Please see the summary of a recently accepted manuscript on REBT for depression in youth.

And congratulations to the lead author F. Iftene and the rest of the research team in Romania

REBT/CBT for Major Depression in Youth. Results of a New Clinical Trial.

☐ Citation: Iftene, F., Stefan, S., Predescu, G., & David, D. (in press). Rational-emotive and cognitive-behavior therapy (REBT/CBT) versus pharmacotherapy versus REBT/CBT plus pharmacotherapy in the treatment of major depressive disorder in youth: A randomized clinical trial. *Psychiatry Research.*

o Correspondence for this article should be addressed to daniel.david@ubbcluj.ro).

Introduction: Eighty-eight (N=88) depressed youths (i.e., major depressive disorder patients) were randomly allocated to one of the three treatment arms: (1) group Rational Emotive Behavior Therapy (REBT) (i.e., a form of cognitive-behavior therapy/CBT; 16 weekly group sessions); (2) pharmacotherapy/medication (i.e., sertraline), and (3) group REBT/CBT plus pharmacotherapy.

Clinical Protocol: Group REBT/CBT used behavior activation and cognitive restructuring techniques to address the core irrational beliefs (i.e., demandingness and self-deprecating, but also catastrophizing/awfulizing and frustration intolerance, if they appear) and restructure them into rational beliefs (e.g., flexibility in the form of preference/acceptance rather than demandingness; self-acceptance rather than self-deprecating). Indeed, group REBT/CBT was focused on: (a) restructuring particularly the irrational beliefs of demandingness and self-depreciation; (2) developing unconditional self-acceptance; and (3) secondary problems like depression about depression (meta-emotions). Negative automatic thoughts were not specifically targeted first in psychotherapy (as in other CBT strategies), but they were identified, analyzed, and used to access and then change core irrational beliefs.

Results: The results - for details see below the Figure 1 - showed that all outcomes (i.e., subjective – depressed symptoms and general distress, cognitive – negative automatic thoughts, and biological – serum serotonin and norepinephrine) significantly change from pre- to post-treatment in all treatment conditions, with no difference among conditions at posttest. Remission rate at post-treatment was defined as scores lower that 19 on the CDI (Children's Depression Inventory), meaning that the patients do not meet the criteria for clinical depression anymore; we found the following remissions rates: 67.85 % for group REBT/CBT; 60.60 % for

pharmacotherapy; and (3) 53.84% for group REBT/CBT plus pharmacotherapy (there were no significant differences among groups). Suicidal ideation significantly decreased from pre to post-treatment ($p < .05$), but there were no differences across groups ($p > .05$). General distress (Profile of Mood States/POMS-SV) was similarly reduced in all three conditions, thus potentially impacting the improvement of the quality of life/social functioning of the participants. Consistent to REBT/CBT theory, pre-mid (8 weeks) changes in negative automatic thoughts (ATQ - Automatic Thoughts Questionnaire) were prospectively associated to the pre-post changes in depressive symptoms (CDI): $r = 0.220$, $p = 0.026$.

Conclusions: To our knowledge, this is the first RCT comparing psychotherapy (i.e., group REBT/CBT), pharmacotherapy/medication, and their combination for depressed youth, assessing multi-level outcomes (e.g., subjective – depressive symptoms and general distress; cognitive – negative automatic thoughts; and biological outcomes: serum serotonin and norepinephrine). At a theoretical level, the results of our RCT indicate that administering group REBT/CBT, sertraline, or a combined intervention for depressed youth generates similar results (i.e., in terms of subjective, cognitive, and biological markers of depression), this opening interesting questions about clinical strategies and mechanisms of change. At a practical level, group evidence-based REBT/CBT protocols are now available to mental health professionals dealing with depression in youth.

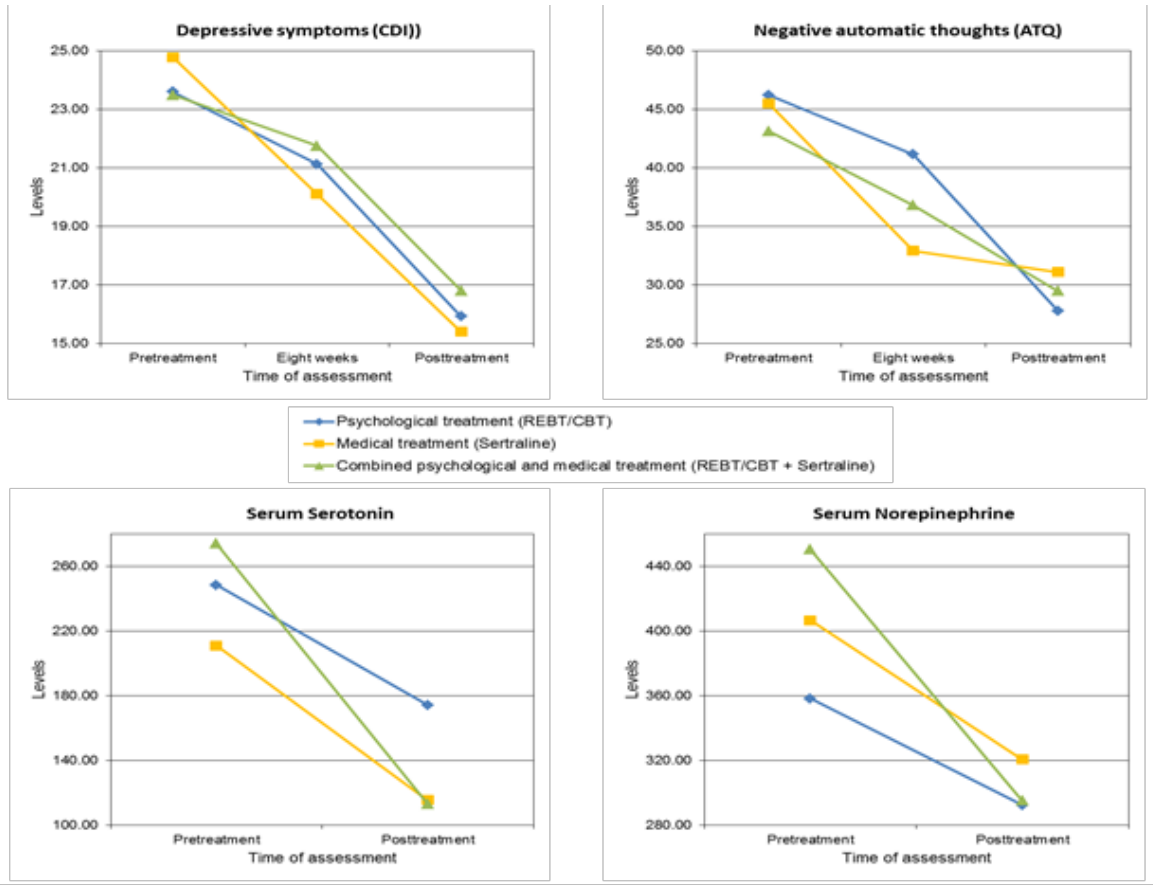

Figure 1. Eighty-eight (N=88) depressed youths (i.e., major depressive disorder patients) were randomly allocated to one of the three treatment arms: (1) group Rational Emotive Behavior Therapy (REBT) (i.e., a form of cognitive-behavior therapy/CBT; 16 weekly group sessions); (2) pharmacotherapy/medication (i.e., sertraline), and (3) group REBT/CBT plus pharmacotherapy. Group REBT/CBT used behavior activation and cognitive restructuring techniques to address the core irrational beliefs (i.e., demandingness and self-deprecating, but also catastrophizing/awfulizing and frustration intolerance, if they appear) and restructure them into rational beliefs (e.g., flexibility in the form of preference/acceptance rather than demandingness; self-acceptance rather than self-deprecating). Indeed, group REBT/CBT was focused on: (a) restructuring particularly the irrational beliefs of demandingness and self-depreciation; (2) developing unconditional self-acceptance; and (3) secondary problems like depression about depression (meta-emotions). Negative automatic thoughts were not specifically targeted first in psychotherapy (as in other CBT strategies), but they were identified, analyzed, and used to access and then change core irrational beliefs. The results showed that all outcomes (i.e., subjective – depressed symptoms and general distress, cognitive – negative automatic thoughts, and biological – serum serotonin and norepinephrine) significantly change from pre- to post-treatment in all treatment conditions, with no difference among conditions at posttest. Remission rate at post-treatment was defined as scores lower that 19 on the CDI (Children's Depression Inventory), meaning that the patients do not meet the criteria for clinical depression anymore; we found the following remissions rates: 67.85 % for group REBT/CBT; 60.60 % for pharmacotherapy; and (3) 53.84% for group REBT/CBT plus pharmacotherapy (there were no significant differences among groups). Suicidal ideation significantly decreased from pre to post-treatment ($p < .05$), but there were no differences across groups ($p > .05$). General distress (Profile of Mood States/POMS-SV) was similarly reduced in all three conditions, thus potentially impacting the improvement of the quality of life/social functioning of the participants. Consistent to REBT/CBT theory, pre-mid (8 weeks) changes in negative automatic thoughts (ATQ - Automatic Thoughts Questionnaire) were prospectively associated to the pre-post changes in depressive symptoms (CDI): $r = 0.220$, $p = 0.026$.

II. OTHER RELATED INFO.

II.1. REBT and depression in adults:

☐ David, D., Szentagotai, A., Lupu, V., & Cosman, D. (2008). Rational emotive behavior therapy, cognitive therapy, and medication in the treatment of major depressive disorder: A randomized clinical trial, post-treatment outcomes, and six-month follow-up. *Journal of Clinical Psychology, 64*, 728-746.

☐ Sava, F., Yates, B., Lupu, V., Szentagotai, A., & David, D. (2009). Cost-effectiveness and cost-utility of cognitive therapy, rational emotive behavior therapy, and fluoxetine (Prozac) in treating depression: A randomized clinical trial. *Journal of Clinical Psychology, 65*, 36-52.

☐ Szentagotai, A., David, D., Lupu, V., & Cosman, D. (2008). Rational Emotive Therapy, Cognitive Therapy and medication in the treatment of major depressive disorder: Theory of change analysis. *Psychotherapy: Theory, Research and Practice, 4*, 523-538.

☐ Macaskill, N. D. & Macaskill, A. (1996). Rational-emotive therapy plus pharmacotherapy versus pharmacotherapy alone in the treatment of high cognitive dysfunction depression. *Cognitive Therapy and Research, 20* (6) , 575-592.

☐ Wang, C. et al. (1999). Comparative study of rational emotive therapy for 95 patients with dysthymic disorder. *Chinese Mental Health Journal, 13*, 172–183.

☐ See also here: http://albertellis.org/rebt-depression-manual/

II.2. Meta-analysis about the evidence-based status of REBT/CBT as psychological treatment for children:

☐ Gonzalez, J. E., Nelson, J. R., Gutkin, T. B., Saunders, A., Galloway, A., & Shwery, C. S. (2004). Rational Emotive Therapy with Children and Adolescents: A Meta-Analysis. *Journal of Emotional and Behavioral Disorders, 12*, 222-235.

III.3. For the evidence-based status of REBT theory and practice see here:

☐ http://albertellis.org/the-empirical-status-of-rational-emotive-behavior-theory-and-therapy/