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# Cognitive Behavioral Therapy with a Depressed Outpatient: Assessing Change in Cognitive Distortions as Measured by the Inventory of Cognitive Distortions

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Philadelphia College of Osteopathic Medicine

Department of Psychology

COGNITIVE BEHAVIORAL THERAPY WITH A DEPRESSED OUTPATIENT:  
ASSESSING CHANGES IN COGNITIVE DISTORTIONS AS MEASURED BY THE  
INVENTORY OF COGNITIVE DISTORTIONS

By Detta S. Tate

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

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**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE  
DEPARTMENT OF PSYCHOLOGY**

**Dissertation Approval**

This is to certify that the thesis presented to us by Netta S. Tate  
on the 13<sup>th</sup> day of December, 2005, in partial fulfillment of the  
requirements for the degree of Doctor of Psychology, has been examined and is  
acceptable in both scholarship and literary quality.

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## Abstract

This single subject case study was conducted to determine the usefulness of a new measure, the Inventory of Cognitive Distortions (ICD). The main purpose was to determine the effectiveness of the ICD in noting changes in dysfunctional thinking during cognitive behavioral therapy. Because of the high incidence of depression in the population, a subject diagnosed with Major Depressive Disorder was determined to be the most appropriate choice for assessing the effectiveness of this measure in the clinical setting. The cognitive behavioral treatment implemented was a manualized approach using Gilson and Freeman's (1999), *Overcoming Depression*. This treatment was a collaborative effort between the individual and the therapist; the individual using the manual for homework assignments and for reinforcement of what was learned in the therapeutic sessions. From baseline to termination the patient attended a total of 10 sessions, with a follow-up approximately one month later. Assessment involved clinical interviews, Multimodal Life History Inventory (Lazarus & Lazarus, 1991), the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I; First, M.B., Spitzer, R.L., Gibbon, M., & Williams, J.B.W., 1997), the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974), the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002), and the Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979). The ICD and the DAS were used at baseline, at termination, and at follow-up to note any

changes (or cessation) in dysfunctional thinking throughout treatment. The research findings indicated reductions in self-report scores as the client and therapist worked through the manualized treatment. Homework was an important component. Three self reports (BDI, BAI, BHS) were completed for each session. Reading and working on the manual and the chapter exercises was essential; other homework varied according to the individual's needs. Those included completion of a Daily Thought Record (DTR) to determine patterns and/or triggers in distorted thinking. Because the client seemed to struggle with passive-aggressive tendencies she used writing as a vehicle to express her feelings calmly; she learned and practiced, in session, the assertiveness skills which were to be used beyond the therapeutic setting. The results indicated that cognitive behavioral therapy, in a manualized format, was effective in reducing depressive symptoms and that the ICD was able to indicate changes in the distorted thinking of the subject, as hypothesized.

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## Case Summary

This single subject case study involved the assessment and treatment of a patient diagnosed with Major Depressive disorder, recurrent, moderate, and without psychotic features. This investigator hypothesized that the utilization of cognitive behavioral interventions with a depressed individual in a 10 session therapy protocol would result in a decrease in the frequency of distorted thinking, as noted by reduced scores on the Inventory of Cognitive Distortions (ICD) and the Dysfunctional Attitude Scale (DAS). Depressive symptoms were monitored at each session with the use of the Beck Depression Inventory (BDI), the Beck Anxiety Scale (BAI), and the Beck Hopelessness Scale (BHS) to determine any decrease in depressive symptomatology. But more particularly, this clinical case study focused on the sensitivity of the ICD to reflect changes in the patient's negative thinking while also aiding the patient in evaluating and challenging her own distorted thinking. This measure was able to indicate a reduction in cognitive distortions so that the subject was able to change her thinking and behavior. A significant reduction in depressive symptoms also occurred, as seen in reduced scores on the self reports.



## Chapter 1

### Introduction

#### Depression

Depression, one of the most common disorders encountered by mental health professionals, is costly, debilitating, and widespread, and it is speculated to become the second most costly illness by 2010 (Young, Weinberger & Beck, 2001; Doris, Ebmeier & Shajahan, 1999). An estimated \$44 billion per year is spent in the United States on the loss of productive time (i.e., absenteeism and reduced performance) due to depression and this does not include costs related to time off for treatment or to disability leave (Glass, 2003). The World Health Organization – Supported Global Burden of Disease Study - projects that depression will become the second leading cause of disability worldwide by the year 2020, and in developing regions it will be the leading cause. The severity and increasing prevalence of this disorder only emphasizes the need for effective, high quality, culturally appropriate treatments for depression (Glass, 2003).

#### *Etiology*

The etiology of depression has not been determined specifically. According to the National Institute of Mental Health (2000) there is no single cause of depression. When there is a family history of depression there appears to be a greater risk for developing the disorder, indicating the inheritance of a biological vulnerability. But some individuals have no family history, suggesting that environmental stressors, biochemistry, and other psychological factors are involved in the onset. Young, Weinberger, & Beck (2001) indicate that that depression is apparently provoked by life events or ongoing difficulties. They note that 66% to 90% of depressive episodes have

had a severe event occurring within 6 months of the onset of depression and that the majority of those affected have experienced some element of loss.

No single cause appears evident, however. Genetic vulnerability combined with environmental factors, such as stress or physical illness, may trigger an imbalance in brain chemicals called neurotransmitters, resulting in depression. There also seems to be a link to imbalances in three neurotransmitters – serotonin, norepinephrine, and dopamine. But it is yet to be determined if these changes in the neurotransmitters are the result of depression or are its cause (NIMH, 2000).

#### *Gender and Age*

Depression affects all ages and all races but it is more common in women. One in five American women, over the course of a lifetime, will experience depressive episodes as compared with about 1 in 10 American men. Hormones and different levels of neurotransmitters may be influential (Mayoclinic.com, 2003; Doris, et al., 1999).

The DSM-IV-TR (2000) corroborates this, noting that women are at a greater risk of developing MDD sometime during their lives, occurring twice as frequently in women as in men. Hormonal influences are also indicated. In addition, core symptoms of depression are usually the same across the age span, with the prominence of somatic complaints, social withdrawal, and irritability more common in children. However, cognitive symptoms such as disorientation, memory loss, and distractibility are more prominent in elderly adults.

### *Culture and Ethnicity*

Alertness to culture and ethnicity is essential in the diagnosis of depression. In some cultures, depression may be exhibited in somatic terms, in complaints of “nerves” and headaches, in weakness, tiredness, or “imbalance”, of being “heartbroken” as well as in minimizing the seriousness of depression. It is important to distinguish culturally distinctive experiences from actual hallucinations or delusions that may be part of Major Depressive Disorder, with Psychotic Features. It is imperative that a symptom not be dismissed because it is viewed as the “norm for a culture” (DSM-IV-TR, 2000).

### *The Cognitive Model of Depression*

Faulty information processing characterizes the thinking of emotionally disturbed individuals and is central to the cognitive model. This model indicates that affect and behavior are mediated by cognition (McGinn & Sanderson, 2001).

The cognitive model postulates that three cognitive constructs are implicated in the etiology and phenomenology of depression: schemata, the cognitive triad, and cognitive distortions (Beck, 1967; Beck, Rush, Shaw, Emery, 1979). Schemata, according to Beck (1967), are the key ingredients and are thought to be stable and enduring cognitive structures. He hypothesizes that “certain early life experiences lead to the development of depressogenic schemata and are rigid, inappropriate beliefs about the self and the world.” Stress is believed to be the activator of depressogenic schemata, which then lead to negative cognitions. These cognitive distortions subsequently cause motivational, affective, and somatic symptoms of depression (Beck, et al., 1979).

According to Beck (1967, 1979), depressogenic schemata, once activated, lead to negative themes and cognitions; these, in turn form a pattern of negative self-referent information processing resulting in systematic thinking errors (cognitive distortions). This type of cognitive processing ultimately leads to the development of a negative cognitive triad.

Automatic thoughts (surface cognitions) are an integral part of schemata (deeper cognitions) and they tend to revolve around central themes, in addition to being repetitive in content and emotions. These themes are negative and involve the self, the world and the future; these predominate the depressed person's cognitive awareness and he or she is unable to alter this thinking. Processing errors, known as cognitive distortions, result (Freeman & Oster, 1998)

Several common cognitive distortions have been identified. Each of these is a representation of the application of schemata that exists. They include arbitrary inference, personalization, selective abstraction, over-generalization, magnification and minimalization, dichotomous thinking, emotional reasoning, disqualification of the positive should statements, externalization of self-worth, perfectionism, control fallacy and comparison (Gilson & Freeman, 1999).

### *Treatment of Depression*

The diagnosis of unipolar depression has increased significantly in the last 20 years in the United States, and this increase is projected to continue. Garland and Scott (2002) state that there are potentially effective psychotherapeutic approaches to treatment of depression; these approaches have a number of features that are similar. These

include: (1) a coherent model base; (2) highly structured therapy; (3) a clear rationale for interventions with the goal of promoting independent use of the skills attained. It is speculated that change would occur if the emphasis were also placed on enhancing the self-efficacy of the individual. This description, according to Garland & Scott (2002) is supportive of Beck's cognitive therapy.

In a recent review of research for the treatment of depression, Garland and Scott (2002) have recommended that psychological approaches should be manualized and short-term because these have been shown to be effective in randomized trials.

Cognitive therapy (cognitive behavioral therapy), short-term and manualized, has been investigated extensively, is more widely used than other therapies, and has been determined to be empirically sound (Beck, 1967; Beck, et al., 1979). This study utilized a manualized, short term protocol by using the Gilson & Freeman (1999) manual, *Overcoming Depression*, to educate, focus, and guide the subject through treatment.

Cognitive therapy is derived from the cognitive theory of depression as hypothesized by Beck (Butler & Beck, 1995). It is an active, structured, problem-focused, and time-limited approach to treatment which is based on the premise that depression is maintained by negative-biased information processing (cognitive distortions) and dysfunctional beliefs (schemata). Treatment is designed to help patients learn to think more adaptively and thereby experience improvements in affect, motivation, and behavior. The efficacy of cognitive therapy for depression has been demonstrated in over 30 clinical trials that were reviewed by Dobson in 1989 (Butler & Beck, 1995).

The focus on treatment goals that are specific, measurable, and achievable are the key features of cognitive behavior therapy (CBT). The setting of these goals leads to the creation of a collaborative treatment plan with the patient. Other essential ingredients in CBT involve agenda setting, symptom assessment, the administration of specific techniques, including an evaluation of the interventions utilized (McGinn & Sanderson, 2001). These methods were integrated in this 10 session protocol to reduce the cognitive distortions and depressive symptoms of the subject in this case study.

### *Measures*

In cognitive behavioral therapy an understanding of symptom severity and diagnosis is essential in the formulation of a treatment plan and an outcome evaluation. These are often insufficient; therefore, the use of collateral measures of outcomes is recommended (Dozois, Cugin & Brinker, 2003). Because the modification of negative automatic thoughts and dysfunctional attitudes is emphasized in CBT, an important component of outcome assessment for depression is the measurement of cognition. It has been postulated in a number of studies that “cognitive change is associated with changes in depressive symptomatology and cognitive change appears to be an important variable to assess in therapeutic change for depression” (Dozois et al., 2003); this was specifically addressed in this study.

Researchers have developed a variety of assessment formats to test the cognitive structures of Beck’s cognitive therapy model. The following are pertinent in assessing an individual with depression and were utilized in this study: Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979) and a new measure, the Inventory of

Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). The Beck Depression Inventory (BDI II; Beck, Steers & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974) are also essential in monitoring depressive thinking and symptoms, as designated by the *Diagnostic and Statistical Manual of Mental Disorders –IV-TR* (DSM-IV-TR, 2000) and were also completed by the subject throughout the study to determine any changes in depressive symptoms.

Until the development of the ICD, there was no single instrument that measured cognitive distortions and their frequency of use by patients. This is the first time that this inventory is being used in the clinical setting. This information is essential in identifying the cognitive distortions that may be contributing to the patient's psychological distress. It can also be used as an educational tool in having patients examine the role that cognitive distortions play in maintaining cognitive, behavioral, and emotional dysfunctional patterns. In addition, the ICD can be used to assess change in a patient's distorted thinking as a result of treatment (e.g., pre, post, and interval tests) (Yurica, 2002)

It was proposed that lower scores on the ICD and the DAS would indicate a reduction in the dysfunctional thinking (cognitive distortions) of the depressed individual. It was expected that this reduction would be noted as the subject participated in cognitive behavioral therapy. It was also expected that depressive symptomatology would be reduced as indicated by lower scores on the self report measures of the BDI, BAI, and the BHS.

### *Purpose*

The purpose of this case study was to assess not only the effectiveness of the ICD in the clinical setting, but also its ability to note changes in cognitive distortions of a depressed subject over time. Secondly, the study examined the effectiveness of the ICD as a clinical tool in aiding the subject and the clinician in the process of identifying particular types of distortions, engaging both of them in the metacognitive processes so crucial to resolving psychological disorders. The case study's major contribution was in supplying information concerning the clinical treatment of depression with cognitive behavioral therapy when using a manualized treatment; this included the effectiveness of this new measure of cognitive distortions, the Inventory of Cognitive Distortions. The results should assist clinicians in developing a more accurate description of the current level of clients' functioning, in assisting with case conceptualization and in targeting interventions, in allowing for confirmation or refutation of hypotheses and impressions of their clients, and ultimately in improving the prediction and prevention of relapse.

### *Summary*

This case study hypothesized that a subject diagnosed with Major Depressive Disorder who participated in a 10 session protocol of cognitive behavioral therapy would have fewer cognitive distortions, as noted by reduced total scores on the ICD, and on the DAS. It was also expected that depressive symptomatology would be reduced, as exhibited by score reduction on the BDI, BAI, and the BHS. The results indicated the ICD was able to note changes in cognitive distortions as predicted and that depressive symptoms were reduced through this 10 session cognitive behavioral protocol.



## Chapter 2

### Method

It was hypothesized that when cognitive-behavioral treatment was implemented with a depressed patient in a 10-session out-patient therapy protocol, there would be a decrease in the frequency of distorted thinking, as exhibited in the difference between baseline and termination, using the Inventory of Cognitive Distortions. It was also hypothesized that depressive symptoms would decrease, coping mechanisms would improve, and the behavior associated with the depressive symptoms would be more rational, as exhibited by decreased scores on several self-report measures: Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and the Beck Hopelessness Scale (BHS). This chapter provides information about the following: 1) Referral and Presenting problem, 2) DSM-IV diagnosis, 3) Recent History, 4) Assessment, 5) Case formulation and clinical impressions, 6) Therapy goals, 7) Rationale for interventions used, 8) Procedure - Annotated session material.

#### *Overview*

The current research study was conducted to determine if the Inventory of Cognitive Distortions was able to reflect a change in the distorted thinking of a depressed individual who was participating in cognitive behavioral therapy, using a manualized treatment approach – *Overcoming Depression* (Gilson & Freeman, 1999).

### *Subject*

This was a single case study of an individual who had been diagnosed with Major Depressive disorder (MDD; American Psychiatric Association, 2000). The subject was drawn from a pool of individuals who requested treatment for depressive symptoms at the Philadelphia College of Osteopathic Medicine's Center for Brief Therapy. The patient participated in an intake evaluation that included the Structured Clinical Interview for the diagnostic and Statistical Manual of Psychiatric disorders for Axis I disorders (SCID I; First, Spitzer, Gibbon & Williams, 1997), the Multimodal Life History Inventory (Lazaraus & Lazarus, 1991), the Beck Depression Inventory (BDII; Beck, Steer & Brown, 1996), Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974), Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979), and the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). The patient fulfilled the diagnostic criteria for Major Depressive Disorder as indicated in the diagnostic Manual of Psychiatric Disorders, 4<sup>th</sup> edition, TR (DSM-IV-TR; APA, 2000) and as measured by the intake evaluation procedures. The patient had the following DSM-IV-TR Multiaxial Assessment profile: Axis I: Major Depressive Disorder, recurrent, without psychotic features; Axis II: No diagnosis; Axis III: No medical problems; Axis IV: moderate stressors at home and work; Axis V: Global Assessment of Functioning was 55 at intake.

### *Inclusion Criteria*

Participation was voluntary, and anonymity was maintained. To be included in the case study, the participant had to be between 18 and 40 years of age. There was no restriction for gender, race or religion. The subject chosen to participate in the study was 35 years old, had graduated from high school, and had the ability to read and understand the measures to be used in the study. The subject also expressed a commitment to participate in the program, and had the ability to comply with all the parameters of the study, such as keeping appointments, complying with homework assignments, completing the self-reports and being quite(?) focused on reducing and/or eliminating depressive symptoms.

### *Exclusion Criteria*

Any subjects who were out of the age range of 18-40 were excluded, as well as anyone who exhibited any psychiatric, physical, or medical conditions that might compound the variable of interest. Individuals who were diagnosed with mental retardation, substance abuse, psychosis, pervasive developmental disorders, tic disorders, delirium, dementia, amnesic disorders, schizophrenia, concurrent psychiatric treatment, severe medical conditions, suicidality and homicidality were excluded. Those who did not have at least an eighth grade were excluded.

### *Reason for Referral and Presenting Problem*

The subject was referred by her psychiatrist for evaluation and treatment to the Brief Therapy Center at the Philadelphia College of Osteopathic Medicine (PCOM) due to the presentation of depressive symptomatology that was not alleviated by medication alone. She complied with therapy which was highly recommended by her psychiatrist.

The subject was struggling with lack of motivation, behavioral changes (increase in irritability, tearful) and physical symptoms (eating and sleeping difficulties). Motivationally, she was experiencing expectations of failure, low sense of self-efficacy, and a perceived inability to cope. She viewed herself as incompetent and indecisive and had difficulty completing daily tasks. Isolation and withdrawal were prevalent in her life; she also experienced low energy and fatigue. All these symptoms indicated a negative view of herself, her world, and her future and are typical manifestations of depression.

### *Initial Evaluation*

An evaluation was conducted at the initial session (6/20/05) at PCOM's Brief Therapy Center in the suite adjacent to one of the therapy rooms. The patient was greeted by the therapist and provided with the "Consent to Treat" (Appendix 1), Informed Consent Form" (Appendix 2) and the "Consent for Taping Sessions" (Appendix 3). After the forms were reviewed, they were signed and the subject was assured of confidentiality. Confidentiality involved locking written material in a file cabinet and maintaining anonymity and privacy in reference to taped, spoken, and written material. The PCOM

Initial Evaluation Questionnaire was then completed, followed by the clinical interview. The evaluation included information about age, gender, ethnicity, race, socio-economic class, prior inpatient and outpatient psychiatric experiences, past medical history, family history, occupational/educational history, current concerns, life stressors, and therapy goals.

The patient was then educated about the purpose of the research study; this was followed by a discussion concerning her interest in participating in the study. The protocol was described and the patient agreed to participate. This initial session also included a description of the manualized collaborative approach to treatment that would be utilized - *Overcoming Depression, A cognitive therapy approach for taming the Beast of Depression* (Gilson & Freeman, 1999); this was to be utilized throughout treatment, including as a focus for homework. This approach focused on the multiplicity of problems that occurs with depression and used the term BEAST as both a metaphor and acronym to remember the aspects of depression. BEAST represents the following components of depression: B=Body (biology and biochemistry), E=Emotion (how you feel), A=Action (what you do), S=Situation (your immediate life experiences), and T=Thoughts (how and what you think).

Because the subject was referred by her psychiatrist, the doctor was consulted regarding her patient's inclusion in this research study. With the subject's consent, a telephone call was placed to the doctor to provide information on the research protocol. The physician gave approval for the patient's inclusion.

Assessment was essential both in learning about the individual and in determining the appropriate diagnosis. Several measures were used to aid in this process at the second session on 6/27/05 and included: The Structured clinical Interview for DSM-IV Axis I Disorders (SCID I; First et al., 1997), the Multimodal Life History Inventory (Lazarus & Lazarus, 1991), the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974), the Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979), and the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). The patient was very cooperative in completing the measures and the remainder of the session focused on a review of problem behaviors that were precipitators to treatment.

The patient (herein referred to as the subject) was an African American female, 35 years of age. She graduated from high school and has been employed in her present position as a data entry operator for 16 years. She received commendations and monetary rewards for her work product during this period, but recently was struggling at her position because of increased stress on the job, exacerbated by the death of her father. She is married and has two daughters. Her husband is a manager at her place of employment but they do not work together. She is very much involved in the Jehovah Witness meetings.

The support system for the subject is minimal. Although she has a close relationship with her mother, it is also a strained relationship because of the mother's

continual criticism. The subject's husband is encouraging and supportive but he is also experiencing stress from his position at work; this often prevents him from being empathetic and understanding. The relationship with her father, which appears to be the precipitator of her depressive symptoms and anxiety, increased following his death; the symptoms have been exacerbated by the relationship with her mother.

#### *DSM-IV Diagnosis*

The assessment measures yielded the following DSM-IV Multiaxial Assessment profile:

AXIS I:	296.32 Major Depressive Disorder, recurrent, moderate, Without psychotic features.
AXIS II:	V. 71.09 No diagnosis
AXIS III:	No medical problems
Axis IV:	Moderate
AXIS V:	Global Assessment of Functioning, present =55

#### Background/Relevant History

##### *Medical History*

The subject indicated no medical problems, other than struggling with Premenstrual Syndrome difficulties each month, which include increased irritability, impatience, reduced motivation, and intolerance. These symptoms usually pass in a week or so.

### *Psychological History*

Therapy was initiated three years ago due to depression but the subject attended only three sessions. She felt it was not helpful and found no connection with the therapist. In November of 2004, the subject presented at the Emergency Room of the local hospital because she was experiencing physical symptoms of stomach distress, an inability to eat, difficulty sleeping and anxiety symptoms of increased heart palpitations, light headedness, and sweating. It was determined that the problem was not physical but psychological. She was then referred to a psychiatrist for treatment, which began shortly thereafter. She was prescribed Wellbutrin (100 mg, 3x/day) for her depression and related anxiety, and Xanax, prn, should the anxiety increase. She continued with this protocol until the Spring of 2005 when there was an increase in depressive symptoms (increased irritability, tearfulness, increased anxiety, difficulty functioning at work, difficulty interacting with others, decreased sleep, problems with eating, poor concentration, lack of focus). She stated that her current concerns were the inability to keep her mind quiet – “no peace of mind”, feeling sad and sometimes hopeless, low energy and low motivation, with poor focus and concentration – “I’m in my own world” – and isolating herself from others. She added that she has “let her friends go” because she wants to isolate herself from others. She also feels that she relies on her husband too much, straining their relationship.



### *Developmental History*

The subject was born into an intact family, with both a mother and father in the home. She is the eldest of four children, 2 boys and 2 girls. According to the subject, her upbringing was difficult and she felt very much responsible to be the perfect child. Her father was a very angry, unpredictable person who continually lashed out at the subject. He was diabetic. Her mother was very controlling and the children were expected to be very well-behaved. The subject was compliant with these rules but felt as if she couldn't express herself, feeling as though "I suppressed the me of me". Her mother had been a victim of incest and was very distrustful of others, conveying this distrust to her children which, in turn limited their friendships. She added that her mother chose their friends. The subject also felt that her mother minimized any of her problems or concerns; this resulted in the subject's feeling unimportant, in addition to the fact that her problems were being dismissed. She often isolated herself from others in the family, feeling uncomfortable and untrusting.

### *Education/Social/Occupational History*

School was a positive because she did well and graduated from high school. She apparently had some friends and did date. She was employed following graduation and has worked for 16 years in the same job, receiving commendations. When dating (her now husband) she became pregnant. The pregnancy was very difficult, fraught with medical problems throughout, especially gestational diabetes. She had to be hospitalized prior to the birth and remained in the hospital due to medical complications for several

days. When the subject returned home from the hospital, her mother became the surrogate mother of the new baby, insisting that the subject was too ill and depressed to take care of her child. The subject was compliant, working nights and sleeping much of the day, with little interaction with her daughter. This continued for approximately four years until the father of the child and the subject decided to get married. They then moved with their daughter to their own dwelling. A second daughter was born; she is now 6. That pregnancy was also difficult, but it was not difficult to the same degree as was the first.

#### *Recent History*

The subject was experiencing difficulties in normal functioning. She was feeling sad every day, all day. Difficulties sleeping and eating, as well as psychomotor agitation, irritability, fatigue, difficulty concentrating and indecisiveness were evident, but the prominent difficulties involved feelings of worthlessness and guilt. These symptoms had increased recently due to stress on the job and had been ongoing for approximately 6 weeks. Her psychiatrist recommended therapy to work on the issues related to this depression because the medication was not sufficient.

#### *Assessment*

In order to determine an accurate and effective case conceptualization, it was necessary to do a comprehensive assessment. The following measures were used to accomplish this task:

The Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID I; First, et al., 1997) is a structured clinical interview constructed by the authors of the DSM-IV (APA, 1994). The instrument exhibits good reliability and validity. The SCID I was designed for mental health professionals to establish comprehensive fine-grained diagnoses. Part I of the SCID assessed for clinical disorders (Axis I). The SCID uses a brief clinical interview.

The Multimodal Life History Inventory (Lazarus & Lazarus, 1991), a 13 page questionnaire, assesses the following information: general information, personal and social history, description of presenting problems, and modality analyses of current problems (i.e., behaviors, emotions, physical sensations, mental images, thoughts, interpersonal relationships, biological factors). Although this inventory does not yield quantitative scores and does not give normative information, it is often quite helpful in developing case conceptualizations, providing therapists with a great deal of information about their clients. The information often helps therapists generate hypotheses about elements of the cognitive model that are specific to their clients.

The Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996), a 21 item inventory, measures symptoms known to be highly correlated to depression according to the DSM-IV criteria. It is rated on a four point Likert Scale with 0=never and 3=severe. It has been frequently used for the assessment of cognitions associated with depression. The inventory is self-administered and takes from 5 to 10 minutes to complete. Within clinical populations, no depression or minimal depression ranges from 0-13, mild

depression from 14-19, moderate depression from 20 to 28, and severe depression from 29-63. Evaluation of content, concurrent, discriminant validity, and factor analysis has been favorable. Within the last 35 years the BDI has been one of the most widely used instruments in assessing depression in clinical populations.

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988). The BAI is a 21 item inventory that measures symptoms of anxiety, primarily physical symptoms. It is rated on a 4-point scale with 0=Not at all and 3=Severely . The maximum score is 63 points. Total scores from 0-7 are considered to reflect a minimal level of anxiety; scores of 8-15 indicate mild anxiety; scores of 16-25 reflect moderate anxiety; and scores of 26-63 indicate severe anxiety. The instrument was designed to measure symptoms of anxiety considered to be shared minimally with symptoms of depression, and to minimize overlap with measures of depression. Consequently, the BAI is constructed with items that more closely represent the diagnostic criteria for panic attacks rather than those associated with generalized anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder or social phobia. The BAI correlated significantly with other measures of anxiety.

The Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974) is designed to measure negative attitudes about the future. It is a 20 item true-false self-report measure that takes approximately ten minutes to complete. It assesses three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations.

The hopelessness construct is a factor that is highly correlated with measures of depression, suicidal intent, and ideation. It is a reliable and valid measure.

The Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979) is a 40 item instrument currently available in two forms (DAS-A and the DAS-B) designed to measure dysfunctional beliefs in depressive patients. The instrument is constructed of single sentence items answered on a seven-point Likert scale. The DAS provides a single scale score, ranging from 40 to 280; lower scores indicate more adaptive attitudes but higher scores represent the presence of more dysfunctional attitudes. Weissman (1979) designed the DAS specifically to validate Beck's (1976) cognitive theory of depression. Beck and Weissman (1978) developed the items to represent an individual's seven major value systems including approval, love, achievement, perfectionism, entitlement, omnipotence, and autonomy. For each value system, items were written to represent the common assumptions, or dysfunctional attitudes of typically depressed individuals. The DAS has significantly correlated with the Beck Depression Inventory and other measure of depression (Beck et al., 1979).

The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) is a 69 item inventory of cognitive distortions and includes short-sentence items that reflect 11 different types of cognitive distortions. It is to be utilized with an adult clinical population. A five-point Likert scale is used to determine frequency with 1=Never and 5=Always. Scores can range between 69 and 345. The total scores indicate the number of cognitive distortions, with higher scores indicating greater distortions. Factor analysis

and cognitive therapy experts have established its content validity. The ICD and the BDI have been correlated positively.

### *Use of Measures*

The SCID I and the Multimodal Life History Inventory were given at the initial evaluation to gain information pertinent to the subject's biopsychosocial history as well as information regarding Axis I diagnostic criteria. The BDI, the BAI, and the BHS were given at this time and were completed at each session throughout treatment to track changes and reductions in depressive symptoms. The DAS and the ICD were given to determine a baseline of cognitive distortions. These two measures were used again at the final session to note changes in the cognitive distortions of this depressive subject.

### *Case Formulation and Clinical Impressions*

Identifying Information: The subject was a 35 year old African American woman who is married and has two daughters (ages 13 and 6). She had been experiencing difficulties at work, having been written up for inappropriate behavior. She was experiencing depressive symptoms (tearful, depressed mood most of the day, markedly diminished interest or pleasure, fatigue, feelings of worthlessness and excessive guilt, decreased ability to think and concentrate) and was having difficulties in her relationship with her husband, mother, and her eldest daughter. These problems were precipitated by the death of her father in 2004. Historically, she suffered from what her mother described as post-partum depression following the birth of her first daughter. She also indicated that she

had struggled with depressive symptoms off and on for several years but stated she had been doing well prior to the death of her father. This loss appeared to trigger schemata and underlying beliefs related to her childhood. The primacy effect became predominant. She began seeing everything in her life through a negative lens and was totally discounting positives. Irritability and impatience increased, as well as passive-aggressive behaviors. Her core beliefs related to herself were: I am not a good person, a good mother, or a good wife; nobody hears me. Her view of the world included: "I think people are self-centered; I think people are rude and do not think of others; people are heartless; people cannot be trusted." Her view of the future is "more negative than positive" but she stated she did not "know about the future."

External triggers such as TV, magazines, and newspaper articles with a focus on illness led to somatic catastrophizing that was irrational. This type of thinking was triggered by her father's life long struggle and her irrational belief that she would have the same problems.

### *Chief complaints*

1) "Dad passing hit me like a bomb" because the subject was hoping to resolve past difficulties but had taken no action in that direction, thinking she had time, and procrastinating, as well. His death shocked her because of the realization that nothing would be resolved. She then began to experience severe guilt and became very self-critical and self-blaming, feeling she should have done something to prevent his death.

2) The past kept encroaching on the present, leading her to feel more depressed and anxious. The continual criticisms from her mother activated the primacy effect, i.e., the past influencing how she experienced the present. Criticism at work triggered the old belief that she wasn't good enough. When receiving this criticism, she immediately reverted to old schemas of vulnerability and personal inadequacy.

3) Difficulties at work. The subject was written up for harassment at work. The subject questioned her manager about everything, challenging her continually, often becoming verbally aggressive. The subject overreacted when she felt that someone was attempting to control her or that someone was criticizing her. When this occurred she got angry and felt as if she were being treated like a child and in turn, acted out.

Problem List: \*Depression (feeling empty and sad; extreme guilt regarding father; difficulties with appetite and sleep, fatigued, low energy, decreased concentration and focus)

- \*Anxiety (feeling overwhelmed); worried
- \*Stress at work resulting in impatience and anger
- \*Marital conflict (husband tired of her complaining; he undermines her with the children; is critical)
- \*Social isolation
- \*Aches and pains (which she then catastrophizes)
- \*Financial stressors (buys things to help her feel better and in reaction to anger at her husband)
- \*Lack of Assertiveness
- \*Decreased Self-esteem



Hypothesized schema: “I need my mother’s approval to be OK”.

“Unless I do things perfectly, I will be rejected”

“Life is unpredictable and scary; I should be able to control it”

“I should have done more for my father”

“I need to please others or they won’t love me”

“I can’t trust anyone”

“I don’t like to be controlled”

“I feel like a child”

Relation of schema to problems:

“Growing up, my father was very unpredictable and angry and my mother was very controlling and distrustful of others. This led to increased worry and fear. I felt uncomfortable and fearful with my family, never knowing what to expect or how to act, so I would stay in my room.”

“I feel like a child; I always had to do everything right. I was always criticized if I didn’t do it right. Feels like this is being repeated.”

“I feel bored and then think too much; I then get more anxious”. “I focus on my father’s medical problems and worry that I have some serious disease, catastrophizing every ache and pain”.

Precipitants of the current problem:

- Bored at work
- Criticized and controlled at work
- Criticized by mother
- Criticized by husband
- Suppressed anger
- Severe guilt over death of her father
- Thinking too much – metacognitions

Origins of the Central problem:

- Mother instilled distrust
- Mother was very controlling and critical
- Father was unpredictable and critical
- Had to be the responsible one
- Had to be the good girl
- Could not have any problems
- Could not express herself

Treatment Plan:

- To reduce depressive and anxious symptoms through CBT
  - Explore emotional triggers of depression
  - Confront feelings of guilt
  - Confront cognitive belief system

Explore expressions of fear

Challenge *misperceptions*

Identify depressive cognitions

Identify and support cognitive strengths

Increase exercise

Focus on healthy eating

Learn and practice relaxation techniques

Teach method of self praise

Follow the manualized treatment

Complete self reports for each session

Be compliant with homework

Predicted obstacles to treatment:

“Things will never get better”

“I will always feel criticized and feel like a child and can’t do anything about it.”

Therapy Goals:

- Long term goals:
1. Develop the ability to recognize and cope with feelings of depression.
  2. Alleviate depressed mood and return to previous level of effective functioning.
  3. Develop realistic cognitive patterns and beliefs about self and the world that lead to alleviation of depressive symptoms.

- Short-term goals:
1. Verbally identify, if possible, the source of depressed mood.
  2. Discuss over-reliance on significant others for support, direction, and meaning of life.
  3. Identify cognitive self-talk that is engaged in to support depression
  4. Replace negative and self-defeating self-talk with verbalization of realistic and positive cognitive messages.
  5. Verbalize hopeful and positive statements regarding the future.
  6. Make positive statements regarding self and ability to cope with stresses of life.
  7. Engage in physical and recreational activities that reflect increased energy and interest.
  8. Participate in social contacts and initiate communication of needs and desires.

#### Procedure - Annotated Session Material

##### Treatment:

A 10-week protocol, designed to test the usefulness of a new measure, the Inventory of Cognitive Distortions was conducted in the clinical setting; its purpose was to discern any changes in the cognitive distortions of a depressed individual. The subject participated in Cognitive Behavioral Therapy guided by the manual, *Overcoming Depression* (Gilson & Freeman, 1999). The subject completed self-report forms weekly (BDI, BAI, BHS) to monitor depressive symptoms and completed the ICD and the

Dysfunctional Attitude Scale (DAS) at the initial and final sessions to assess any change in dysfunctional thinking from baseline to termination. The purpose of the protocol was explained to the subject in the introductory session (6/20/05). The early sessions focused on providing exercises to facilitate the identification and expression of depressive symptoms and anxiety; the manual was used as the guide. Due to the subjects stress level, emphasis was placed on teaching and practicing relaxation techniques to reduce the level of anxiety (Gilson & Freeman, 1999). This emphasis continued throughout the 10 sessions. Emphasis was placed on addressing the depressive symptomatology by examining the BEAST of Depression, the focus of the manual: B=biology and biochemistry, E=emotions, A=actions, S=situation and T=thoughts. The goals, guided by the manual, were to help the subject develop skills to identify specific pieces that go into depression and then to understand not only thinking patterns associated with depressed mood but to understand also the connection between negative thinking, low moods, and withdrawn behavior. The 2<sup>nd</sup> goal was to work on making changes in her life. This took a problem-focused approach by teaching her how to track the way she thinks, by determining what to do between sessions and by working on strategies for change through the working relationship with this therapist (Beck, 1967; Gilson & Freeman, 1999; Needleman, 1999).

Many cognitive therapy techniques were utilized and included: (1) Questioning what the person really means (2) Questioning the evidence (3) Examining options and alternatives (4) Decatastrophizing (5) Examining expected consequences (6) Labeling

distortions (7) Cognitive rehearsal (8) Self-instruction (9) Thought stopping (10) Focusing.

During the protocol, the subject was introduced to the manual and asked to read one chapter for each session. At each session the therapist and subject worked collaboratively, discussing the chapter and the review questions at the end of each chapter, along with addressing any questions or concerns the subject was experiencing. The subject also completed self-enhancement exercises from the manual; these were designed to enhance what she had learned in therapy and to contribute to her self-improvement through practice.

This brief therapeutic intervention protocol (10 sessions) was desirable for several reasons: a) it offered a focused, problem-solving approach. b) it provided a psycho-educational format. c) it emphasized self-responsibility and self-efficacy, rather than dependence on others. *The Overcoming Depression manual* (Gilson & Freeman, 1999) was the guide throughout the protocol. The goals of the manual were to help the subject understand the thinking patterns associated with a depressed mood, as well as to understand the connection between negative thinking, low moods, and withdrawn behavior. The chapters in the manual set forth goals not only to increase the subject's awareness of depression and its symptoms, but also to emphasize the aspects of cognitive therapy, including the cognitive triad, the elements of distortion, and the role of schema. Each chapter focused on an element of the BEAST of depression – B=body, E=impact of emotion, A=action, S=life situations and vulnerability, and T=thoughts and depression.

Agenda setting was another important component and the importance of this was emphasized at the beginning of each session. Agenda setting not only helped the client to know what to expect during the session but also helped to maintain focus both for the therapist and the subject. In this case study, the major focus of the agenda for each session in this 10 session protocol was a review of the BEAST chapter goals in relation to the aspects of depression and to the introduction of any relevant techniques to increase awareness and reduce the depressive symptoms.

Following the agenda setting, relevant excerpts, taken verbatim from the taped sessions, are provided. The excerpts chosen for inclusion reflect significant issues with which the patient struggled in an effort to reduce her depression and anxiety. It is possible that they would be different for another patient. The excerpts also reflect cognitive-behavioral methodology that has been proven to be empirically sound in the treatment of depression (Beck et al., 1979). A summary of the main areas of focus for each session is provided at the end of each session. In the sessions the patient is referred to as the subject, indicated as S, and the investigator as the Therapist, indicated as T.

Session 1, June 27, 2005

Agenda set (Beck, 1979)

-Completion of self report forms (BDI, BAI, BHS, DAS, ICD)

-Review of Life History Inventory

-Introduction to the manual, *Overcoming Depression* (Gilson & Freeman, 1999)

-Review of presenting problems

-Assignment of homework

Excerpt. Because the initial evaluation session on June 20, 2005 entailed the completion of PCOM intake evaluation forms, only one research protocol assessment measure was completed, the Multimodal Life History Inventory. Review of this occurred at the next session on 6/27/05 for clarification of information. The Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID I; First, et al., 1997) was then completed. The self reports were reviewed and completed (BDI, BAI, BHLS, DAS, ICD) as well as the first chapter from the manual, *Overcoming Depression* (Gilson & Freeman, 1999). Following this, focus was placed on the problem behaviors that were interfering with the subject's life. These included (1) stress on the job leading to negative consequences (2) irritability both at home and at work (3) negative thinking affecting her behavior (4) primacy effect of schema and belief system.

Addressing the precipitators of the subject's depressive symptoms, the subject shared the following information.

S: I was written up for harassment at work.

T: What do you mean? Can you explain?



S: My negative behavior and thinking increased; it's getting near to the anniversary of my father's death. I was acting out.

T: What negative behavior in particular?

S: I question everything my manager does; I challenge her...I have a problem with people. I don't like to be controlled.

T: So what behaviors did you exhibit?

S: I was more irritable and intolerant of others. I was feeling criticized and that got me angry!

T: Have you experienced this criticism at other times?

S: Yeah, yeah...I have always been criticized by my parents. Makes me feel like a child; I always had to do everything right. I always complied; I was a good girl but I still got criticized.

T: Sounds like you think "I must do everything right or I am no good" (schema)

S: Yeah, yeah, but I do everything right and I still get criticized, just like at home.

T: Sounds like work is exemplifying old criticism from home.

Subject continues to relate past experiences of criticism to work problems.

S: At work, I walk on egg shells, waiting to be criticized, as I did as a child. My boss is very volatile, as my father was. I cope with this by going to the bathroom frequently to calm down, rather than acting out.

T: So it seems as if you are repeating some of the same behaviors from the time you were a child – the anticipation of a problem, the concern about the unpredictability of your boss leading to “walking on egg shells” and the isolation – going to the bathroom frequently.

S: Yeah, yeah, it’s difficult and it makes me angry.

Alternative actions were then addressed.

T: Have you thought about moving to another department?

S: Yeah, yeah, but when I asked it was denied. They told me that no other manager want to work with me.

T: How come?

S: Because I question things. I was never allowed to question things as a child. And when I’m bored I think too much and then get frustrated and sad.

T: So how does this interfere with your work?

S: I have been questioning every little thing. And I make suggestions and they never use my ideas. They are good. I question that, too. Then I get irritable and argue.

T: Is this helping you?

S: No, no. They just watch me more and look for stuff. But it makes my thing of my childhood. (primacy effect)

T: In what way?

S: As a child I couldn't express myself; I suppressed "the me of me". I was different, quiet, didn't go outside. I would isolate myself. My mother was very controlling. She chose our friends. She didn't trust anybody. She was a victim of incest. Incest messes with the next generation, too. She always said, my bad day was worse than yours will ever be. This makes me feel unimportant and dismissed.

T: But is this happening now? Is it happening at work?

S: It feels that way. They treat me the way my mother always did and I get frustrated and angry. So...I go back at them. I couldn't do that when I was a child.

T: No, but you are no longer a child.

S: Yeah, but I was a cranky, evil child. I stayed to myself. I didn't want to be bothered. I was always on guard.

T: So your belief system is "I can't trust anybody"?

S: Yeah, yeah, and I still feel that way. I even feel uncomfortable when home (at mother's home) with everybody (her family of origin). I don't know how to behave. I feel like I have to be on guard and so I then go to the old pattern and isolate.

T: So a lot of these old beliefs and patterns continue, even though you are no longer a child?

S: Yeah, but I followed the rules all the time because I didn't want to burden her (mother) because we heard the stories over and over again (about her abuse – incest). Sometimes you want to act out, too, but I never did.

T: Do you think you are not acting out at work?

S: Yeah, yeah, but it's upsetting and makes me nervous. So I then have to isolate to calm down.

T: Do you think there's another way of handling the work situation.

S: I don't know; I want to.

The remainder of the session entailed a review of the manual, *Overcoming Depression* (Gilson & Freeman, 1999) and looking at how depression and negative thinking affects emotions and behavior. At the end of the session, the subject shared the information that, at the suggestion of her psychiatrist, she was taking a medical leave from work. She added that she was coping during the last week by not talking “too personally” at the office and distancing herself – “I am all business”. She noted that

when her supervisor wrote her up, standard procedures were not followed. She asked them “to get off her back.” “What do they want from me”? Subject added that she feels that it is both of them (she and the supervisor). The subject stated that she is depressed and the manager has lots of personal problems which complicate the situation, making it worse.

Homework was then discussed and agreed upon, including: 1) reading Chapters 2 and 3 in the manual, 2) completing the exercises at the end of each chapter, and 3) completing the self reports (BDI, BAI, BHS).

Session 2, July 7, 2005

Set Agenda (Beck, 1979)

- Reviewed self reports (BDI, BAI, BHS)

- Reviewed the manual, chapters 1 through 2 (Gilson & Freeman, 1999)

- Reviewed status of week

- Discussed any problems/concerns

- Assigned homework of self-reports, read chapter 4 in the manual and complete the exercises.

Excerpt. The subject was very compliant and much motivated to reduce her depression and to change her behavior. Because of this attitude, the subject is compliant with

homework, focusing on reading the manual and completing the exercises, desiring to learn and to understand her depression. She asked good questions that were then discussed, using the manual as a guide for the session.

S: Wanted to know what cognitive behavioral therapy (CBT) was (although discussed briefly in the first session).

T: It is a therapy in which you look at your thoughts to see how they are affecting your emotions and behavior. CBT helps you to examine how you look at the world and how you respond to it – your of yourself, your environment (world) and your future.

S: Well, that's what I thought. I looked it up in the dictionary and it said knowledge, and that's what it is, right?

T: Basically. It helps you to understand your negative thoughts and low mood. It is a problem-focused approach. You look at the problem and figure out the best way to handle it. Knowledge, then, would be a good answer because you are learning, and therefore, gaining knowledge.

T: It helps you to track the way you think because your thinking really drives your emotions. It also focuses on homework, as you know, in between sessions.

S: Schema. I looked that up and I got diagram, plan or scheme.

T: Schema are really things that underlie your main belief system. Remember we talked about your belief system before- those thoughts that do not automatically occur to

you, based on your belief system. It's sort of based on an abstract idea, again going back to the self, world, and future.

S: OK.

T: The schema we talked about before is your trust schema. You don't trust because of the belief system that your mother reinforced.

S: Yeah, yeah, ok, ok, it's a belief system.

T: Yes, schema influences the content of your beliefs. And schema sort of helps you to define yourself. You have a belief system and then you behave and think a certain way, based on the way you think.

S: And then you act a certain way and the schema influences all. Then you go against it...

T: Uh, uh, then you have to figure out other ways to handle it.

S: And deal with it.

T: Any other questions? Seems like you really did your homework.

S: Yeah (laughing), I had a dictionary, but some of the questions I put little footnotes.

T: Ok, do you want to review them with me?

S: Yes, like...suicide part (p. 9). I never really wanted to kill myself but I wished myself out of the picture, like maybe go away – like nobody will miss me.

T: Like passive suicide thoughts? That is how we refer to those. Where you actually wouldn't act on it but, you think life might be a whole lot easier if you weren't here?

S: If I could disappear or if I was in an accident, something happened to me, people, you know, wouldn't be affected, you know.

T: When did you have those thoughts?

S: Maybe like after an argument or if I felt bad, or if I was incorrect in dealing with my children, you know, or my husband.

T: So then you get really upset with yourself and blame yourself?

S: Just thinking, I didn't like the way I handled it...I could have handled it better.

T: Well, do you then get that negative about yourself and kind of blame yourself?

S: Yeah, if I wasn't around...

T: Do you still do that?

S: Yeah, sometimes. Like I said, I don't think no one would miss me, you know. Sometimes I could be a burden to others, you know, 'cause I get upset. Look, people, genuinely don't want to be bothered with other people's problems. You know, 'cause



they have their own. You know, when something happens and they'll say "I'll be there for you", when you call them on it, they are not there for you.

T: Do you find that a lot?

S: That's how I feel, yes, yes...

T: But do you ever call on people to help you?

S: Mmmmm, no because I feel as though they're not going to help me. (cognitive distortion of fortune telling – negative assumptions)

T: So you sort of assume they wouldn't help you, so you wouldn't ask?

S: It's just like they say, you can call me anytime or...but I don't trust that.

T: So you don't really trust that?

S: Yeah, yeah, I have a problem with trust. I don't trust my manager; I don't trust people at work, you know, I just trust that people can handle it my way, you know.

T: Does it always have to be your way?

S: Of course. I never thought I was like that but maybe I think I am like that.

T: Do you think it should always be your way?

S: No, because my way is not always right 'cause I'm thinking about...my way of thinking is not always right because I am going by my belief system – or negatives, the way I grew up. You know, other factors, you know, take place.

The subject was able to be more self aware and to look at the way her thinking affected her emotions and behavior. She was also able to note how the primacy effect influenced her – how the events from early in her memory influenced the way she experienced the present.

T: So you kind of aware that some of your thinking (interrupted)

S: Is wrong! Is inappropriate!

T: So you are aware of your schema, your belief system?

S: Yeah, it makes me feel more comfortable even though I know it's sometimes not right. "Cause other people have other ways of doing things, you know. So that's why I'm here; I am trying to work on that; just so I'm not so uptight!

Summary: The subject was able to see the connection between her negative thoughts and recognize how the primacy effect continuously interferes with present thinking and behavior.

Session 3, July 11, 2005

Agenda set (Beck, 1979)

- 1) Review of insurance form for medical leave, verifying specific information
- 2) Chapter 2 and 3 goals from manual were reviewed (Gilson & Freeman, 1999)
- 3) Self reports reviewed (BDI, BAI, BHS)
- 4) Reviewed status to date
- 5) Assigned homework (completion of self report forms [BDI, BAI, BHS], reading of chapter material and completion of exercises in the manual).

Excerpt. The subject noted that her anxiety can be increased by publications about illness and that she then gets scared, adding “everything is negative in the world and that frightens me”.

The therapist then guided her in addressing these thoughts and feelings through the use of the cognitive triad – negative thinking about self, the world, and the future.

S: If there is something negative, I cling to it. I can't read something negative without putting myself into the situation.

T: So if you read something about cancer then do you say, Oh, I have the same thing?

S: Yeah, yeah, I do.

T: Even if you don't?

S Yeah, yeah or even in my head I wonder. Or I have a pain and I wonder and catastrophize.

Subject is becoming more aware of her negative thinking and her use of cognitive distortions, noted by her indicating that she catastrophizes.

T: And then what do you do with that? Do you say to yourself, well, wait a minute?

S: Well, I do challenge myself by reflecting on what I do that is positive in taking care of myself. (An example of increased self-awareness by the subject; she is learning to challenge her own thinking.)

T: So you refute your own thoughts?

S: Yeah.

T: So you recognize that you're catastrophizing?

The subject is increasingly aware of her anxieties and their relationships to the way she is thinking, recognizing the need to challenge her thinking.

Subject then stated that she had stopped reading negative information and stopped watching negative TV. She was also listening to positive music and no longer renting scary movies. But she indicated that when her father died these positive actions ceased.

T: What happened when your father died? Why do you think it all stopped? All that work that you were doing (to decrease your negative thinking)?

S: I was so upset at how the body just turns on you, even though, some of it was his fault – a lot of it was his own fault. He did not take care of himself for years. So I have to remind myself about that. But when you are depressed you don't sit back and think.

T: No you don't

S: So sometimes you have to sit back, close your mind, and think – this is not your fault. And I am going back to that.

The therapist and the subject then reviewed her relationship with her father for the last couple of years of his life. It was confusing, at times because she is a poor historian, but the subject was able to convey the information that approximately two years earlier she had taken her father into her home because he was so sick. No one else volunteered but other family members assured her that they would be there to help her. No one helped. She became very upset and overwhelmed with the burden. She began to feel rejected and hurt both by her father, who was very difficult to deal with, and by the family members who had abandoned her. She determined that this arrangement was becoming detrimental to her, both physically and emotionally, so her father went to live with his son. Following that move, he went downhill and the subject feels responsible for this, feeling as if she failed in some way, leading to her guilt. Therapist then focused on the positives of what she did.

T: Didn't you do the best you could possibly do for him? (To remind her of the positives of self and getting her to question the evidence)

S: Yeah, but...nobody helped me. They would come over and leave.

T: So did you and your husband make a decision that this would be best? (To move your father with your brother) Did you talk with your father about it?

S: I told him he's have to go back home and I discussed it with my mother. She said something about taking him to the hospital and just leaving him there. And I was like – what! But I didn't know my brother was crazy. So I thought it would be a good idea if he could set it up so he could live in his own house where he could live comfortably. And I could take care of him. I live around the corner; I didn't live too far. And I thought...I didn't know my brother...my brother has always been and S.O.B. since a baby...he was a monster from day one.

T: So you didn't realize it was as difficult for your father at his home (with your brother) than it ended up being?

S: I didn't know; he wouldn't let us in. I guess we should have called the cops.

At this point the subject has indicated her feeling responsible for the decline in her father's health and guilty in thinking that she should have done more. Challenging this thinking was important, emphasizing the reality of the situation and the positive role she did play. She was feeling deceived by her family because they did not provide the help

they stated they would give. This deception led to her feeling increased distrust of others. Her father eventually had to be placed in a nursing home and her husband encouraged her to visit him there, which she did.

S: My father started getting worse and he was not eating. So I would visit him. And he asked me to bake him a cake. I am so glad I baked him that cake.

T: Did you resolve any of the feelings that you had?

S: I wanted to come up and kiss him but...I forgave him...I forgave him. But I didn't tell him. I told him I loved him. It seems like I am the only one who is affected.

T: What is it that affects you?

S: That I could have done more.

T: What more could you have done? (questioning the evidence)

S: I would have made sure he ate right.

T: But you can't make somebody eat. (looking at the realities of the situation)

S: I know, I know, I know...you can't make a dumb person do right. Even when he lived with me he stopped taking his medicine. He was like a child. Sometimes he didn't know who he was. One day my older brother came over and he didn't know who he was. Even when he lived with me, I knew he wasn't going to make it to 60 'cause one day I bought all these cookbooks for diabetics so I could cook the right way for him. And one

day, I cooked this meal for him and I went up to his room and found it in the trash; he was like a child. I knew he wasn't going to make it. I already knew it. He's throwing his vegetables away. The therapist only came for a couple of weeks; nobody helps you and then you're by yourself. But they came to help him exercise...but he did nothing. He just laid there.

Helping her to look at the reality and circumstances of the situation was important, leading to some awareness. Stress was placed on having her look at her emotional involvement this time as well as at the thinking that keep fueling her guilt.

S: He was so grouchy; he was a mean S.O.B.

T: So even though your family said they would help you when you took him, they abandoned you?

S: Yeah, yeah, and I'm mad, but I don't say nothing.

T: Why not?

S: Cause then they are going to say something about me and, you know

T: What could they say about you?

S: Who do you think you are? Um...we put up with you...you're pretty cranky, you're this...I have my own life to live...my mother, she can say some pretty nasty things. And I don't believe in talking back to get just as nasty as she can. I could get just



as nasty and rude as she could, but I control myself cause that's my mother. But I say what she wants.

T: Sounds like you always expect criticism? What makes you take it?

S: Well, last week, when she got nasty, I hung up on her.

It is clear at this point that she is exhibiting lack of assertiveness, decreased self esteem, and is exhibiting the cognitive distortions of externalizing of self worth and of fortune-telling. She is fearful of criticism and always assumes negative consequences. It was important at this juncture to begin educating the subject regarding the differences among passive-aggressive behavior, aggressive behavior and assertive behavior.

T: Do you remember when we talked about things like this last week, about how it would be helpful to say, "I get upset about this"? And if she doesn't respond or starts getting nasty, to then hang up.

S: Yes, but nothing has happened since then. But if ...I just...I just want to say...I want to get something off my chest. I don't think she could sit through that.

T: But you don't have to ask her permission. You just have to say, Mom, I get upset when you treat me like this.

S: Also I want to tell her what I feel, what I have been feeling for years.

T: If you don't feel you can speak it to her, what about writing to her?

S: I was going to write her a letter.

Therapist commended her for this thinking and encouraged the alternative way of being assertive, especially because she was feeling the need to express herself to her mother regarding her feelings of abandonment, criticism, and discarding of her opinions.

This was followed by some reality testing.

S: Mom just criticizes.

T: So, if you know your mom is really negative, how come you keep going to her?

S: I know, I know. Sometimes I'm around her...that makes me depressed. ...there is always something going on and ...she's always telling somebody what to do...you know, she doesn't know how to talk. "Hurry up...my way is the only way. You are not ready; where are my keys!" It is always something!

T: How does she interfere with you?

S: Oh, um...with my daughters. They tell her I've been mean to them, irritable, you know. She'll call and tell me how to raise my daughters, especially my oldest. I want to say "who are you telling me how to raise my daughter"! When you know...but then she (mom) kept bringing up her past and reminding me that our childhood had been all right, especially since hers was so bad! Our childhood doesn't matter; it is all about her and her suffering.

T: But why do you keep focusing on your childhood? You keep going back to it. Can you change it?

S: Yeah, there is nothing I can do about my childhood.

T: Right.

S: I don't know: I think I just can't get past not being about to be who I wanted to be.

T: You can be that now, or do you think you can't?

S: I don't, I don't know. I don't know how to do it without upsetting my mother!

T: What makes you think you need your mother's approval? You are an adult.

S: I know, I know, I know...

T: What is it that holds you there?

S: I don't know, I really don't know

T: You know, if you don't approve of yourself, nobody will ever approve.

Therapist then helped her to look at her impediment to moving on through reality checking, helping her to recognize her fear of rejection and criticism and encouraging her to focus on herself. The therapist was helping the subject to review the situation and to

question her own behavior in relation to her mother with the goal of taking more responsibility for herself and her actions.

T: So maybe because you say you are always negative, maybe you convey that to your mother. Maybe you say those things to your mother, she hears negativity, and she continues the negativity. And she's already negative and critical. So...it becomes reinforcing. Do you know what I mean? It's almost as if you allow her to come back at you without stopping her. And then you sort of believe it?

S: Yeah, yeah, yeah...

This was followed by a discussion of the subject and her relationship with her oldest daughter. The discussion involved the subject's feelings of inadequacy in relation to her daughter due to her mother's raising the child, primarily, for her first four years, combined with the continual criticism by her mother. The daughter has lived with the subject and her husband for about 7 years but the subject's mother continually interferes and encourages the subject's daughter to come to her with problems. Getting her to address the reality of this situation was imperative to improve the relationship between her and her daughter as well as getting her to look at her own avoidant behavior. The therapist encouraged her to take some action steps (with both her mother and her daughter) to help change the relationship, instead of remaining passive.

She then spoke of a shopping trip with her daughter in which the subject set rules and regulations. It did not go well.

S: Two weeks ago we went shopping. I told my daughter what she could get and what she couldn't get. So...everything I said just went out the window. So...I was just so upset with her.

T: How did it go out the window?

S: Everything she showed me was what I told her she couldn't buy. And, I lost it! I got tired and I was impatient with her. I guess I should have said "you really shouldn't wear that" ...after the fact, but I didn't.

T: What do you think triggers you in getting so angry?

S: Maybe I'm not really angry at her but maybe I'm angry that nobody is listening to me. Nobody never listened to me! As a child, maybe that's it, nobody ever listened to me. So when I see nobody is listening to me, I get irritable and I get angry.

Subject again slides back to old beliefs and schema of needing approval – from mother, from daughter, from husband, from work.

The issue of attachment with her daughter was discussed and she noted the fact that she was angry because she was so sick during her pregnancy. Following the birth the subject's mother took control of the baby and the subject allowed it because, again, she was withdrawing and avoiding conflict and criticism. Focus was then placed on what she could do now to be the mother she would like to be and have a better relationship with her daughter.

S: She kind of chooses them (subject's mother and sister) over me. You know what I am saying...you know...I guess she... maybe she's mad at me.

T: Did you ever talk to her about this?

S: No

T: How come?

S: Sometimes it's hard to talk. Sometimes you don't want to hear the truth.

T: What do you mean, from her?

S: Yeah, from her

T: You mean you are kind of hesitant about what she is going to say?

S: Yeah!...yeah!

T: Well, what's the worst thing she could say?

S: ...That I am not a good mother.

T: What are you doing for her now? You can't go back and correct what you consider might have been post-partum depression. What can you do now to make it better?

Emphasis was placed on looking at the relationship and addressing alternative ways of improving the relationship with her daughter. She described a particular incident in which the subject was joking around and her daughter took it seriously.

S: When I heard her crying in the kitchen I went in and apologized and said I'm sorry, I'm just playing.

T: Was she OK then?

S: Well, she pushed me away. So I patted her on the back and went back into the other room. You...my husband was joking too, but...you know...why can't I?

T: Well, because she's sensitive to you. Just as you want approval from your mother, she wants it from you.

S: Yeah, yeah, ...and I don't...and sometimes it takes somebody else to tell you that. Or sometimes, a light goes off in my head, she wants to say things she wants.

T: She does; she's desperate for your love.

S: I know...and... I know...

T: Do you love her?

S: Yes, I love her but...

T: Do you tell her?

S: Um...I can't remember...sometimes...I don't say it enough, right? Like if they are going to bed (my kids sleep together), at bedtime I say, I love you all and I close the door.

T: What about taking the time to just give your oldest daughter a hug and say I love you. Just take a moment; it doesn't take a lot.

S: I guess because nobody did it to me.

T: It doesn't mean you can't do it.

S: I know, I know. I do it to my youngest one.

T: Well, then, do it to her. Don't you think your oldest looks and sees what you do with the youngest? Do you think she might wonder why she's not getting your affection?

S: Yes, yes, I know

T: Well, you need to do something about it before it is too late. Do you want the same relationship with her as you have with your mother? You can do this, if you want to.

The therapist stressed assertive behavior, especially in dealing with her daughter and her mother. The emphasis was then placed on looking at action steps she could take, helping her to become more self aware and insightful regarding her relationship with her daughter. Assertiveness skills were reviewed to increase coping and to encourage taking action steps to break the negative patterns for behavior change.



Chapter 4 in the manual, “Understanding how you are thinking” proved beneficial in evaluating this process. Specifically looking at the differences between thoughts and feelings, the subject was able to distinguish accurately (as noted in the exercise on page 45) the difference between a thought and a feeling.

Review of exercises continued.

T: Based on your responses on page 50 (that were related to self-compassion as an aid to emotion), you are self critical; we know that. Just because that is what happened to you growing up...you can change...You can challenge that thinking and say, Well, that is not who I am now or you can say, “That’s my mother talking.”

Pages 17 and 18 in the manual, requested that the subject assess her level of motivation by completing the exercise – Reasons to change. Her answers indicated a strong desire to change and she was reminded of this.

T: What I hear is that you continually go back to your childhood. And it seems to me, by the way you say it, you wish it were better. Do you think it can be?

S: Yes, but not my childhood.

Reemphasis on the reality that she is no longer a child and a reminder that she can change her thinking helped her to look at consequences of her passivity. Assertiveness skills were reviewed to encourage behavior changes necessary in taking care of herself.

T: It goes back to your underlying belief system: you don't trust people; and you don't want to be controlled but you want approval from others. So...is it these old schemas and belief systems that are underlying all this?

S: I don't trust nobody; I don't trust people; I don't trust people to do things right.

T: Well, do you think you are the only one who can do the thing right?

S: No, I mess up. I figure if there is going to be a mess up, let me mess up. I don't need to help with people messing, I will make my mistakes. ...I think all managers are liars. I think my husband is a good manager. (cognitive distortion – overgeneralization)

T: So, therefore, not all managers are bad.

Subject then talks about how her husband handles things at work, adding that she thinks he's a great manager and that people respond well to him.

T: Sounds like he listens.

S: He says he has to look himself in the mirror.

T: (checking the evidence) Where is the evidence that trust shouldn't occur. It seems as if you generalize, all managers can't be trusted. Well is that true?

She was then reminded to check the evidence regarding her thinking.

Summary: The emphasis of today's session was focused on the relationship between the subject and her mother, the subject and her daughter, the triangulation with grandmother,

mother and daughter, looking at steps she can take to change the situation. The goal was to seek ways for the subject to work cooperatively with her daughter.

Session 4: July 21, 2005

Agenda set (Beck, 1979)

Homework reviewed (self-reports scored)

Focused on chapter 4 goals in relation to self (Gilson & Freeman, 1999):

- Understanding the differences between thoughts and feelings
- Identifying symptoms of depression related to emotion
- Evaluating her level of depression
- Understanding emotion and the role it plays in depression
- Understanding self-compassion

Reviewed realities of father's death

Discussed and evaluated problems at work

Assigned homework – completions of self reports (BDI, BAI, BHS), read chapter 5 and complete exercises.

Excerpt. The subject briefly reviewed her recent trip with her family. An assessment of how she was feeling led to a focus on her use of cognitive distortions. The emphasis was placed on challenging her thinking, on her reality checking and on her looking for the evidence.

T: How have you been feeling?

S: Better, the last couple of days. I am going to the doctors, gynecologist. Always worried anymore (since father died). I try not to focus on the negative and try not to read anything about illness or disease because I tend to think and worry that I might have it. So I really restrict myself. I get nervous they might find something wrong.

T: Have they ever found something?

S: Yes, a cyst but it was nothing and even if they find anything wrong they would probably be able to do something about it, right?

At this point she is reminding herself not to be so negative, focusing on ways to avoid this negativity. Medical concerns were reviewed further, looking at the evidence again. The cognitive distortion of catastrophizing was evaluated, looking at the increased anxiety due to unrealistic fears. She was able to note some positive change and the steps that led there.

T: But when you think about your father, think about how he died.

S: He didn't take care of himself.

T: Exactly.

S: I decided things have been changing. I only take little naps and increased my exercise and try not to think about anything, rather than focusing on the negative. I take some small accomplishments and focus on them.

T: It looks like you have more energy.

S: I do, even though I've been cranky 'cause I'm getting my period.

Therapist then looks for steps that can be taken.

T: What do you do when you know your period is coming?

S: I can't control it; it's like a monster and I am nasty, vicious. I went to do my exercises on the DVD. I felt better after my exercises.

A suggestion was then made that she also ask her gynecologist for any additional steps she could take to reduce the difficulties she experiences with her period.

Subject then related an incident that happened while she was waiting for her scheduled appointment with the doctor. She had to wait for 2 hours, even though she had a scheduled appointment. She was pleased that she was able to handle a difficult situation. Husband, however, was critical so a review of her behavior occurred.

S: He (husband) didn't want me to say anything. But I said I wasn't going to sit here any longer. ...When I get upset he doesn't like it. I say, it's my right to say what I want to say.

T: It's your right to do that but how did you say it? Maybe it's the way you say it that he's concerned about? I don't know that he's saying you shouldn't stand up for yourself, but it's the way you present it.

S: Yeah, yeah, it's the PMS and things that never bothered me at any other time.

There was a time I was having more patience, I was more relaxed. I'm trying to get back to that. Sometimes I can be charming and polite, but when the monster come out – look out! And I want to control that monster!

The therapist focused on looking for symptoms, looking for steps that could be taken to alleviate the “monster behavior”.

T: How do you recognize that you are having PMS? Do you notice any body symptoms?

S: Yes, cramps, sore breasts, body aches and the time of my period – I keep track of my period.

T: So when you notice that you are starting to get symptoms of PMS, that's when you should start practicing the relaxation techniques that we discussed. Be aware, and then try to handle it by relaxing, reminding yourself that PMS is going on and that you need to take more control of yourself. Stop and think before reacting. Say to yourself that the monster is not going to come out. It is hard but you can control it.

S: If we can come out with things for men to have sex but for women we have nothing to control estrogen or hormones. Why can't we come up with something? At work we all seem to have our period around the same time.

T: Do you think that affects work?

S: Yes, yes, she (supervisor) goes through it too. Now I think it's past that. I think it's more personal. She's dealing with some things. I'm dealing with the death of my father. I am bored and she's doing 2 jobs.

T: So she's stressed out?

S: Yes, and I told her manager. Some of it has to do with what is going on with her; it's not all me and he keeps saying it is all me. Some of it is her!

T: What does she say to you?

S: That I'm going through something. I bring my personal life to work. She's done the same thing. He covers for her. She's very aggressive and I think he covers for her. She's pushy, aggressive. One manager came out of her office crying. So...I don't let her push me around; I push right back, because I grew up with a father that was aggressive and pushy and nasty. So I push right back. But I want to get to the point where I let it roll off.

Her usual behaviors in the office were reviewed and consideration was given to other ways of handling the stress.

T: When you say you push her back, how do you do it?

S: I go right back at her.

T: But do you do it calmly or angrily or what?

S: Nasty, I just get mad and I get just as mad as she is.

T: Well, what's the point in that?

S: There is no point and that's why I am tired of it. And I stopped it, after the write up for my behavior. Even though she was in my face I was wrong. When I feel myself getting upset I usually go for a walk. She didn't give me any room. I told her to get off my back. Write me up for that because believe me, I believe I deserved it. I didn't deserve all the other stuff they added. I told her that I deserve some of the write up. And after that I was just all business. Before I would bring in stuff and be friendlier. Now I am all business; and she is business. I can be very business and I guess she doesn't like that.

T: Do you think you went from one extreme to the other?

S: I had to; that's what the write up tells me. I feel the write up tells me there is no middle ground. And when there was a meeting, I called it, they didn't.

T: What did you learn from the meeting?

S: I learned that it's me. ...And I said I am not accepting this. I said, no, it's not all me. I stood my ground. They cover for her.

The subject was able to accept some responsibility for her negative behavior but continues to feel blamed for problems that she is not responsible for. She then described some other difficult situations at work. She was able to handle a situation assertively but



frequently reverts to passive aggressive behavior. In addition, she frequently blames PMS or her period for her negative behaviors. The therapist focused on steps to change.

T: In the future, if you recognize that PMS is affecting your behavior, could you stop and think and calm yourself down?

S: Before, when I feel that way I go and take a walk. But now I can't do that because my supervisor doesn't like me going to the ladies room so much. I now have to get a note from my doctor. I don't want that in my file. I do go to the bathroom a lot. Did have things straightened out but it was all being conducted in a business way. Went for 2 weeks. But then she called me over and asked me if I was having problems and I said no, I was going to the bathroom. And then she said, "I want you to focus on your work.." And I said, "That's it, I am out of here."

T: So let's review what happened.

S: She called me over behind the wall and said, "There's something wrong with you." I said, "No." She said, "You are always walking around". I said, "No, I am going to the bathroom". But I was crying at my desk. ...Sometimes I go and do my breathing, calm myself down. Sometimes I get real bored and when I get bored my mind wanders and I act up. I calm myself down, get a drink of water...so she just watches us. That is nerve wracking.

T: I understand it's an uncomfortable feeling but you sort of have to say, Oh well, there she is watching me. Since that is her job right?

S: I felt like I was being picked on. But when she called me over again I got really upset and felt like I was going to have a nervous breakdown. I had been written up 2 weeks ago and I was trying to do the best possible!

The subject decided to talk with her psychiatrist about taking a leave due to feeling overwhelmed and stressed because of the work situation. This was granted. Therapist then focused on the identification of possible triggers of upset to increase her self awareness and to help her to look at better ways of handling a difficult situation.

T: Well, what do you think the triggers are that get you upset?

S: If I had nothing to do, I would find something to do. If I have enough work I am all right. I have to stay busy. But this problem only started. It didn't use to get me in trouble but now everything is starting to bother her (supervisor).

T: So now, all of a sudden everything is not OK.

S: And it's not just me; it's certain people. And now I'm just part of the group. Each time she is going to find something wrong. Other people have requested to leave her; I am not the first one.

T: Sounds like you are up against a really difficult situation.

S: I asked to leave but he (person in charge) said nobody want to work with me but he didn't tell me the reason why. What I don't understand is that I get good reviews and I

get bonuses. So, if I am such a bad employee who do I get money? I get rewarded. He even tells me I'm a good worker. But...I think I know what upsets them, I ask questions!

T: You're not supposed to?

S: No, I am just as forward as the managers. The others ask questions but never say anything and just go back to their desks and complain. The others are docile. But if I have a problem I address it. I'll even call and ask.

The subject was able to recognize the aggressive behaviors that lead to her difficulties, but also recognized that when she behaves rationally it is more productive. She is also becoming more self-aware, recognizing that control, or the lack of it, is a problem.

T: The rational Tanya needs to come out a lot more. Don't you think the stress is taking its toll and you are feeling put upon.

S: I want control. I want control of everything in my life!

T: Do you think you can have that?

S: No, you can't! I was being patient! Nothing bothered me before. But as soon as my father died I felt as if life had let me down!

Here she was able to recognize one of the triggers of her depression and the resulting behavior change.

S: And I just went back to the old way. Always with my hair up: my dander's up, you know. Always ready for something.

T: Always ready to be defensive.

S: Yes, yes, exactly. Because as a child I couldn't do what I wanted. But...you can't say the things you want...you have to pick and choose. I learned that when I wasn't upset I could sleep and enjoy the weekend. It was working.

T: But everything changed when your father died?

S: I want back to the old me.

T: But why?

S: I was angry; just mad at the world.

Here the subject recognizes her anger and is able to look at it. She also has a self realization about her anger and the direction it takes.

T: Because?

S: Because I felt as if I had the right to be.

T: So you were angry at your father?

S: I was angry at anybody.

T: Where do you think that anger came from? What was it about?

S: Um...can't really pinpoint it...unfinished business – um.

T: So you were angry that you weren't able to tell him the things you wanted to tell him?

S: Maybe if I was raised different I could have been a different person.

T: So, because he died?

S: Unresolved issues...my mother, she acted like it was just another day. And she thinks she's the cream in the soup.

T: So she thinks she's pretty special.

S: Yes, because of her childhood. And, um, maybe I am angry at her; maybe angry at both of them.

T: So both your parents?

S: Yeah, just angry. I am angry at my brothers who turned out to be bums...instead of being angry at the people that I am angry at, I am taking it out on other people.

T: What good does it do to be angry at these people?

S: It does nothing; it does nothing. And it's tiresome.

T: And it's upsetting to you; it interferes with your life.

S: But, but, I was taking care of that (before father died). That's why I am trying to go back cause I'm just hurting myself.

Emphasis was then placed on continuing to look for triggers by using the Daily Thought Record (Beck, 1979). This was explained and an example was presented. The therapist then reminded the client to continue to practice relaxation techniques.

T: The key is to practice relaxation breathing, like this...then the therapist and the subject practiced together.

S: Yeah and I just sit back and listen to calm music.

T: It is also helpful to do some positive self talk when you are doing the slow deep breathing. If you practice this enough you won't have to get up and go to the ladies room as frequently when you are at work.

Summary: During this session #4, the subject was able to look at her behaviors and increase her self awareness by looking at the triggers. She is better able to recognize the actions she can take that could prove beneficial.

Session 5, July 25, 2005

Set Agenda (Beck, 1979)

-Reviewed homework (self reports-BDI, BAI, BHS)

-Reviewed and focused on goals of chapter 5 (Gilson & Freeman, 1999):

- Understanding the importance of taking action to recover from depression
- Identifying activities and environments that are pleasurable
- Breaking the habit of procrastination
- Learning methods for improving mood by engaging in new activities
- Evaluated the DTR
- Reviewed guilt issues and challenging thinking
- Reeducated about cognitive distortions
- Assigned homework – completion of self reports (BDI, BAI, BHS), read chapter 6, complete exercises

Excerpt. The initial part of the session focused on a review of her gynecological appointment. She was more trusting of this doctor, which was a positive step. She was encouraged to take action steps to help herself with the symptoms of PMS as well as during her period. The focus then turned to the exercises in the manual.

T: I was wondering if you saw your patterns of low moods.

S: I wrote some stuff down. Do you want to hear it?

T: Sure

S: Um, things about my day (recurring situations that were associated with feeling bad): going to work, coming home from, public transportation, dealing with the kids, finding something to eat, washing,...just thinking about getting dressed...I sort of think ahead.

T: And then do you get overwhelmed?

S: Yeah, but I am doing it to myself. When I am watching TV my mind is not focusing on anything. I really am not watching and my mind starts to wander.

T: And where is it wandering?

S: ...I just start to think about something else.

T: But are they negative thoughts that you think about?

S: yeah, yeah.

T: Like what?

S: Thinking about my father, thinking about the future; if hip hurting thinking its disease (catastrophizing).

Addressing this negative thinking and the patterns that occur led to her continual feelings of guilt regarding her father. The therapist had her again question the evidence and the subject began to realize the irrationality of this thinking.



S: I don't think it through when I get to that part (about feeling I should have done more when he was staying with her brother). Sometimes...I do think it through and I realize it is not my fault and I do calm myself. And sometimes I think I enjoy the pain.

T: Really? What would make you think that?

S: 'Cause I keep on...I don't stop myself. I should say "this is not my fault. He didn't eat right; he was mean, he was very mean. Um...I couldn't take it; I had nobody helping me."

T: Right

S: If I really wanted to, for the con I could have had a pro. Yeah, I could talk myself out of it. Sometimes I don't.

T: What do you think is the trigger when you don't talk yourself out of it?

S: Um...I call it a cleansing. I cry. Sometimes when you cry it feel right.

T: Yeah, can be kind of a relief.

S: Yeah, sometimes I think it's a relief. Sometimes I feel a little better.

T: When you cry, though, do you let go of that negative thinking?

S: Yeah, yeah, that's why I sometimes don't stop it; I just let it come out. To get it out. And sometimes I just say look...it's not my fault. He didn't take care of himself; he was a SOB. He was very mean and people were scared of him. And I talk myself out of

it. But other times, I just go ahead and just let it out and sometimes I do feel better. Then, other times I don't stop myself. Sometimes I go to bed when I don't stop myself.

The therapist checks on the effectiveness of crying, focusing on its potential in changing her thinking. The subject does begin to realize that the crying releases negative thinking and emotions.

S: After I cry I am all right. I don't have nightmares or nothing about it. And I don't have bad dreams. I used to have bad dreams but I don't have them any more.

T: When you were completing these exercises, did you see a pattern?

S: Um...my pattern is If I'm idle, then my mind wanders, I need to be doing something mind provoking, like I read, or if I work on my plants, or something.

T: So, it's almost like a distraction? But when you say you're idle, is it because you want to be idle or is it because you have finished everything?

S: I could find something to do. So sometimes I just go ahead and do it.

The therapist then helps the subject examine her thinking and behavior and helps her to realize that she can control this negative thinking, especially because she is even more aware that these are triggers. The therapist then reemphasizes with the subject the realities of her father's illness and encourages her to question her thinking looking for the evidence.

T: So then do you revisit what you did or did not do (for your father)?

S: Revisit why he didn't take care of himself. He didn't follow any of the rules.

T: Was any of that your fault?

S: No.

T: Well, that's what you have to say to yourself.

S: I know, I know. But I am starting to do that. Saying, look, that's just not my fault. I take care of myself (so there's no reason to think I am going to be sick like him).

The therapist then commends her for taking good care of herself. She accepts and recognizes the positives of what she does for herself.

S: Yeah, yeah. I give myself a pat on the back, but not for the small things. But the small things start adding up and I am starting to appreciate that. Like now, it's raining and I'm not even going to get upset. I'm going to put my rain hat on and my umbrella up and I'm going in town.

The therapist reviews what the subject will do in town. She was originally going to buy an expensive bracelet but decided it would not be a good idea and that she should not spend the money. The therapist commends her for stopping and thinking before acting.

The therapist checks to see if the subject is practicing the relaxation breathing exercises noted in the manual [on page 69]; this had been emphasized at other sessions.

S: Yes, yes.

S: Yes

T: In what way?

S: They compete.

T: With each other?

S: With me.

T: How?

S: Ummmm...they like to...they tell on me...they tell my husband on me

T: What would they tell?

S: If I went shopping and bought something, they tell everything I bought. ...We could be driving and it's quiet but as soon as I start a conversation, they butt in. Or they correct me when I'm talking to my husband?

T: How do you handle that?

S: Um...I tell them I'm talking to their father and, I know I shouldn't do this, but sometimes I tell them to shut up 'cause I think it is inappropriate for a child to correct a parent.

The subject indicates that she withdraws and stops talking to them, following her aggressive stance. The therapist helps subject to look at more assertive, rather than

T: And are they helping?

S: Yes, yes

The therapist then gave a positive supportive reminder to practice the breathing exercises anytime the subject feels tense or nervous. Together they reexamined the review section at the end of chapter 5 (page 70).

The subject recognized that the best thing to do when depressed is to exercise and to make some changes. She was cognizant of scheduling pleasurable things as a positive action and realized that procrastination maintains the BEAST of depression. She also was able to recognize that taking small steps and breaking things down would be important to reduce the feeling of being overwhelmed and anxious. Stressors then became a focus. The subject indicated she has stopped doing enjoyable things with her family.

T: So you indicated that you stopped doing enjoyable things with your family. Like what?

S: I mean, I didn't stop doing them. Sometimes I don't enjoy it.

T: How come?

S: 'Cause my kids is with me. (laughing nervously)

T: Are they big stressors for you?

aggressive, ways of dealing with communication problems both with her children and with her husband (who often undermines her efforts with the children). The focus of the session then became her relationship with her husband.

T: So, he doesn't really back you up?

S: No.

T: Have you ever talked to him about this? How upsetting is it for you?

S: No.

T: Because?

S: Either I forget or I don't feel like being bothered.

T: Why not deal with it at the moment, and just say (when you're calm) I really get upset when you do that.

S: Yeah, well, then he's going to get upset.

This response is typical because she anticipates being criticized and avoids situations in which she perceives that this will occur, thus allowing the irritating behaviors to continue. She then resorts to passive aggressive behavior. The therapist encourages her to take action calmly, rather than assuming negative consequences and using avoidance as a coping skill.

T: Remember we talked about “I” statements and feeling words to address these problems.

S: I told him I don’t appreciate that.

T: And that it hurts you?

S: And I stopped myself from being just as nasty.

T: Well, good for you. But how would that have helped (being just as nasty)?

S: Yeah, yeah, that’s what I thought. Or sometimes I just don’t pay him no mind. I just ignore him. And he doesn’t like that and then I tell him well, I don’t like what you said to me earlier.

T: And then do you talk about it?

S: Ummmm...No, not really. I just tell him I don’t like it.

A review of these behaviors was important to help her recognize her passive aggressive tendencies, but she is beginning to express her thoughts and feelings. Increased use of assertive techniques both with her husband and with her children was encouraged. In relation to the behaviors of the children, the therapist recommended having a family meeting to work on the problems that continue to occur, especially disrespecting her.

S: Well, we did do that one time.

T: Did it help?

S: They didn't like it, they were crying. But...I did it very professionally and calm. I was calm but they were upset because they upset my husband. He called me on the phone at work and said the kids upset him so much that his eye was twitching. But I tell him, pick and choose your battles. Some of the stuff he wanted them to do was... I said don't worry about the back room or this room...wait 'til the weekend and wake them up early. Sometimes when I come home from work I see trash and I just step over it and go upstairs, take a bath, change my clothes, whatever. I said, after I take a bath, if I want to deal with it, then I deal with it

T: So you deal with it when you are calm.

S: Yeah, yeah. He wants to deal with it; he's law and order. I tell him no. No, you are not law and order. And I think he really thinks that he is law and order.

T: He has to control everything and make sure everybody has to be OK and it has to be his way or no way?

S: Yeah, yeah.

T: But where do you fit into this?

S: I'm just there; I'm the "take the blamer" – use me. And when he does give me credit, sometimes it will be a couple of years later, or a couple of months. He won't give me credit right then and there. One time he actually told me this...and I wanted to go



upside his head...he said I don't tell you certain things because I don't want you to get a big head. And I said, you know what, my head is so small...I said, it is not going nowhere, trust me, my head is not big. You keep it at the right size! (laughing) You are keeping it nice and small. I don't know, is it a racial thing, men not telling their women how they feel about them or, saying I need you or .... In the beginning he used to write me letters. He used to write me the most beautiful letters and I kept some of them – before the stress of living. One day I put out a letter he had written and I said, this is the old you that I fell in love with.

She then states that she feels as if he confides in other male friends telling them, not her, how he feels; this causes her to feel left out.

S: OK, this is what gets me. If he is on the phone talking to another guy, the whole conversation is different than when he is talking to me.

T: In what way?

S: Um, he says what he feels, to any male. I walk by and I think I didn't know that, you know, and sometimes I won't say anything and sometimes I will. I say why didn't you get that deep with me in the conversation? But then, I guess, I got to remember they (men) feel more comfortable talking to a male than a woman.

T: Yes, but you're his wife.

S: Yeah, yeah, he could tell me something. When he gets on the phone, I know it's the same subject, but it sounds like two different conversations. You know, it's more in depth, more information and I'm like...I got the short version.

T: You might ask him, how come he does that?

S: Well, I think I did ask him but I forgot what he told me. He had an answer. He even wrote a letter to me saying I know I don't open myself up to you and I'm sorry about that and I'll try to work on it, but that was years ago. Maybe I need to bring that letter out (laughing).

T: Sure, bring it out and say this is what I miss, as you said before.

The discussion focused on understanding the changes in their relationship, on the fact that these changes were brought about by both of them, and in looking at ways to work on the problem. Communication was stressed, as was assertiveness. The direction then changed to focusing on her perception of herself and the fact that she feels different from others, but also on the fact that she actually likes that.

S: ...I love being different. But I don't think like everybody else and sometimes people get upset with me when they ask me a question. But I say, you asked me a question, if you don't like my answer...

T: So you're not trying to impose your answer?

S: No, no, and I don't go with the majority. If somebody asked, you at work, I'll discuss and I'll say what I think about it and they'll say, oh, we can't ask her, she's old fashioned! She's weird; she's different. And I say, whatever. You asked me and I told you my opinion.

T: Does it make you feel bad?

S: No, no, I like being different. I don't want to be like other people. No, no, that doesn't bother me. It bothers me if maybe my husband says something, you know, maybe my family, especially my mother.

T: Does she tell you you're different and you're weird?

S: No, no. only...her own problem is she, in my opinion she doesn't ever say that's a good idea or that's a nice idea. But some people just push their own ideas, saying you should do this and that.

T: Is that what she does?

S: Yes, yes.

T: So, she imposes herself on you?

S: Yes, and that's very irritating. So sometimes I stop and sometimes I just sit in the car and be quiet, just don't talk 'cause I'm at the point where I just want to shut up.

...That's how I feel. 'Cause it's like a build up of not saying anything (when she has been controlling and critical at other times). Subject then relayed an incident when they were traveling and her mother was severely critical.

S: When we went to the Bahamas...it was a social night and the lady told us don't move these utensils off the table. So, I removed them because I hadn't heard what she said.

T: So you didn't know she said that?

S: No, 'cause the music was loud. So my mom said something to me loud. And she came back to the table and I said, "Don't talk to me like a child; I'm not a child". And she did apologize.

The subject is recognizing that assertive behavior is effective and she is practicing it more. Stress was then placed on using this behavior as often as possible, in all situations.

Homework: Complete the weekly self-report forms and continue to read in the manual, completing the exercises in the chapter and the Daily Thought Record (DTR).

Summary: The subject is learning to stop and think and to use assertive behaviors more effectively, to recognize her negative thought patterns and to challenge them.

Session 6: August 1, 2005

Set agenda (Beck, 1979)

-Reviewed self reports (BDI, BAI, BHS)

-Reviewed remaining exercises in chapter 5, with some discussion of chapter 6  
(Gilson and Freeman, 1999)

-Assigned homework – complete self report forms (BDI, BAI, BHS), read remainder of chapter 6 and complete exercises.

Excerpt. The therapist addressed the subject's thoughts and feelings regarding the psychiatrist's recommendation that she return to work (due to progress). The focus was then placed on the relationship between thoughts and feelings.

T: Because you're upset about going back to work, what is it that upsets you?

S: Doing the same I've been doing, with the same people.

T: Well, it's been a long time (16 years). You said you needed a change. Is there any way that you could (make a change)?

S: And my mother is not supportive!

The subject often reverts to her old schema of needing approval from her mother.

T: Well, your mother is not supportive about what?

S: She's not supportive of me getting another job.

T: I though you told me recently that she thought it would be a good idea?

S: No, no

T: But it's not up to your mother, is it?

S: No, I know but, you know, she thinks it's not important.

T: But, can you set is aside and say, "Well, that's my mother"?

S: yeah, yeah, I can do that... The doctor said I seemed fine and returning to work would be OK. Some people, they will go in and fake it, but I don't do that, I don't fake it. If I feel all right, I feel all right, and I really did feel all right on Friday.

T: Well, you seem to be doing better. It sounds like this return to work is pulling you down. Well, what can we do to help you?

The therapist and subject then discussed various options that the subject could pursue to see if she could extend her leave a couple of weeks, because that is what she would prefer. They also looked at other action steps she could take in her desire to get another job.

S: I was going to go back to working but still look for a job; just deal with it.

T: Can you though?

S: Well, I have no choice. ...I'll go back to work; I'll deal with it; maybe I'll have better coping skills, you know. (positive thinking)

T: What would you do when you go in and this woman who is your supervisor, and you go to your desk and let's say she tell you to do something?

S: I'll just go ahead and do it.

T: I sense you feel yourself getting tense. What if you do some slow deep breathing just at your desk?

S: I forgot what kept me calm (previously). I used to listen to books while I worked and my tape cassette broke. Today I am going to go to the library and pick up some cassette books and get another tape cassette. Now those really worked.

T: Well, good.

S: And I kept thinking, cause I said, something was working that I could deal with this job and then I find out it was the books. I had no books. But I used to listen to them while I was at work and it really helped.

T: How can you do that and work at the same time?

S: I can.

T: I would think you would get a little distracted.

S: Well...I can do it; I can do it. I've been doing this job for so long, that it is just routine.

The focus then reverted to the Daily Thought Record that she had worked on for homework; she was looking for triggers and patterns.

T: Did you learn anything from this DTR?

S: Just on certain items.

They reviewed the DTR together.

T: So, you're feeling scared? You are sitting on the porch and you are getting scared and your automatic thought is "I am getting sick". Is that your fear, that you'll get sick.

S: Yeah, yeah, aches and pains, and sometimes my hip bothers me.

T: So, then you think, oh my goodness, something worse?

S: It went away for a couple of days but it came back again. I've been exercising and walking a lot and doing aerobics. I also got fancy and went back to wearing high heels; it's better when I don't wear high heels. But sometimes you want to look better.

The subject continued to do some catastrophizing, but she is able to identify reasons for her aches and pains, which then decreases her negative thinking.

T: Well, let's review the manual. ...Is there anything where you notice a pattern? Any particular problem/situation?



S: No, I just feel sad.

T: Do you understand how certain situations or events can trigger your mood? The same with places and things?

S: Yes, yes

T: Are you able to challenge your thoughts, now that you are recognizing the triggers. For instance, if you see something about diabetes, do you say to yourself, that you father didn't take care of himself?

S: Yeah, yeah, when I want to.

It was important at this juncture to review her progress, especially in relation to her automatic thoughts about her father that continue to lead to catastrophizing. She has improved on challenging these negative thoughts and recognizing how effective it is to step back (stop) and think. The therapist and the subject then addressed efforts to change by consulting the manual (p. 63).

T: So, in making an effort to change, do you think you procrastinate?

S: Mmmm, my personal opinion is no.

T: Ok, I just wanted to check it out. The only reason I ask the question is, you don't like your job and you really haven't done a lot to get a new job. Well, what is that about?

S: Well, that's procrastination. Um...maybe I think I'm not smart enough to learn something new. But then again I think I am, I think I am.

T: What makes you think you're not?

S: Um...well, because I need to learn more about the computer but I asked him, my husband, to teach me.

T: Did he say he would?

S: Yeah, oh yeah. He wants me to get another job.

T: Well, I'm sure he doesn't like to see you so sad and upset.

S: He said, no, get another job. He said it's time for me to move on.

T: Well, and that's the way he feels? Does he encourage you to do that?

S: Yeah, yeah, my mom doesn't but...that's my mom.

T: And you have to remind yourself of that.

S: Yeah, that's the negative.

T: Yes, and the decision should be between you and your husband.

S: Except I have to stop calling her and telling her my business.

T: Why do you do that?

S: Well, you know what? I am a glutton for punishment! I must be a glutton for punishment!

T: Does it help to connect with her or are you seeking her approval?

S: I don't know, I don't know. I just want to have a conversation with my mother, but I am realizing I can't, you know. Me talking to her is not doing me any good. I can't. I need to stop it. It's not doing me any good to talk to her.

T: Well, that's a good realization. That doesn't mean you can call and just say hi but you don't have to share everything.

The subject is becoming more aware of assertive steps she needs to take. She is becoming more self aware, recognizing the need to change. The therapist and subject then engaged in role playing a possible situation with her mother, looking for alternatives for coping with mom. Evaluating her relationship with her oldest daughter became a focus.

S: Me and my oldest daughter, I think...her period just came on and I can't take that. I'm at the point where I'm ready to ask her to move out.

T: Because, what's going on?

S: I can't say nothing to her; she's always crying. I say please stop being such a drama queen.

T: Did you ever think about how you feel when you have your period? Remember you told me that you feel so awful when you have your period. How about showing some empathy or understanding for her, possibly saying “I know how bad you feel; maybe if you just rest in your room”, rather than taking it personally.

S: Well, all she does is sleep. And I wake her up and tell her to clean and she doesn't want to do it.

T: Well, what if you sit down, remember we talked about this; you sit down and talk with her about a better way to do it, rather than nagging her. It's counterproductive. So if you could sit down when you are both calm. (interrupted)

S: I'm not being sympathetic. I could be selfish at times.

T: Step back and say, “Is this working”? and see what you can do differently.

S: Sometimes I go behind her and clean because she doesn't know how to clean.

T: Well, what if you gave her a lesson on how to clean?

The subject and therapist discussed more productive ways of working with her daughter to enhance their relationship. The discussion led her to recognize that much of what she is doing with her daughter is similar to what her mother does with her – never recognizing the positives and continually being critical.

S: Yes, yes, I am (controlling) and I know that.

T: Well, if you know it, you have control of doing something about it.

S: Yeah, I need to break the pattern.

T: I think the key is to calm down. The calmer you are, the easier it will be to think more clearly. When you're angry, it becomes ineffective.

S: Sometimes I say it's just horrible. Yesterday she was supposed to clean the house. So...I went behind her.

T: Well, that sort of negates everything she's done. Have you ever told her she's done a good job?

S: Um, um...I'm starting to tell her. I say you did a good job. I say thank you. I say thank you for going to the store. Not all the time, but I am trying to remember to say thank you.

T: It's nice to be appreciated.

S: And, and, as adults we forget that children are people too. I do get upset with her. She then described an incident that upset the subject (related to her daughter's lack of appreciation of what she has).

T: Yeah, sometimes they (children) don't appreciate things. But you know what, they need to learn and they'll learn from you by your saying thanks for doing that or

thanking your mother for things she does for you. If she (your daughter) sees that appreciation from you, that will help her. Children learn from modeling.

S: I just started, and I know I should talk to her more calmly.

The therapist encouraged her to continue working on that and also stressed the use of assertiveness skills when the children speak to her disrespectfully, giving consequences for any negative behavior in a rational way.

The therapist gave positive reinforcement to the subject for becoming more aware of her automatic thoughts and for her recognizing how these thoughts affect her emotions and behavior; ultimately, the goal is to work on the subject's changing.

Summary: The subject was able to examine difficult situations that upset her, to recognize her behaviors, and to observe how she is trying to look at situations differently; ultimately the subject is working to become changed.

Homework: Continue reading the manual and completing the exercises in chapter 6; completing the self-report forms (BDI, BAI, BHS).

Session 7: August 8, 2005

Unfortunately the tape malfunctioned and the therapist was unable to obtain verbatim information from the tapes. The following, therefore, is a summary of what occurred, based on session notes and a review of completed exercises from chapter 6 in manual.

Agenda set (Beck, 1979)

- Self Report homework reviewed (BDI, BAI, BHS)
- Focused on chapter 6 goals in manual (Gilson & Freeman, 1999)
- Understanding the relationship between mood and life circumstances
- Gaining control when presented with life situations
- Understanding the role of vulnerability factors in depression
- Learning to decrease vulnerability to depression by evaluating and prioritizing stressors
- Assessed return to work
- Presented psychoeducation on assertiveness skills (Bourne, 1990)
- Assigned homework – self reports (BDI, BAI,BHS), write letter to mother & guilt letter

Excerpt. Session 7 began with the subject presenting her self-report homework. The discussion then led to her degree of hopelessness (as indicated on the BHS) and the cause that hopelessness. The focus became her sadness surrounding her father. She stated that she should not have done what she did. When questioned about what that meant she stated, “I should have never taken him into my home.” I really had no relationship with

him. When challenged about this thinking, she stated that she agreed to this because the family agreed they would help. However, no one helped and it became increasingly difficult to deal with him. He was a very angry, irritable person who was very demanding. She did the very best she could but she was becoming more and more overwhelmed with this burden. (Although it was not stated, it appears that she was hopeful that a relationship could be established [an unrealistic expectation]. When this did not happen, her anxiety increased. She was also continually criticized by him, no matter what she did. She started to get sick about this – stomach problems, increase in anxiety. She finally concluded that she could not do this. He then went to live with her brother. During that short period of time, her brother would not allow any contact either with himself or her father. After about a month, her father was placed in a nursing home. At a family funeral, which her father attended, he did not even acknowledge her – no recognition or verbal contact. She did eventually visit him in the nursing home and things were better. He asked her to bake him a cake and she did. He did not live very long after that.

In reviewing the aforementioned with her, emphasis was placed on her thinking. What was it that was so upsetting (since she became very tearful)? Specific questions were used to help her to look at the evidence and at the realities of the situation.

T: Did you not do your best? What more could you have done? What expectations did you have when you took him into your home?



S: She stated that she had expectations of her family members and they did not follow through adding “they cannot be trusted”. (This is just further confirmation of her schema that “people cannot be trusted”.) This was challenged, again looking at expectations.

T: The therapist asked if they (her family) had ever behaved like this before.

S: Yes

T: Could you ever count on them?

S: No

T: Do you think you did the best you could?

S: Yes.

Again the subject made a reference to her mother, stating that her mother continually criticized her; it happened more often (?) at this time.

S: No one ever said thank you!!!

T: Had they ever said thank you before?

S: No. I just want my mother to acknowledge I do a good job.

T: Has she ever said that in your life?

S: No, but I was always doing my best and was a “good girl”, even though sometimes I didn’t want to be.

The emphasis was then placed on whether or not she would be willing to accept her mother for who she is, recognizing that her mother may be incapable of giving positive feedback to her.

S: My mother is always talking about my brother who is a bum! She is always helping him, worried about him.

The therapist then reviewed this with her, comparing her with her brother realistically, helping her to see that she is quite capable, doesn't need help the way her brother does. She was able to look at this with insight.

Emphasis was then placed on recognizing her own achievements, reminding herself of how well she does. Reminders were given to her that it would be nice to have her mother give positive input; however, it has never happened and there is the likelihood that it never will, suggesting that her mother may not know how. (looking for evidence)

There was some insightful thinking on the subject's part regarding her supervisor at work. The subject was able to recognize, on her own, that she might be responding to this woman at work in a negative way because she reminds her of her mother.

There was a review of relaxation techniques; the subject responded by using positive self talk and assertiveness about continuing to work on all these techniques.

A recommendation was made that she role-model positive behavior for her mother. Because the subject has a difficult time talking with her mother, a recommendation was also made that she could write her a letter. She could also write a letter to her father about feeling guilty.

Homework was assigned: Complete the self reports (BDI, BAI, BHS); read and complete exercises in the manual; write the letter to her mother; remember to stop and think before speaking, calm down, think about what to say, and then say it.

Session 8, August 17, 2005

Agenda set (Beck, 1979)

- Self report homework reviewed (BDI, BAI, BHS)
- Reviewed behavioral homework (relaxation exercises, assertiveness)
- Presented assertiveness psychoeducation (Bourne, 1990)
- Continued to review chapter 6 goals and exercises (Gilson & Freeman, 1999)
- Some discussion occurred about chapter 7 and the goals:
  - Understanding how thoughts are categorized in the cognitive triad model
  - Identifying thinking patterns that maintain depression
  - Understanding the elements of cognitive distortions
  - Developing the ability to work with techniques for challenging cognitive bias

-Learning how to rework your thoughts and improve your mood with the thought record

Excerpt. The subject was experiencing difficulty with the concept of negative events and labeling distortions. Educating her and looking at her distortions or errors in thinking became the focus.

T: So...what is it that you don't understand?

S: It asks, um, about negative events...sometimes you can't remember what they are. Maybe later you remember.

T: You mean the labeling distortions (p, 99, 100 in chapter 7). Do you remember what distortions are?

S: Distortions are, um...things turned around the way you think of things.

T: Exactly. For instance, let's say you are talking about your manager and you're looking for another job. But you say, well, all managers are like this one. That's called overgeneralization; that's a distortion. Distortions are negative ways of thinking. So sometimes you, let's say you stub your toe and then you catastrophize. "Oh no, I hurt my toe, my foot must be broken; I'll have to go to the hospital; they'll amputate my foot, etc. That is distorting reality. That is another example of a distortion. So, what they are asking you to do here is to label them, these errors in thinking.

S: I know what distortions are. But what do they mean labeling your negative thoughts. What do they mean by that?

T: Basically they want you to look at your thinking to see what kind of a distortion you're making. Is your thought realistic? Are you catastrophizing, overgeneralizing, or using any other unrealistic, negative way of thinking? This recognition helps you then to question this thinking and challenge it, looking for the evidence.

S: OK. But I find this chapter really hard. Questions that make you think more.

T: So what is the problem about this?

S: Just, really thinking about yourself and putting it down, you know.

T: Maybe that is hard because maybe you don't do that?

S: Yeah, and it is hard to write it down.

T: What makes it hard to write it down.

S: Um...sometimes I think that it might come true, or...

T: Like what?

S: A negative thought, if you think one. Mine (negative thought) is a terrible disease, you know.

T: So because you think it, you think that it might come true? But we talked about this before and the need for you to challenge that thinking, looking for the evidence. The thought about disease is your fear. Why do you think that that fear is so great?

The subject then reflects on this and is able to recognize more positive aspects of her family history (regarding illness and early death).

S: Well, I have, I did have a lot of people in my family that lived to be old age...90, 80, but it just...my father just messed me up. I don't know why, because then...I had family that I never met because they died when I was little.

T: But they were probably old, weren't they?

S: Yeah, but you don't think about that kind of stuff.

T: Well, no, not when you are little.

S: And my grandmother, she was 81 when she died; my grandfather was 83 and my great-grandmother was 90 something.

T: So, you do have longevity in your family.

What is it about your father's dying that frightens you, that makes you look at yourself and then frightens you?

S: That messes me up! 'Cause I was there for the whole thing.

T: So you watched him suffer?

S: Yeah, for years.

T: But why did he suffer?

S: Because he didn't take care of himself.

T: Right. That that's what you have to remind yourself.

S: But...I get mad because I see other people not taking care of themselves and they are still living.

T: That happens. A lot of times there is no reason for that; I mean, we don't have all the answers, as you know. But maybe he just did greater damage to his body. And you seem to recognize that, but there seems to be something emotional regarding this that you haven't gotten in touch with yet. What do you think it could be? How do you feel when you think of him?

S: Well, first of all, I didn't like him.

T: So, if you didn't like him...usually when you don't like somebody, you usually don't care as much about what happens to them. But we talked about this before, you didn't like him but do you think you were angry at him?

S: Yeah, cause, um...it messed me up as a person. I think, I think, if he were a different father I would have been a different person.

T: But you can't go back..

S: No, no, no, I'm just saying. I am just angry that we was a terrible father, terrible.

T: But yet, even though he was a terrible father, you took him in. That was wonderful. Did that give you any...(interrupted)

S: I don't know how to give myself credit.

T: How come?

S: 'Cause nobody ever gave it to me.

T: But you have to learn to give it to you. That was a wonderful thing you did; nobody else would do it.

S: As a child nobody ever said to me – good job, good daughter.

T: I certainly understand that. But focusing on this doesn't really help you. Although all of us want that recognition from our parents and need that, it didn't stop you, did it? It's sort of like you turned around and said, all right, I am going to show you. And you did. But... you showed them, but I don't think you showed you. I think you are still this little hurting girl inside.

S: I am.

T: But you are not a child.

The therapist then guided the subject in looking at her positives, recognizing them for herself, and helping her to help herself.



T: When you struggled in your childhood and you were always criticized and never given any positives, you needed to learn how to take that child within you and give that child, today, what you wanted before. You need to learn to soothe yourself; you need to ask for the compliments that you didn't get. You need to give yourself a compliment. Look how hard you work.

S: I have to tell myself that (I did a good job). I have to learn to tell myself that even with little small things "you did a good job today".

T: Exactly, you have to learn because...(interruption)

S: Nobody else will say it.

T: And you need to ask for it. ...You have to learn to ask for what you want and it's OK to ask for what you want.

S: I am starting to ask for what I want.

The therapist guided the subject in recognizing that she needs to take care of herself and that she cannot rely on others for approval; she needs to approve of herself. This is a difficult concept for her, but she is gaining some insight and understanding into the idea that her belief about the reliance on approval from others interferes with her progress.

The subject then discussed issues regarding her husband. She is struggling with feeling left out and unappreciated. She also feels he is changing and that the job is

changing him. She has told him this but in a brutally honest manner. Looking at more appropriate methods of communication became a focus, as well as her reducing passive aggressive behaviors with him.

S: I tell him the job is changing him. He says no. Somebody must have told him that I said that and I didn't care that somebody told him, that's how I feel. And that's one thing I do, I say what I feel.

T: Sometimes you can't. Sometimes it is too brutally honest. So sometimes, as we talked before, you have to stop and think before you speak. Because sometimes, although you are being honest, sometimes that can be hurtful. And, sometimes people take it the wrong way, even if it isn't meant to be hurtful.

S: I said, you have less patience for me. Every day it seems like I don't do anything right lately.

T: That must be hard.

S: So, so, I ain't washing his clothes! I am going to put them right in the basement; I might hide them (laughing). Oh, shoot, I may just wash a couple underwear but I am not washing his clothes!

T: Because?

S: Because he said I don't do nothing so I am not going to do it.

T: But then you are going to prove to him that you do nothing!

S: That's the PMS in me this week.

The subject often blames her negative behaviors on her PMS or her period. An emphasis was placed on taking action to help herself and stop the blaming.

T: But if you know it's the PMS, step back and say, wait a minute, how is that helping things?

S: It's not.

T: It won't. So what could you do instead of that?

S: I don't know, 'cause...

T: Why can't you talk to him?

S: 'Cause he doesn't want to talk.

T: Well, what if you wrote him a note explaining your thoughts and feelings.

S: See, see...sometimes you need other insight! OK. That's good. I need to remind myself to do that (write him a note).

The therapist then used self-disclosure to emphasize the effectiveness of expressing oneself in a note if unable to express oneself verbally. Subject responded well to this and was able to review how effective it could be, adding that she might do it tonight, recognizing the relief she felt when writing the letter to her mother.

The therapist encouraged the subject to use writing to help to remind herself of her positives by making affirmation cards for herself.

S: Yeah, yeah, just to write. I read in a book once that you should stand in front of a mirror and say it. Say it to yourself. One book said to send yourself a card once a week.

T: Well, do it. And you know here is another good idea. Make little cards, called affirmations, praising yourself and reminding yourself that you are a good person.

S: Oh, yeah, I do that and hang it up.

T: Some people carry them in their bags. Because when you feel down, or nobody is caring, take one out. Those are the kinds of things that can really help you get through the day. To remind yourself that, yes, you are a good person. You are a great person and you do the best that you can do and you need to remind yourself of that. You need to be your own champion!

S: Yeah, I should do that.

Relationship issues then became the focus, including her distress at her husband's criticism of her. She reviewed the history of their relationship and the many positives about it. She brought it to the present and talked of the difficulties – the criticisms and the anger, especially about feeling controlled. This was reviewed and she was able to recognize some of her passive aggressive behaviors with him. But she resorted again to

blaming PMS for these behaviors. The therapist emphasized the need to stop and think before she resorted to old behaviors, emphasizing the need to relax and remain calm.

Homework included self reports (BDIL, BAI, BHS), writing, and continuing with reading the manual and completing the exercises.

Summary: The subject is making progress but often reverts to old thinking and behavior. She is better able to recognize her patterns and is slowly taking steps to help herself.

Session 9, August 23, 2005

Agenda set (Beck, 1979)

- Review of self-report homework (BDI, BAI, BHS)

- Review status of work

- Homework - Continue to review chapter 7 and related exercises in manual (Gilson & Freeman, 1999) and complete the self reports (BDI, BAI, BHS)

Excerpt. The subject was not feeling well because of a severe cold (as did the therapist). She continues to feel vulnerable, physically, precipitated by her father's illness and death (at such a young age) and, at this time, feels irritable.

T: So, how have things gone in the last week?

S: Um...could have been better.

T: Because? What happened?

S: Just in a bad mood.

T: What puts you in a bad mood?

S: Getting sick and not being able to take care of my family.

T: Well, when did you get sick?

S: Past weekend.

T: Were you in bed a lot?

S: No, no, just enough to irritate me.

T: So you didn't have the energy to take care of people?

S: Yeah, I could wash clothes and things like that but...

T: Well, then what do you mean?

S: Just getting sick in general, you know, you hear about people being sick.

T: Except, though, that's not what is happening with you.

S: I know, but I keep thinking it is, or something is going to happen.

T: Because you have a cold?

S: Every little ache and pain I think something's wrong with me now. I never was like that before.

T: Only since your father died?

S: Yeah, yeah, only since my father died have I been feeling like this.

T: Well, remember last week when you said it would be a good thing to challenge that thinking. Like when that thinking comes up you should say to yourself, "what am I doing"?

S: I been doing that; I been sitting back and challenging it, saying stop it, just let your mind get the best of you. Um...it's just your anxiety talking; it's just thoughts. Let em go.

T: Does it help?

S: Yeah, I'm getting back to, um...the last couple days I've been better; I've been talking to myself better.

T: Good.

S: And writing more affirming thoughts down now. I even did it at work. In between work I wrote something down and it got me through.

T: Well, that's important.

S: So, I'll stop and I'll write something. (She then reverts to not feeling well.)

Since my father I feel like I just can't get better. I feel like I let my defenses down. My immune system is like 0.

T: Except that you haven't been sick, have you?

S: Well, I feel sick. I don't feel like myself since he died.

T: In what way?

S: Um...I just pay more attention to my body, my body symptoms, you know; I just nit-pick with myself. Before I just never worried about things. Little pain didn't matter. Now, I think, oh my God, what's the matter, what's the matter?

T: Well, when somebody close to you dies, it often makes you feel very vulnerable.

S: But every little thing is like what is it, what is it?

T: However, we also talked about reminding yourself that you do take good care of yourself, and he didn't.

S: Not at all; not at all.

T: So because he died young and suffered the way he did is not a reflection on you.

S:: But it's just...I can't believe I let myself get this way. I can't get past it; it's irritating it's getting on my nerves. I am getting mad!

T: Mad at you?



S: Yeah, yeah (laughing)

T: Because you do this catastrophizing?

S: Yeah, yeah, and death.

T: But you said before that it was getting a little bit better because you were challenging it (the thinking).

S: Yeah, yeah, well, just this week I've been fighting back. I been like, I can't live like this every day

T: No, you can't.

S: It's just awful. It's no way to live and I'm fighting it, you know more. I just started challenging it.

T: Do you think that that interferes with all the other parts of your life, too, because you are worried that you are going to get sick.

S: Yeah, yeah, 'cause I am in another world.

T: Because you're thinking about?

S: Getting sick.

The therapist and subject then reviewed these thoughts and feelings about getting sick, with an emphasis on challenging these thoughts and ideas by looking at positives of

self, and addressing ways to decrease related anxiety. She is taking action to help herself, both physically and mentally and reinforcement of these positives was emphasized.

S: But like I said, I have my good weeks, I have my bad weeks. This was just a bad week.

T: Well, what can you do to help yourself during the bad week? Is there some way you can soothe yourself or help yourself to relax more?

S: Well, what I've been doing the last couple of days – I've been taking a bath in lavender and reading a book.

T: So that's relaxing and calming?

S: Yeah, that's what I've been doing and listening to opera; it calms the BEAST inside.

Therapist checked on the writing of the guilt letter. She has not written it yet.

S: No, I haven't written the guilt letter. I was going to write it today but...I just wasn't feeling good and couldn't concentrate. So, I am going to write because when I started writing the mother letter I saw that it was just coming out (the thoughts). So once I write the guilt letter I think it's just going to come out.

T: I think it will release a lot of those (interrupted)

S: Yeah, release! I just couldn't believe how it was just coming out when I was writing that letter to my mother! I thought it was just going to be stuck but it was just coming out...and I still have time for more – I could write more –so I said the guilt letter, I should be able to - have it come out. But today, the last couple of days, if I'm not feeling right, I'll stop what I'm doing and write a little note and write it down on a piece of paper and I will feel good!

T: Good!

S: Yeah, I feel better. I did it today. I stopped and took a piece of paper off my desk and wrote something. If I'm bored my mind wanders. When I started getting bored I wrote myself a little note and I felt better. I put it to the side and I moved on and I started working again.

T: Well, great; I am glad that is working for you. Was it an affirmation?

S: Yeah, so I wrote myself a positive note; I wrote it down and it worked!

T: Well, keep doing that. It helps because you are not keeping it all inside.

S: Yeah, yeah, so now I'm tired of the way I've been feeling so I'll now just write little notes.

T: It helps you to cope?

S: Yeah, yeah, instead of keeping it in. Stop worrying; save your worries for another day. Or save it for tonight, but only spend 15 minutes on it and then move on.

T: Yes, scheduling your worries can be very helpful.

Subject kept emphasizing how helpful writing has become. She then was able to look at other ways of coping.

T: So, did you go home and worry?

S: No, no. By the time I got home I was too tired to worry.

T: That's even better.

S: So what I do is, if I start to worry, I do something like throw a load of clothes in.

T: Well, that's good; you are distracting yourself.

S: Yeah, distract myself. And that's what I do; I distract myself but I wrote down, don't worry right now. This is not the time; this is not the place; you are going to be all right. I know what it was; don't look for other people to make you strong, only you can make yourself strong. (insight)

T: That's true.

S: I said, "Don't look for your husband to make you strong or your mother. Only you and God can make you strong." And I was like GO! It helped me....I kept looking for my husband and my mother but they're not going to make me feel better. ...And I wrote, "You can't look for your husband and your mother to give you strength; you have to give yourself strength." When I wrote that I thought , mmmm, that feels good!

T: Sounds like it felt powerful.

S: Yes it did, yes it did; it felt great!

The therapist and subject then discussed how the Jehovah Witness meetings help her.

T: In what ways do the meetings help you?

S: 'Cause you can't do it yourself but you can't rely on other people either because they have their own problems.

T: So they encourage you to do it between you and God?

S: I tell myself.

T: Does the meeting say that too?

S: Other men have their own issues, so I can't rely on them, and they tell me I can't rely on them so now I have to rely on myself. Well, God and myself. So now I am realizing I can't stop relying 'cause they...don't rely on them anymore. And, I'm tired of relying on them because I am tired of being let down. "Cause that's all they are doing is letting me down. And then I get mad and angry at them."

T: That doesn't help you does it?

S: No, no, 'cause I'm just angry.

T: Right, then you are not taking care of yourself at all.

S: Then I get mean and vicious and I say mean and vicious things to them.

T: Sounds like you are turning a corner.

S: Yeah, so when I wrote that...Only you can give you your strength, not them, I say boy, that is so powerful!

T: That is very good.

S: It just came out; it just came out and I said, wow, that is some strong stuff. I can't believe I just wrote this and I just went back to work. I forgot, I think I was feeling low. My husband, he was angry, 'cause I slow him down in the morning. He said he would stop taking me to work. I wrote him a little letter and put it in his bag and said "You know what, you don't have to take me to work any more, I'll take public transportation."

T: That's not a bad idea; it sounds like a good compromise. You can take your time in the morning, not hold him up, and then arguments don't occur.

S: I am sitting in the car and feeling stressed and so I said, "Here's the solution, I am going to go ahead and take public transportation so I won't make you late, so you can be there early and do what you have to do and you won't go to work upset and I won't go to work upset."

T: That is a good solution.

S: Remember we talked about writing a letter; well, I wrote my husband a letter. I told him I felt that he has changed into somebody else and I said I really think it's the job. You can't let the job become all of you. You still have to live. I didn't bring the note up after I gave it to him. I left it on the dresser and I said, "I left something on the dresser for you" and then I left it alone.

ST: Did it feel good to write it?

S: Oh, yeah, oh, yeah.

T: And you weren't necessarily having any expectations?

S: No, I had no expectations. I didn't care if he didn't say anything. He brought it up but I didn't feel like discussing it so...I just want him to read it. It wasn't, it was just how I felt and I didn't feel like discussing it.

T: ...Well you said what you had to say.

S: Yeah, and that was it. There was nothing to discuss.

T: Yes, you wanted him to be aware.

S: And I didn't want him to say anything. I didn't want his opinion or his defense. I didn't expect him to say anything; I didn't care if he said anything. I just wanted to write what I felt and that's what I did.

The subject then related information and stressors about the relationship with her husband and the fact that he does not understand depression.

S: Well, he said, you didn't want to discuss the letter? I didn't want to argue with him and I didn't care and he said, "oh.." He told me I'm a needy person and all his girlfriends weren't needy. I am the first person that was needy. So I wrote, "Well, I am sorry I'm a needy person and I know all your girlfriends weren't needy but I am your wife, and whatever..." but to myself, once I get passed that I think he's not going to like.

T: And how needy are you? You work a full time job, you run a household...

S: Yeah, he says I am a needy person.

T: Do you think he says that because you would like his approval?

S: No, I think it's because of the depression. You know, he just can't handle the depression.

T: Well, it is sometimes difficult for people to understand (depression).

S: Yeah, yeah, and I tell him.

T: I have some material about depression that would be helpful for him. It may help him to understand.

S: I have a lot of stuff on depression, lots of books.

T: Well, does he read them?



S: No, No, he doesn't read it. I don't ask him to; I think he doesn't care. He cracks jokes or whatever...

T: Like what kind of jokes?

S: Like if I'm not acting right, he'll say "Oh, did you take medicine today"? You know, stupid stuff. And I think he is insensitive. I even told him that he's insensitive.

T: If he could read something about depression and learn to understand it, I don't think he would feel that way. But that is not unusual; it's unfortunate and it doesn't help you.

S: Well, I'm learning. Like I wrote today; I am learning.

T: Good for you.

The therapist then reviewed with the subject how she (the subject) has been coping with her mother and her daughter.

S: With my daughter I have been more patient. I say "Can you do this, please". I say, "thank you." I call her up and I say, "I love you", before I go to work. My mom, that's another story.

T: How come?

S: I don't even bother with her. She upsets me so I just don't bother with her sometimes.

T: Well, that's OK. You are taking care of yourself by doing that.

S: Like, I just let her talk and talk and talk – talk herself silly, 'til she can't talk no more. She just want to hear herself talk. Nobody else can talk. So I just think – whatever!

T: Well, if you recognize that, then at least you don't get mad at her...just say "well, there she goes again."

S: Yeah, I said, there she goes; she's talking. Well, let the lady talk. Maybe she didn't get a chance to talk...So there she goes. When she talks, I just let her go. But she is always critical of me.

T: So you are not now taking it so personally?

S: No, no, because I can do it right back at her but I don't want to because I respect her.

T: Sounds like it doesn't make you as angry.

S: No, no, cause there's nothing you can do, what can you do?

T: Well, you can't change her. But you can change you and the way that you think and it sounds like that's what happening.

S: Yeah, yeah, I just tune her out, and comment casually throughout the conversation.

T: Well, that is totally different than what you did a couple of weeks ago when you would just get so angry. That's a real positive.

S: Yeah, I say, "bye, I love you, OK."

T: I think you do love her, but you don't like what she does.

S: Yeah, yeah, and she's not going to change.

Homework: Self reports forms to be completed. The next session is the last one, so a short discussion occurred about that.

Session 10: August 24, 2005

#### Agenda Set (Beck, 1979)

-Reviewed the process of therapy

-Reviewed work status and coping

-Completed self reports – BDI, BAI, BHS, ICD, DAS

Excerpt. This was our last session. The therapist reviewed with the subject her thoughts on the therapy process. She then reported an incident that had occurred at work and described how she handled it.

T: Well, this is our last session and I was wondering how you thought it went?

S: I think it was really good.

T: What did you like best?

S: The fact that I could talk to someone about my concerns, someone who didn't know me, and get another opinion. I was able to talk about things that I usually couldn't talk about. I feel like it has changed me. Like today. I am really happy with the way I handled today.

The subject started to relay an incident that occurred at work that morning. Apparently she came in a little late for work but her manager, or someone else, had seen her husband and assumed that she was there also. Because of that, she was summoned to the manager's office. The subject was able to say to the manager that she (the manager) was misinformed about the occurrences, and the subject was able to do so in a calm manner. The manager, however, continued to criticize her. The subject continued to remain calm and, in the end, stated to her manager that she was right. (Subject conveyed the fact she did this because the manager had not been listening to anything she said and she felt it would be better to just agree to diffuse the situation, especially knowing she (the subject) was right.)

S: They are watching me, maybe I should start watching them!

T: Just be careful with that.

S: But that's intimidation, that every time you walk by you know someone is watching you. It goes both ways. I was going to call or put it down on paper that even

my team leader is watching everything I do. He was wrong today. Whatever he tried to do, he was wrong.

T: You know what might be a good idea, just keep a little log of the occurrences.

S: Yeah, yeah, I was doing that. I'm going to have to go back to it. I know, I know.

T: But the way you handled it today...(interrupted)

S: Plus I also call HR and I just want it logged in that this is my complaint for today. I don't want anything done, I just want it written down on paper. I just want it written down so that there is a record that I have called and complained, especially if something should happen. I want them to know that I have been complaining about my management; that they have been harassing me, and this and that. I do call.

T: Good for you. You shouldn't be treated like that.

S: Yeah, yeah because most of the time, when you see it on TV, people ask why didn't you file a formal complaint? That happens a lot so, you know, so...I want to keep it on record.

T: So you are keeping a log of it yourself?

S: I called today but I'm glad I didn't get through because I didn't know the whole story that he (team leader) was in on it too. Which he was totally wrong about what time I came in and what I was doing, you know. ...They thought I was just walking around but I was actually bringing supplies over to the team. He thought I came in at this time,

but I didn't, so he assumed I was playing around for twenty minutes. I was actually late, so I wasn't there at the time he said I was there. But, I said, I'm not letting no knucklehead ruin me 'cause they are knuckleheads; there are other things to worry about. They ought to worry about their jobs. I'll be worried about my job.

T: It doesn't seem to make sense because remember you told me you get reviews that are really good and you get cash bonuses.

S: Yeah, so I have that in case anything comes down but ...I am really changing; I didn't say anything!

T: Well, what you are doing is stopping and thinking!

S: Yes, yes.

T: That is really important. I am glad you are able to handle this so well and it sounds like you are too.

S: Yeah, yeah. I don't think I am the same person I was. Today was great. I couldn't believe I talked myself out of a bad mood, a bad mood, a bad day. Yeah, I was smiling when I was coming here, waiting for the bus, walking. I went and had some tea and bought a necklace. I said the day turned out different than this morning.

T: Because you were able to turn it around?

S: Right, I turned it around. Tomorrow is another day. So...I feel good.

T: You should feel good; you have handled it very well. Do you want them to win or you to win? You actually won that because you didn't get upset. Seems like they want you to get upset.

S: I also got a phone call at the exact time that she saw me not working...so I said, OK she saw me on the phone and I told her I got a phone call but, I said tomorrow is another day. I did not get upset. ...And I probably would have laid it out and then gotten written up again but I did not react.

T: So behaving the way you behaved today was excellent.

S: I smiled and I put my headphones on and I smiled. Tomorrow is another day.

T: That it is and I hope you feel better.

S: Yeah, ...I can go home and relax because I didn't get into an argument, even when she called me into the office.

T: So, the rest of the day when well?

S: Yeah, yeah.

The remainder of the session was spent on the completion of the self report forms of the BDI, BAI, BHS, ICD, and the DAS.

Summary: The subject expressed the fact that therapy has helped her. She is now able to stop and think, rather than react. She is better able to focus on her job and remind herself

that she needs to focus on the here and now. She feels as though she is changing and she is seeing the positives. Recommendations were made that she continue reading the manual (Gilson and Freeman, 1999), reviewing the exercises, practicing relaxation techniques and assertiveness skills to maintain her progress and her improved coping.

The therapist and subject then discussed meeting again in approximately one month to review the maintenance of her progress. The therapist would call her and schedule the appointment for follow-up.



## Chapter 3

### Results

The investigator hypothesized that a depressed outpatient who participated in a 10 session protocol of cognitive behavioral therapy would exhibit changes in dysfunctional thinking by reduced scores on the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). Decreased scores on the Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979) were predicted and would indicate changes in cognitive distortions. Depressive symptoms would also be reduced as noted on reduced scores of three self report measures: Beck Depression Inventory (BDI; Beck, Steers & Brown, 1996), Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974). The research questions were: 1) In the clinical setting, would the ICD be able to note changes in the dysfunctional thinking of a depressed outpatient following the protocol? 2) Would the ICD subscales note a reduction in particular ways of the thinking? 3) Would the Dysfunctional Attitude Scale (DAS) demonstrate a reduction in cognitive distortions? 4) To what extent would depressive, anxious, and hopeless symptoms decrease during the course of cognitive behavioral therapy, as indicated by the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and the Beck Hopelessness Scale (BHS)?

### *Measures of Cognitive Distortions*

The focus of this investigation was to assess the sensitivity and effectiveness of the Inventory of Cognitive Distortions in the clinical setting. The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) is a 69 item inventory of statements that represent the way people think and feel about themselves, about others or about situations. It includes short-sentence items that reflect 11 different types of cognitive distortions. The frequency is determined by the use of a 5 point Likert scale; the subject responds with 1=never and a 5=always, with a total score falling between a low of 69 and a high of 345. To test the hypothesis that scores would decrease on this measure as a result of the subject's participating in cognitive behavioral therapy, this inventory was completed by the subject at session 1 to determine a baseline score and at session 10 to determine if any changes in cognitive distortions or dysfunctional thinking had occurred during the cognitive behavioral 10 session protocol. The subject completed this inventory again at follow-up to look for maintenance of changes. The subject's score on the ICD at session 1 (baseline) on 6/27/05 totaled 209. When the ICD was completed at termination on 8/24/05 the subject scored 194. As predicted, a decrease in the frequency of distorted thinking was noted, with a total difference of 15 points. At the follow-up session on 10/10/05, the subject scored a 179, a further decrease of 15 points, indicating a 14% reduction from termination in the subject's cognitive distortions. The results, therefore, support the hypothesis that cognitive behavioral therapy would lead to a reduction in distorted thinking (cognitive distortions) as exhibited by a decrease in the total score of the ICD as indicated in Table 1, Inventory of Cognitive Distortions, that follows.

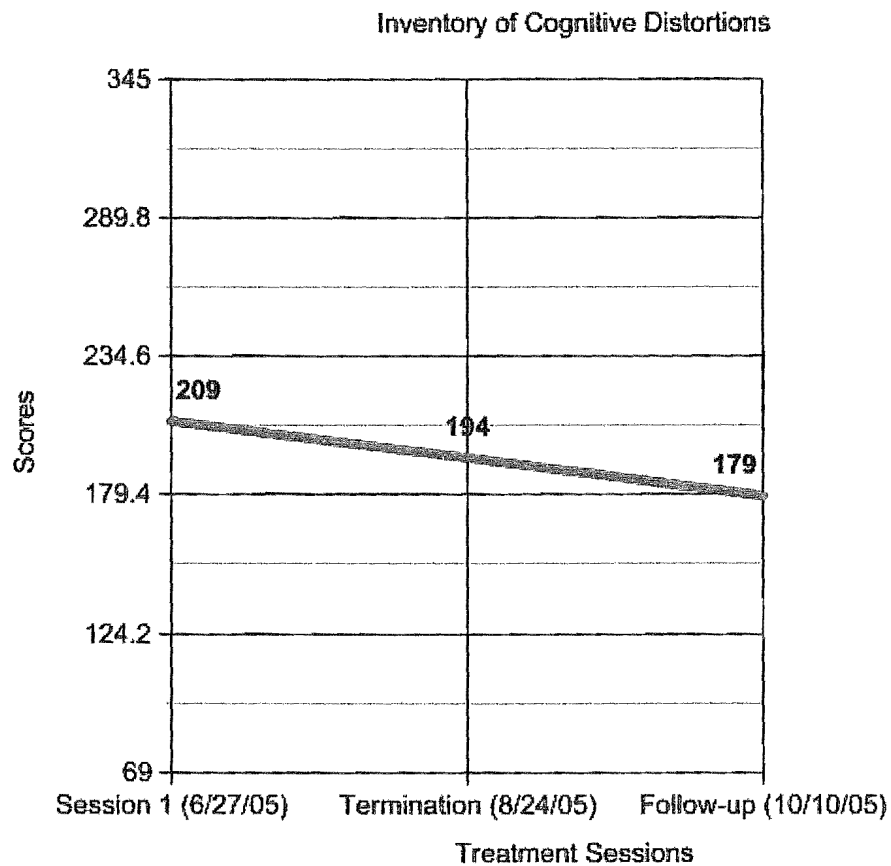


Table 1

The Inventory of Cognitive Distortions consists of 11 subscales which assessed the depressed subject's particular ways of thinking and the ways in which these dysfunctional thoughts have maintained her depression. The subscales include: 1) Externalization of Self-Worth 2) Fortune-Telling 3) Magnification 4) Labeling 5) Perfectionism 6) Comparison to Others 7) Emotional Reasoning 8) Arbitrary Inference/Jumping to Conclusions 9) Emotional Reasoning and Decision-Making 10) Minimization and 11) Mind Reading.

It was hypothesized that a reduction or elimination of these particular ways of thinking would be exhibited by reduced scores on the 11 subscales from pre-test to post-test on the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). The pre-test was completed on 6/27/05; the post-test was conducted on 8/24/05.

The first subscale, Externalization of Self-Worth, assesses primarily the subject's need for approval. Of a possible high of 75, the subject scored a 48 at pre-test and a 37 at post-test. Subscale 2, Fortune-Telling, assesses the subject's tendency to predict negative outcomes in the future. The subject scored a 37 at pre-test and a 33 at post-test out of a possible high of 55. Subscale 3, Magnification, assesses the tendency to exaggerate either the positives or negatives of a personal trait or circumstance. Of a possible high score of 35, the subject scored a 23 at pre-test and a 20 at post-test. Subscale 4, Labeling, assesses the tendency to use derogatory terms regarding oneself or others. The subject scored a 17 at pre-test and a 14 at post-test out of a possible high score of 25. Subscale 5, Perfectionism, assesses the tendency to strive constantly to live up to some internal or external representation of perfection. The possible high score for this distortion is 20. The subject scored a 13 at pre-test and a 12 at post-test. Subscale 6, Comparison to Others, assesses the tendency to compare oneself with others, reaching negative conclusions about oneself, leading to feelings of inferiority. The possible high score for this distortion is 20. The subject scored a 10 at pre-test and a 9 at post-test. Subscale 7, Emotional Reasoning, assesses the tendency to form conclusions about oneself, about others or about situations, based on emotional states. The possible high score is a 20. The subject scored 12 at pre-test and a 12 at post-test. Subscale 8,

Arbitrary Inference/Jumping to Conclusions, assesses the tendency of drawing negative conclusions in the absence of evidence to support the conclusion. The possible high score is 15. The subject scored a 9 at pre-test and 7 at post-test. Subscale 9, Emotional Reasoning and Decision-making, assesses the tendency to rely on emotions to make decisions. The high score is 10. The subject scored 7 at pre-test and 5 at post-test. Subscale 10, Minimization, assesses the tendency to discount the importance of a trait, circumstance, or event. The high score on this distortion is 10. The subject scored 4 at both pre-test and post-test. Subscale 11, Mind Reading, assesses the tendency of an individual to believe that he or she knows what others are thinking about him or her, assuming it is negative, with no evidence to support this. The high score for this cognition is 10. The subject scored 7 at pre-test and 5 at post-test.

Nine of the eleven Subscales had decreased scores from pre-test to post-test but two of the subscales (#7, Emotional Reasoning and #10, Minimization) received the same score at pre-test and at post-test. At the follow-up on 10/10/05, the subject's scores continued to decrease on seven of the subscales (#1, Externalization of Self-Worth, #2, Fortune-Telling, #3, Magnification, #5, Perfectionism, #6, Comparison to Others, #7, Emotional Reasoning, and #11, Mind Reading). However, two of the subscales increased: #4, Labeling increased from 14 to 16 from post-test to follow-up and #9, Emotional Reasoning & Decision-Making increased from 5 at post-test to 6 at follow-up. Additionally, two of the subscales remained the same from pre-test to post-test: #8, Arbitrary Inference/Jumping to Conclusions and #10, Minimization. The increases can

be attributed possibly to the subject's stopping her antidepressant medication (Wellbutrin) and the discontinuation of therapy for approximately one month.

The hypothesis that scores would be reduced on the 11 Subscales, therefore, was only partially supported due to two subscales remaining the same from pre-test test and 2 subscales increasing at follow-up. (Table 2)

Table 2  
Subscales of the Inventory of Cognitive Distortions Results

Subscales	6/27	8/24	10/10	Range
1. Externalization of Self-Worth	48	37	36	0 – 75
2. Fortune-telling	37	33	29	0 – 55
3. Magnification	23	20	19	0 – 35
4. Labeling	17	14	16	0 – 25
5. Perfectionism	13	12	10	0 – 20
6. Comparison to Others	10	9	8	0 – 20
7. Emotional Reasoning	12	12*	10	0 – 20
8. Arbitrary Inference	9	7	7**	0 – 15
9. Emotional Reasoning/ decision making	7	5	6	0 – 10
10. Minimization	4	4*	4**	0 – 10
11. Mind Reading	7	5	4	0 – 10

\*No change exhibited from session 1 (pre-test on 6/27/05) to session 10 (post-test on 10/10/05).

\*\*No change exhibited from session 10 (post-test on 8/24/05) to follow-up on 10/10/05.

### *The Dysfunctional Attitude Scale*

(DAS; Beck & Weissman, 1978; Weissman, 1979) is a measure of the dysfunctional beliefs of depressed individuals. It contains 40 items and is constructed of single sentence items answered on a 7 point Likert scale. It provides a single scale score ranging from 40 to 280, with lower scores indicating more adaptive attitudes but higher scores representing the presence of more dysfunctional attitudes. It was designed specifically to validate Beck's cognitive theory of depression.

The subject completed the Dysfunctional Attitude Scale (DAS) at session 1 (baseline) on 6/27/05, at session 10 (termination) on 8/24/05, and again at the follow-up session on 10/10/05. The subject's scores decreased from a baseline (6/27/05) score of 136 to a final session (8/24/05) score of 129. The follow-up session (10/10/05) score decreased further to 105. These results support the hypothesis that changes in cognitive distortions would be exhibited by a decrease in scores on the DAS.

## Chapter 3

### Results

The investigator hypothesized that a depressed outpatient who participated in a 10 session protocol of cognitive behavioral therapy would exhibit changes in dysfunctional thinking by reduced scores on the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). Decreased scores on the Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979) were predicted and would indicate changes in cognitive distortions. Depressive symptoms would also be reduced as noted on reduced scores of three self report measures: Beck Depression Inventory (BDI; Beck, Steers & Brown, 1996), Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974). The research questions were: 1) In the clinical setting, would the ICD be able to note changes in the dysfunctional thinking of a depressed outpatient following the protocol? 2) Would the ICD subscales note a reduction in particular ways of the thinking? 3) Would the Dysfunctional Attitude Scale (DAS) demonstrate a reduction in cognitive distortions? 4) To what extent would depressive, anxious, and hopeless symptoms decrease during the course of cognitive behavioral therapy, as indicated by the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and the Beck Hopelessness Scale (BHS)?



*Measures of Cognitive Distortions*

The focus of this investigation was to assess the sensitivity and effectiveness of the Inventory of Cognitive Distortions in the clinical setting. The Inventory of Cognitive Distortions (ICD; Yurica & DiTomaso, 2002) is a 69 item inventory of statements that represent the way people think and feel about themselves, about others or about situations. It includes short-sentence items that reflect 11 different types of cognitive distortions. The frequency is determined by the use of a 5 point Likert scale; the subject responds with 1=never and a 5=always, with a total score falling between a low of 69 and a high of 345. To test the hypothesis that scores would decrease on this measure as a result of the subject's participating in cognitive behavioral therapy, this inventory was completed by the subject at session 1 to determine a baseline score and at session 10 to determine if any changes in cognitive distortions or dysfunctional thinking had occurred during the cognitive behavioral 10 session protocol. The subject completed this inventory again at follow-up to look for maintenance of changes. The subject's score on the ICD at session 1 (baseline) on 6/27/05 totaled 209. When the ICD was completed at termination on 8/24/05 the subject scored 194. As predicted, a decrease in the frequency of distorted thinking was noted, with a total difference of 15 points. At the follow-up session on 10/10/05, the subject scored a 179, a further decrease of 15 points, indicating a 14% reduction from termination in the subject's cognitive distortions. The results, therefore, support the hypothesis that cognitive behavioral therapy would lead to a reduction in distorted thinking (cognitive distortions) as exhibited by a decrease in the total score of the ICD as indicated in Table 1, Inventory of Cognitive Distortions, that follows.

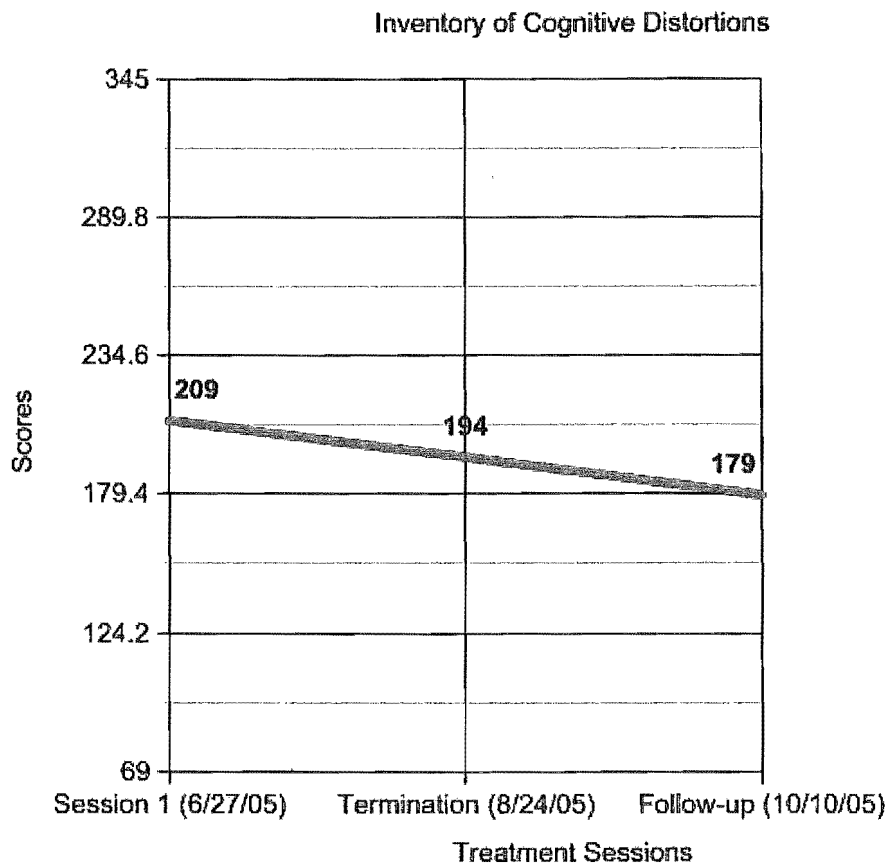


Table 1

The Inventory of Cognitive Distortions consists of 11 subscales which assessed the depressed subject's particular ways of thinking and the ways in which these dysfunctional thoughts have maintained her depression. The subscales include: 1) Externalization of Self-Worth 2) Fortune-Telling 3) Magnification 4) Labeling 5) Perfectionism 6) Comparison to Others 7) Emotional Reasoning 8) Arbitrary Inference/Jumping to Conclusions 9) Emotional Reasoning and Decision-Making 10) Minimization and 11) Mind Reading.

It was hypothesized that a reduction or elimination of these particular ways of thinking would be exhibited by reduced scores on the 11 subscales from pre-test to post-test on the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). The pre-test was completed on 6/27/05; the post-test was conducted on 8/24/05.

The first subscale, Externalization of Self-Worth, assesses primarily the subject's need for approval. Of a possible high of 75, the subject scored a 48 at pre-test and a 37 at post-test. Subscale 2, Fortune-Telling, assesses the subject's tendency to predict negative outcomes in the future. The subject scored a 37 at pre-test and a 33 at post-test out of a possible high of 55. Subscale 3, Magnification, assesses the tendency to exaggerate either the positives or negatives of a personal trait or circumstance. Of a possible high score of 35, the subject scored a 23 at pre-test and a 20 at post-test. Subscale 4, Labeling, assesses the tendency to use derogatory terms regarding oneself or others. The subject scored a 17 at pre-test and a 14 at post-test out of a possible high score of 25. Subscale 5, Perfectionism, assesses the tendency to strive constantly to live up to some internal or external representation of perfection. The possible high score for this distortion is 20. The subject scored a 13 at pre-test and a 12 at post-test. Subscale 6, Comparison to Others, assesses the tendency to compare oneself with others, reaching negative conclusions about oneself, leading to feelings of inferiority. The possible high score for this distortion is 20. The subject scored a 10 at pre-test and a 9 at post-test. Subscale 7, Emotional Reasoning, assesses the tendency to form conclusions about oneself, about others or about situations, based on emotional states. The possible high score is a 20. The subject scored 12 at pre-test and a 12 at post-test. Subscale 8,

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be attributed possibly to the subject's stopping her antidepressant medication (Wellbutrin) and the discontinuation of therapy for approximately one month.

The hypothesis that scores would be reduced on the 11 Subscales, therefore, was only partially supported due to two subscales remaining the same from pre-test test and 2 subscales increasing at follow-up. (Table 2)

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The subject completed the Dysfunctional Attitude Scale (DAS) at session 1 (baseline) on 6/27/05, at session 10 (termination) on 8/24/05, and again at the follow-up session on 10/10/05. The subject's scores decreased from a baseline (6/27/05) score of 136 to a final session (8/24/05) score of 129. The follow-up session (10/10/05) score decreased further to 105. These results support the hypothesis that changes in cognitive distortions would be exhibited by a decrease in scores on the DAS.

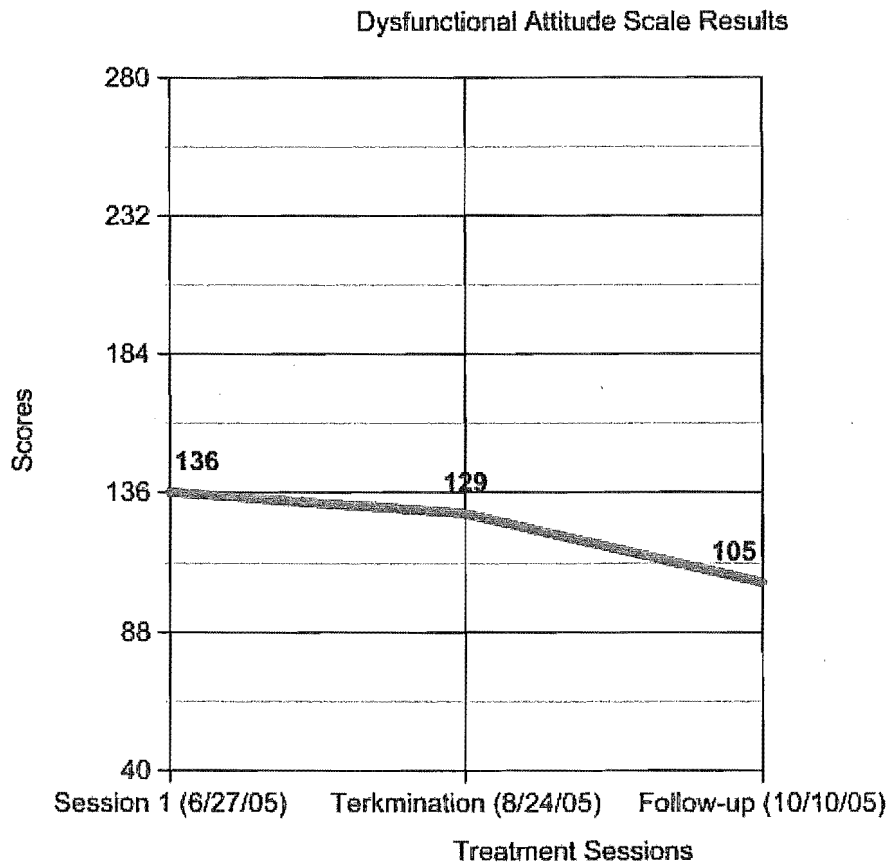


Table 3

### *Standardized Instruments*

The following self report instruments were utilized in this study to measure depressive symptoms: the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974). The subject completed these forms at each session for the 10 session protocol, and again at a follow-

up session approximately one month after termination. A description of the results follows.

The Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) is a 21 item inventory that measures symptoms known to be highly correlated with depression according to the DSM-IV criteria. It is rated on a 4 point Likert scale with scores ranging from 0=never to 3=severe, with a total score between 0 and 63. This inventory assessed the subject's depressive symptoms at each session, from session 1 (baseline) on 6/27/05 to the 10<sup>th</sup> session (termination) on 8/24/05. The subject had a baseline score of 20 on 6/27/05, placing the subject in the moderate range (20-28). At the second session, the subject's score decreased to a score of 4, indicating the minimal range (0-13).

Throughout the remaining 8 sessions, the subject's scores remained in the minimal range with scores between a high of 6 and a low of 1. At the final session on 8/24/05, the BDI score was a 1, indicating the subject remained in the minimal range of depressive symptoms. These results support the hypothesis that the subject's depressive symptoms would decrease during the course of cognitive behavioral therapy (see Table 4). At the follow-up session (# 11) on 10/10/05, the subject scored a 14 on the BDI, indicating an increase in depressive symptoms to the mild level (14-19), due possibly to her discontinuation of both her antidepressant medication (Wellbutrin) and therapy.



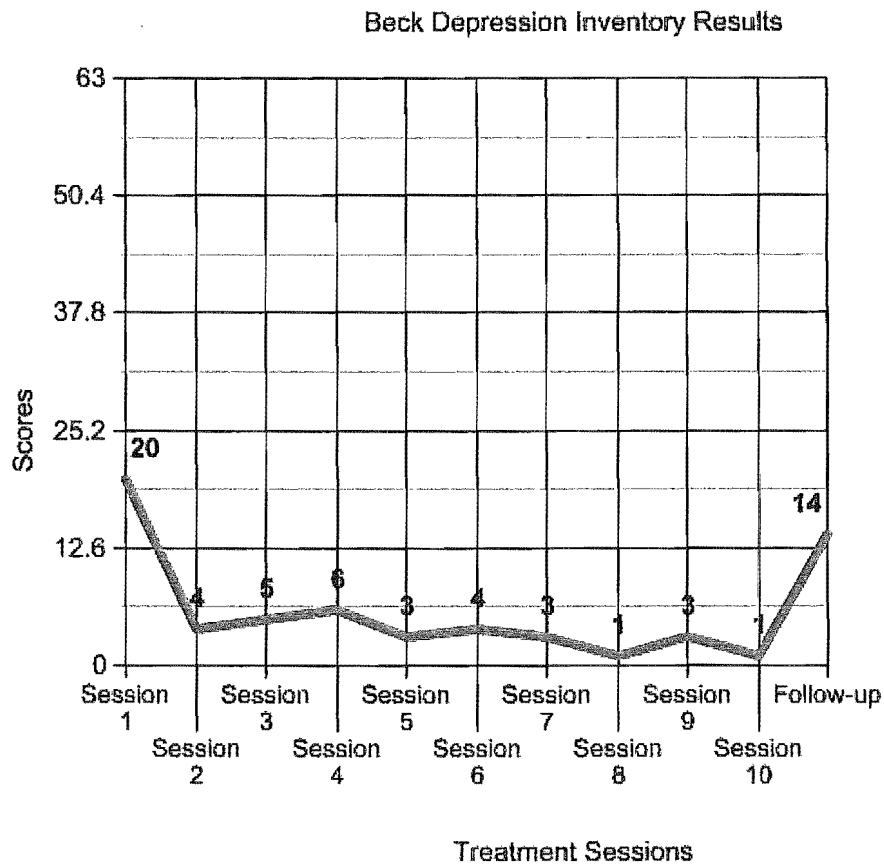


Table 4

Session changes in the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) scores from baseline session 1 (6/27/05) to termination session 10 (8/24/05) to follow-up on 10/10/05.

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988) is a 21 item self report inventory that measures symptoms of anxiety. It is rated on a 4 point scale from 0=never to 3=often, with total scores in the range from 0 to 63. It was designed to measure anxiety symptoms that are often shared with depression. This inventory assessed the subject's anxiety symptoms related to depression at each session

from the first session (baseline) on 6/27/05 to the 10<sup>th</sup> session (termination) on 8/24/05, and at a follow-up session on 10/10/05. The subject scored 39 at baseline on 6/27/05, indicating anxiety symptoms in the severe range (26-63) but the score was reduced at the second session on 7/7/05 to 17, placing the subject's score in the moderate range (16-25). By the 4<sup>th</sup> session, the subject's score had decreased to 12, which was in the mild range (8-15). The scores continued to decrease to a low of 7 or the minimal range. At the last session on 8/24/05, the score was an 8, placing the subject in the mild range. At the follow-up session (#11) on 10/10/05 the subject scored a 9. Although the score increased by 1 point from termination, the score remains in the mild range. These results support the hypothesis that depressive symptoms would decrease during the course of cognitive behavioral therapy. (Table 5)

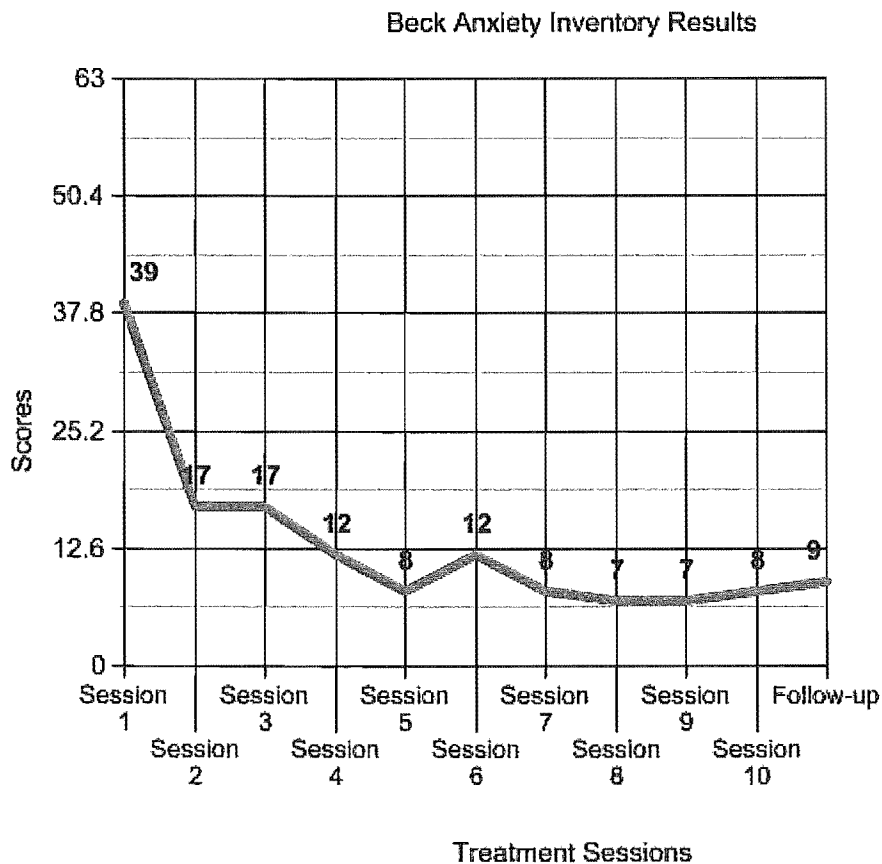


Table 5

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Table 5. Session changes in the Beck Anxiety Inventory (BAI; Beck, Epstein & Brown, 1988) scores from Session 1 (baseline) on 6/27/05 to session 10 (termination) on 8/24/05 and to follow-up on 10/10/05 (#11).

The Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974) is designed to measure negative attitudes about the future. It is a 20 item true-false measure that assesses 3 major aspects of hopelessness: feelings about the future, loss of motivation, and expectations; the total scores range from 0-20. This scale assessed the

subject's symptoms of depression as related to negative attitudes about the future from the first session on 6/27/05 to the 10<sup>th</sup> session on 8/24/05 and again at the follow-up session (#11) on 10/10/05. The subject scored a 10 at baseline on 6/27/05, indicating negative attitudes in the moderate range (9-14). The subject's scores decreased to a 5, which is in the mild range, at the second session. The scores for the remaining 8 sessions decreased to the minimal range (0-3) with scores ranging from a high of 3 to a low of 1. At the follow-up session (#11) on 10/10/05 the subject scored a 2, maintaining her low level of hopelessness in the minimal range. The results support the hypothesis that depressive symptoms would decrease during the course of cognitive behavioral therapy. (Table 6)

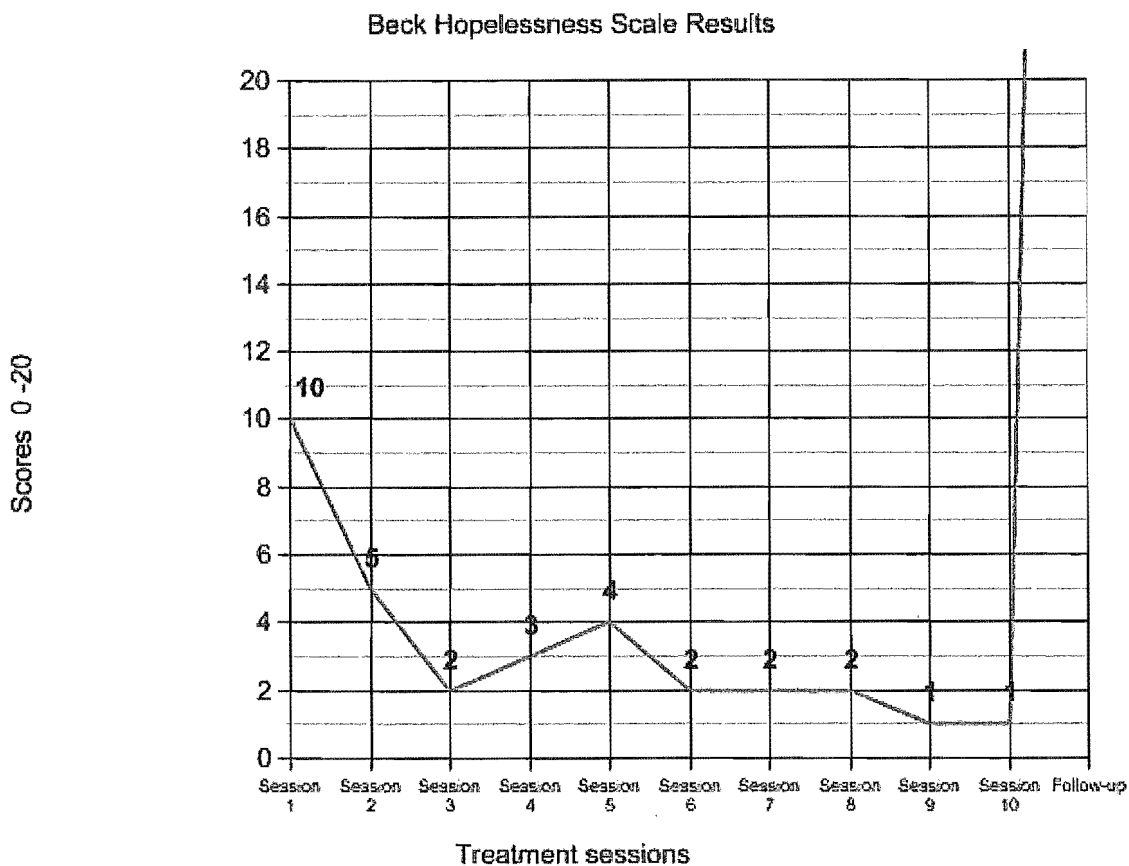


Table 6

Table 6. Session changes in the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974) scores from Session 1 (baseline) on 6/27/05 to Session 10 (termination) on 8/24/05 to the follow-up session (#11) on 10/10/05.

### *Summary*

The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) was able to show a decrease in the frequency of distorted thinking from baseline (6/27/05) to termination (8/24/05). The total score at baseline was 209 and at termination the score was 194, indicating a decrease in the total score of 15 points. At the follow-up session on 10/10/05, the score decreased an additional 15 points to 179. These results support the

hypothesis that a reduction in distorted thinking would occur as exhibited by a reduction of the total score on the ICD.

The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) consists of 11 subscales that include Externalization of Self-Worth, Fortune-Telling, Magnification, Labeling, Perfectionism, Comparison to Others, Emotional Reasoning, Arbitrary Inference/Jumping to Conclusions, Emotional Reasoning and Decision-Making, Minimization, and Mind Reading. Nine of these 11 subscales exhibited lower scores from pre-test (6/27/05) to post-test (8/24/05), with two subscales remaining the same - #7, Emotional Reasoning and #10, Minimization. At the follow-up session on 10/10/05, 7 of the 11 subscales were reduced although 2 remained the same - #8, Arbitrary Inference and #10, Minimization. Two others increased slightly -#4, Labeling and #9, Emotional Reasoning. It was hypothesized that there would be a reduced score on the 11 subscales of the ICD, indicating a reduction in particular ways of thinking. Because only 9 of the subscales exhibited a reduction in the score from pre-test to post-test, the hypothesis can be only partially supported.

The Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979) scores were reduced from a baseline score of 136 to a score of 129 at termination. The score at the follow-up session was reduced further to 105, a reduction of 24 points. These results, therefore, support the hypothesis that changes in cognitive distortions would be exhibited by decreased scores on the DAS.

The Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996), given at each session throughout the treatment protocol, exhibited a reduction in scores from baseline to termination, with scores ranging from a high of 20 (moderate range) to a low of 1 (minimal range). The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988) and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974) were also completed at each session and at follow-up, assessing depressive symptoms. All these measures exhibited reduced scores from baseline to termination. Scores on the BAI ranged from a high of 39 (severe range) to a low of 7 (minimal range). The BHS scores ranged from a high of 10 (moderate range) to a low of 1 (minimal range). The hypothesis that depressive symptoms would decrease as exhibited by lower scores on the BDI, and the additional measures of the BAI and the BHS is supported. The follow-up score on 10/10/05 for the BDI, however, increased from the minimal range (0-13) to the mild range (14-19) of depression. This could be attributed to the subject's discontinuation of antidepressant medication (Wellbutrin) and therapy.

The total scores of the ICD decreased from baseline to termination and again at follow-up. The subscale scores of the ICD also decreased, indicating the effectiveness of the ICD in noting changes in distorted thinking. Changes in cognitive distortions were also indicated by the reduced scores of the DAS. The BDI, BAI, and the BHS utilized at each session noted a significant reduction in depressive symptoms. Although it was anticipated that as depressive symptomatology decreased, as noted by the scores on the BDI, BAI, and the BHS, cognitive distortions would decrease similarly. This did not occur. The depressive symptoms decreased significantly and can be attributed to several

factors. The implementation of therapy for this subject yielded a venue for her to share her thoughts and feelings. The therapist provided an empathetic understanding, helping her to express and release concerns that she had never discussed. This therapeutic relationship helped the subject experience the feeling of being understood and accepted. This collaborative relationship instilled hope and optimism about being helped as well as a comforting sense of security. The resulting effect was a reduction in her depressive symptoms including also a sense of well-being.



## Chapter 4

### Discussion

The major focus of this research study was to test the clinical applicability of the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002). The ICD is a new self-report measure that was designed to assist cognitive behavioral therapists in identifying and documenting the presence of the underlying cognitive processes (cognitive distortions) of their clients, especially depressed individuals. “Cognitive distortions have been identified as playing a role in the maintenance of emotional disorders” states Yurica (2002). It is important, therefore, to identify these cognitions through the therapeutic process to help the patient alter his/her dysfunctional thinking to aid in the remediation of symptoms. It has also been noted by Gilson & Freeman (1999) that manualized treatments are beneficial both for patients and for clinicians, especially when working with a depressed individual, to maintain focus and increase understanding. The use of the manual, *Overcoming Depression* by Gilson & Freeman (1999) helped the subject develop skills to identify and to understand her thinking patterns associated with her depression. It aided the subject in understanding the connection between her negative thinking, her low moods, and her withdrawn behavior. This manual, utilizing a problem-focused approach, was designed to help the subject identify her depression and assess her motivation to change it. The manual utilized the acronym BEAST, which was designed to aid the subject in addressing each area that was affected by her depression: B=biology and biochemistry, E=emotions, A=actions, S=situation and T=thoughts. The use of this

manual throughout treatment helped the subject to maintain focus, with the goal of reducing her depression.

This case study represented the initial use of the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) in a clinical setting to determine if the measure could detect a reduction in cognitive distortions through participation in cognitive behavioral therapy. Depression is considered the “common cold of emotional problems because most people have experienced it sometime in their lives” (Gilson & Freeman, 1999); therefore, a subject who was experiencing depression was chosen to participate in this single subject case study research. The subject had been referred to PCOM’s Brief Therapy Center by her psychiatrist because medication was not ameliorating the subject’s symptoms. The subject, who had been prescribed 100 mg. of Wellbutrin taken 3x/day and 1 mg of Xanax, taken as needed (prn), was compliant with this medication regime. The subject was educated about the research study and agreed to participate. The fee for each session was waived and the subject received the manual, *Overcoming Depression* by Gilson & Freeman (1999); this was used as a guide in the therapeutic process and was also used for homework to increase knowledge and understanding.

This 10 session protocol of cognitive behavior therapy used the treatment manual, *Overcoming Depression* by Gilson & Freeman (1999) to standardize the treatment, allowing replicability. At the initial session, five different measures were utilized: The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002), The Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979), the Beck Depression

Inventory (BDI; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974), to gain a baseline of distorted thinking and depressive symptoms. Throughout the protocol, three self reports were completed prior to each session to note any changes in depressive symptomatology. They included the BDI, BAI, and the BHS. At the 10<sup>th</sup> session (termination) the original five measures were completed again to determine if distortions and depressive symptoms had decreased from baseline through participation in cognitive behavioral therapy. A follow-up session was conducted approximately one month later when the subject completed the following five measures (as used at termination): ICD, DAS, BDI, BAI, BHS.

#### Hypotheses

Hypothesis 1 theorized that the cognitive distortions of a depressed individual would decrease through participation in cognitive behavioral therapy as indicated by a reduction in the scores of the Inventory of Cognitive Distortions self-report. This hypothesis was supported.

At the first session the subject completed the ICD to determine a baseline score of cognitive distortions. The subject's score appeared high (209 out of a possible high of 345) and indicated that the subject was experiencing many cognitive distortions. During the course of the ten week protocol of cognitive behavioral therapy the subject began recognizing her patterns of dysfunctional thinking (cognitive distortions). This realization appeared to be the result of the therapeutic alliance with the therapist (Beck, Shaw, Rush & Emery, 1979; Freeman, Simon, Beutler & Arkowitz, 1989) and the

continual use of the manual, *Overcoming Depression* (Gilson and Freeman, 1999). The manual focused on the use of cognitive behavioral therapy. It emphasized the development of new skills to identify and to understand thinking patterns associated with depression and the connection between negative thinking, withdrawn behavior, and low moods. The manual used a problem-focused approach that encouraged tracking how the subject thought, what to do between sessions, and working on strategies for change. (Gilson & Freeman, 1999).

Malik, Beutler, Alimohamed, Gallagher, Thompson and Thompson (2003) suggest that the use of manuals be advocated as a way of providing “the clearly specific psychological treatments required for the identification of empirically supported treatment”. In addition, manuals provide a way for therapies to be applied in an accurate and replicable manner in different settings by different clinicians.

At termination, the subject’s score on the ICD decreased and the total score was further reduced at follow-up approximately a month later. These results supported the hypothesis that reduced scores on the ICD would indicate fewer cognitive distortions. However, the reduction in the score was minimal (209 to 194) and indicated that the subject was still experiencing dysfunctional thinking. The continual use of cognitive distortions could best be attributed to particular problems in thinking with depressed individuals. Weishaar (1996) described this noting that

“depressed individuals become more rigid and biased in their thinking, judgments become absolute, and the core beliefs about the self, one’s personal world, and the future become fixed. Errors in logic,

called cognitive distortions, negatively skew perceptions and inferences, and lead to faulty conclusions.”

The subject’s dysfunctional thinking and maladaptive responses appeared to be maintained by this rigid, biased thinking, particularly by the core beliefs about herself and her world, reinforced by the ongoing negative treatment by others. According to Needleman (1999), “each time an individual receives a negative message, it may activate a primitive mode that results in maladaptive responses. In addition, the repeated negative messages can eventually lead individuals to form negative core beliefs that perpetuate their distress”. The subject was an example of this. She continued to receive negative messages on a daily basis from her mother and her husband (and at work) and took no action to change this pattern due to her negative thinking. The primacy effect was significant with this subject because she often reverted to early childhood memories that continued to influence her present experiences. Her belief system and schemata were so embedded that she allowed the continuation of this pattern although this upset to her. This was addressed throughout treatment and she became more aware of how her thinking affected her emotions and behavior but struggled with making significant changes due to the belief that she “had to be a good girl”; she, therefore, had a great deal of difficulty becoming more assertive.

Throughout therapy, as indicated in the annotated portion of the Method Section, the subject continually returned to issues from her past, ones that seemed to be maintained by the negative interactions she experienced with those close to her. Although she was working on behaving more assertively, this was uncomfortable for her

because her core belief was the need for approval, especially from her mother. She was raised in a matriarchal system and had the belief that she had to submit to her elders while, at the same time, she was becoming more angry and depressed; this was due to her inability to handle situations effectively, which was maintained by her cognitive distortions.

During the course of treatment, the subject began practicing assertiveness skills, (Bourne, 1990) and saw success, but she often reverted to her old way of thinking. Needleman (1999) suggests that socially alienating behaviors such as, complaining, expressing pessimism, exhibiting hostility, looking depressed, and not exhibiting interest in others lead to and maintain adverse conditions in the social environment of the individual (rejection or hostility); these, consequently, maintain the depressive thinking. The subject exhibited these socially alienating behaviors with her family and in her work place, helping to maintain her cognitive distortions of “nobody likes me”, “I am not a good person”, “I am not a good mother or wife” and “I am not a good, nice person”. Because this type of thinking is so embedded, the ten session protocol did not exhibit as great a change in the subject’s cognitive distortions as hoped. Therefore a recommendation would be to change the protocol to include an increase in the number of sessions in order to continue to focus more specifically on changing the subject’s cognitive distortions. Although these negative behaviors and cognitive distortions were addressed throughout treatment, the subject had a difficult time moving beyond the primacy effect (Gilson & Freeman, 1999). Perhaps having the subject complete the ICD

at each session and reviewing each statement carefully with the subject, may have helped alter some of these core beliefs and cognitive distortions that were being maintained.

At the follow-up session the subject completed the ICD, and a further decrease in the total score was noted (194 to 179). This confirms the fact that the ICD is able to note changes in dysfunctional thinking (cognitive distortions) in the clinical setting. In addition, it appears that the subject was able not only to maintain progress but to improve it by a further reduction in her cognitive distortions. This continued improvement could be the result of her increased awareness and the acquisition of new skills (stopping and thinking, looking for evidence, challenging her thinking).

Hypothesis II theorized that particular ways of thinking would be reduced or eliminated as exhibited by reduced scores on the 11 subscales of the ICD from pre-test to post-test. The subject's scores were computed at the first session (pre-test) to gain a baseline score. The score at baseline was then compared with the post-test score to note any changes in thinking for each of the subscales.

The eleven subscales of the ICD are described, addressing the subject's related thinking.

1) The Externalization of Self-Worth Subscale reflected the degree of need and approval. The subscale is based almost exclusively on how the external world views one and refers to the development and maintenance of self-worth. External locus of control appears to be the concept that is relevant; this is in addition to negative comparison. Those scoring high on this factor have a strong tendency to seek approval and recognition from others which they use to validate their self-worth (Yurica, 2002). The subject's

score on this subscale decreased from above the mid-range ((48 of 75) to the mid-range at post-test (37 of 75), indicating that the subject experienced some problems with her self-worth but was improving, as noted by the reduced score. The subject's fairly low self-worth became apparent during therapy because of the subject's expressed need for approval from her mother, a continual quest that frustrated her leading her to feel "less than". This became a factor of therapeutic importance because the client achieved progress in dealing with her mother by looking at her cognitive distortions, assessing their relevance, looking at the evidence and using assertiveness skills to cope and take care of herself (Bourne, 1990).

2) The Fortune-telling subscale measured a person's tendency to predict negative outcomes in the future. This cognitive distortion is indicative of the process of predicting negative outcomes of future events. Selective Abstraction is also represented in this subscale. The cognitive distortion is a process of focusing exclusively on one negative aspect of a situation, magnifying that negativity, and placing a negative cast on the whole situation. Those who have high scores on this subscale tend to display a strong tendency to predict negative future outcomes for themselves, as well as to look at the present situation negatively, often discounting any possibility of positives. The subject scored above the mid-range (37 of 55) at baseline but the score decreased both at post-test and follow-up to the mid-range (29 of 55), indicating that the subject appeared to be thinking more positively about the future and was no longer looking at life through such a strong negative lens. However, because the final score was in the mid-range it was evident that she still maintained some of this negative thinking.



3) Magnification. This cognitive distortion indicates the tendency to exaggerate either the positive or negative aspects of a personal trait or circumstance. Assigning greater significance to events or magnifying smaller problems into larger ones seems to occur in this distortion. Improvement was noted. The subject's score decreased from pretest to post test (23 to 19), indicating that she was making some progress as noted in therapy sessions because the subject used new skills such as stopping and thinking and looking for the evidence of her thinking (Gilson & Freeman, 1999).

4) Labeling. The tendency to use derogatory terms regarding oneself or others indicates the cognitive distortion of labeling. These labels are often extreme and indicate all or nothing or dichotomous thinking (Yurica, 2002). Reduced scores from pre-test to post-test (17 to 16) were noted but were minimal. The subject continued to work on this distorted thinking but experienced some anger and frustration toward family members; she had yet to deal with them, thus maintaining this distortion. This was a continual focus of therapy with a recommendation that this focus be maintained in her continuation of treatment.

5) Perfectionism. Constantly striving to live up to some internal or external representation of perfection is the description of this cognitive distortion. Those who have high scores on this subscale hold standards of perfection both for themselves and others without examining the evidence for this unreasonable thinking. The subject's score was reduced from pretest to post-test (13 to 10), placing her score in the mid-range (10 of 20). Although the subject indicated some evidence of perfectionist thinking as indicated by these scores, looking at the evidence of this type of thinking was a focus of

therapy and as indicated by the decrease in her score, she was able to evaluate her thinking and make some degree of changes.

6) Comparison to Others. High scores indicate a tendency to compare oneself with others, reaching negative conclusions about oneself, thus leading to feelings of inferiority or of feeling less than others. The subject's scores on this subscale indicated that she has some of these tendencies, especially related to comparing herself with other family members. This was exhibited by her mid-range score at pre-test. However, on the post-test the score was reduced (10 to 8) and she exhibited the ability to look at these comparisons with siblings realistically, recognizing her faulty thinking.

7) Emotional Reasoning. Those who have high scores on this cognitive distortion tend to form conclusions about themselves, about others, or about situations which are based on emotional states. (Yurica, 2002) The subject's score was reduced to mid-range by post-test (12 to 10), indicating that she was still using this thinking pattern but not as frequently. She resorted to this kind of thinking when affected by Pre-menstrual Syndrome.

8) Arbitrary Inference/Jumping to Conclusions refers to the process of drawing a negative conclusions in the absence of evidence to support the conclusion. The subject scored above the mid-range (9 out of 15) but through work in therapy her score at post-test reflected a reduction of 22%.

9) Emotional Reasoning and Decision-Making. Relying on emotions to make decisions is typical of those who experience this cognitive distortion. Yurica (2002) states that this usually refers to people who rely on their gut feelings. The subject scored

above mid-range (7 out of 10) at pre-test and her score at post-test was only minimally reduced (6 out of 10), remaining in the same range. The subject struggles with hormonal problems (PMS and menses). During this time, the subject behaves more emotionally, over-reacting and making poor decisions. The focus of the treatment was to work on increasing her awareness of the timing of this physical state so she could take some steps, behaviorally, to reduce her emotional decision-making. She is very much aware that she does this, which is a positive, and emphasis was placed on her taking preventive steps to ward off any increased emotionality.

10) Minimization. Minimizing or discounting the importance of a trait, circumstance, or event is typical of someone who has this cognitive distortion. The subject's baseline score was below mid-range (4 of 10) with the subject remaining in this range at post-test also. This is in the lower range and suggests that she does not use this distortion very frequently. In therapy the subject interpreted this subscale as her minimization of expressing herself to others. She was unaware of the brutal honesty she often expressed in communicating with her co-workers and with her eldest daughter, in particular. When this was addressed in treatment she was better able to recognize her minimizing of such occurrences; she looked at better ways of communicating, and began working on it to some degree. Further work would prove beneficial.

11) Mind Reading. Those with this cognitive distortion tend to believe they know what others are thinking about them and assume that it is negative, with no evidence to support the conclusion. The subject scored above mid-range (7 out of 10) but was able to reduce her score to below mid-range (4 out of 10) at post-test. This decrease appeared to

indicate her awareness of this thinking. Efforts to change this distortion by stopping and thinking and looking for the evidence were also indicated in therapy.

Hypothesis III theorized that changes in cognitive distortions would occur and would be exhibited by decreased scores on the Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979). The DAS appears to distinguish reliably between the depressed and the non-depressed (Dozois, Covin & Brinker, 2003)

The DAS was completed by the subject at the first session, at the last session (termination), and again at follow-up. Initially, scores indicated depressive thinking at the mid-range level (136 of 280). There was a 5% decrease at termination and a 17% reduction at follow-up. This reduction in the total scores on the DAS supported the hypothesis that reduced scores would indicate few cognitive distortions because there was a reduction in the total score from pre-test to post-test and a further decrease at follow-up. This was a further indication that the subject was continuing to work on changing her thinking.

The subject stated that therapy had proved beneficial. She indicated the positives of learning new skills, aided by the manual, *Overcoming Depression* (Gilson & Freeman, 1999) and was now able to stop and think, evaluate situations, weigh the evidence and problem-solve. However, the scores had not decreased as dramatically as the investigator had hoped. Gilbert (1998) states that “even though people can be taught quite quickly how to identify their cognitive errors and distortions they may find it extremely difficult to apply logic and reason even if they would strongly wish to.” Whenever the subject faced difficult life circumstances and criticism in particular, her negative schema

appeared to be activated and this, in turn, inhibited her abilities to think clearly and to address the situation logically. A possible explanation for this came from Dohr, Rush and Bernstein (1989), who reviewed studies that investigated the stability of deeper cognitive processes (dysfunctional attitudes) and found that “endorsement of dysfunctional attitudes on the DAS either was not significantly reduced or remained elevated in comparison with normal control levels during a remission of depressive symptoms, which implied that the dysfunction is traitlike”, a relatively persistent and consistent behavior manifested in a wide range of circumstances.

Hypothesis IV theorized that clinically there would be a decrease in depressive symptoms as indicated by a decrease in scores on the Beck Depression Inventory (BDI-II). This hypothesis was supported.

To determine the range of depression, the subject completed the BDI-II at the first session and at every session throughout the 10 session protocol. The subject scored in the moderate range at pretest (20 out of 63) but her scores decreased significantly to the minimal range (0-13) at session 2. Throughout the remaining 8 sessions, the scores remained in the minimal range.

The most prominent reduction in the subject’s score occurred between the first and second sessions, from a score of 20 in the moderate range to score of 4 in the minimal range. Freeman & Oster (1998) indicated that most improvement is noted in the first weeks of therapy. This decrease in the scores on the BDI, indicating a significant reduction in depressive symptoms, was reviewed with the subject to determine what

factors were relevant in this resulting improvement. She conveyed the fact that she was feeling much better, less depressed and less anxious, because she was able to discuss her thoughts and feelings with someone who was accepting, understanding, and non-critical, an example of the therapeutic alliance (Beck, 1967). The subject added that she previously had kept everything to herself and it felt good to be able to talk about her concerns. She also indicated that the use of the manual increased her knowledge and understanding about depression. She began to recognize her dysfunctional thinking patterns. She learned new techniques to aid in reducing the depression, such as Questioning the Evidence, Reattribution, Examining Options and Alternatives and Decatastrophizing (Gilson & Freeman, 1999). The subject noted that thought - stopping proved most beneficial. At the follow up session, the subject's scores increased, moving her from the minimal range to the mild range. Although depressive symptoms were low, this increase was notable. The change could be attributable to the subject's discontinuing the anti-depressant medication she had been taking throughout the 10 session protocol. The subject had been prescribed medication to aid in the decrease of depressive symptoms. Those included Wellbutrin, 100 mg, 3x/day for depression, along with Xanax, 1 mg., prn, to cope with accompanying anxiety. Discontinuing this medication in addition to not participating in therapy could certainly have contributed to this increase in symptoms.

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988) and the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974) were also utilized to measure accompanying depressive symptoms. These measures were

presented at each session to monitor any change in the subject's level of anxiety and hopelessness that were related to her depression.

The BAI score (39) at the first session of the ten session protocol indicated that the subject was experiencing severe anxiety(39 of 63). However, the score dropped to the moderate range by the 2<sup>nd</sup> session. Scores continued to decrease throughout treatment to the mild level of anxiety. This reduction in anxiety was also noted observationally. The subject presented as less nervous and agitated and more relaxed during sessions. The subject stated she was much less anxious and better able to cope with difficult situations. She attributed this progress to talking about her fears and worries and learning new skills. The decrease from severe anxiety at the first session to moderate at the second session was a further indication that the subject's depressive symptoms were ameliorating. As treatment continued, the subject's anxiety level continued to decrease, reaching the mild range. This improvement in the first few weeks of therapy is typical, as noted by Freeman & Oster (1998). But this early improvement, along with skill building, aided the subject in remaining less anxious throughout the remainder of treatment and at follow-up.

The subject completed the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler1974), designed to measure negative attitudes about the future, at the first session and scored in the mid range (10 out of 20). Again by the 2<sup>nd</sup> session, as noted with the BDI and the BAI, scores dropped to the minimal range. By termination, the subject indicated that she no longer felt hopeless, having reviewed this thinking, looking for evidence. This progress was maintained from termination to follow-up, suggesting a

reduction in her dysfunctional thinking. The improvements noted in the scores on this measure are reflective of the progress noted on the BDI and the BAI and typify the improvements noted in the first few weeks of therapy (Freeman & Oster, 1998).

#### *Implications for Clinical Practice*

As hypothesized, the Inventory of Cognitive Distortions (ICD) was sensitive enough to note changes in the cognitive distortions of the depressed subject experiencing Major Depressive Disorder. The use of this measure in the clinical setting proved beneficial for the following reasons.

1) This measure was able to provide a more accurate description of the subject's current level of functioning and her related thinking patterns.

2) The ICD assisted in the case conceptualization by looking at her schemas, her cognitive distortions, and her related behaviors. With this knowledge, target interventions were able to be implemented more clearly.

3) This measure also allowed confirmation or refutation of hypotheses and impressions of the subject. Although this subject was diagnosed with Major Depressive Disorder based on other measures (BDI, BAI, BHS), the ICD was able to confirm this diagnosis, specifically addressing the negative thinking that was interfering with functioning.

4) The use of this measure at different points throughout therapy afforded the opportunity to monitor efficacy over time. This subject did improve, as noted by the reduction in the scores on the ICD, indicating fewer cognitive distortions.



5) The ICD was able to help the therapist and the subject to address the cognitive distortions that would improve prediction or prevention of relapse. In this subject's case, her cognitive schemas and beliefs were so embedded that she maintained many of her distortions indicating, however, that a relapse was certainly possible. With the knowledge provided by the ICD, further therapy was recommended to work on changing these distortions.

Overall, the ICD is an invaluable informational tool regarding clients thinking and associated behavior. Although each subject is different, in general the ICD can provide information in the therapeutic process that can enhance collaboration, provide feedback for the client leading to the creation of goals and plans for treatment, and address specific cognitive distortions that might be interfering with progress or is maintaining the dysfunctional thinking.

#### *Research Implications*

Although the results of this study supported three of the hypotheses, and partially supported another, the discrepancy between the reduction in cognitive distortions and the decrease in depressive symptomatology is notable. Research (Beck, et al., 1976), Freeman & Oster (1998) indicate that as cognitive distortions decrease, depressive symptoms decrease accordingly. In this study, although depressive symptoms decreased significantly, the decrease in cognitive distortions was minimal, from baseline to termination. The scores, however, did continue to decrease at follow-up, indicating the subject's use of skills learned in treatment.

The maintenance of many cognitive distortions could be due to an individual's personality style and could lead to relapse. As noted in Volume 31 of the *Monitor on Psychology* (2000), Jackie Gollan, Ph.D., a psychology intern at Brown University Medical School, conducted a study "Personality styles may predict susceptibility to depression" with the results indicating that "individuals who depend little on others were more likely to relapse." He also found that those who "show hostility or distrust of others at the end of treatment also were likely to have another bout of depression." The article speculated that the reason may be related to a patient's having difficulty making friends and, therefore, having fewer social supports.

Another contributing factor for this discrepancy and the possibility of future relapse was noted by Gilbert (1998). He stated that "even though people can be taught quite quickly how to identify their cognitive errors and distortions, they may find it extremely difficult to apply logic and reason even if they strongly wish to." The intensity of their embedded beliefs may not be able to be reduced (in short-term therapy).

A recommendation for future research would include continuous assessment with the use of the ICD at each therapy session not only to rule out threats to internal validity but also to strengthen the internal validity of the case study. This continuous assessment could provide information for the future that could serve as a testable prediction (Kazdin, 1998). This, in conjunction with the use of the manual, and an increase in the number of sessions, as determined by the elimination of cognitive distortions that interfere with functioning, would prove beneficial.

Future research may also emphasize the inclusion of significant others in therapy. With this subject, relationship problems with her husband and mother seemed to interfere with a more significant reduction in cognitive distortions. Their criticisms and negativity triggered the primacy effect - reverting to childhood beliefs and schema that contaminated her present thinking, maintaining her many cognitive distortions.

### *Limitations*

This study lacks external validity and the ability to generalize the results. Findings may not generalize to depressive patients who take alternative medications, or to those who have different backgrounds and ethnicities, different races, socio-economic class and religions. Another limitation might be the length of the protocol. Increasing the number of sessions might lead to greater change in cognitive distortions because the emphasis on them would increase.

In conclusion, this case study has provided sufficient information regarding the effectiveness of the ICD in the clinical setting. The ICD appears to be a valuable instrument in the evaluation and treatment of depression, as well as in addressing the cognitive distortions that not only interfere with functioning, but also lead to relapse.

### Literature Review

#### *Depression*

##### *History*

For over 2000 years, depression has been recognized as a clinical problem. Depression has resulted in more human suffering than any other single disease affecting mankind. Centuries ago it was described as “melancholia”; Hippocrates described it

clinically as “sad, or dismayed, or sleepless”. The descriptions and symptoms to diagnose depression today are based on the ancient descriptions but also include disturbed mood, self-castigation, self-debasing behavior, physical and vegetative symptoms. These descriptions have followed a consistent path to the present. Low mood, pessimism, self-criticism, retardation or agitation are symptoms of depression that are universally accepted (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979).

*The Diagnostic and Statistical Manual of Psychiatric Disorders IV-TR* (DSM IV-TR; 2000) states that the essential features must include a loss of interest or pleasure in all activities and a depressed mood for at least two weeks. Four other symptoms must all occur during this time period: sleep disturbances, changes in appetite or weight, decreased energy, decreased concentration and difficulty thinking and making decisions, feelings of worthlessness or guilt, and suicidal ideations, intent, plan or attempts. These are all significant symptoms that have remained consistent for centuries in the diagnosis of depression. However, despite all our knowledge about depression, the incidence is ever increasing.

### *Epidemiology*

Depression is one of the most common disorders encountered by mental health professionals. Data provided by the 1999 National Institutes of Mental Health indicate the following:

- (1) more than nineteen million adult Americans will experience some form of depression each year;
- (2) depression is the leading cause of disability;
- (3) the

associated costs are more than thirty billion per year; (4) depression increases the risk of heart attacks and is a frequent and serious complicating factor in stroke, diabetes, and cancer.

Depression is costly, debilitating, and widespread and is speculated to become the second most costly illness by 2010 (Young, Weinberger & Beck, 2001; Doris, Ebmeier & Shajahan, 1999). An estimated \$44 billion per year is spent in the United States on lost productive time (i.e., absenteeism and reduced performance) due to depression and this does not include costs related to time away from work for treatment or for disability leave (Glass, 2003). The World Health Organization-Supported Global Burden of Disease Study projects that depression will become the second leading cause of disability worldwide by the year 2020, and in developing regions it will become the leading cause. The severity and increasing prevalence of this disorder only emphasizes the need for effective high quality, culturally appropriate treatments for depression (Glass, 2003).

In Americans 18 years and older, major depressive disorder (MDD) has a one month prevalence of 2.2% and a lifetime prevalence of 5.8%. Indications from other studies estimate that females have a lifetime prevalence of MDD of 26%, but males have a lifetime prevalence of 12%. Those who have a first-degree biological relative affected by the disorder are 1.5 to 3 times more likely to be affected also. Predisposition to depression can be exacerbated by chronic general medical conditions and substance abuse, specifically alcohol and cocaine. Psychosocial stressors such as the ending of a relationship, either by death or by marital separation, also can lead to depression. (APA Practice Guidelines, 1996; Doris, et al., 1999)

The report by Kessler, et al. (2003) on the results from the National Comorbidity Survey Replication (NCS-R) noted a significant increase in major depression disorder, resulting from an increased awareness that depression is not only a common, but also a serious, illness. The NCS-R national household survey of mental disorders of 9090 respondents was designed to update information based on the DSM-IV criteria and changes in treatment in the last decade. The prevalence of MDD, as reported by the NCS-R, was 16.2% for lifetime depression and 6.6% for the 12 months prior to the interview. The report indicated the ratio of 12-month to lifetime prevalence was approximately 40% and was similar to national population projections of 32.6 to 35.1 million US adults with lifetime MDD and 13.1 to 14.2 million with 12-month MDD. Comorbidity with lifetime MDD occurred in approximately 72.1% of the respondents, with 59% experiencing anxiety. For those with 12-month MDD, 64% met the criteria for a comorbid disorder, 57.5% with anxiety. An inability to function was indicated by 96.9% of those reporting 12-month MDD due to their depression. Clearly, MDD is a major public health concern.

In community samples, the lifetime risk for MDD has varied from 10 to 25% for women and 5 to 12% for men. The prevalence rates for MDD appear to be unrelated to ethnicity, education, income, or marital status. The DSM-IV-TR (2000) also reports that

The number of prior episodes predicts the likelihood of developing subsequent MDD. At least 60% of individuals with MDD, Single Episode, can be expected

to have a second episode. About 5-10% with MDD, Single Episode, subsequently develop a Manic Episode (i.e., develop Bipolar I disorder). MDD may end completely (in about 2/3 of cases) or partially or not at all (1/3). Follow-up naturalistic studies suggested that 1 year after the diagnosis of an MDD Episode, 40% still have symptoms that are sufficiently severe to meet criteria for a full MDD Episode, 20% have some symptoms that don't meet criteria, and 40% have no Mood Disorder. The severity of the initial MDD Episode appears to predict persistence. Chronic general medical conditions are also a risk factor for more persistent episodes. MDD is 1.5 to 3 times more common among first-degree biological relatives of persons with this disorder than among the general population. There is also evidence for an increased risk of Alcohol Dependence in adult first-degree biological relatives, and there may be an increased incidence of an Anxiety Disorder or ADHD in children of adults with MDD.

### *Etiology*

The etiology of depression has not been specifically determined. According to the National Institute of Mental Health (2000) there is no single cause of depression. When there is a family history of depression there appears to be a greater risk for developing the disorder, indicating the inheritance of a biological vulnerability. But some individuals have no family history of depression, suggesting that environmental stressors, biochemistry and other psychological factors are involved in the onset. Young et al. (2001) state that it appears that depression is provoked by life events or ongoing difficulties. They note that 66% to 90% of depressive episodes have a severe event

occurring within 6 months of the onset of depression and the majority experience some element of loss.

Sanderson (2003) states that particular negative ways of thinking increase individuals' likelihood of developing depression when they experience stressful life events. This theory of cognitive vulnerability proposes that vulnerability to depression is related to maladaptive cognitive patterns. These are noted in individuals who engage in negative processing about themselves, about their environments, and about their futures when faced with stress. Beck (1967) has postulated that negative self-schema is evident in depression prone people; they exhibit themes of worthlessness, failure, and loss. The depressed individual uses this negative thinking to guide perceptions, interpretations, and memories of his/her experiences leading to negative biases of all aspects of the environment and, in turn, depressive symptoms develop.

Perris (1989) states that "depression is one of the most ubiquitous of emotions." Feelings of sadness, despondence, and helplessness may accompany any experience of significant loss; therefore, it is not unusual that anyone can experience some depressive feelings during the course of a lifetime. However, clinicians look at depression differently; by definition it is marked by symptoms that are well-defined; the patient experiences discomfort along with impairment, socially, vocationally, and interpersonally.

Beck and Weishaar (1989) note that there are many factors that predispose an individual to depression. These factors include: "hereditary susceptibility, physical disease leading to cognitive vulnerabilities, inadequate personal experiences or



identifications to provide coping mechanisms, and maladaptive cognitive patterns such as unrealistic goals, assumptions, or imperatives.” Chronic, severe, or acute stress and physical disease can be the precipitators of depression. They also add that cognitions are an intrinsic part of the disorder but are not the cause. Psychological distress occurs when an individual perceives a situation as threatening to his or her interests. This leads to an impairment, functionally, that interferes with normal cognitive processing. The individual perceives and interprets events rigidly, selectively, and egocentrically. There is then an inability to stop the distorted thinking or correct the misperceptions. This can continue for six months or more if untreated, but the duration is usually variable. Those who suffer a depressive episode have a 50% chance of experiencing another.

No single cause appears evident, however. Genetic vulnerability combined with environmental factors, such as stress or physical illness, may trigger an imbalance in brain chemicals called neurotransmitters, resulting in depression. There also seems to be a link to imbalances in three neurotransmitters – serotonin, norepinephrine, and dopamine. It is yet to be determined if these changes in the neurotransmitters are the results of depression or are its cause (NIMH, 2000).

#### *Gender and Age*

Depression affects all ages and all races, and is more common in women than in men. One in five American women, over the course of a lifetime, will experience depressive episodes as compared with about 1 in 10 American men. Hormones and different levels of neurotransmitters may be influential (Mayoclinic.com, 2003; Doris, et al., 1999).

The DSM-IV-TR (2000) corroborates this, noting that women are at twice the risk of developing MDD sometime during their lives; it occurs twice as frequently in women as it does in men. Hormonal influences are also indicated. It is also noted that core symptoms of depression are usually the same across the age span, with the prominence of somatic complaints, social withdrawal, and irritability more common in children. However, cognitive symptoms such as disorientation, memory loss, and distractibility are more prominent in elderly adults (DSM-IV-TR, 2000).

In 1988 Lewinsohn, Hoberman, and Rosenbaum conducted a prospective study of risk factors for unipolar depression. The primary goal of this longitudinal, prospective study was to determine the variables that lead to the development of depression. Their results extended the findings of previous retrospective studies, finding that women were more susceptible to developing depression than were men. A negative cognitive style was determined to be a contributing, but indirect factor in the development of depression. Lewinsohn and his colleagues state that this negative cognitive style leads to negative affect and eventually to depression.

#### *Culture and Ethnicity*

Being alert to culture and ethnicity is essential in the diagnosis of depression. In some cultures, depression may be exhibited in somatic terms, complaints of “nerves” and headaches, of weakness, of tiredness, or “imbalance”, of being “heartbroken; it may also be exhibited in minimizing the seriousness of depression. Distinguishing culturally distinctive experiences from actual hallucinations or delusions that may be part of Major Depressive Disorder, with Psychotic Features is important. But it is imperative that a

symptom is not dismissed because it is viewed as the “norm for a culture” (DSM-IV-TR, 2000).

### Theoretical Models of Depression

#### *Psychoanalytic Model*

During the first half of the twentieth century Freudian influence predominated. Freud differentiated between melancholia and mourning, both of which result from loss. Both of these depressions, according to Freud, exhibit a decrease in activity, a loss of interest in the outside world, an inability to love, along with painful dejection. But psychoanalytic theory also postulates that diminished self-esteem results from the losses and that a traumatic experience, usually in childhood, can predispose an individual to depression (Bailey, 1997).

#### *Behavioral Model*

Behaviorists look at depression quite differently, viewing depression as a result of a lack of positive reinforcement for behavior. Depression can also occur when the behavior is reinforced although the behavior does not actually occur (e.g., receiving a paycheck whether an individual works or not). This leads to a reduction in behavior and, in turn, decreased feelings of self-worth as a consequence of this low rate of response contingent reinforcement (Bailey, 1997).

According to behavioral theory, McGinn & Sanderson (2001) indicate that emotions become learned via a process of classical conditioning, and hence can be unlearned. Lewinsohn advanced Bandura’s social learning theory of depression which posits that depression is a result of changes in reinforcement from environmental

interactions. A vicious cycle appears to occur in depression with an increase of depressive feelings leading to decreased activity, resulting in even less reinforcement; this, in turn, causes increased depression – hence the vicious cycle. Multiple pathways are posited by Lewinsohn’s behavioral model. Two features of this model indicate that the availability of interactions that proved positive in the past is unavailable. In addition, skill deficits that restrict interactions leading to positive outcomes are apparent; these, in turn, also interfere with the ability to gain any social reinforcements (McGinn & Sanderson, 2001).

The Association for the Advancement of Behavior Therapy (2000) states that the conceptualization of depression as espoused by Lewinsohn drew on Bandura’s learning theory and emphasized the reduction of overall activity as depression’s defining characteristic. Thorpe and Olson (1997) state that Lewinsohn’s behavioral model of depression is viewed as a “person-behavior-environment transaction”. Changes in the environment precipitate feelings of depression. When these feelings are activated they elicit negative reactions and consequences, leading to a vicious cycle. In other words, when few positive outcomes result from a person’s behavior or lead to negative consequences, depressed mood, thinking, and behavior result.

#### *Cognitive Model*

Faulty information processing characterizes the thinking of emotionally disturbed individuals and is central to the cognitive model. This model postulates the idea that affect and behavior are mediated by cognition (McGinn, & Sanderson, 2001).

Based on clinical studies, Beck (1967) formulated the concept that depression is directly related to loss, whether it is real or is perceived, and that it has substantial significance to individuals, affecting their views of themselves, their world, and their future.

Sanderson & McGinn (1999) note that

Cognitive theories of depression hypothesize that particular negative ways of thinking increase individuals' likelihood of developing and maintaining depression when they experience stressful life situations or events. According to these theories, individuals who possess specific maladaptive cognitive patterns are vulnerable to depression because they tend to engage in negative information processing about themselves and their experiences.

The cognitive theory that has generated the most empirical research is Beck's diathesis-stress theory of depression. The main focus of this theory is schemata, which are defined as

stored bodies of knowledge that affect the encoding, comprehension and retrieval of information. These schemata exert this effect by guiding attention, expectancies, interpretations and memory searches. Depressogenic schemata provide access to a complex system of negative themes and cognitions that contribute to the onset of a pattern of negative self-referent information processing characterized by systematic errors in thinking. Engaging in such cognitive processing increases the likelihood that individuals will develop a negative cognitive triad or a negative view of self, the world, and the future. Beck

postulates that the negative cognitive triad is a sufficient cause of depression and is responsible for depressive symptoms such as deficits in affective, motivational, behavioral, and physiological functioning (Abela and D'Alessandro, 2002; Beck, 1967).

The cognitive model postulates that three cognitive constructs are implicated in the etiology and phenomenology of depression: schemata, the cognitive triad, and cognitive distortions (Beck, 1967; Beck, et al., 1979). Schemata, according to Beck (1967), are the key ingredients and are thought to be stable and enduring cognitive structures. He postulates that "certain early life experiences lead to the development of depressogenic schemata and are rigid, inappropriate beliefs about the self and the world." Stress is believed to be the activator of depressogenic schema which then leads to negative cognitions. These cognitive distortions can then cause motivational, affective, and somatic symptoms of depression (Beck et al., 1979).

### *Schemata*

Segal (1988) states that "schemata about the self are considered an important feature in cognitive accounts of depression maintenance and enduring vulnerability." And, he adds, the cognitive model proposed by Beck (1967) postulated that schema about the self has the greatest influence in depression. He also argues that the schema construct retains its greatest explanatory potential when it is conceptualized as a cognitive structure.

Freeman and Oster (1998) indicate that early life events and learning, according to the cognitive perspective, help to form information processing patterns termed schema.

They add that “schema guide the process by which a person organizes and structures information about the world.” Schema also helps to determine and guide the individual about judgment and decision-making. When persons are faced with difficult dilemmas they tend to rely on past knowledge and behavior patterns (schemas), especially when information that is disconfirming is not available, is abstract, or is ambiguous.

Because there have been relatively few studies that evaluated the etiology of Beck’s cognitive theory, Abela and D’Alessandro (2002) conducted a study that attempted to provide a test both of the causal mediation and the diathesis-stress components of Beck’s cognitive theory of depression. They hypothesized that there would be an interaction between dysfunctional attitudes and a negative stressor to predict increases in depressed mood. They also postulated that depressed mood would increase in participants with dysfunctional attitudes because of the development of the negative views of self and of the future.

According to Abela and D’Alessandro (2002), this study provided support for Beck’s diathesis-stress component of cognitive theory, and also advanced research on the etiological component of his cognitive theory of depression. This research, they add, by explicitly examining the “interaction of depressogenic schemata with a subsequently occurring negative event is among a minority of studies that have stringently assessed the validity of the etiological chain of Beck’s theory.”

Results from this investigation by Abela and D’Alessandro (2002) provide support for Beck’s prediction that individuals who possess depressogenic schemata are more liable to exhibit an increase in depressed mood following aversive events than those

who do not. The study also provides evidence that a specific component of the negative cognitive triad (negative view of the future) arises from the interaction of depressogenic schemata and negative life events, leading to depressive mood reactions. Abela and D'Alessandro (2002) conclude that their findings extend previous research by activating depressogenic schemata prior to assessing them, assessing depressed mood at multiple time points which occur at systematic intervals following the occurrence of the stressor; they also examine the specific types of causal mediators of the relationship between diathesis-stress interactions and ensuing change in mood postulated by Beck et al. (1979).

Depressed individuals, according to Beck (1967), have stable cognitive schemas (underlying assumptions or core beliefs) that develop as a consequence of early learning. These schemas predispose an individual's negative interpretations of life events (cognitive distortions or automatic thoughts), leading the depressed person to engage in depressive behavior.

Beck's cognitive diathesis-stress theory of depression has generated a vast body of empirical research. The primary construct of this theory is schemata. Schemata refers to bodies of knowledge that are stored and affect the "encoding, comprehension, and retrieval of information" (Abela and D'Alessandro (2002). These schemata, according to Beck (1967), guide our attention, interpretation, expectancies, and memory searches but they all vary idiosyncratically.



### *Cognitive Triad*

According to Beck, (1967; 1979), depressogenic schemata, once activated, lead to negative themes and cognitions which, in turn, form a pattern of negative, self-referent information processing, which results in systematic thinking errors (cognitive distortions). This type of cognitive processing ultimately leads to the development of the negative cognitive triad. Beck hypothesizes that this negative cognitive triad is “a sufficient cause of depression and is therefore responsible for the onset of depressive symptoms such as deficits in affective, motivational, behavioral, and physiological functioning” (Beck, 1967, 1979; Abela and D’Alessandro, 2002).

Beck et al.(1979) hypothesized that depressed patients possess negative self-schemata (beliefs) and have a negative view of themselves (e.g., feeling inadequate, unlovable, deficient, or worthless), of their environments (e.g. overwhelming, filled with obstacles and failures), and of their futures (e.g., hopeless, nothing can be done to change the course). Beck postulated that this negativistic thinking permeated an individual’s perception, interpretation, and memory of person experiences, leading to a personal negative bias, resulting in depressive symptoms.

Barton and Morley (1999) investigated Beck’s negative cognitive triad as a model of depressive thinking and their results broadly support the negative references to self, world, and future and found them highly correlated with depression.

McIntosh and Fischer (2000) conducted a study that examined Beck’s cognitive triad and its factorial validity by utilizing the Cognitive Triad Inventory. Their results theoretically corroborate the triad but indicate that only one dimension would be

necessary in describing the nature of the triad – “negative view of self”. This negative attitude toward self, they postulate, would lead to negativity relating to experiences (world) and prospects (future) rather than being separate constructs.

### *Cognitive Distortions*

According to Segal (1988), “Cognitive distortions are the products of the misinterpretation or misperception of objective reality in such a way that the conclusions reached by depressed people confirm their negative expectations.”

Automatic thoughts (surface cognitions) are an integral part of schema (deeper cognitions) and they tend to revolve around central themes; they are also repetitive in content and emotions. These themes are negative and involve the self, the world, and the future. These thoughts are predominate in a depressed person’s cognitive awareness; thus the depressed person is unable to alter this thinking. In addition to this problem, processing errors known as cognitive distortions will result (Freeman and Oster, 1998).

Freeman and Oster, (1998) identified thirteen distortions common in emotional disorders, including depression. Each of these is a representation of the application of schema that exists. They include arbitrary inference, personalization, selective abstraction, over-generalization, magnification and minimalization (Freeman and Oster, 1998).

The following is a description of these major forms of cognitive distortions:

Arbitrary inference is evident when a depressed individual attributes negatives to an event which is actually either neutral or positive.

Personalization occurs when a person attributes failure and loss to himself or herself, discounting factors related to others or the situation.

Selective abstraction is represented by depressed individuals through their continual seeking of information that is consistent with their negative views of themselves, their world, and their futures.

Over-generalization occurs when a person attributes to a whole class of experiences what is actually related only to the specific; it is global reasoning.

Magnification and minimization occur when the person either overestimates the negative experience or underestimates the positive experience (Freeman and Oster, 1998).

Other cognitive distortions have also been identified, as noted by Freeman and Oster, (1998):

Dichotomous thinking or “all or nothing” thinking or placing experiences in opposite categories.

Emotional reasoning leads a person to rely on his or her emotions as indicative of the truth.

Disqualifying the positive occurs when a person looks at a neutral or positive experience through negative glasses.

Should statements lead to guilt. In this instance an individual attempts to motivate himself or herself with shoulds and shouldn'ts.

Externalization of self-worth occurs when a person's self-worth is dependent on what others think.

Perfectionism is evident when a person believes that everything he or she does has to be perfect otherwise he or she will become a failure or be criticized.

In the Control Fallacy, a person believes he or she must control every contingency in his or her life

Comparison is displayed when a person feels incompetent in comparison with others due to his/ or her continually making comparisons.

### *Interpersonal Model*

The primacy of interpersonal relationships is emphasized in the more psychodynamically oriented interpersonal model. It is similar to the other therapies in its time-limited and manualized approach but focuses less on the etiology of interpersonal functioning and depression. Instead, depression is thought to occur within the context of interpersonal relationships and often impairs these relationships; however, this is not necessarily the cause of depression. In this model four problem areas are identified: grief, role dispute, role transition, and interpersonal deficits (AABT, 2000).

Cornes and Frank (1994) state that Interpersonal Psychotherapy (IPT) was developed by Klerman & Weissman in 1984 for the treatment of unipolar depressed, non-psychotic patients. It is based on Sullivan's interpersonal school of psychiatry and on empirical data related to social roles and attachment bonds.

Stuart and O'Hara (2002) define it as a therapy focusing on the "here and now" interpersonal problems experienced by the patient. The hypothesis is that the reduction of interpersonal stresses will, in turn, alleviate the depression of the patient.

Theoretically, attachment and interpersonal theory are the underlying approaches to IPT. Bowlby's attachment theory stresses that there is a biological drive for individuals to form meaningful relationships with one another, which in turn leads to a reciprocal caring relationship. Bowlby maintains that this drive is instinctual and in order to be mentally healthy the formation of flexible attachments is essential. Attachment theory postulates that depression can occur when an individual with less secure attachments is faced with stressful life events.

The disruption of interpersonal relationships can also lead to depression. Losses through divorce, death, or "emotional disengagement", especially in childhood, can impact an individual's attachment style that develops during adulthood. Communication theory also contributes to IPT. This theory proposes that needs are communicated to others in a manner that leads to complementary responses (Stuart & O'Hara, 2002; Klerman, Weissman, Rounsaville & Chevron, 1997).

Interpersonal therapy focuses on an individual's primary interpersonal relationships, especially those related to grief, disputes, interpersonal sensitivity, and role transitions. Progress is noted when the individual, through therapy, works on repairing disrupted interpersonal relationships and by communicating this need for emotional support more clearly (Stuart & O'Hara, 2002).

### *Psychopharmacology*

It is difficult to determine the exact cause of depression. Physicians attribute the cause to a chemical imbalance in the brain. They postulate the idea that genes or difficult life events may be the link to depression, and that environmental factors play a role.

Another theory states that the brain has a deficient supply of the neurotransmitters serotonin and norepinephrine. This neurotransmitter deficiency appears to be true in women who naturally have a lower serotonin level than men and this may contribute to the increased tendency to depression (Nordenberg, 1998; Mayoclinic.com).

### *Treatment of Depression*

The diagnosis of unipolar depression has increased significantly in the last 20 years in the United States, and this increase is projected to continue. Garland and Scott (2002) state that there are potentially effective psychotherapeutic approaches to treatment of depression; these have a number of features that are similar. These features include: (1) a coherent model base; (2) highly structured therapy; (3) a clear rationale for interventions with the goal of promoting independent use of the skills attained. It is speculated that change would occur if the emphasis was also placed on enhancing the self-efficacy of the individual. This description, according to Garland & Scott (2002) is supportive of Beck's cognitive therapy.

Jarrett and Rush (1994) summarized the literature on acute-phase, short-term psychotherapy for adult outpatients with major depressive disorder. They specifically addressed behavior therapy, cognitive therapy, interpersonal psychotherapy and brief dynamic psychotherapy. They determined that behavior therapy, cognitive therapy, and interpersonal psychotherapy share the following features: (1) each aims to decrease depressive symptoms and to decrease the risk of relapse and recurrence; (2) each is based on a distinct model of human behavior; (3) each includes specific techniques; (4) each targets psychosocial or emotional responses; (5) each teaches techniques to replace the

depressive symptoms with adaptive functioning; and (6) each is short term and usually time limited. All the therapies referred to are educationally oriented and aimed at current functioning, in addition to being structured by setting specific goals.

Garland and Scott (2002) state that a recent review of research for the treatment of depression recommended that psychological approaches should be manualized and short-term because these have been shown to be effective in randomized trials (Garland & Scott, 2002). Cognitive therapy, interpersonal therapy, and behavioral therapy are all time-limited and focus on problem resolution and symptom reduction. Cognitive therapy, however, has been investigated extensively and is more widely used than the others, because it has been determined to be supported empirically.

### *Cognitive Therapy*

Cognitive therapy is derived from the cognitive theory of depression as hypothesized by Beck (Butler & Beck, 1995). It is an active, structured, problem-focused, and time-limited approach to treatment which is based on the premise that depression is maintained by negatively biased information processing and by dysfunctional beliefs. Treatment is designed to help patients learn to think more adaptively and thereby experience improvements in affect, motivation, and behavior. The efficacy of cognitive therapy for depression has been demonstrated in over 30 clinical trials that were reviewed by Dobson in 1989 (Butler & Beck, 1995).

Garland and Scott (2002) state that

cognitive therapy is a collaborative hypothesis-testing approach that uses guided discovery to identify and challenge distorted cognitions and dysfunctional beliefs.

The interventions proposed are selected on the basis of a cognitive conceptualization that uniquely explains the onset and maintenance of depression in that individual. If the patient shows a low level of functioning, behavior techniques may be used to improve activity levels and enhance problem solving and coping skills, but the goal is still to identify negative cognitions (cognitive distortions) and underlying beliefs (schemata). Verbal interventions are initially employed to challenge negative cognitions, usually leading to improved mood and a reduction in acute depressive symptoms. Later, cognitive and behavioral interventions are used to try to modify underlying dysfunctional beliefs so as to reduce vulnerability to future relapse.

Extensive research has been conducted on the use of cognitive therapy with depressed individuals, both in out-patient settings and in primary care. Garland and Scott (2002) note that several meta-analyses were undertaken to evaluate cognitive therapy in these venues. They report first on Andrews and Harvey (1981) who analyzed 81 non-drug studies comparing patients with a primary diagnosis of depression, including neurotic disorders, who were treated with psychotherapy or with a waiting list control condition. Cognitive and behavioral therapies were found to be more effective than other specific therapies. Andrews concluded from this, and from a further review of outcome data, that cognitive therapy was the most powerful psychotherapy for depressive and anxiety disorders and for some personality disorders (Garland and Scott, 2002).

Next they looked at Dobson's review (1989) which specifically addressed research on the efficacy of cognitive therapy in depression. Dobson reviewed 28 studies



published between 1976 and 1987. All of the studies employed Beck's model of cognitive therapy and used the BDI as one of the outcome measures. When cognitive therapy was compared with either no treatment or a Waiting List Control, the mean ES (Effect Size) was 2.15, indicating that patients treated with cognitive therapy had a better outcome than 98% of control subjects. Individuals treated with cognitive therapy had an outcome that was superior to approximately 70% of patients treated either with behavior therapy or other forms of psychotherapy. Eight studies compared cognitive therapy with pharmacotherapy and again the mean ES (0.53) suggested an advantage for cognitive therapy treated patients.

Cognitive therapy has demonstrated that the use of concrete techniques such as thought change, mood change, hypothesis testing, and completion of between session assignments are associated with significant reductions in depressive symptomatology (Garland & Scott, 2002).

DeRubeis and Feeley (1990) found that early changes in attributional style, dysfunctional attitudes, and hopelessness predicted the final outcome for cognitive therapy but not for pharmacotherapy-tested patients.

Garland & Scott (2002) conclude that the aforementioned meta-analyses confirm the fact that "part of the attraction of the cognitive model of depression is that it tries to provide a coherent, testable theory of vulnerability, psychopathology, and therapeutic change."

Butler and Beck (1995) state that "depression is maintained by negatively biased information processing and dysfunctional beliefs. Treatment is designed to help patients

learn to think more adaptively and thereby experience improvements in affect, motivation, and behavior. The efficacy of cognitive therapy for depression has been demonstrated in over 30 clinical trials” (Butler & Beck, 1995).

Cognitive therapy for depression guides patients through learning experiences that are structured. This learning involves recognizing the relationship between “thoughts, feelings, physiology, and behavior”. Recognizing the “validity and utility” of their cognitions, the patient “tests them out empirically” and works on changing these dysfunctional cognitions to ones that are more realistic and adaptive. A variety of strategies are employed by the cognitive therapist to assist the patient in looking carefully at his or her cognitions, such as behavioral experiments, imagery, Socratic questioning, role playing, guided discovery, and psychoeducation (Butler & Beck, 1995).

There have been extensive studies on the efficacy of cognitive therapy for depression, as noted by Butler & Beck (1995), and these have indicated that cognitive therapy was as effective as or superior to alternative interventions. They also report that cognitive therapy is as effective as pharmacotherapy as indicated in several studies; follow-up studies in major controlled trials also suggest that pharmacotherapy is not as effective as cognitive therapy in preventing relapse.

Beck et al. (1979) state that the behavior therapy movement has made a substantial contribution to the development of cognitive therapy. Behaviorism, with its specification of discrete goals, its delineation of the specific procedures necessary for achieving the goals, as well as its prompt feedback, has provided a new dimension to

cognitive therapy. The inclusion of these behavior techniques to cognitive therapy led to a new reference for cognitive therapy; it is now known as cognitive behavioral therapy.

McGinn and Sanderson (2001) note that cognitive and behavioral traditions have been integrated mainly because of their use of experimental methods to assess, understand, and remediate changes in psychopathology, including an emphasis on symptom resolution and problem-solving.

The focus on treatment goals that are specific, measurable, and achievable are the key features of cognitive behavioral therapy (CBT). The setting of these goals has led to the creation of a collaborative treatment plan with the patient. Agenda setting, symptom assessment, the administration of specific techniques and an evaluation of the interventions utilized are also essential ingredients in CBT. (McGinn & Sanderson , 2001)

Another important element in CBT is assessment. Selected self-report questionnaires are used to increase efficiency and to supplement the clinical evaluation. The clinician is then better able to formulate a case conceptualization and a formulation of the problem, which leads to the selection of specific strategies to aid the patient in symptom and problem resolution. Assessment in CBT is ongoing throughout treatment (McGinn & Sanderson, 2001).

The focus of CBT for depression according to McGinn and Sanderson (2001) is on publicly observable behavior, dysfunctional automatic thoughts, and inferred underlying cognitive structures or schemas. Treatment is conducted in a progressive manner so that the therapist focuses on overt behavioral change;

teaches the client to assess and, when necessary, correct situation-specific distortions in thinking; and finally, moves to the identification and modification of more stable depressive schemas and presumed cognitive structures.”

Jarrett and Rush (1994) add that cognitive therapy is based on a “phenomenological or perceptual model of human behavior.” They concur with Beck that therapists should address the distorted cognitions of the patient regarding the self, the world, and the future. Techniques utilized by cognitive behavioral therapists include the logical analysis of the patient’s thinking (cognitions) and hypothesis testing based on the evaluation of homework exercises conducted between treatment appointments.

King (1998) considers CBT to be a “family of treatments which includes cognitive therapy and is widely considered to be an empirically validated or evidence-based treatment likely to be of benefit to people suffering from major depressive disorder of at least moderate severity”. He adds that CBT is the preferred treatment for depression and is the “most extensively researched psychological treatment for non-psychotic, unipolar outpatient depressive disorder.”

#### *Manualized Treatment*

Treatment manuals in clinical practice have been used as guides in conducting psychotherapy. These manuals are thought to provide clearly specific treatments that are necessary for empirically supported treatment (EST) identification. Manualization can also provide a way for more replicable and reliable therapies, without regard to differences in clinicians, clients, and settings. (Malik, Beutler, Alimohamed, Gallagher-Thompson, Tompson, 2003).

The American Psychological Association (APA), as noted by Malik et al. (2003) considers manuals essential for empirically supported treatment of specific, defined diagnostic populations such as cognitive therapy with depression. APA, Division 12 Science and Practice Committee has added that “different treatment manuals are functionally equivalent if they derive from the same conceptual framework and advocate similar methods” (Malik, et al., 2003).

Rounsaville, O’Malley, Folely, & Weissman (1988) state that manuals provide “greater detail about the operationalization of the particular treatment approach being used.” The use of manuals can aid diagnostic reliability by providing a foundation for validity assessment of the categories regarding diagnosis. But a great benefit lies in enhancing the consistency of psychotherapy. This consistency would increase the internal validity by having therapists perform treatment as described. In addition, it can enhance therapeutic performance by providing specific techniques that provide clear standards that add to the performance of the therapist. Manuals can also aid in the formation of treatment plans by defining therapeutic goals and strategies that can be utilized in obtaining those goals (Rounsaville et al., 1988).

### *Homework*

Homework is an essential component of Cognitive Behavior Therapy and provides several advantages:

- (1) New skills can be practiced outside the therapy session.
- (2) New views of self and the world, including new behaviors and action plans, are promoted through homework assignments.

(3) Problems can be addressed when they are evident and meaningful, outside of therapy.

(4) Homework emphasizes self-efforts as an essential ingredient in recovery.

(5) Homework teaches the patient to identify and solve problems before they lead to a more serious episode.

(6) Homework provides a way of addressing problems as they arise in everyday situations.

(7) Homework provides an invaluable resource for the therapy sessions (Freeman, Pretzer, Fleming, Simon, 1990; Kuehlwein, 2002; Persons, 1989).

Burns and Spangler (2000) report in a research study, that “homework compliance was significantly correlated with reductions in depression during treatment.”

Improvement was noted in those patients who completed homework consistently as compared with those who did few or no assignments.

In 1991, Burns and Nolen-Hoeksema stated that the emphasis of Cognitive Behavioral Therapy is in training depressed individuals to modify their cognitive distortions and dysfunctional behaviors that may cause or prolong a depressive episode, Homework and self-assignments provide an additional avenue to teach patients coping skills. In the study which they conducted to address this issue, results indicated that those who complied with the homework assignments consistently, showed more improvement. They suggested, therefore, that an essential ingredient in the therapeutic process would be the participation in self-help assignments (homework).

### *Behavior Therapy*

The postulate that depression results from a stressor that interrupts normal behavior, causing “a low rate of response contingent positive reinforcement” is indicative of the behavioral model of unipolar depression (Antonuccio, 1998; Jarrett & Rush, 1994). Behavioral psychotherapy emphasizes increasing the frequency and quality of pleasant experiences for patients with depression.

Depressed individuals exhibit behavioral problems exhibited by the decreased frequency of engaging in pleasurable activities, by low mood, and by diminished social skills. The goals of behavior therapy are to teach techniques and strategies to cope with these problems, such as improving social skills, increasing the frequency of pleasant activities, relaxation training, activity scheduling, stress management techniques, self-control techniques, and problem solving (Antonucci, 1998; Jarrett & Rush, 1994).

Overall studies as noted by Jarrett and Rush (1994) indicate that the utilization of “acute phase behavior therapy” in reducing depressive symptoms is superior to waiting-list controls but is usually not significant when compared with other forms of therapy, especially cognitive therapy.

### *Interpersonal therapy*

Interpersonal psychotherapy is based on the models of Adolf Meyer, Harry Stack Sullivan, and Frieda Fromm-Reichmann, who focus on environmental and familial factors in the development of psychopathology. Interpersonal psychotherapy targets grief, role transition, role disputes, and interpersonal deficits. *Interpersonal*

*Psychotherapy of Depression* by Klerman is the standard treatment manual for this therapy (Stuart & O'Hara, 2002)

IPT is a time-limited, manual-based treatment for depression. The patient's current life situations are the main focus. This therapeutic approach attends to current symptoms of depression and to the related interpersonal context. Assessment includes a "systematic review of relations with current significant others". One or two problem areas in the patient's interpersonal functioning become the therapeutic focus, which is always in the here and now. (Klerman et al., 1997)

The goal of IPT, as noted by Klerman et al. (1997) was to create an "explicit and operationalized approach to depression based on theory and empirical evidence."

Although IPT is based on Freudian psychoanalysis, there are significant differences. The psychodynamic approach focuses on the unconscious mental processes, whereas IPT focuses on social roles and interpersonal interactions in the individual's past and current life experiences. The focus is on interpersonal relations, with the therapist also listening for the patient's role expectations and disputes.

Three phases of treatment occur in IPT. During the initial phase, depression is diagnosed and explained to the patient, via the medical model. Identification of the major problem occurs with a collaborative treatment contract drawn to work on the specific problem. Following this phase, work focuses on current, major, interpersonal problems. There is then a termination phase in which discussion occurs regarding treatment, review of progress, and the work that remains to be done. (Klerman et al., 1997)



IPT tries to change the way the patient thinks, feels, and acts in problematic interpersonal relationships. Behaviors such as lack of assertiveness, guilt, lack of social skills, emphasis on unpleasant events, and negative cognitions are not focused on, but are addressed in the way these behaviors or cognitions impinge upon the interpersonal relationships. (Klerman, et al., 1997)

IPT therapists are concerned about the patient's distorted thinking but only in relation to its effect on interpersonal relationships.

#### *Psychoanalytic/Psychodynamic therapy*

This therapy addresses the roots of dysfunction and of childhood conflicts that are unresolved. It encourages the patient to reevaluate assumptions about oneself and others so that more effective functioning can occur both personally and interpersonally. The main focus of brief psychodynamic therapy is to learn and to practice new coping skills in order to reduce inner conflicts. This is accomplished through transference with the therapist in the therapeutic setting. Research is limited regarding this type of therapy because criterion-based psychiatric diagnoses are not the method used for patient classification (Jarrett & Rush, 1994).

Arkowitz & Hannah (1989) add that the link between cognition and affect are essential in psychodynamic therapy. This therapy "relies on a form of experiential and affectively based learning that occurs in the context of the patient-therapist relationship." The focus is to increase the patient's insight by creating conditions in which the patient re-experiences defensive interpersonal styles and maladaptive behaviors within the therapy. Insight results from new experiences which then lead to behavior change. This

re-experiencing is essential for the identification and understanding of the underlying meaning of the patient's behaviors and attitudes, including affective arousal.

### *Pharmacotherapy*

The use of antidepressant medications has become a major approach for treating depression. The effects of these medications on the brain is not completely understood, but substantial evidence has indicated that the brain's chemical balance is restored (Nordenberg, 1998). According to the Mayo Clinic (2003), medication often becomes the first line of treatment because it can relieve symptoms of depression. They add that treatment with psychotherapy may help the depressed individual to cope with the ongoing problems that may contribute to or trigger the depression. The Mayo Clinic (2003) recommends a combination of treatment that would include medication and brief psychotherapy.

### *Measures*

In cognitive behavioral therapy an understanding of symptom severity and diagnosis is essential in the formulation of a treatment plan and an outcome evaluation. Therefore the use of collateral measures of outcomes is recommended (Dozois, Cogin & Brinker, 2003). Because the modification of negative automatic thoughts (cognitive distortions) and dysfunctional attitudes is emphasized in CBT, an important component of outcome assessment for depression is the measurement of cognition. It is postulated in a number of studies that "cognitive change is associated with changes in depressive symptomatology and cognitive change appears to be an important variable to assess in therapeutic change for depression" (Dozois et al., 2003).

Cognitive measures can also be used in the prevention of relapse. Jarrett et al. (1999) have found that relapse rates improve when the length of therapy is extended until patients score consistently in a minimal range on depressive severity. At present there are no comparable data using cognitive measures. However, because depression is a recurrent disorder and cognitive therapy seems to yield a prophylaxis against relapse, the assessment of self-reported cognitive variables makes intuitive sense and may also be pertinent to prevention.

Researchers have developed a variety of assessment formats to test the cognitive structures of Beck's cognitive therapy model. The following are pertinent in assessing an individual with depression: the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974), Dysfunctional Attitude Scale (DAS, Beck & Weissman, 1978; Weissman, 1979) and the Inventory of Cognitive Distortions (ICD, Yurica & DiTomasso, 2002).

#### *Beck Depression Inventory*

The Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) is a 21 item inventory that measures symptoms known to be highly correlated with depression, according to the DSM-IV criteria. It is rated on a 4 point Likert scale with scores ranging from 0=never to 3=severe. It has been frequently used for the assessment of cognitions associated with depression. The inventory is self-administered, requiring from 5 to 10 minutes for completion. With clinical populations, absence of depression or minimal depression scores range from 10-18, moderate to severe depression scores range from 19

to 29, and severe depression from 30-63. Evaluation of content, concurrent, discriminant validity, and factor analysis has been favorable. Within the past 35 years, the BDI is one of the most widely used instruments in assessing depression in clinical populations.

#### *Beck Anxiety Inventory*

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988) is a 21 item self-report inventory that measures symptoms of anxiety. It is rated on a 4 point scale from 0=never to 3=often. It was designed to measure anxiety symptoms that are often shared with depression. It is reported to have high internal consistency reliability and it correlates significantly with other measures of anxiety.

#### *Beck Hopelessness Scale*

The Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, Trexler, 1974), designed to measure negative attitudes about the future, is a 20 item true-false measure that takes approximately 10 minutes to complete. It assesses 3 major aspects of hopelessness: feelings about the future, loss of motivation, and expectations. The hopelessness construct is a factor that is highly correlated with measures of depression, suicidal intent, and ideation. It is a reliable and valid measure.

#### *Dysfunctional Attitude Scale*

The Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978, Weissman, 1979) was designed to measure dysfunctional beliefs in depressive patients. It is a 40-item instrument that is constructed of single sentence items answered on a seven-point Likert Scale. A single score is provided, ranging from 40 to 280. Adaptive attitudes are indicated by lower scores but dysfunctional attitudes are represented by higher scores.

The DAS was created specifically to validate Beck's (1976) cognitive theory of depression by Weissman (1979). The items were developed by Beck and Weissman (1978) to address seven major value systems of an individual. These include achievement, approval, autonomy, entitlement, love, omnipotence, and perfectionism. Items were written that would represent dysfunctional attitudes of depressed individuals, bearing in mind and addressing the seven major value systems mentioned above. Yurica (2002) adds that six original cognitive errors defined by Beck (1976) were addressed in this measure and were utilized to construct items in the DAS; these include: dichotomous reasoning, personalization, overgeneralization, magnification or minimization, arbitrary inference, and selective abstraction.

The DAS is reported to have good internal consistency, good stability with test-retest correlation, and excellent concurrent validity. It has also been correlated significantly with the Beck Depression Inventory (Yurica, 2002)

#### *Inventory of Cognitive Distortions*

The Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002) was designed as a self-report inventory of cognitive distortions to be used in adult populations. Four measures were completed by a comparison control group and by an outpatient psychiatric group to assess the psychometric properties of the ICD. Positive psychometric properties resulted with acceptable levels of internal consistency being demonstrated (Yurica, 2002).

The ICD is the most comprehensive and most recent self-report for measuring cognitive distortions in an adult clinical population. It is a 69-item inventory of cognitive

distortions that is composed of short-sentence items which reflect sixteen different types of cognitive distortions. The scoring for the ICD is based on frequency, using a 5-point Likert scale: 1=Never and 5=Always. The scores can range between 69 and 345. The higher the score the greater numbers of cognitive distortions; subscale scores are also indicated (Yurica, 2002).

Cognitive therapy experts have established content validity, as well as factor analysis. These experts agreed independently on the 69 items and the 11 cognitive distortions (subscales). It was also determined that the ICD was positive and significantly correlated with measures of depression, such as the Beck Depression Inventory II (BDI-II), the Beck Anxiety Inventory (BAI), and the Dysfunctional Attitude Scale (DAS) (Rosenfield, 2003).

### *Conclusions*

It is apparent that Cognitive Behavioral Therapy (CBT) is an empirically sound treatment for ameliorating and/or eliminating the symptoms of depression. It has also been noted that CBT has a more prophylactic effect on depression than other psychotherapies or medication.

This treatment is proven effective because of its emphasis on the cognitive triad, that is, the individual's negative beliefs about himself or herself, the world, and the future. This negativity is based on negative thinking or cognitive distortions, stemming from underlying belief systems or schemas. These cognitive distortions are predominant in the Cognitive Behavioral Model of depression. It is important, therefore, to assess and to measure these distortions for change and to determine the patient's current level of

functioning, from baseline throughout treatment, and through follow-up. This can be implemented through the use of the Inventory of Cognitive Distortions. (ICD; Yurica, 2002)

## Empirical Study Proposal

### Rationale

Cognitive therapy developed by Beck (1967) has proved to be a highly effective treatment for unipolar, non-psychotic, depression (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979). The basic assumption of this therapy is related to the individual's negative beliefs about the self, the world, and the future, as well as to unrealistic and distorted thinking (cognitive distortions). The goal of cognitive therapy is to aid the patient in changing his or her negativistic thinking that will, in turn, change his or here behavior and affect. There have, however, been few studies that have examined the ways in which different therapies affect change in cognitive distortions with patients who have been diagnosed with Major Depressive Disorder (Whisman, Miller, Norman, Keitner, 1991).

Study: This study will be conducted to test the outcome of two forms of psychotherapy – Cognitive Behavioral Therapy and Interpersonal therapy – as indicated on measures of depression (Beck Depression Inventory [BDI], Beck Anxiety Inventory (BAI), Beck Hopelessness Scale [BHS]) and specific measures of cognitive distortions (Inventory of Cognitive Distortions [ICD] and the Dysfunctional Attitude Scale [DAS]). In particular, this study will evaluate the cognitive distortions of depressed individuals who are receiving cognitive behavioral therapy through the use of a new measure that specifically assesses cognitive distortions, the Inventory of Cognitive Distortions..

Until the development of the ICD there was no single instrument that measured cognitive distortions and their frequency of use by patients. This information is essential



in identifying the cognitive distortions that may be contributing to the patient's psychological distress. It can also be used as an educational tool in having patient's look at the role that cognitive distortions play in maintaining cognitive, behavioral, and emotional dysfunctional patterns. In addition, the ICD can be used to assess changes in patient's distorted thinking as a result of treatment (e.g., pre-, post-, and interval tests) (Yurica, 2002).

#### Research Question

Is change in the cognitive distortions of an individual with unipolar depression specific to cognitive behavioral therapy?

- Hypotheses: (1) Therapy outcomes will be equal on measures of depression (Beck Depression Inventory [BDI], Beck Anxiety Inventory (BAI), Beck Hopelessness Scale [BHS]) for both Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT).
- (2) Treatment outcomes will be better both for Cognitive Behavioral Therapy and Interpersonal Therapy as compared with the Wait-List Control on the BDI, the BAI, and the BHS.
- (3) Cognitive Behavioral Therapy will demonstrate more change on the Inventory of Cognitive Distortions (ICD) and the Dysfunctional Attitude Scale (DAS). Interpersonal Therapy will exhibit more change than the Wait-List Control.

(4) Cognitive Behavioral Therapy will be more effective at preventing the relapse of depression as measured by the BDI, BAI, and the BHS.

## Method

### Subjects

Participants will be outpatients between the ages of 18 and 40 who meet diagnostic criteria for Major Depressive Disorder (MDD) as indicated by the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I; First, Spitzer, Gibbon & Williams, 1997) and the Multimodal Life History Inventory (Lazarus & Lazarus, 1991), the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996), the Beck Hopelessness Scale (HS; Beck, Weissman, Lester, Trexler, 1974), the Dysfunctional Attitude Scale (DAS; Beck & Weissman, 1978; Weissman, 1979) and the Inventory of Cognitive Distortions (ICD; Yurica & DiTomasso, 2002).

Subjects will be drawn from a pool of 90 depressed individuals requesting treatment at an outpatient treatment center who were assessed using the aforementioned measures. Each will be randomly assigned to one of three groups. Thirty (30) will be assigned to the CBT group, 30 to the IPT group, and 30 to the Wait-list Control group (who will receive treatment later). Randomization will also assign each client to one of 6 therapists; each therapist will treat 10 clients per treatment regime (i.e., 3 therapists for CBT, 3 for IPT). The Wait-list Controls will receive treatment following the completion of CBT and IPT treatments.

Participation will be voluntary and anonymity will be maintained. Exclusion criteria will include mental retardation, substance abuse, psychosis, pervasive developmental disorders, tic disorders, delirium, dementia, amnesic disorders, schizophrenia, concurrent psychiatric treatment, severe medical conditions, and suicidality. Participants must have at least an eighth grade education in order to complete the measures. The patients who are chosen will exhibit the greatest interest in participating in the program and will be able to comply with all the parameters of the study, such as keeping appointments, complying with homework assignments, completing the self-reports and being more thoroughly focused on reducing and/or eliminating depressive symptoms. A Consent to Agree to Participate in this study will be reviewed and signed prior to participation, with all information remaining completely anonymous. The patient will also complete a Consent to Tape form.

### Setting

Therapy will take place at an outpatient therapy center. Each therapist will receive training in the particular therapeutic treatment to be utilized. This will be done through the use of manuals which will guide the therapist in the activities, themes, therapeutic maneuvers, topics, techniques, and procedures of the specific therapeutic approach. The trainers will be experts in each of the designated therapies as determined by certification in the particular model. The CBT trainers and supervisors will also have received training at the Beck Institute or from the Academy of Cognitive Therapists. The IPT therapists will have had advanced training based on Klerman's IPT model.

Specific training will occur to enhance compliance with prerequisite therapeutic skills to be utilized; these will be practiced through role-play, practicing pilot cases that are videotaped for feedback and for further training. Videotapes of good sessions will be used to convey the style and provide guidelines about how the particular therapeutic style should be implemented.

Continual case supervision will occur both on an individual basis and a group basis for each therapeutic approach. Audio and videotaping will be used for weekly meetings to provide feedback and to reinforce the manualized guideline compliance with the implementation of treatment. Additional monitoring and consultation will occur during follow-up sessions.

Measures of competence will be utilized as well. The National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) of 1989 in their comparison of treatments used the Cognitive Therapy Skill (CTS; Young & Beck, 1980) measure to determine competence in Cognitive Behavioral Therapy. This measure, consisting of 11 items rated on a 7-point Likert scale, will be used in this study. General therapeutic skills (e.g. appropriate agenda setting, interpersonal effectiveness) and the evaluation of more specific CBT skills (CBT techniques leading to change) will also be utilized. Rating guidelines are noted in a manual. The overall level of competence is indicated by the summed score for all the items. An overall Cognitive Therapy Skill factor, which includes both technical and general skills, and a Structuring Skills Factor are identified. This instrument has been tested psychometrically (Elkin, 1999).

The TDCRP used two major components for measuring the competence of IPT: the Therapy Strategy Rating Form (TSRF) and the Process Rating Form, which will also be utilized in this study. The rater for the TSRF identifies the patient's major IPT "problem type (e.g., role disputes, grief and loss) and then evaluates if the nine strategies for addressing these problems are present. This is done on a 7-point scale, rating the implementation of the skill strategies. The Process Rating Form looks at both of the nine techniques as well as at the quality of their application. An index of overall therapist skill is derived from the means of the item ratings on each of these forms as well as from four general rating of IPT skills and a rating of overall quality of the session. (Elkin, 1999)

Interpersonal Psychotherapy is a brief (12-16 weeks), exploratory individual psychotherapy used in the treatment of major depression. IPT has two major goals: improvement in social functioning and alleviation of depression. The therapist is essentially nondirective and the process is exploratory. Klerman, Weissman, Rounsaville, & Chevron (1984) developed the training program and manual.

The Cognitive Therapy manual to be used will be *Overcoming Depression, a Cognitive Therapy Approach for Taming the Depression BEAST* (Gilson & Freeman, 1999), which is an adaptation of Beck's model of cognitive therapy (1967, 1979). The goals will be to understand the thinking patterns associated with depression and to understand the connection between low moods, withdrawn behavior, and negative thinking. The emphasis will be on making changes in the life of the patient through a problem-focused approach and on changing the patient's cognitive distortions. The

teamwork or collaborative approach is the essential component of this manualized treatment for the reduction of depression.

The course of therapy both for IPT and CBT and the Wait-list Controls will be 12 sessions, with follow-up at 3 months and at 6 months and at one year. An independent assessor will conduct the follow-up assessments using the BDI, the DAS, and the ICD. This independent assessor will be an expert in the field of depression based on experience, training, and ABPP Board certification and will have been recommended as an expert by The Beck Institute.

#### Measures

Several measures will be utilized throughout this research study.

*The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I;* First et al., 1997) is a structured clinical interview constructed by the authors of the DSM-IV (APA, 1994). The instrument exhibits good reliability and validity. The SCID I was designed for mental health professions to establish comprehensive, fine-grained diagnoses. Part I of the SCID assess for clinical disorders (Axis I). The SCID uses a brief clinical interview.

*The Multimodal Life History Inventory* (Lazarus & Lazarus, 1991) is a 13 page questionnaire that assesses the following information: general information, personal and social history, description of presenting problems, and modality analyses of current problems (i.e., behaviors, emotions, physical sensations, mental images, thoughts, interpersonal relationships, biological factors). Although this inventory does not yield

quantitative scores and does not give normative information, it often is quite helpful in developing case conceptualizations. It provides therapists with a great deal of information about their clients. The information often helps therapists generate hypotheses about elements of the cognitive model that are specific to clients.

*The Beck Depression Inventory (BDI)*: Beck, Steer & Brown, 1996) is a 21 item inventory that measures symptoms known to be highly correlated with depression according to the DSM-IV criteria. It is rated on a 4-point-Likert scale with 0=never and 3=severe. It has been frequently used for the assessment of cognitions associated with depression. The inventory is self-administered and takes from 5 to 10 minutes to complete. Within clinical populations, no depression or minimal depression ranges from 10-18, moderate to severe depression from 19-29, and severe depression from 30-63. Evaluation of content, concurrent, discriminant validity, and factor analysis has been favorable. Within the past 35 years the BDI is one of the most widely used instruments in assessing depression in clinical populations.

*The Beck Anxiety Inventory (BAI)*: Beck, Epstein, Brown & Steer, 1988) is a 21 item self-report inventory that measures symptoms of anxiety. It is rated on a 4 point scale from 0=never to 3=often. It was designed to measure anxiety symptoms that are often shared with depression. It is reported to have high internal consistency reliability and it correlates significantly with other measures of anxiety.

*The Beck Hopelessness Scale (H)*: Beck, Weissman, Lester, Trexler, 1974) is designed to measure negative attitudes about the future. It is a 20-item true-false measure and takes approximately 10 minutes to complete. It assesses 3 major aspects of

hopelessness: feelings about the future, loss of motivation, and expectations. The hopelessness construct is a factor that is highly correlated with measures of depression, suicidal intent, and ideation. It has been verified and is a reliable and valid measure.

*The Dysfunctional Attitude Scale* (DAS; Beck & Weissman, 1978; Weissman, 1979) is designed to measure dysfunctional beliefs of depressed individuals. It contains 40 items and is constructed of single sentence items answered on a 7-point Likert scale. It was designed specifically to validate Beck's cognitive theory of depression (Beck, 1976). The reliability is high and it has good internal consistency. The DAS has excellent test-retest correlations and excellent concurrent validity. It also correlates significantly with the Beck Depression Inventory.

*The Inventory of Cognitive Distortions* (ICD; Yurica & DiTomasso, 2002) is a 69 item inventory of cognitive distortions, which includes short-sentence items that reflect 11 different types of cognitive distortions. It is to be utilized with an adult clinical population. A 7-point Likert scale is used to determine frequency with 1=Never and 7=Always. Scores can range between 57 to 285. The total score indicates the numbers of cognitive distortions, with higher scores indicating greater distortions. Factor analysis and cognitive therapy experts have established its content validity. The ICD and the BDI have been correlated positively.

### Statistical Hypothesis

A Multivariate Analysis of Variance (MANOVA) will be used to evaluate the statistical significance of the effect of the three independent variables (CBT therapy, IPT



therapy, and a Wait-list Control) on a set of five dependent variables (SCID, BDI, BHS, DAS, ICD). Sample means will then be compared.

These measures (dependent variables) will be administered through a pretest and posttest for all three groups with follow-up at 3, 6, and 12 months for the CBT and IPT groups. The Wait- list control will have follow-ups at 3, 6 and 12 months following their treatment.

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PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE

CENTER FOR BRIEF THERAPY

Consent to Treat

I hereby authorize the PCOM Psychological Services Center/Center for Brief Therapy to provide the following services for  myself  my child

Individual Psychotherapy  Family Psychotherapy  
 Group Psychotherapy  Psychological Evaluation

It has been explained to me that my therapist, \_\_\_\_\_, is providing services as part of his/her advanced clinical training in the Center for Brief Therapy, and I agree with this arrangement. I understand that my case will be discussed with a licensed psychologist who is a full-time core member of the faculty in the Psychology Department at PCOM who is providing supervision to my therapist. I understand that I will get a copy of this form. I understand that this consent is freely given, and may be withdrawn at any time.

Name of Patient (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name of Parent/Guardian (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name of Parent/Guardian (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent to Tape

I hereby give permission for the clinical session(s) for  myself  my child at the PCOM Psychological Services Center to be:

Audio Taped  Video Taped  Observed  Any  Neither

I understand that these tapes will be treated with the same safeguards for confidentiality as are all other clinical notes, treatment plans, evaluations forms and other documents related to treatment.

Furthermore, I understand that these tapes are to be utilized for supervisory and training purposes only, and will not be utilized for any other purposes without separate and explicit written permission given by me.

I understand that these tapes will not be distributed without express written permission and that I may rescind this permission at any time without incurring any negative consequences for me/my child, or the management of my/his or her treatment. All tapes will be securely filed with my/my child's other treatment documents.

Name of Patient (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name of Parent/Guardian (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name of Parent/Guardian (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name of Clinician (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name of Supervisor (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT FORM

### TITLE OF STUDY

Cognitive Behavioral Therapy with a depressed outpatient: Assessing changes in cognitive distortions as measured by the Inventory of Cognitive Distortions

### PURPOSE

You are being asked to be part of this research project to study how the treatment of depression can help change the way you think. You will take part in Cognitive Behavioral Therapy which helps you to look at how your thinking affects your feelings and behavior. You will be asked to fill out 5 forms, 3 on a weekly basis and one before therapy and at the end of therapy. The questions on these forms ask you about your thoughts, feelings, and behaviors.

### INVESTIGATOR(S)

Name: Robert A. DiTomasso, Ph.D., ABPP, Principal Investigator  
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Phone: 215-871-6455

The doctors and scientists at Philadelphia College of Osteopathic Medicine (PCOM) do research on diseases and new treatments. The case study procedure/treatment you are being asked to volunteer for is part of a research project.

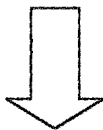
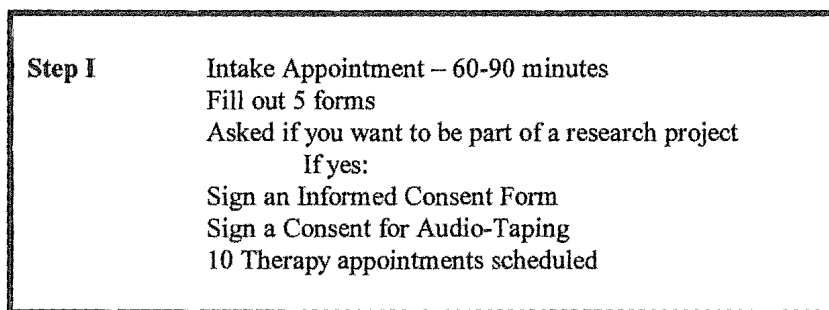
Even though this research project is to study the Cognitive Behavioral Treatment of Depression, using the Overcoming Depression manual by Gilson and Freeman (1999), with measurement of thinking errors by the Inventory of Cognitive Distortions, no one can say that this will be better than the usual treatment.

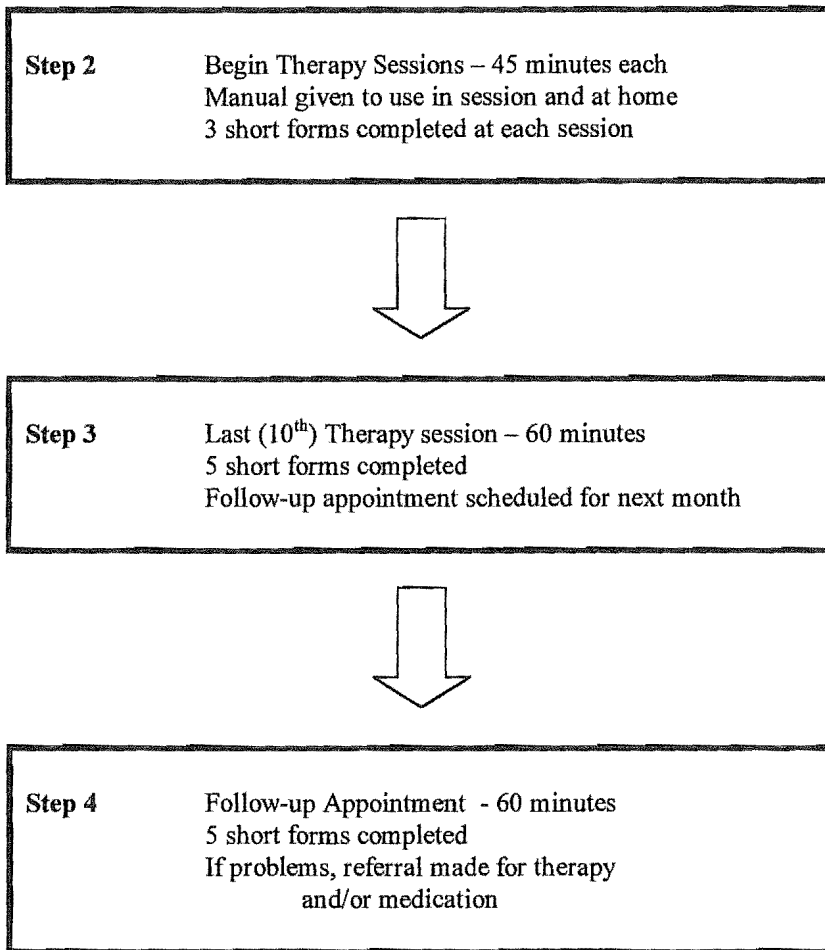
If you have any questions about this research, you can call Dr. DiTomasso at (215) 871-6455. If you have any questions or problems during the study, you can ask Dr. DiTomasso, who will be available during the entire study. If you want to know more about Dr. DiTomasso's background, or the rights of research subjects, you can call Dr. Frederick J. Goldstein, Chairperson, PCOM Institutional Review Board at (215) 871-6337.

## DESCRIPTION OF THE PROCEDURES

After calling the Philadelphia College of Osteopathic Medicine Center for Brief Therapy, an appointment will be made for your intake evaluation, which will take about an hour. You will be asked questions about your life and experiences. You will then fill out 5 forms, telling how you feel, think and behave. At the end of this first meeting, a treatment plan and appointment will be arranged. You will be told about the research and asked if you would like to be part of this study. The study will include ten therapy sessions in which you and the therapist work together to help you feel less depressed. Therapy sessions will be 45 minutes and will be audio-taped, with your agreement. A manual will be used for therapy called "Overcoming Depression, A Cognitive Therapy Approach for Taming the Depression BEAST" by Arthur Freeman and Mark Gilson (1999). You and the therapist will work on this together and you will receive your own copy. You will be asked to complete 3 forms weekly to see if there are any changes in how you feel, think, and behave. Therapy will end after 10 sessions. At this tenth session you will complete five forms to determine your progress. You will continue, on your own, to use the skills you learned in the manual that helped the most during therapy. Four weeks later you will have an appointment to see how you are doing. Five forms will be completed at this time. If you are experiencing problems a referral will be made for further therapy and possibly a psychiatric referral for medication.

### PROCEDURES FLOW CHART





**POTENTIAL BENEFITS**

This therapy may help you to feel better, think more clearly, and not feel as depressed. It will also help you to learn that the way you think can also change how you feel and act.

**RISKS AND DISCOMFORTS**

There are no known risks or discomforts from being in the study. Therapy may lead you to look at some upsetting issues, but this is a normal part of treatment. If, per chance, problems emerge they will be addressed in treatment, with a referral to a psychiatrist, if necessary.

**ALTERNATIVES**

The other choice is to not be in this study and to have treatment elsewhere.



## PAYMENT

You will not receive any payment for being in this study.

## CONFIDENTIALITY

All information and medical records relating to your participation will be kept in a locked file. Only the doctors, members of the Institutional Review Board, and the U.S. Food and Drug Administration will be able to look at these records. If the results of this study are published, no names or other identifying information will be used.

## REASONS YOU MAY BE TAKEN OUT OF THE STUDY WITHOUT YOUR CONSENT

If health conditions occur that would make staying in the study possibly dangerous to you, or if other conditions occur that would damage you or your health, Dr. DiTomasso or his associates may take you out of this study. In addition, the entire study may be stopped if dangerous risks or side effects occur in other people.

## NEW FINDINGS

If any new information develops that may affect your willingness to stay in this study, you will be told about it.

## INJURY

If you are injured as a result of this research study, you will be provided with immediate necessary medical care.

However, you will not be reimbursed for medical care or receive other payment. PCOM will not be responsible for any of your bills, including any routine medical care under this program or reimbursement for any side effects that may occur as a result of this program.

If you believe that you have suffered injury or illness in the course of this research, you should notify Frederick J. Goldstein, Ph.D., Chairperson, PCOM Institutional Review Board at (215) 871-6337. A review by a committee will be arranged to determine if your injury or illness is a result of your being in this research. You should also contact Dr. Goldstein if you think that you have not been told enough about the risks, benefits, or other options, or that you are being pressured to stay in this study against your wishes.

**VOLUNTARY PARTICIPATION**

You may refuse to be in this study. You voluntarily consent to be in this study with the understanding of the known possible effects or hazards that might occur while you are in this study. Not all the possible effects of the study are known.

You may leave this study at any time.

You also understand that if you drop out of this study, there will be no penalty or loss of benefits to which you are entitled.

I have had adequate time to read this form and I understand its contents. I have been given a copy for my personal records.

I agree to be in this research study.

Signature of Subject: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_ AM/PM

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_ AM/PM

Signature of Investigator: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_ AM/PM

**Consent for Taping Sessions**

I, \_\_\_\_\_, agree to allow my treatment sessions with  
Detta Tate to be voice-taped and then copied for typing.

I understand that these tapes will be keep secure and private as are all other notes,  
treatment plans, forms and other papers related to my treatment. Also, I understand that  
these tapes are to be used for study and research only and will not be used for any other  
purpose unless I agree in advance and in writing.

I understand that the taped sessions will be typed and will become part of a  
written record of my case to include in a study. My name will not be used in either the  
tapes or the written paper from the tapes. No one will know that the tapes or the written  
paper is about me, except for Detta Tate.

Further, I understand that this permission will not effect how my treatment is  
managed. My treatment will not change if I agree or do not agree to allow my sessions to  
be taped.

\_\_\_\_\_

Patient Name (Print)

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Witness Name (Print)

\_\_\_\_\_

Witness Signature

\_\_\_\_\_

Date