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Cognitive therapy as a treatment technique of depression

Abstract

A substantial body of research has indicated that the cognitive theory of depression, as well as the use of cognitive therapy in the treatment there of, has experienced widespread acceptance in the psychotherapeutic community. 1 Etiological theories of depression have been diverse, ranging from speculations concerning biochemical deficiencies and hereditary-constitutional deficits and speculation concerning internal psychological factors or subtle disruptions in patterns which travel between the organisms and the environment. Despite this diversity, the observed clinical syndrome has generally been described in strikingly consistent terms. Traditionally considered to be a disorder of affect, most descriptions also specify changes in cognitive, behavioral, motivational, and vegetative components.

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COGNITIVE THERAPY AS A TREATMENT TECHNIQUE OF DEPRESSION

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

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In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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by

Kathleen Moon Jordan

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has been approved as meeting the research paper requirements for the Degree of Master of Arts.

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Date Approved	Advisor/Director of Research Paper
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A substantial body of research has indicated that the cognitive theory of depression, as well as the use of cognitive therapy in the treatment there of, has experienced widespread acceptance in the psychotherapeutic community.

Etiological theories of depression have been diverse, ranging from speculations concerning biochemical deficiencies and hereditary-constitutional deficits and speculation concerning internal psychological factors or subtle disruptions in patterns which travel between the organisms and the environment. Despite this diversity, the observed clinical syndrome has generally been described in strikingly consistent terms. Traditionally considered to be a disorder of affect, most descriptions also specify changes in cognitive, behavioral, motivational, and vegetative components.

Coyne and Gotlieb (1983) suggested that as measured by the sheer number of articles appearing in the journals, cognitive approaches have achieved ascendency over alternative psychological conceptualization of the disorder. Kendall and Hollon (1979) noted that the cognitive model of depression, differs from traditional views which hold that all other symptoms are secondary to the basic affective disturbance. Kendall and Hollon (1979) have stated that converging lines of research from basic experimental psychology to descriptive

psychopathology have led to the articulation of cognitive and behavioral theories of depression.

The purpose of the paper was to define the cognitive theory of depression, and to explore the cognitive approach to treatment. The issues to be addressed include: a) The cognitive theory of depression, b) How does it differ from other theories of depression?, c) What evidence exists to support this theory?, and d) Cognitive therapy as a treatment approach.

The Cognitive Theory of Depression

The central tenet of the cognitive model is that the idiosyncratic, distorted conceptions of depressed clients are central in the development and maintenance of depressive symptomatology.

Krantz and Hammen (1979) described depressive distortion as the construct hypothesized-by the cognitive therapists as the central mechanism in the cause and maintenance of dysphoria and other symptoms of depression. Seligmann (1975) posited that depression occurs when an individual has acquired a cognitive set of learned helplessness. The central characteristic of this set is said to be the individual's belief or expectation that his behavior and its outcome are independent events. Seligman (1975) presented the cornerstone of the learned helplessness model of depression as learning

that outcomes are uncontrollable which results in the motivational, cognitive and emotional components of depression. The cognitive deficit consists of:

a) difficulty in learning that responses produce outcomes and is also seen as a consequence of expecting response outcome independence.

b) the negative cognitive set is displayed by the depressives belief that their action is doomed to failure.

c) finally, depressed affect is a consequence of learning that outcomes are uncontrollable.

Cognitive theory suggests that these dysfunctional beliefs and distorted information processing style serve both to depress mood and to lead to behavioral processing possibility.

Beck (1963, 1964, 1967) published a systematic theory of the origins of depression in the early 1960's. He placed a great deal of importance on the Adlerian view that we do not suffer from the shock of our experiences - the so-called trauma - but what we make out of them. We are self determined by the meaning we give to our experiences, and there is most likely always a mistake involved when we take particular experiences as the basis for future life. Meanings are not determined by situations but we determine ourselves the meanings we give to situations.

The Beck et al. (1979) cognitive model has drawn upon three concepts to account for the psychological state of depression: a) the cognitive triad, b) schemas, and c) cognitive errors. The cognitive triad consists of the depressed individual's negativistic views of self, which leads to an overwhelming sense of worthlessness and self-hatred. The second component of this triad involves the depressed individual's interpretation of daily experience. The world is seen as more demanding and a larger burden than the depressive can handle. The third facet of the triad is the depressive's view of the future as hopeless.

Their second major concept: "Schema" or stable, long standing negative thought patterns about the depressives self and environment. In order for the negative schemas to be maintained, the depressive must consistently keep them alive in spite of evidence which would refute their validity.

The following are conceptualized as cognitive errors: a) Artibrary inference, b) Selective abstraction, c) Over generalization, and e) Personalization, absolutistic, dichotomous thinking (Beck, et al., 1979).

Lewinsohn (1974a, 1974b) asserted that a lack of social skill represented a major antecedent condition for the maintenance and possibly the origin of depressive behavior. A study by Lewinsohn, Mischel, Chaplin, and Barton (1980)

offered provocative data concerning depression associated differences in self evaluation of social skills. Lewinsohn, et al. (1980) concluded that depressed persons may be realistic in their perceptions, whereas non-depressed persons enjoy self-enhancing rather than self deprecating distortions.

Blaney (1977) defined the similarities in the theories as considerable overlap among the three theoretical positions. Taken together, they suggest the importance of three variables in depression: perception (espoused by Beck (1967) and Seligman (1975)), control (Seligman, 1975; Lewinsohn, 1974a), and rate (Lewinsohn, 1974b). The unique contribution of Beck's theory lies in his focus on particular cognitions not addressed by the others. The unique contribution of Seligman's theory lies in the experimental procedures suggested by it. The unique contribution of Lewinsohn's theory is its attention to the question of rate or amount of reinforcement.

In summation, the role of cognition in depression has been defined by the two major contributors to the theoretical position as well as the significant data offered by Lewinsohn. The cognitive explanation for the development and persistence of depression as offered by these theorists, is then the framework for the cognitive theory of depression.

How Does it Differ From Other Theories of Depression?

Kendall and Hollon (1979) have stated that depression is one of the oldest recognized disturbances of psychological life and also one of the most prevalent. There are four major theories of depression: a) cognitive, b) biochemical, c) behavioral, and d) dynamic-motivational.

Current biological or biochemical theories generally focus on presumed imbalances of biogenetic amines, such as norepinephrine, or indoleamines, such as serotonin. Both substances serve as neurotransmitters to the brain. It is thought that deficits in the substances are associated with depression.

Behavioral theories are generally divided into three subgroups. These include: affect mediated, outcome mediated, and cognitive mediated.

The affect mediated theories focus on the role of conditioned anxiety. It is suggested that excessive levels of anxiety may be directly transformed into depression.

The outcome-mediated theory focuses on the quality and rate of environmental events and speculates that depression might be produced by any of the three following situations: a) low rates of reinforcement, b) high rates of punishment, or c) the removal of discrimination stimuli for response-reinforcer sequences. Lewinsohn (1974a, 1974b)

developed his research focusing on low rates of response-contingent reinforcement as a critical factor in depression.

Dynamic theories of depression have traditionally focused on the role of retroflected anger - anger turned against the self following a real or symbolic loss. Depression, self deprecation and anxiety result from a mysterious "alchemy" generated by the anger that can neither be dismissed nor expressed.

Coyne and Gotlieb (1983) stated that a viable model of depression would have to take into account how depressed people think. Current cognitive models of depression are correct in their claim that in order to understand the behavior and distress of depressed persons we must understand how they process information that is available to them.

What Evidence Exists to Support This Theory?

The primary requirement of any theory is the presumption that causal phenomenon co-varies with the phenomenon under scrutiny. Several studies have been reported, describing cognitive aspects of depression . . . with investigators arguing that depression related cognitions are the cause, a symptom or the consequence of depression.

The material reviewed has indicated differences between depressives and non-depressives in terms of manifest dream

content, with depressives reporting themes of personal loss and failure. Beck (1967) found the tendency to endorse negatively distorted outcomes on a multiple-choice measure of expectancy.

Coyne and Gotlieb (1983) suggested that studies of attribution for positive and negative experiences are among the most direct tests of Beck's and the learned-helplessness models of depression. The main supportive finding is that depressed persons, relative to non-depressed individuals, make more internal attributions for negative experiences.

The second requirement of cognitive theory is that cognitive factors influence behavioral performance and motivational factors. Miller and Seligman (1975) in their review of the evidence for psychological deficits in depression concluded that deficits exist in performance between depressives and non-depressives across a wide variety of tasks. It would appear that these deficits are attributable to either cognitive (negative expectations, low self-confidence) or motivational (non-interest in outcome) factors.

In summary, the studies cited seem to indicate that depressives differ from non-depressives in terms of cognitive processing in areas such as attributions for success and failure, perception of control, perception of reinforcement,

expectation of success and/or reinforcement, recall of information, and search for information.

Cognitive Therapy as a Treatment Approach

Cognitive therapy is generally conducted within a time-limited framework. The most extensive treatment manual available (Beck, et al., 1979) outlined a 20 session treatment program. Given the remitting nature of depressive episodes, time-limited treatment is particularly desirable.

Specific Techniques

a. Self Monitoring Skills

It is usually advantageous to have the client initiate systematic self-monitoring of relevant phenomena from the onset of therapy. Mood, ongoing events, pleasant activities, and mastery behaviors are frequently rated categories.

b. Behavior Techniques

A variety of techniques involve the systematic alteration of the client's ongoing behavior. Behavioral techniques are chosen and implemented in order to maximize the probability of participation and to enhance the potential for disconfirmation of previously held beliefs. Behavioral procedures are always implemented in conjunction with cognitive-symbolic techniques.

c. Graded Task Assignment

Graded task assignment orders the sequences in which tasks are attempted, from least demanding to most demanding, in order to maximize the individual's probability of initiating and completing any given sequence. Kendall and Hollan (1979) cited the ability to generate small success as being associated with an increase in observed motivation. The process allows for the collection of beliefs or predictions generated prior to task initiation.

d. Activity Scheduling

Activity scheduling involves planning the client's days in a systematic fashion. The client and therapist schedule, on an hour-by-hour basis, activities. This appears to reduce passivity and to decrease the amount of time spent in rumination.

e. Scheduling Pleasurable Activities

Clients may have lost the capacity to derive satisfaction from their experiences. They may experience little pleasure simply by not engaging in those activities that are most likely to produce pleasurable consequences (Beck, et al., 1979; Lewinsohn, 1974a, 1974b). In the latter instance, activities most likely to be rewarding, can be prescribed. Encouraging the client to record anticipatory thoughts regarding the scheduled pleasurable events, along with their

subsequence, reactions to these events. Frequently, clients discover that much of their dysphoria was either anticipatory or based on self-fulfilling prophecy.

f. Mastery and Pleasure Technique

Mastery has been defined as engaging in any task that initially seemed difficult or in which the client overcame the sense of inertia or doubt in order to complete. Pleasure is defined as any subjective positiveness or any sense of relief from dysphoria.

Summary

Change in cognition can occur in terms of process (the actual occurrence of automatic thoughts) or in terms of content, the meaning attached by the client. Content, or silent assumptions, correspond closely with the irrational beliefs discussed by Ellis (1962). Cognitive procedures seek to a) facilitate the identification of the operation of self statements; b) help the client to learn to "distance him or herself from the certainty with which the particular belief is held"; and c) promote the evaluation of the accuracy of those beliefs.

The heart of cognitive therapy involves examining the validity of beliefs on a moment to moment basis. Ellis (1962) and Beck (1970) discussed distancing as the recognition that

any belief is, at best, only a hypothesis, not a fact. Once a belief or set of beliefs has been recognized, it can be subjected to critical scrutiny. The client can be trained to ask several standard questions to facilitate the hypothesis-testing process. As the client develops a repertoire of behavioral and cognitive tools, with which to counteract depressive phenomena, therapy then focuses on dealing with specific target symptoms and beliefs and toward identification of the underlying assumptions that appear to organize the belief system of the client.

Cognitive therapy, a combination of cognitive and behavioral techniques based on the cognitive theory of depression appears to be an effective intervention in the treatment of non-psychotic, non-bipolar depression. To date, only cognitive therapy has been shown to be more effective than pharmacology in the treatment of depressed clinical populations.

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