Cognitive therapy for depression assignment

Psychology

Abstract The purpose of this paper is to inform the reader of the theory of Cognitive Therapy for Depression. In doing so, I will discuss the evidence that supports the use of cognitive therapy for depression, the advantages and the disadvantages. The usage of cognitive therapy with children for depression and ending with the assumptions associated with the theory. Cognitive Therapy for Depression Cognitive Therapy (CT) is a form of psychotherapy that was developed by the famed psychiatrist Aaron T. Beck. This style of therapy is one that seeks to change the unrealistic views and way of thinking of the client.

Psychologists using a cognitive therapy approach recognize that psychological problems such as depression can develop from a variety of life experiences. It’s here that Beck uncovered that cognitive therapy was an effective and perhaps the most effective intervention for treating depression (Wikipedia, 2007). The primary goal of CT is to provide relief by helping patients to become aware of and challenge their negative thoughts and imagery. It is the therapist’s role to use this design as it was intended with accuracy; this is the key to this form of treatment working as applied.

Cognitive therapy aims to help the client to become aware of thought distortions, which are causing psychological distress, and of behavioral patterns that are reinforcing it, and to correct them. The objective is not to correct every distortion in a client’s entire outlook; virtually everyone distorts reality in many ways. The therapist will make every effort to understand experiences from the client’s point of view, and the client and therapist will work collaboratively with an empirical spirit, like scientists, exploring the client’s thoughts, assumptions and inferences.

The therapist helps the client learn to test these by checking them against reality and against other assumptions. Supporting Evidence Cognitive therapy was developed as a departure from traditional therapeutic approaches to mental illness. While working with patients, Aaron Beck, a pioneer in cognitive therapy, observed that negative moods and behaviors were usually the result of distorted thoughts and beliefs, not of unconscious forces as proposed in Freudian theory (Beck, 1995). Numerous studies and meta-analyses convincingly that Cognitive Therapy or CBT effectively treats patients with major depression (Beck, 1995).

Two comprehensive meta-analyses showed that Cognitive Therapy is as effective as interpersonal or brief psychodynamic therapy in managing depression (Beck, 1996). They also showed that Cognitive Therapy is as effective as and possibly more effective than pharmacotherapy in managing mild to moderate depression (Beck, 1995). The National Institute of Mental Health Treatment of Depression Collaborative Research Program compared the effectiveness of two forms of psychotherapy interpersonal therapy and CT with imipramine (Tofranil) or placebo in the treatment of 250 patients with major depressive disorder (Miller, 1989).

The study found no significant differences between the therapies; however, the two psychotherapies were slightly less effective than imipramine but more effective than placebo (Miller, 1989). A meta-analysis of four studies, which included 169 patients with major depression, showed similar results for tricyclic antidepressants and CT (Miller, 1989). The evidence suggests that cognitive therapy is a valid alternative to antidepressants for patients

with mild to moderate depression and possibly for patients with more severe depression (Miller, 1989).

The Department of Health group concluded that there is good evidence supporting the effectiveness of psychological therapies in the treatment of depression in general adult and older adult populations, including in-patient care (Miller, 1989). Cognitive Therapy and interpersonal therapy proved to be effective treatments for depression, and a number of other brief structured therapies such as psychodynamic therapy showed some possible benefit, as did other forms of psychological therapy, including focal psychodynamic therapy, psychodynamic interpersonal therapy and counseling (Miller, 1989).

Advantages of Cognitive Therapy Antidepressant medication is the most popular treatment for depression. Studies have suggested that cognitive therapy of depression might have a significant advantage over medication in preventing relapses or recurrences (Robinson, 2005). Despite the alarming prevalence of depression in society, there is yet no completely adequate explanation as to how or why it occurs (Robinson, 2005).

The three major etiological models for understanding depression are cognitive models (based on the work of Beck & Ellis), biological models that link depression to variance in biochemistry (Robinson, 2005), and diathesis-stress models that view depression as the result of a complex interaction of contextual factors and intra-individual factors (Robinson, 2005). There is some evidence to suggest that once treatment-to-remission-from-depression

is terminated that pharmacologically treated patients were twice as likely to relapse than patients treated with cognitive therapy (Miller, 1989).

Many studies have reported evidence of negative cognitive patterns among depressed individuals. A self-deprecating style, negative attitudes toward the future and negative automatic thoughts frequently are associated with depression (Miller, 1989). Scholars have identified latent cognitions or dysfunctional attitudes as triggers to depression. Cognitive models such as those suggested by Beck and Ellis contends that individuals are vulnerable to depression because of depressogenic self-schemas. Scholars tested these models with 93 undergraduates with a range of scores on the Beck Depression Inventory.

Participants were followed prospectively for 4 monthly assessments of stressful life events and depression (Miller, 1989). Support was found for the association between depression and depressogenic cognitive schemas. Beck measured cognitive bias among 632 undergraduates who completed the Beck Depression Inventory, the Life Events Inventory, and a Cognitive Distortion inventory (Miller, 1989). They found that the more depressed participants endorsed a greater number of depressed-distorted responses. There is evidence to suggest that cognitively based treatments are differentially effective depending on the treatment domain being addressed.

In a review it was found that cognitive restructuring techniques were superior in treating depression whereas performance-based techniques were more effective in treating phobic anxiety. Recent evidence has suggested that cognitive theories of depression can benefit from taking into

consideration the complex transactions among cognitive, stress, and interpersonal variables (Beck, 1996). This measures the connection between global levels of perceived stress, negative life events, and depression. In their study, 120 undergraduates completed a perceived stress scale, the Life Experiences Survey, and the Beck Depression Inventory (Beck, 1996).

They found that depression levels increased as negative life change scores increased and that global levels of perceived stress significantly moderated the relationship between depression and negative life events. Cognitive Therapy is based on the fact that emotions, thoughts and behavior are intertwined. How you feel, what you think, and what you do is the entire one thing. Much of your current distress is the result of certain thoughts that that are constantly dwelled upon. Disadvantages of Cognitive Therapy Prevalent in both psychiatric inpatients and outpatients, personality disorders usually pose a distinct therapeutic challenge.

In general, patients with Axis I (syndromal) disorders complicated by Axis II (personality disorder) diagnoses improve less from pharmacologic and psychological treatments than patients without such co-morbidity (Coyne, 1983). However, cognitive therapy has been found to be efficacious for this population. Cognitive therapy-a structured, educative, active approach-emphasizes teaching patients to identify and modify their distorted thinking and dysfunctional behavior as well as to solve their problems (Coyne, 1983).

While most Axis I disorders can be treated by focusing primarily on current issues and problems, Axis II treatment incorporates an additional emphasis on identifying dysfunctional beliefs learned in childhood and changing

patients fundamental assumptions about themselves, their personal experiences and other people (Friedberg, 2002). Treatment is often longer and more complex than Axis I treatment, since the personality disorder patients bring to the therapeutic relationship the same dysfunctional beliefs and behavior that predominate in their other, often troubled, relationships (Coyne, 1983).

DSM-IV describes a personality disorder as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (Friedberg, 2002). Certain dysfunctional behavioral, attitudinal and experiential characteristics, are present not only during acute Axis I episodes, but significantly interfere with patients' adjustment across many situations and across time.

The dysfunctional behavioral patterns are usually the most easily observed: dependent patients rely almost exclusively on others to make decisions, obsessive-compulsive patients demand regularity, order, neatness; histrionic patients seek attention and demonstrate hyper emotionality (Friedberg, 2002). Better-adjusted personalities demonstrate similar or identical strategies at times. A crucial difference is that personality disorder patients use these behavioral strategies inflexibly, compulsively and no adaptively; they do not have a broad range of behaviors from which to select according to the situation.

Rather, they show a consistent pattern regardless of situation or consequence (Miller, 1989). Aaron Beck theorizes that a significantly skewed distribution of genetic characteristics interacting with early experiences predisposes individuals to a personality disorder. Hereditarily shy children with physically and emotionally abusive parents, for example, may come to believe that they are bad and worthless and may continually avoid intimate relationships for fear of rejection.

Children with genetic traits of avoiding risks or challenges and whose parents are overprotective and fearful of psychological or physical harm for their offspring, may develop beliefs that they are incompetent and weak and will fail to develop skills of self-sufficiency and self-reliance (Friedberg, 2002). Using Cognitive Therapy with Children Cognitive Therapy is a user-friendly model of therapy. The concepts are easily understood and put into practice.

There is no hidden agenda because the therapist and patient embark on a collaborative fact-finding mission that leads to new ways of viewing problems and changing thinking, feelings and behavior. It is a powerful model because it follows the scientific method by testing hypotheses and the empirical usefulness of various thoughts, feelings, and behaviors. Tests can be constructed to measure the impact and effectiveness of specific thinking and behavior. Patients can qualitatively test the validity of specific cognitions. For example, an anorexic patient may be asked to survey her friends to see how they feel about her current weight.

She may then be asked to report her findings to the therapist for exploration. Cognitive therapy works because it is understandable, structured, pragmatic

and present-centered in focus. It seeks to help individuals explore their thinking and dig out thought processes that are maladaptive. It is applicable to a myriad of disorders, which gives it efficacy and comprehensive utility as a model for changing human behavior. Although CT has been used with young children under the age of 9 years, it has been found to benefit older children more (Friedberg, 2002).

A meta-analysis of CT with children under the age of 13 years old concluded that although children of all ages benefited from CT, younger children benefited less (Rupke, 2006). In cognitive therapy treatment used in the present study, tasks and goals are explicit and critical components. Consequently, alliance is a good candidate for identifying processes important to treatment (Friedberg, 2002). Adolescents may be more amenable to cognitive therapy approaches due to their developmentally more mature abilities in perspective taking, and expressive and receptive language abilities as compared to younger children (Friedberg, 2002).

Children may be more distractible, easily disengaged, and have difficulties organizing their memories (Rupke, 2006). In actual fact, there is research support for the appropriateness of cognitive-behavioral approaches with adolescents rather than children (Friedberg, 2002). For example, in a meta-analysis of 64 studies on the use of cognitive-behavioral therapies with children and adolescents (1991) found that cognitive therapies were about two times more effective with adolescents (11-13 years) than with children (7-11 years).

This finding may be explained by that cognitive therapies assume significant abilities in perspective taking and verbal comprehension and expression of which children may be less competent (Miller, 1989). Conduct disorder in children is associated with objective and subjective burdens to families, caregivers and teachers, and has a poor prognosis in adulthood. It has proved somewhat resistant to treatment with the current cognitive therapy methods that were developed for use with adolescents rather than children.

The co morbidity of conduct disorders with a number of other childhood disorders, and the possible involvement of family or environmental pathology in its sustenance suggests the need for multimodal approaches in its treatment. School psychologists involved in the treatment of children with conduct disorders could design methods of treatment that take regard of the stage of development needs of children, such as less cognitively complex treatment regimens and affinity with non-deviant peers. Cognitive therapy treatments that train in pro-social skills with peers in school settings appear to have some promise with children (Friedberg, 2002).

Assumptions associated with the theory Cognitive therapy for depression is used to establish a rapport with the client, ventilate their suppressed feelings and to help prioritize their problems. Cognitive theory considers motives toward personal growth and fulfillment. It does not only concentrate the attack on the inner psychic structure to the neglect of situational alternation. Instead of emphasizing the in changeability of human nature, cognitive learning bases its techniques on the premise that people are capable of changing their behavior by altering the immediate environmental circumstances in which they function.

The philosophy of cognitive theory is comparatively more optimistic towards human nature that people have much potential to change the environment that they should not give up themselves. In what I have realized concerning cognitive therapy, it is highly educational in nature and the worker assumes a teaching role, teaching clients the concept of communication and problem-solving skills. It is the therapist responsibility to establish a collaborative relationship in which both client and therapist participate in formulating the problem and establishing a plan of action. References Beck, J. S. (1995).

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