively. Lack of, or mild depression, moderate depression and severe depression are respectively classified by scores of 0-13, 20-28 and 29-63. The reliability and validity of the Persian version of this questionnaire have also been approved (Dabson and Mohammadkhani, 2007). The collected data were analyzed using SPSS V.19 and through descriptive statistical tests such centrist indicators, scattering indices, tables, as well as inferential statistics such as t-test and repeated measures considering α=0.05.

Summary of GCBT sessions:

First session (A review of depression): welcoming, introducing and making participants acquainted with each other, providing a summary of interventions for each session, emphasis on the need for mutual respect, a sense of security and confidentiality and privacy, a short description of depression, risk factors, cognitive - behavioral model of depression, the importance of activities offered, the necessity of doing assignments, and monitoring activities, mood effects and recognition of emotions.

Figure 1: The protocol of intervention in experimental group in the present study. As seen here, data collection was done in four phases; Pre-GCBT and, 1 week and 1 month after latest session of GCBT.



Second session (depression-activity link): reviewing daily activity sheet, completing the mood grading sheet, reemphasizing the importance of doing the assignments, using the experiences of the group members to help increase positive behaviors, providing a list of enjoyable activities to increase positive events or self-caring mood.

Third session (Thought-depression link): reviewing assignments and mood grading sheets, identifying negative thoughts in depression, showing ineffective thought patterns (mental rumination-distraction-distraction), using activity planning strategy to overcome distraction and concern

Fourth session (fighting negative thoughts): reviewing assignments and completing mood grading sheet, mentioning cognitive distortions of depression, fighting useless and negative thoughts through raising three challenging questions

Fifth session (creating hope): reviewing assignments and completing mood grading sheet, providing reasons for an optimistic outcome, organizing the treatment, setting realistic goals, using behavioral methods to foster a more optimistic thinking style.

Sixth session (efficient anti-suicide program): reviewing assignments and completing mood grading sheet, identifying specific reasons of survival, cooperative agreements in the field of precautions, identifying cognitions and adaptive behaviors, fostering strategies to deal with stressful factors increasing suicidal thoughts

Seventh session (meaning of life): reviewing assignments and completing mood grading sheet, setting life goals, providing coping strategies in pressure situations

Eighth session (Conclusion and saying goodbye to the group): - reviewing assignments and completing mood grading sheet, review of what I learned, reviewing the personal operators and depression, stating positive things to each other, saying goodbye to each other.

Findings

After collecting and analyzing data, Chi-square test showed that the control group and experimental groups were homogenous in terms of qualitative variables such as gender, marital status, level of education, employment status, place of residence, history of suicide attempt, history of suicide in the family and the number of hospitalizations. Also, the independent t-test for quantitative variables, including age and duration of diagnosis of depression showed that both groups were homogenous in terms of these variables; so chi-square and t-tests analysis showed no significant difference between the control group and two experimental groups in terms of demographic variables. The average demographic information of samples is shown in (Table 1).

Table 1: The demographic characteristics of variables. All the variables were reported as mean ±SEM.

The variations	Control		Experiment
Age	30.35±6.44		28±6.68
Duration of diagnosis	7.3±3.3		8.15±2.87
Gender	Male	12 (52.2%)	11 (47.8)
	Female	8 (47.1%)	9 (52.9)
Marital status	Single	8 (47.1%)	9 (52.9)
	Married	12 (52.2%)	11 (47.8)
Level of education	Diploma	5 (45.5%)	6 (54.5%)
	Associate	4 (40%)	6 (60%)
	bachelor or higher	11 (57.9%)	8 (42.1%)
Job status	Employed	4 (50%)	4 (50%)
	Unemployed	4 (40%)	6 (60%)
	Student of university	12 (54.5%)	10 (45.5%)
Residential location	City	14 (50%)	14 (50%)
	Village	6 (50%)	6 (50%)
Family history of depression	Yes	3 (50%)	3 (50%)
	No	17 (50%)	17 (50%)
History of suicide attempt	Yes	9 (47.4%)	10 (52.6%)
	No	11 (52.4)	10 (47.6%)
Familial history of suicide attempt	Yes	1 (20%)	4 (80%)
	No	19 (54.3)	16 (45.7%)
History of Hospitalization	Once	15 (50%)	15 (50%)
	Twice or more	4 (44.4%)	5 (55.6%)

Before the intervention, there was no significant difference between the average scores of suicidal thoughts intervention in the control and experimental groups (p = 0.023); but immediately after the intervention and one month after the intervention the average score of suicidal thoughts was decreased in the experimental groups compared with the control group subjects who take only their prescribed medications (P = 0.0001 in both cases) (Table 2).

Table 2. The statistical comparison between control and experimental groups by ANOVA. The results demonstrated that there is a significant difference between

	Control	Experiment	P value
Pre-GCBT	22.85±10.25	28.95±5.30	.023
1 week after of GCBT	6.75±2.82	17.35±6.19	.0001
1 month after GCBT	5.45±3.02	15.35±7.12	.0001
ANOVA (RM)	0001	.0784	

Discussion

As mentioned, the current study aimed to investigate the effect of GCBT on suicidal thoughts of patients with major depressive disorder. Data analysis showed that there was no significant difference between the two groups in terms of effective demographic variables, including age, gender, marital status, level of education , employment status, place of residence, history of suicide attempt, history of suicide or depression in the family and the number of hospitalizations, duration of depression. However, the study suggests that age, gender, marital status, unemployment, low education levels, low economic status, mental disorders, history of self-injury, aggressive behaviors, history of suicide attempt or successful history of suicide in the family and the self-harm thoughts are considered as suicide risk factors (Haerian et al., 2012, Barkhordar and Jahangiri, 2009, Stanley and Brown, 2012, Cheng et al., 2010). But considering the homogeneity of the three groups in terms of all demographic variables, the results can be judged with more confidence. Also, the results showed that there was no statistically significant difference between the mean scores of suicidal thoughts in both experimental groups and control group before the intervention, which is consistent with the results obtained in other studies on the effect of psychological interventions on suicidal thoughts in patients (Cheng et al., 2010). With respect to the mean suicidal thoughts scores in patients with major depression before the intervention, it can be shown that patients in experimental and control groups lack favorable condition in terms of suicidal thoughts scores. In this regard, the results of the study conducted by Sucu et al. (2008), which was conducted on 4,712 young individuals in Italy, the prevalence of suicidal thoughts, planning to commit suicide and lifetime suicide attempts have been reported to be 3%, 0.7% and 0.5%, respectively. The probability of planning, and suicide attempt was respectively 6.24% and 2.18% in those who had a history of suicidal thoughts (Karbalaei et al., 2011). Although the findings of this study showed that the mean scores of suicidal thoughts were decreased significantly in both experimental and the control groups a week and a month after the intervention, the difference between the average scores of suicidal thoughts shows that the decline in the experimental group is more significant than the control group. The results of this study also show that there is no significant change in the declining trend of suicidal thoughts scores within one month follow-up after the intervention. Regarding the reduction of suicidal thoughts scores in the two groups, it can be said that both drug therapy and drug therapy along with GCBT was effective in reducing suicidal thoughts; but considering the further reduction in the suicidal thoughts scores in the experimental groups, it can be concluded that this reduction is related to the effect of GCBT. Although there are few studies on the superiority of drug therapy over cognitive behavioral therapy, Casacalenda et al. believed that cognitive behavioral therapy is equal to drug therapy (Casacalenda et al., 2002). Furthermore, studies that are consistent with the present study, indicate that psychological therapies, particularly cognitive - behavioral therapy are more effective than pharmacological methods and the results of some of these studies are as follows:

The results of the study conducted by Dimov (2007) who investigated the effectiveness of dialectical behavior therapy, cognitive behavior therapy combined with drug therapy on chronic depressed patients, showed that the recovery of patients who received this type of therapy and in those who were treated using drug therapy alone, was 71% and 47%, respectively (Dimeff and Linehan, 2008). The results of the study conducted by Stanley (2009) who aimed to investigate the effect of cognitive-behavioral therapy on the prevention of suicide in depressed patients aged 13 to 19 years, showed that this approach significantly reduced the suicidal scores among adolescents (Stanley et al., 2009). In a study on the effect of cognitive behavioral therapy (CBT) on suicidal thoughts of schizophrenia patients showed that CBT led to significant reduction in the suicidal thoughts at the end of treatment and sustainability during follow-up (Bateman et al., 2007). Furthermore, the findings of the study conducted by Brown et al. (2005) showed that CBT has reduced suicide attempts by 50% when usual care programs were promoted in patients who committed at least one suicide attempt (Brown et al., 2005). Wales and Hilborn (2012) also conducted a study with the aim of using family-based CBT for the treatment of suicide. The findings show that despite the very complex nature of adolescent suicide, this treatment was critical for saving the life of these individuals (Wells and Heilbron, 2012). Khojasteh, Mehr et al. examined and compared the effectiveness of family-centered CBT and solution to eliminate suicidal thoughts among individuals who committed suicide attempts and were hospitalized in the poisoning ward of Razi Hospital, Ahvaz, Iran. The findings

showed that both methods led to a significant reduction in suicidal thoughts (Abbaspour et al., 2014). According to sources and previous research, we can interpret the effectiveness of GCBT in reducing suicidal thoughts as follows: cognitive behavioral perspective shows the patient that thoughts are always associated with emotions and behaviors. As a result, each time a patient goes in any way to commit suicide, he/she will experience suicidal thoughts or ideas. Therefore, the patient learns the relationship between his/her thoughts and feelings and therefore can better understand and control these thoughts. Cognitive restructuring helps the patients to know their cognitive distortions during treatment and this somehow helps them predict and control the path leading to suicidal attempts (Hassanzadeh and Abedini, 2012, Wenzel and Beck, 2008). Basically, suicidal patients often have mental rumination. They are also extremely irritable, disappointed and pessimistic about the future and tomorrow situations, and feel isolated . These people have low self-confidence and defective thinking about the surrounding phenomena. Assignments help patients recognize the connection between their thoughts and mood states. So, individuals become familiar with a variety of cognitive distortions during therapy sessions and identify their attitude about themselves, others, expectations of others, their abilities, their past and the relationship between these thoughts and destructive daily behaviors using the worksheet. The most common aspects studied in this treatment type include self-blame, shame, inferiority, humiliation, feeling of helplessness, a feeling of emptiness. Also, the group therapy strengthens the communication network by strengthening factors such as group interconnectedness; therefore, the patients experience hope, altruism and tranquility in their interaction (Handley et al., 2013, Ealati and Abonajmi, 2006). Therefore, considering lower scores of suicidal thoughts of the control group who used just the drugs prescribed by the psychiatrist, the results can be explained with reference to previous studies: Based on Henden's view (2009), drugs are taken to prevent suicide attempts according to the rule that a successful drug therapy for an underlying psychiatric disorder (depression) will reduce the risk of suicidal thoughts and attempts (Henden, 2017). In this respect, in a study on the emergence or rise in the suicidal thoughts during treatment with drugs "selective serotonin reuptake inhibitors", Zisuk et al. (2009) conducted, that 57% of patients recovered and 5% were worsened (Biancosino et al., 2010). To justify why the treatment outcomes didn't change at the follow-up phase (one month after the intervention) compared to the post-test phase, it can be said that according to Beck, CBT can be sustained in the long term. Overall, the level of suicidal thoughts was decreased in the experimental and control groups in the present study, but the mean difference was more significant in the experimental group than the control group. Limitations of this study included impossibility of using the placebo group, and lack of annual follow-up. Therefore, to determine the effectiveness of this method, it is recommended to compare it with other methods of suicidal thoughts treatments in future studies as well as to use the placebo group, if possible, and longer-term follow-ups.

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