2. INDIVIDUAL COGNITIVE BEHAVIOR THERAPY FOR DEPRESSION

2.1 BACKGROUND AND RATIONALE

Of all the existing forms of psychotherapy for unipolar depression, cognitive behavior therapy (CBT: Beck et al., 1979) and interpersonal psychotherapy (Klerman et al., 1984) are best supported by outcomes research. Both were significantly more effective than placebo plus clinical management, and nearly as effective as imipramine in the NIMH Treatment of Depression Collaborative Research Program (TDCRP: Elkin et al., 1989). However, although other studies of interpersonal therapy have also shown promising results (e.g., Frank et al., 1990), a much more extensive database supports the efficacy of CBT for depression (AHCPR Clinical Practice Guidelines: Treatment for Major Depression, 1993; Dobson, 1989; Hollon et al., 1991; Robinson et al., 1990).

Patients who are both depressed and socially withdrawn or who have poor social skills tend to do better with CBT than with interpersonal psychotherapy (Rude et al., 1991; Sotsky et al., 1991). By design, such patients are likely to constitute a large proportion of the ENRICHD sample.

Cognitive-behavioral interventions are also well-matched to the typical psychosocial problems and the mild-to-moderate severity of depression commonly observed in cardiac populations (Carney et al., 1987). For example, behavioral activation and desensitization of health-related anxieties (e.g., overcoming unwarranted fears about and avoidance of returning to work, leisure activities, sexual intercourse, etc.) are typical themes in the early phases of psychotherapy with post-MI patients. Cognitive distortions (e.g., "catastrophizing" in response to mild exertional fatigue, "fortune telling" in response to fears of abandonment, "black and white thinking" in response to the need to discontinue medically risky leisure activities and to identify safer alternatives, etc.) are commonly identified during treatment. Finally, as a relatively brief, goal-oriented, collaborative, and emotionally supportive form of treatment, CBT is generally well accepted by cardiac and other medical patients.

For these reasons, CBT was chosen as the psychotherapeutic intervention for depression in this clinical trial. As in other clinical trials, ENRICHD counselors are expected to adhere to a manualized treatment protocol. However, the ENRICHD protocol is not a rigid cookbook. Instead, it is a reasonably flexible approach to CBT that provides considerable latitude within which to deliver the best, most effective clinical care possible. Our overriding goal is to ensure that our depressed patients get better.
The required treatment manuals for ENRICHD are (1) *Cognitive Therapy of Depression* (Beck, Rush, Shaw, and Emery, 1979), which is the core CBT protocol and which has been used in most previous outcome studies of CBT for depression, and (2) *Cognitive Therapy: Basics and Beyond* (J.S. Beck, 1995), which supplements the core CBT protocol. The J.S. Beck (1995) manual is designed to help CBT therapists to increase their clinical sensitivity and flexibility by expanding their repertoire of cognitive-behavioral techniques. It will help ENRICHD counselors to maximize effectiveness while working within the core framework of the Beck et al. (1979) CBT protocol.

Like most other research projects that have used Beck et al. (1979) as their treatment manual, we have also had to augment the manual in other ways to address the particular needs of the ENRICHD study. This section of the Manual of Operations thus focuses on issues that go beyond the material covered in Beck's (1979) core CBT protocol. Specifically, it (1) addresses critical non-technique aspects of treatment (such as when to refer for pharmacotherapy); (2) provides case examples involving cardiac patients to illustrate specific cognitive techniques; (3) discusses strategies for overcoming problems that commonly arise in treating cardiac patients; and (4) summarizes the use of process and clinical assessment tools for CBT, which are discussed in greater detail in the appendix entitled “Process Measures and Clinical Tools.”

### 2.2 INITIAL (PRETREATMENT) CLINICAL EVALUATION

As the treating clinician, you will have access to the results of the screening and baseline assessments that were conducted by the case coordinator when the patient was recruited to participate in the trial. However, you are required to conduct an independent clinical evaluation of your own, prior to beginning counseling. In addition to evaluating the participant, use the initial evaluation session as an opportunity to start building rapport, to instill hope, and to induct the participant into counseling.

The principal purposes of the initial clinical evaluation are (1) to assess the participant’s current problems and concerns; (2) briefly characterize the participant’s social network; (3) diagnose the participant’s depressive disorder according to the DSM-IV criteria for major depressive episode, minor depressive episode, and/or dysthymic disorder; and (4) determine the severity of the current depressive episode. The counselor also has the option to: (1) identify comorbid Axis I and Axis II psychiatric disorders which may affect the course of treatment; (2) characterize the participant’s past psychiatric history; and (3) rate the participant’s current functioning on the DSM-IV Axis V Global Assessment of Functioning Scale. The counselor also assess the participant’s expectations about treatment and obtains other information that may be needed to formulate an individualized treatment plan. The initial clinical evaluation includes the DISH, which assesses current depressive symptoms and the 17-item Hamilton Depression score. You are also required to administer the Beck Depression Inventory unless the baseline BDI was obtained less than one week before the initial clinical evaluation.
If the participant has had any prior episodes of depression, determine what treatment, if any, was received, and how well the participant responded to it. If pharmacotherapy was used, the agent should be identified. The participant’s response to that agent should be noted and this information should be provided to the study psychiatrist in the event that pharmacotherapy is considered.

The initial clinical evaluation is initiated at Session Zero and completed as soon as possible after that. Conduct the initial evaluation and initiate individual counseling as soon as is possible, preferably while the participant is still in the hospital. If there is not enough time to arrange Session Zero before discharge, or if the participant is not ready to tolerate a full session, it may still be possible to arrange a brief visit or telephone contact to start building rapport with the patient.

2.3 PROCESS MEASURES AND OTHER CLINICAL TOOLS

Starting with the initial clinical evaluation and continuing throughout treatment, you will be required to utilize several treatment process measures. These measures are mandatory and are used to assess the participant’s problems, document the implementation of the treatment protocol, track the participant’s progress in treatment, and determine whether the participant has successfully completed treatment. A variety of optional clinical tools are also available. The optional tools may be used when needed, at the discretion of the counselor and his/her supervisor. See Appendix for further details and instructions.

2.4 CONCURRENT PSYCHOPHARMACOLOGY

Participants who are severely depressed (defined as a Hamilton Depression score of 24 or higher) will be evaluated for antidepressant therapy in consultation with the study’s psychiatrist and the participant's cardiologist and/or primary care physician. As the treating counselor, you are to reassess the severity of the participant's depression as part of your initial clinical evaluation. You may find that a participant who scored below 24 on the baseline Hamilton Depression scale now scores 24 or above on the basis of your interview. If so, you should refer the participant to be evaluated for antidepressant therapy.

During the course of counseling, you should also refer participants with major depression to the study psychiatrist for evaluation and consideration of additional treatment with an antidepressant if their BDI scores have not decreased by at least 50% by the fifth week of treatment or if they become more severely depressed. Moreover, if the participant scores >20 on the Hamilton Depression Scale at the time of the 6-month conclusion of treatment, referral to the study psychiatrist is also indicated. Not every participant will necessarily be prescribed an antidepressant following psychiatric evaluation. However, referral for psychopharmacology is
an option at any time during treatment if, the counselor’s judgment, the participant is not responding to CBT. (see chapter 3)

2.5 TREATMENT SCHEDULE

During the initial phase of treatment, participants with major or minor depression will receive individual CBT. If possible, participants should be scheduled for twice-a-week sessions for the first two weeks of treatment, as this may help to promote more rapid improvement. Most participants will be seen once per week for the remainder of the initial phase of treatment. However, twice-weekly sessions may be scheduled for participants if, in the counselor’s judgment, this would be advisable (e.g., due to severe depression or suicidal ideation).

Once-or twice-weekly 50-minute sessions of individual CBT and/or weekly sessions of group CBT will continue until the participant has met the criteria for successful counseling. The criteria are met when the participant has completed at least 6 sessions of individual or group counseling, has met the CBT performance criteria, and has scored 7 or below on the BDI for at least two consecutive weeks (see section 1.3). Ordinarily, participants will be seen for no more than 16 sessions of individual CBT. However, more sessions may be required in particularly difficult or unusual cases, or in cases in which the participant has remitted and then relapsed.

2.6 CBT PERFORMANCE CRITERIA

As noted above, one of the factors to consider when deciding whether to terminate CBT is whether the participant meets certain criteria that suggest a mastery of CBT skills. You may have additional criteria of your own for an individual participant. The following are performance criteria that are to be applied to all of your depressed participants and that are derived from the Beck (1979) and J.S. Beck (1995) treatment manuals. Refer to these sources for additional information. All participants should be rated on these criteria after every session using the CBT Performance Criteria Scale (See Appendix).

1. The participant initiates and utilizes behavioral activation techniques.

2. The participant identifies problematic situations and emotions.

3. The participant identifies dysfunctional thoughts in problematic and/or emotionally arousing situations.

4. The participant uses cognitive-behavioral techniques to evaluate and modify dysfunctional thoughts and beliefs.

5. The participant uses cognitive-behavioral techniques for active problem solving.

6. The participant demonstrates the willingness and ability to apply cognitive-behavioral skills to new and future problems and relapses.
2.7 SESSION-BY-SESSION GUIDELINES

The following is a model treatment outline based on the Beck et al. (1979) and J.S. Beck (1995) manuals. It is not intended to be a rigid schedule, but you are expected to use it as a guideline for treatment planning. Counselors should read the 2 manuals and the CBT training materials carefully and completely. They describe many techniques and procedures which will be helpful in treating depressed patients in the ENRICHD trial.

2.7.1 Pre-Treatment Visit or Call

If it is not possible to hold a full Session Zero immediately after randomization, call or visit the participant to start building rapport and interest in the treatment program.

2.7.2 Session Zero

1. Start building rapport and interest in the treatment program.

2. Conduct an initial clinical evaluation (see Appendix). Complete as much of the evaluation as possible in Session 0, and complete any remaining portions of the evaluation in subsequent sessions.

2.7.3 First Session

1. Continue building rapport.

2. Finish the initial clinical evaluation.

3. Discuss participant’s expectations about counseling and recovery.

4. Check participant’s present mood.

5. Review post-heart attack recovery since discharge from hospital, including adherence to medication and overall treatment regime.

6. Elicit negative attitudes regarding self, counseling, or counselor.

7. Pinpoint most urgent and accessible problem (e.g., hopelessness, suicidal wishes, loss of functioning, severe dysphoria).

8. Describe the cognitive model of depression.

9. Explain cognitive-behavioral strategies with emphasis on the rationale for behavioral assignments and homework.

10. Review Activity Chart for recording activities until next session.
11. Give the participant *Coping with Depression* or *Coping With Depression After a Heart Attack* (J.S. Beck, 1996) to read (optional).

12. Elicit verbal feedback about the session. Initiate use of the Client’s Session Feedback Form, if the patient is ready (optional). *Note:* Most participants feel better by the end of the first session; if not, counselor should probe for reasons for lack of positive reaction (or adverse reaction).

### 2.7.4 Second Session

1. Mood check.

2. Inquire about effects of first session.

3. Review Activity Scheduling form.

4. Discuss reactions to *Coping with Depression* and/or cognitive model of depression.

5. Discuss problems and accomplishments since previous session.

6. Schedule activities until next session.

7. Discuss recording mastery and pleasure ratings on Activity Schedule (optional).

8. Prepare agenda and focus on the problem(s) to be discussed.

9. Inquire about reaction to this session.

### 2.7.5 Third Session

1. Prepare agenda.

2. Inquire about effects of second session

3. Review homework assignments

4. Provide instruction in identifying negative automatic thoughts (use “induced fantasy” or role playing if indicated).

5. Explain how these automatic thoughts represent distortions of reality and are related to other symptoms of depression.
6. Elicit automatic thoughts, specifically in relation to homework assignments.

7. Prepare homework assignments.

8. Elicit feedback regarding today’s session.

2.7.6 Fourth Session

1. Follow some general format as in third session.

2. Continue instruction in identifying negative automatic thoughts.

3. Continue to clarify how these automatic thoughts represent distortions of reality and are related to other symptoms of depression.

4. Elicit automatic thoughts, specifically in relation to homework assignments.

5. Instruct patient in using the Dysfunctional Thoughts Records (optional).

2.7.7 Fifth Session

1. Follow some general format as in previous session.

2. Review schedule of activities with special reference to mastery and pleasure

3. Review and discuss automatic thoughts

4. Demonstrate to the participant ways of evaluating and correcting cognitive distortions (automatic thoughts).
2.7.8 Sessions 6, 7, and 8

1. Same format as above.

2. Continue to remove psychological blocks to return to premorbid level of functioning.

3. Continue to identify negative automatic thoughts.

4. Continue work on rational responses to automatic thoughts.

5. Give additional homework assignments.

6. Discuss the concept of basic assumptions (Chapter 12).

2.7.9 Sessions 8 - 12

1. Progressively delegate more responsibility for setting the agenda to the participant.

2. Progressively delegate more responsibility for homework to the participant.

3. Identify and discuss basic assumptions, testing the validity of the assumptions.

2.7.10 Closing Sessions

1. Prepare participant for termination of individual therapy.

2. Emphasize continuation of homework assignments and practicing other strategies after termination. Emphasize counseling as a learning process that continues throughout the individual’s life.

3. Delineate anticipated problems and rehearse coping strategies.
2.8 ESSENTIAL ELEMENTS OF COGNITIVE THERAPY

The above outline is meant to be a guideline for each session of CBT, not an inflexible, invariant step-by-step procedure for treating depression in this trial. It is understood that it may be necessary to vary the content of sessions to some degree in order to address the particular needs of each patient. However, the treatment must stay within the generally accepted framework for CBT. The following is an overview of the essential elements of CBT that must be part of the depression intervention.

There are four essential elements to CBT as taught and practiced for the ENRICHD trial. For reasons of quality assurance, all four of these elements must be evident in the course of any given counseling case for it to be considered valid CBT.

The four elements are:

1. There must be a relatively invariant structure for the individual counseling sessions.

2. The counselor must demonstrate clear understanding of the cognitive model and teach the model to the participant using the participant’s own problems as examples.

3. Within the first 2 counseling sessions, the counselor must establish a cognitive formulation of the participant that consistently informs and guides the counselor’s decisions over the course of the case. The cognitive formulation is continuously modified and elaborated upon over the course of counseling. The counselor shares the formulation with the participant and engages him/her in discussions about the adequacy of the formulation.

4. The counselor must build a strong therapeutic alliance with the participant and carefully maintain it over time.

2.8.1 The Structure of Individual Counseling Sessions

"Cognitive therapy sessions are structured. No matter what the diagnosis or stage of treatment, the cognitive therapist tends to adhere to a set structure in every session...checks the patient’s mood, asks for a brief review of the week, collaboratively sets an agenda for the session, elicits feedback about the previous session, reviews homework, discusses the agenda items, sets new homework, frequently summarizes, and seeks feedback at the end of each session. This structure remains constant throughout therapy....Following a set format makes the process of therapy more understandable for both the patient and his/her therapist and increases the likelihood that the
patient will be able to do self-therapy after termination. This format also focuses attention on what is more important to the patient and maximizes use of therapy time (J.S. Beck 1995, p. 8)

2.8.2 The Cognitive Model

Cognitive therapy is a systematic approach to applying the cognitive model of human behavior to the participant’s problems. It is not merely a collection of psychotherapeutic techniques. Although cognitive therapists must master a variety of techniques, they must be sensitive to the needs of the individual patient and flexible in the manner in which these techniques are applied.

"Cognitive therapy is based on the cognitive model, which hypothesizes that peoples’ emotions and behaviors are influenced by their perception of events. It is not a situation in and of itself that determines what people feel, but rather the way in which they construe a situation... The situation itself does not directly determine how they feel; their emotional response is mediated by their perception of the situation. The cognitive therapist is particularly interested in the level of thinking (quick, evaluative thoughts dubbed automatic thoughts) that operates simultaneously with the more obvious, surface level of thinking (J.S. Beck 1995, p. 14).”

Automatic thoughts spring from beliefs people develop about themselves, other people, and their worlds, beginning in childhood. Their most central or core beliefs are understandings so fundamental and deep that they often do not articulate them, even to themselves. These ideas are regarded by the person as absolute truths, just the way things are. This belief may operate only when he/she is in a depressed state or it may be activated much of the time...Core beliefs are the most fundamental level of belief; they are global, rigid and over generalized. Automatic thoughts, the actual words or images that go through a person’s mind, are situation specific and may be considered the most superficial level of cognition. There is a class of intermediate beliefs that exist between the two (Beck J, 1995, pp. 15-16).

2.8.3 Cognitive Formulations

"Treatment is based on both a cognitive formulation of a specific disorder and its application to the conceptualization or understanding of the individual patient. The therapist seeks in a variety of ways to produce cognitive change -- change in the patient’s thinking and belief system -- in order to bring about enduring emotional and behavioral change (J.S. Beck 1995, p. 2).”

“Cognitive therapy is based on an ever-evolving formulation of the patient and his/her problems in cognitive terms” (J.S. Beck 1995, p. 5).” This formulation encompasses problematic behaviors, precipitating factors, key developmental events, and the patient’s enduring patterns of interpreting these key developmental events.
2.8.4 Therapeutic Alliance

The therapist must demonstrate “warmth, empathy, caring, genuine regard, and competence. The therapist shows his/her regard....by making empathic statements, listening closely and carefully, accurately summarizing thoughts and feelings, and being realistically optimistic and upbeat. He/she also asks the patient for feedback at the end of each session to ensure that he/she feels understood and positive about the session” (Beck J, 1995, p. 5).”

2.9 REFERRAL TO GROUP COUNSELING

All patients are referred to ENRICHD group counseling as soon as a group becomes available and there are no contraindications to group counseling (e.g., presence of psychotic features, severe psychomotor retardation, Axis II disorders, severe social anxiety). Several weeks before the group is scheduled to begin, describe this part of the program to the participant and discuss his or her expectations about it.

The groups are designed to continue and extend the work that was begun in individual counseling by targeting depression and by focusing on maintenance of treatment gains and prevention of relapse. Depending upon the participant's particular needs, individual counseling may continue to run concurrently with group counseling, or it may be terminated before the group counseling begins.

If there is a gap of more than two weeks from the time that individual counseling ends and group counseling begins, the counselor should initiate telephone contacts each week with the participant to assess his/her functioning and depression status. The counselor should also ask the participant to complete a BDI once a week during this time. If the participant reports a return of depression symptoms or scores 7 or higher on the BDI, schedule an appointment to evaluate whether the participant needs to resume individual counseling.

Participants should be administered BDIs on a weekly basis during group counseling. If the participant shows signs of relapse as defined by reporting of symptoms or a BDI of 7 or higher, individual counseling may be resumed. The decision to resume individual counseling is based on the counselor’s clinical judgment and the participant’s preference.
2.10 MAINTENANCE COUNSELING AND RELAPSE PREVENTION

It is not uncommon for minor depression to progress to major depression, particularly in the context of a past history of major depression, and many participants with major depression who initially respond to treatment will subsequently relapse. Not even the most effective short-term treatments for depression, including CBT, are able to prevent relapses in every case.

Participants who are unmarried, who have recurrent or severe depression, who score high on measures of dysfunctional attitudes, who respond slowly to counseling, or who have residual symptoms (i.e., are only in partial remission) at the termination of counseling are among those who are most likely to relapse.

There is strong evidence that maintenance sessions can reduce relapse rates following short-term interventions. For example, Jarret et al. (1990) added 10 individual sessions of CBT over 8 months, and found that 51% of the controls compared to only 20% of patients receiving the maintenance sessions relapsed during the follow-up period. Similarly, in a group of patients with endogenous depression, Thase et al. (1991) found that 75% of patients receiving only short-term treatment relapsed, compared to only 10% of patients who also received maintenance CBT.

Group counseling may be sufficient to prevent relapse in patients treated for minor depression or for relatively mild and uncomplicated major depression. However, monthly individual maintenance counseling sessions may be needed to prevent relapse in some participants, even if they are concurrently participating in the group counseling. This is particularly important for participants with a history of recurrent depression and for those with moderate to severe major depression in partial remission at the end of the active (≥ weekly) phase of individual CBT.

Thus, at the termination of active (≥ weekly) individual counseling, determine whether your participant needs monthly individual maintenance CBT sessions to prevent his or her depressive disorder from relapsing, and if so, to treat him/her accordingly. It is important to note, however, that there is a time limit beyond which the participant will no longer receive treatment from ENRICHD project personnel. In most cases, the limit is six months from the time of enrollment in the project, although maintenance pharmacotherapy may continue for up to one year for participants who are treated with antidepressants.

Furthermore, all depressed participants will be asked to complete the BDI by telephone on a monthly basis for the remainder of the 6 months after termination of the active treatment phase. If it is determined during the telephone contacts that the patient’s BDI score is 7 or higher, or if the counselor otherwise determines that the participant's psychiatric condition is deteriorating,
the participant should be encouraged to resume individual counseling to prevent relapse or further deterioration.

Both the Beck et al. (1979) and the J.S. Beck (1995) manuals include materials on relapse prevention and maintenance (booster) sessions. Refer to these sources for guidelines for maintenance counseling.

2.11 ADAPTATIONS OF THE STANDARD CBT PROTOCOL FOR ENRICHD

Because you are treating a special clinical population (i.e., patients who are recovering from an acute myocardial infarction), and because of the special circumstances within which you are delivering your treatment services (i.e., a large, multicenter clinical trial), you may encounter a variety of problems that are not discussed in the standard CBT manuals. The following section lists some of the kinds of problems you might encounter in working with ENRICHD participants, along with some potential solutions.

2.11.1 Problem

Take-home reading materials and written homework assignments may present adherence problems. For participants who are not yet sufficiently invested in the treatment, these problems are likely to occur early and decrease as counseling proceeds. For participants with lower literacy levels, these problems will persist throughout counseling.

2.11.2 Suggested Solutions

A. Adapt reading materials for low-literacy patients.

B. Adapt CBT terms used in-session for cultural and educational appropriateness.

C. Allow time, and develop a standard procedure, for completing homework assignments (behavioral as well as written) in-session, especially early in counseling.

D. Assign behavioral homework (i.e., specific behavioral tasks) whenever possible, especially early in counseling. However, mastery and pleasure ratings and other simple recording activities may accompany even the behavioral tasks.

E. Try to enlist the help of other family members whenever appropriate.
2.11.3 Problem

Many participants with CHD define their problems as physical rather than psychological in nature and thus are less amenable to psychological counseling. In order to maximize adherence and reduce drop-out early in treatment, participants must realize that treatment of their depression is important to their recovery.

2.11.4 Suggested Solutions

A. Educate the participant about the prevalence of depression following a myocardial infarction (i.e., normalize their experience), and about the role of depression in CHD morbidity and mortality.

B. Focus on CHD and issues related to the heart attack as a framework for early CBT sessions, while at the same time attending to, and encouraging discussion of, other issues. For example, the counselor may encourage the participant to focus on scheduling pleasurable activities and on overcoming limitations initially imposed by the heart attack, using graded activities, pacing, etc. to accommodate the participants with physical limitations. As participants become more invested in counseling, issues concerning their heart attack may become secondary. This will occur at different points in the early phases of counseling for different patients. The counselor may have to maintain some contact with the participant's physician, cardiac rehab therapist, etc. for reasons of medical safety and to minimize the possibility of failure experiences.

C. Obtain endorsement for the treatment from the participant’s own physician. You may ask referring physicians to support the treatment program by speaking with them or writing a note to them about it.
2.12 COGNITIVE DISTORTIONS IN POST-MI PATIENTS

Although there have been many attempts to delineate the most common cognitive distortions or irrational beliefs of depressed patients, one of the clearest and certainly the most popular is the list provided by David Burns in *Feeling Good* (1980). The following are, according to Burns, the 10 most common cognitive distortions.

1. **ALL-OR-NOTHING THINKING:** You see things in black-and-white categories. If your performance falls short of perfect, you see yourself as a total failure.

2. **OVERGENERALIZATION:** You see a single negative event as a never-ending pattern of defeat.

3. **MENTAL FILTER:** You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the drop of ink that discolors the entire beaker of water.

4. **DISQUALIFYING THE POSITIVE:** You reject positive experiences by insisting they don’t count for some reason or other. In this way you can maintain a negative belief that is contradicted by your everyday experience.

5. **JUMPING TO CONCLUSIONS:** You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.
   
   a. Mind reading. You arbitrarily conclude that someone is reacting negatively to you, and you don’t bother to check this out.

   b. The Fortune Teller Error. You anticipate that things will turn out badly, and you feel convinced that your prediction is an already-established fact.

6. **MAGNIFICATION (CATASTROPHIZING) OR MINIMIZATION:** You exaggerate the importance of things (such as your goof-up or someone else’s achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow’s imperfections). This is also called the “binocular trick”.

7. EMOTIONAL REASONING: You assume that your negative emotions necessarily reflect the way things really are: AI feel it, therefore it must be true.

8. SHOULD STATEMENTS: You try to motivate yourself with shoulds and should nots, as if you had to be whipped and punished before you could be expected to do anything. “Musts” and “oughts” are also offenders. The emotional consequence is guilt. When you direct “should” statements toward others, you feel anger, frustration and resentment.

9. LABELING AND MISLABELING: This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself. “I’m a loser”. When someone else’s behavior rubs you the wrong way, you attach a negative label to him: “He’s a goddamn louse”. Mislabeeling involves describing an event with language that is highly colored and emotionally loaded.

10. PERSONALIZATION: You see yourself as the cause of some negative external event for which in fact you were not primarily responsible.

Most depressed cardiac patients have problems similar in nature to those of other depressed patients, including marital conflicts, interpersonal loss, work-related stress, etc. Furthermore, most of the depressed post-MI patients you will treat during this study will be in the middle of a depressive episode that pre-dated the heart attack, and many will have a prior history of depressive episodes that may have begun decades before their heart disease became apparent. Some participants may actually be relatively unconcerned about their medical problems but extremely distraught about something else.

However, many of your participants will present with concerns specific to their cardiac illness and its sequelae. The following are examples of cognitive distortions that involve these kinds of issues.

a) “You’re either healthy or you’re good for nothing. I just had a heart attack, so obviously “I am good for nothing”. (All or nothing thinking).

b) “If I can’t work as hard and as long as I used to, there is no point in my even trying to return to work”. (All or nothing thinking)
c) After being told by his doctor to take it easy for a few weeks: “I will never be able to take long walks again”! (Over generalization).

d) After being told to reduce foods high in saturated fats from his diet: “I will never be able to eat good food again”. (Over generalization).

e) “I can’t do anything I used to be able to do anymore”. (Over generalization)

f) After an otherwise very positive physical examination, his doctor noted that his blood pressure was a little high: “I am still very sick, I am just not getting any better since my heart attack”. (Disqualifying the positive).

g) After being told by his doctor that he is making good progress in lowering his cholesterol levels by watching his diet: “He is just trying to make me feel better. He really doesn’t mean that. He thinks I am not trying”. (Disqualifying the positive, fortune telling).

h) “No matter how hard I try to get better, nothing changes. It doesn’t matter”. (Disqualifying the positive)

i) “No matter how hard I try to exercise, my wife doesn’t believe that I am really doing my best”. (Mind reading).

j) “My family believes that I am not fulfilling my responsibilities since my heart attack. They are angry with me for not doing my share, even though they haven’t actually said anything”. (Mind reading).

k) “If I ask for help with the housework, my husband thinks I am using my illness as an excuse for being lazy”. (Mind reading).

l) “My life is over now that I have had a heart attack. It will never be fun or exciting again”. (Catastrophizing).

m) “I am convinced that I will have another heart attack! I know that there is nothing I can do to get better. I might just as well quit trying” (Fortune telling)
n) “Now that I have had my heart attack, none of my friends will want to be around me. They all think that I might have another one when we're out together.” (Fortune telling).

o) “I should be able to continue to care for my family like I use to. (Should statement).

p) “I should be able to lower my cholesterol. I am hopeless.” (Labeling and mislabeling, shoulding).

q) “I should have quit smoking a long time ago. I brought this heart attack on myself.” (Personalization and should statements.)

In summary, the cognitive model can be adapted to the problems experienced by depressed post-MI patients. Some of their problems (e.g., interpersonal difficulties) may be the same as those seen in every depressed patient population, whereas others may be closely related to the participant’s cardiac problems and/or hospitalization.

2.13 REFERENCES


