II. Overview of Theoretical Assumptions

Cognitive therapy is a theoretically guided. Time-limited, active, here-and-now, and structured approach to the treatment of depression. CT is the best studied psychosocial treatment of depression. Unlike more traditional, insight-oriented therapies, CT seeks a rapid reduction of depressive target symptoms by examining concrete examples of the patient's thoughts, feelings, and behaviors in specific situations. The CT therapist uses a collaborative-empirical approach, including behavioral strategies and guided discovery of cognitive factors (via Socratic questioning style) to actively engage the patient in a problem-solving process.

There are several assumptions that provide the theoretical rationale for CT. One underlying assumption is that an individual's behavior and mood are largely determined by the way, in which she or he psychologically perceives the world. CT examines the primacy of an individual's perception of the problematic situations and the cognitions (ideas and thoughts) that arise as a result. We explore with the patient how negative cognitions play a part in the generation and maintenance of unpleasant emotions (affects or moods), dysfunctional behaviors, and vegetative symptoms of depression. Cognitive therapy seeks to effect change through a process akin to the scientific method of seeking evidence to support or reject a hypothesis. The therapist and patient engage in "collaborative empiricism," the guided exploration of the difficulties in the patient’s life according to the principles of CT. Patients are encouraged to examine the evidence for their beliefs and to use their own behaviors to test the validity of those beliefs. CT uses behavioral techniques as well to challenge the patient's assumptions and predictions and to advance the pace of symptom reduction. For example, it is fully appropriate to incorporate stimulus control strategies or progressive deep muscle relaxation to help a patient cope with severe insomnia. The time-limited structure of CT is one example of how we use our knowledge of the treatment course of major depression to model for the patient our expectation that remission of depressive symptoms will be accomplished by the end of the acute phase treatment contract.

Verbalized negative cognitions (Negative Automatic Thoughts or negative ATs) may plague a depressed person in many ways. Generally, AT's can be grouped according to the "cognitive
triad;” negative thoughts about one's self, world, and future. For example, ATs may present as thoughts about the person ("I am no good."); or as a prediction about a contemplated action ("I will never get it done right."); or as a conclusion about self in relation to others ("No one cares enough to help me."). ATs also may take the form of visual images or daydreams. CT trains therapists to assess and evaluate the person's underlying attitudes, assumptions, and operational rules (schemas or core beliefs). The therapist examines with the patient how cognitions are derived from his or her core beliefs or schemes. Therapeutic techniques are designed to help the patient to recognize ATs, establish the emotional impact of the cognition, test the validity of the ATs and consider alternate views, and ultimately to revise the dysfunctional behaviors, rules, and schemas. An important principle of CT is that changes in core cognitive vulnerabilities will provide more enduring protection against depressive relapse.

ATs are most readily recognized during times of emotional arousal (i.e., "hot thoughts"). Consider a common example from everyday life, such as picking the wrong (i.e., slowest moving) check-out lane at the supermarket. An angry or frustrated affect is often accompanied by the cognition "This always happens to me!" Of course this is not true — it is virtually impossible to always pick the wrong line — but the certainty of cognition helps to focus and direct the affective arousal. The distorted or inaccurate context of ATs thus typically reflects one or more affectively mediated errors in information processing, described best by Beck et al. (1979) and Burns (1980). In our experience, the functional significance of helping patients to recognize examples of faulty information processing is that it provides prima facia justification for challenging the distorted content of ATs. Said another way, if the evidence in support of a criminal charge is discovered to have been biased or tampered with, the certainty of guilt must be reevaluated.
The major strategies employed in CT for depression include, but are not limited to, the following:

1. Socialize the patient to the cognitive model.
2. Identify and monitor negative ATs.
3. Recognize the cognitive triad in specific incidents in the patient's life.
4. Examine evidence for/against negative ATs, including the impact of errors in information processing.
5. Substitute more realistic alternative interpretations for negatively biased cognitions.
6. Learn to identify and alter dysfunctional beliefs that predispose the individual to distort their experiences.

Techniques used to explore the logic behind and the basis for specific cognitions and assumptions include but are not limited to:

1. Patient is given an explanation of the rationale for therapy and asked to relate this to their problems.
2. Patient is taught to recognize, monitor, and record negative ATs using Weekly Activity Schedule (WAS).
3. Patients are taught to examine the logic, validity, and adaptive utility of negative ATs, and to enhance positive behaviors rather than reinforcing pathologic behavior through the use of the Dysfunctional Thought Record (DTR).
4. Patient is taught to test their thoughts to determine if the thoughts are disordered or realistic.
5. Patient is taught to examine overinclusive, all-or-nothing beliefs through the use of graded task assignments.
6. Patient is taught to practice new attitudes and behaviors with homework assignments.
7. Patient is taught focal strategies to challenge dysfunctional thoughts and beliefs.
CT is a highly structured therapy. The typical duration of the CT treatment is 3-4 months and in STAR*D we will be completing a complete course of CT in 12-14 weeks, consistent with the duration of the other treatments in Level 2. During this period of time, we expect there to be 12-20 sessions of CT, depending upon the needs of the individual patient as determined by the CT therapist. Ideally, sessions are held twice weekly for the first month or even longer if indicated. Thus greater treatment intensity during the first month is helpful to effect more rapid cognitive and behavioral change. Thereafter sessions are held weekly until the termination phase of the therapy when sessions may be biweekly for one month two months and then monthly for the final one or two sessions.

Studies have consistently shown CT to be as effective as pharmacotherapy for depressed individuals. In an interesting study, Hollon et al. (1992. Appendix XX) found that cognitive therapy alone was as effective as imipramine hydrochloride therapy. Initial severity did predict response within the pharmacotherapy group but not in the CT group. Combining CT and medication therapy did not markedly improve response over that of either modality alone and the authors found only indications of a modest advantage of combined treatment.

Stages of Treatment

Major Components of Cognitive Therapy

[J. Beck, chapters 2,3,4,5,14]

[Appendix A]

Structuring Sessions

Each CT session has 3 or 4 surprisingly discrete segments. The initial portion of the session includes an update on symptoms and progress, a review of homework, and setting an agenda to: the remainder of the session. It must be recognized that failure to review homework in a meaningful manner decreases the likelihood that future homework
assignments will be completed. It is also important for the therapist to realize that patients who complete homework assignments are more likely to respond to therapy as compared to those patients who do not do their homework assignments. The second portion typically addresses one or two problem areas using an appropriate cognitive or behavioral strategy. As therapy progresses, the type of strategies selected typically shifts from more behavioral to more cognitive in focus. Each transition point provides the therapist the opportunity to ask for feedback. The final segment is used to summarize the material covered in the session and collaboratively construct relevant and feasible self-help plans for homework. It is the therapist's responsibility to communicate the importance of homework and to fully integrate the notion of self-help within the therapy hour.

*Providing a Rationale*

- Socialize patient to cognitive approach
- Introduce therapy as a **skills-training approach**
- Emphasize importance of “**homework**”
- Inquire about expectations for therapy

*[Appendix B]*

- Ask for reactions to "Coping with Depression' (given to the patient after the first session)
- Listen to patients concerns and generate **problem list** of problems to be solved
- Introduce **cognitive model** (A-B-C's)
- Inquire about patient's explanations for problems they've encountered
- Examine **beliefs/thoughts** that underlie **affects** and **behaviors** in that situation
- Provide a **realistic alternative** cognitive conceptualization for current life difficulties
- Demonstrate how cognitive therapy will work
- Work through example by examining accuracy of beliefs
- Relate change in belief to change in affect and behavior
- Suggest how process could be applied to other problems on list
- Assign homework based on problem-list and example worked above
- Invite patient to summarize processes involved
- Use of CT Notebook beginning Session #1

Training in Self-monitoring

[J Beck, chapter 12]
[Appendix C]

- Rationale for systematic self-monitoring
- Specific training in self monitoring techniques - **Dysfunctional Thought Record**

- Often useful to relate moods to activities
- Can be adapted to other purposes (e.g., master and pleasure)
- Setting up homework as "no lose" experience
- Review self-monitoring with patient
- Let patient walk you through
- Invite patient to consider what it means

Behavioral Activation Strategies

[Appendix D]

- The more depressed, the more behavioral
- Use behavioral assignments to test patient's beliefs
- Always concretize and simplify

Specific examples:

- Activity scheduling (**WAS**): plan activities in advance
- Graded task assignment ("chunking" big task into component steps)
- "Success" therapy (start with something simple and easy to complete)
- **Mastery and pleasure** (scheduling specific tasks that produce each)
- Act first, comfort (or confidence) later

**Identifying Beliefs and Distortions**

*[J. Beck, chapters 6, 7, 8, 9, 13]*

*[Appendix E]*

- Identifying **beliefs**
- **Automatic Negative Thoughts** (ANT) versus "underlying beliefs"
- Recognizing automatic thoughts
- Use in vivo situations, role play, and imagery to identify thoughts
- Link specific thoughts to feelings and behaviors in specific situations
- **Dysfunctional Thought Record** (DTR)

*[cf. Appendix C]*

- Introduce first three columns first (ABC's)
- Be sure patient doesn't "contaminate" categories
- Rate intensity of affect and degree of belief
- Exploring underlying meaning system
- Link specific thoughts to specific affects
- Exploring meaning of specific thoughts (downward arrow)
- See if underlying beliefs make even better sense out of affects
- Use own empathetic reaction to assess adequacy of mapping
- Use reaction of "universal other" to assess adequacy of mapping
- Identifying **cognitive distortions** in information processing *[cf Appendix E]*
- Look for examples distortions in patient's thinking
- Describe other types of distortions and look for them
- Encourage patient to label distortions in thought records
Dealing with and Evaluating Beliefs

[J. Beck, chapters 10, 11, 12]
[Appendix F]

- Distraction and Thought-stopping
  - Distancing from beliefs
  - Three questions for evaluating beliefs:
    - "What's my evidence for that belief?"
    - "Are there any alternative explanations for that event?"
    - "What are the real implications even if that is true?"

Other useful questions:

- "What perspective would I have if this were happening to a friend?"
- "Is it functional for me to think about this right now?"

- Dysfunctional Thought Record
  - Use questions to examine beliefs
  - Rate degree of belief in alternative responses
  - Re-rate intensity of affect and degree of belief in automatic thoughts
  - Empirical hypothesis testing (experiments)
  - Problem-solving (develop action plan to deal with remaining problems)

Underlying Assumptions and Core Beliefs (Schemas)

- Use cognitive conceptualization to explore underlying core beliefs [cf. Appendix G]
- Core beliefs (traits assigned to self or others)
- Conditional assumptions (rules about how things work)
- **Compensatory strategies** (coping behaviors predicted on beliefs)
- Infer on basis of numerous instances of automatic thoughts
- Present as hypotheses, not as facts to be believed
- Invite patient to join in process of making sense out of core belief

*Underlying Assumptions and Core Beliefs (Schemas) continued*

- Historical reconstruction often highlights genesis of beliefs and attitudes
- Once formulated, concretize and test as you would any other belief
- Use **Core belief worksheet** to examine beliefs [*cf. Appendix H]*
- Relate specific automatic thoughts to underlying beliefs
- Reconsider conditional assumptions (rules) from more mature perspective
- Develop action plans that substitute more adaptive behaviors for compensatory strategies

*Relapse Prevention and Termination*

Relapse prevention facilitated by:

- Role playing potential problems (stress-inoculation)
- Emphasize skills training approach (e.g., "shower" analogy)
- Sensitize patient to looking for emergence of core belief
- Preparation for termination
- Start talking about it from first session onward
- Use as rationale for skills-training approach (e.g., homework)
- Explore “pros and cons” of continuing/discontinuing
- Treat reductions in session frequency as practice for termination