2321 Theory & Practice 2: Lecture 9

Contemporary Practice of Cognitive Therapy with Specific Problems (Depression)

Ian R. Ridgway PhD

Introduction

Aaron Beck first worked in research within the psychoanalytic tradition. Specifically, he was studying the dream content of depressed subjects and investigating the hypothesis that depression is the depressed person's anger turned back inwardly against the sufferer. Beck's attention was struck by the fact that the 'automatic thoughts' or thinking processes[1] of these depressed sufferers were distorted. With time, his findings led him to adopt the assumption that distorted cognition precedes (*and is causative of*) dysfunctional emotions and behaviour.[2]

A. Depressive Structure

If the surface of depression consisted of negative automatic thoughts, where do these thoughts come from? This question was answered in an important development in cognitive theory with a hypothesis of *dysfunctional schemas* or *core beliefs*. Such schemas were said to 'cause behavioral and emotional problems' (Westermeyer, 2003, n. p.). They began in early life[3] and are built up throughout life. Repeated negative experiences of abuse, neglect, and absence from parents and other loved ones may contribute to the formation of dysfunctional schemas which may leave the child with a feeling of being flawed. Such a schema (i.e., 'I'm flawed') renders the person vulnerable to depression.

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[1] As you are aware, Beck identified seven faulty thinking errors: arbitrary inference, selective abstraction, overgeneralisation, magnification and minimisation, personalisation, labelling and mislabelling, polarised thinking.

[2] We should note in passing that Beck's experience does not prove that depression is not anger turned inward. In fact, if depression is the sufferer turning anger against herself then one would expect her cognitive life to be distorted and distorting. Nor is it hard to see how such a process may arise. An abused infant feels unwanted and unworthy and concludes that she deserves to be punished for being as she is. So, she punishes himself in anger because the two are invariably linked in her experience. However, as we shall see, Beck and his associates have had to backtrack on a number of their early formulations.

[3] Early life founding of dysfunctional schemas begins to sound more like a psychodynamic emphasis!

In a further development, Westermeyer[4] (2003), drawing on the work of Judith Beck (daughter of Aaron Beck), addressed the question of why this feeling of being flawed may not felt all the time. For example, we might not feel flawed when we are complimented by others or when we do a task particularly well. Depending on our history, we might not feel flawed when we are warmly received and honoured by another person. Cognitive theorists asked themselves, what was operating in these situations that prevents the flawed feeling from surfacing?

They came up with two interconnected answers to this question:

- first, 'flawed'[5] persons develop ***conditional rules/beliefs*** which are expressed in the form of **if-then** statements,

- second, they develop **protective behaviours**.

Firstly, we examine the conditional rules/beliefs pattern. If, for example, warmth and honour from others has been associated with feeling OK about ourselves then we might develop the conditional rule, **'**If **others voice warmth and honour towards me** then **I might be OK'.** However, if such warmth and honour is not forthcoming then we develop the opposing rule: '**If others do not voice warmth and honour then I'm flawed'.**

These rules vary according to what has been associated with feeling OK about yourself. For example, if feeling OK about yourself has been associated with **perfect** accomplishments then your conditional belief may be, **If I do everything perfectly then I may not be flawed**, or, **If I don't do everything perfectly then I am flawed.**

[4] Westermeyer (2004: n. p.) has written a good practical article for what to do when depressed.
[5] Those who feel or sense they are flawed.

These rules are also known as 'protective' rules because they protect the person from falling into depression. However, they do this at a cost, the cost of a deep-seated vulnerability to life-long depression.

Summarising we can observe three levels (see diagram from Westermeyer Appendix A). First, the automatic thoughts level (e.g., 'I did a bad job' – because no one told me she thought it was good; 'I'm an idiot') which lie on the surface of the person's consciousness. At the deepest level, dysfunctional core beliefs such as 'I'm flawed' are stored.

And, next to that deep core structure are stored **conditional if-then protective statements.** The latter are believed to explain why depressed people dip in and out of depression.

The last aspect of this picture is 'protective' behaviours because they protect people against the activation of their dysfunctional core beliefs. Such behaviours for depression might include approval seeking, inauthentic behaviour, perfectionism, and avoidance (i. e., not doing things because one cannot do them perfectly).

Westmeyer emphasizes the point that negative automatic thoughts ***strengthen*** the whole dysfunctional system of automatic thoughts, protective rules and behaviour, and core beliefs. This occurs because inwardly saying that 'I'm an idiot' after failing to reach perfection in some endeavour reinforces perfectionistic behaviour, fortifies the conditional rule, and adds another memory to the core belief of 'I'm flawed'.

B. Treatment

Hence, the clinical implication of this structure is that therapy should focus on change at all four levels: automatic thoughts, protective rules and behaviour, and core beliefs.

1. Automatic thoughts

Unchecked automatic thoughts tend to strengthen the dysfunctional system and therefore, must be altered using a disputation of one's thoughts. To do this CT is invited to keep a record of thoughts and shown how to dispute them identifying the illogical patterns above. A 5-column technique can be used in which we place, from left to right, *situation, feelings, thoughts, errors, alternatives.* Every time this process works, a new, conflicting memory has been added to the system but more is better to get maximum benefit.

2. Conditional rules

Therapy aims to find conditional rules and establish more healthy options. After identification, the conditional rule is tested via cognitive disputing and behavioural experiments.

3. Protective behaviours

'Exposing oneself to behaviors which counter dysfunctional protective ones is a powerful part of cognitive therapy' (Westermeyer). For example, if perfectionism is an identified protective behaviour then have the CT purposely do something that is not perfect! However, Westermeyer recommends that such behaviours be changed *gradually* so that the process is not overwhelming. If a CT feels overwhelmed, she is likely to abandon efforts to change.

4. Core beliefs

Core beliefs are far more resistant to change than are automatic thoughts (which are the products of core beliefs). Cognitivists understand these beliefs to be 'our realities'[6]. Longer-term cognitive therapy attempts to modify and change these core beliefs. [How this is done is not discussed.]

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[6] This understanding follows from the assumption that the world around us has no inherent structure or order other than the one we autonomous human beings give it. Christians understand from revelation that creation is ordered by God's Word just as God's Word created it.

C. More Recent Developments

1. Rational Suggestion Therapy (RST)

RST may not appeal to some of you because of its association with hypnosis. However, RST attempts to respond to the fact that changing the "B" in the ABC of REBT is often very hard!

This difficulty is believed to rest on the fact that beliefs have an anchor in the *sub*conscious.[7] [8]The subconscious is understood as primarily *imagination*. RST accepts the notion that a conflict often exists between imagination (the subconscious) and thought (conscious). In such a conflict, imagination inevitably wins.

Hence, RST attempts to approach imagination and speak in its language of suggestion (affirmation). RST is defined as a 'hybrid' therapy that combines 'the therapeutic goals and philosophical foundations of RET . . . with the principles of cognitive suggestion' (Blumenthal, 1984: n. p.).

Araoz (cited in Blumenthal, 1984/2007: n. p.) proposed that autosuggestion[9] 'forms a subconscious predisposition to specific emotional and behavioral reactions'. Hence, 'we [humans] seem to be in a continual process of suggestion-reaction-suggestion' (Blumenthal). While various self-talk techniques are effective ways 'to intervene in unhealthy suggestion cycles' 'subconscious therapy' with 'rational suggestion' may provide an added boost to efficacy.

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[7] As far as I can ascertain, ***Pierre Janet***, a French psychologist who was an opponent of Freud's psychoanalysis, used this term. The psychoanalytic school invariably used the term unconscious. Note that the two terms are *not* synonymous.

[8] Also notice how this development accepts that the 'subconscious' may be an authentic part of human nature.

[9] This term implies an easy link with REBT's idea of self-talk.

RST is a cognitive technique because it aims its new, rational suggestions at ideas (irrational suggestions) (not at behaviour or emotion) believing that ideas[10] cause emotions and behaviour.

The therapist aims to identify the offending autosuggestion and help the CT to replace it. Baudouin[11] (cited in Blumenthal) observed that forcing new ideas upon the subconscious promotes resistance because we become 'obsessively concentrate[ed] . . . on the undesired idea' which leads to a frustration of 'the individual's willful efforts'.

But, how are we to overcome this apparent difference between the conscious and subconscious? We do it, says RST, by placing the CT into a more suggestible state of consciousness which can be reached in deeper states of relaxation.[12] The heightened state of suggestibility allows 'the subconscious . . . [to] . . . be addressed directly and purposefully' with appropriate suggestions.

2. Mindfulness-Based Cognitive Therapy (MBCT)

Another more recent development in the use of cognitive therapy for depression[13] has been the reaction to the observation that sufferers of depression are prone to go on experiencing successful bouts of the condition throughout life. Indeed, the time between these bouts tends to diminish over time believed to be because a smaller trigger can set off all the associated thoughts, feelings, and bodily sensations of the earlier depression(s). With depression being a major problem in health care and set to become even more of a burden on resources, it has become important to

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[10] One notes in passing that RST's theory seems very lax in its use of 'ideas' for in this context idea appears to mean 'suggestions'.
[11] A disciple of Emile Coué whose famous affirmation was, 'Every day and in every way I am getting better and better'.
[12] Without knowing it, some of you would have been entering these states when you did your relaxation assignment! If one tries to wilfully relax, relaxation does not come because relaxation is not something we can will to happen.
[13] MBCT also be used for anxiety. See Orsillo, Roemer, Lerner and Tull (2004).

devise treatments that will reduce this vulnerability to further bouts of depression.

Williams (2002) believes that in depression 'negative mood[14] occurs alongside negative thinking and bodily sensations of sluggishness and fatigue' and that 'when the episode is past, and the mood has returned to normal, the negative thinking and the body sensations tend to disappear as well'. However, the link between negative moods and negative thoughts does not disappear.

He states that knowing that this link between negative moods and negative thoughts is lying dormant, so to speak, in well people who have formerly suffered from a depressive episode, is of *singular importance*. Its importance lies in the fact that in order to prevent initially mild states of depression from becoming serious we need to *break the link* between the negative mood and ruminative thinking (either about the past or about the future).

Ruminating thought concerns itself with ceaselessly asking the questions of 'What is wrong with me?', 'Why is this happening to me?' and, 'How will this end?' It will also include the judgments, 'I am a failure', 'I am weak', I am a worthless person', or for Christians, 'I am a bad Christian, a bad witness, et cetera.' Another feature of the thinking of depressed people is that they tend to recall events in highly generalised, non-specific ways. For example, if asked to report an event that made them happy they will tend to say that, 'Going for walks'.[15] Overgeneralised memory tends to blur bad, neutral and good memories into each other. More importantly, present problems are much harder to solve because the past repository of successful problem-

[14] Note the use of the word 'mood' which is probably a better description for depression than feeling or emotion. Anger and fear tend to be more simple in structure, whereas depression seems to have a more complex structure and hence, are better termed 'mood'.
[15] In contrast, a non-depressed person might say, 'I went for a walk with Sally and we meet a very friendly dog and its owner'.

solving is indistinct. So, the word 'happy' does not conjure up specific activities that might help the person through his present difficulties. If this person were able to retrieve specific memories such as 'going with a friend to the theatre', and, 'having coffee with my wife at a local café', then more hints come to him about how to deal with his present blue mood.

Hence, two issues need to be addressed: the rumination that can quickly lead to an out of control, downward spiral into deeper depression and the 'overgeneralised' memory of the depressed person. (If I understand Williams correctly, he does not believe that we can prevent the negative mood that will follow some losses[16] but we can stop this mood plummeting out of control.)

How is this to be done? He recommends what is termed, 'mindfulness-based cognitive therapy'[17] [18]. According to Segal, Teasdale and Williams (2004: 51), the MBCT development occurred from the observation that CBT may not work so much because of changes to the *content* of CTs' thinking as to changes in CTs' '*relationships* to their negative thoughts and feelings'. When CTs repeatedly identify what they are thinking and then take distance from their thoughts to assess them for accuracy or appropriateness they are also taking a certain perspective to those thoughts. Although the notion of 'mindfulness' is associated with Buddhist practice where it is used to develop awareness that what the West calls the self does not exist, MBCT uses the technique in a western framework of thought which is stressed in the literature. I appreciate that some of you may reject this development out of hand because the technique comes from 'tainted' Buddhist sources.[19] Anything we adopt should be done with critical discernment humbling

[16] When you are counselling depressed people always look for losses and a pattern of further losses. Often, some kind of primal loss of mother/father/sibling may have occurred.
[17] A growing scientific and practical (see the Internet) literature exists on this procedure.
[18] See Appendix B for a mindfulness procedure.
[19] However, to use something from such a source is not necessarily a compromising of one's faith. Our days of the week come from pagan gods, as do our months of the year, as does the date of Christmas and our word for Easter. Our counting numbers came to us from a Hindu-Arabic source.

realising that the 'self' in the West is an autonomous idol demanding its freedom from the sovereign God.[20]

MBCT was specifically developed to reduce the likelihood of depressive relapses. Mindfulness training is somewhat similar to what you have done with your relaxation tapes but it is much simpler in terms of the given instructions. However, one should not mistake simple for undemanding. As most of you found out relaxing is a demanding exercise particularly for Westerners who always like to be busy. One Eastern spiritual approach asks its followers simply to sit. We all think this is easy to do until we start to do it. Then our minds start to wander onto what we have done during the day, or what we still need to do, or have to do tomorrow or we become bored. All of this experience is valuable and is normal. We talk about how good it would be to stay in the present more often but when faced with the opportunity we flee away from it (as Fritz Perls once commented).

MBCT aims to increase one's awareness of 'present, moment-to-moment, experience' by tuning in to one's bodily sensations and focussing on one's breathing. When one practises this procedure as a consistent pattern 'cycles of ruminative thinking' are interrupted and hence, the conditions, which can lead to a negative mood becoming established, are destabilised. Williams and colleagues have conducted research that indicates the reduction of rumination in those that have practised mindfulness.

Alongside this positive development, the issue of recall of the past has also been researched. A mindfulness training group recalled its past more specifically as opposed to a control group after an 8-week period. Therefore, both issues that are raised by the recurrence of depression (damaging ruminations and overgeneralised memory) seem to be addressed by the use of MBCT.

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[20] My comments do not mean that I accept Eastern monism with its egoless-ness either.

D. Concluding Comments

1. MBCT still claims to be a Cognitive Therapy but uses a method that runs somewhat counter to its normal procedure. Is the 'mind' of MBCT our western notion of mind which is dominated by intellect and reasoning or is it more like the middle-eastern mind of the Ss? 'You shall love the Lord your God with all your heart, soul, mind and strength'. Nevertheless, I would allow that the kernel of this method can be situated within a Christian understanding of humanness as breathing, embodied image of God.
2. MBCT can be used with anti-depressant treatment in which, because of my own experience, I am a strong believer. However, medication does not seem to work for everyone for a number of reasons, one of which is lack of skilled but empathic clinicians who have had *personal* experience of the side-effects of medications which can be very distressing!
3. The Stoic connection that I have talked about bedevils all cognitive-type therapy. When we argue that thinking or beliefs should control strong moods, emotions, feelings we are implicitly assuming that the Fall did not affect the former but did affect the latter. We are also assuming that the rational aspect defines whom we are but we are not just rational selves.

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APPENDIX A

Figures taken from Westermeyer (2002: n. p.).

The configuration of core beliefs, rules, and protective behaviors leads to distorted automatic thoughts which strengthen the existing style of thinking and behaving at all levels.

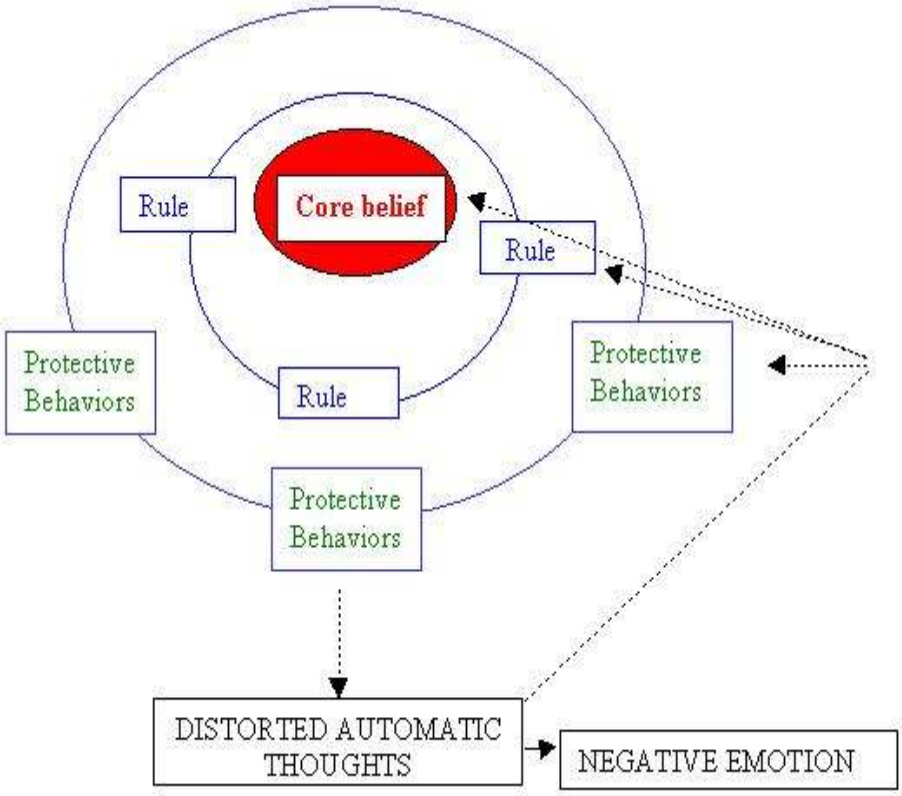

Figure 1 Structural Model

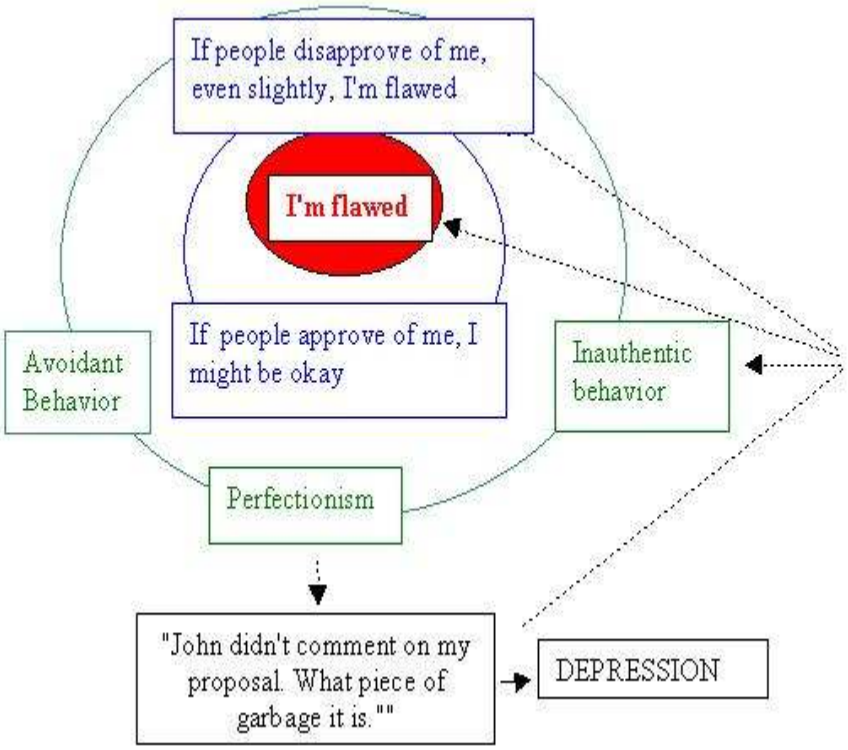

Figure 2 Example

APPENDIX B

A 3-minute Breathing Space is described by (Williams, 2002: 1-3) in 3 stages as awareness, gathering, expanding.

- In the **first stage**, there are three actions.
  First, You bring yourself into the present moment by sitting erectly and closing your eyes. *Second*, you then ask yourself, 'What is my experience right now …. in thoughts …..in feelings ….. and in bodily sensations?' *Third*, you acknowledge and register your experience, even if it is not wanted'. [This last direction is most important because, as some of you found out in your relaxation, not all your feelings are necessarily nice. But, if we can just allow them to be, sometimes they will dissipate and float away. Allowing the undesirable just to be there is one of the techniques used by Albert Ellis, a westerner! He derived it from the Stoics.]

- **Second stage**, gathering
  Direct your full attention to your breathing. Watch what happens as you breathe in and out.

- **Third stage**, expanding
  Expand the field of your awareness around your breathing so that it includes a sense of the body as a whole, your posture and facial expression.