A study of the effects of cognitive therapeutic techniques in depression with specific attention to hopelessness

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ABSTRACT
SOCIAL WORK

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A STUDY OF THE EFFECTS OF COGNITIVE THERAPEUTIC
TECHNIQUES IN DEPRESSION WITH SPECIFIC
ATTENTION TO HOPELESSNESS

Advisor: Anne Fields-Ford, Ph.D.

Thesis dated May, 1995

The overall objective of this single systems research
design was to reduce symptoms of depression, specifically
feelings of hopelessness, in a person suffering from
clinical depression. The Beck's Depression Inventory was
used to rate the severity of depression and feelings of
hopelessness. The study introduced cognitive therapeutic
techniques as a method for decreasing symptoms of
depression, specifically feelings of hopelessness.
A STUDY OF THE EFFECTS OF COGNITIVE THERAPEUTIC
TECHNIQUES IN DEPRESSION WITH SPECIFIC
ATTENTION TO HOPELESSNESS

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
ALYCE ELLINGTON WELLONS

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
MAY 1995
TABLE OF CONTENTS

LIST OF FIGURES ........................................ iii

Chapter

I. INTRODUCTION ........................................ 1
   Scope of the Problem .................................. 1
   Purpose of the Study ................................ 7

II. LITERATURE REVIEW ................................. 8
   Historical Perspective .............................. 8
   Research Studies .................................... 10
   Cognitive Therapy and Depression ................ 12

III. METHODOLOGY ....................................... 16
   Research Design ..................................... 16
   Study Design ........................................ 16
   Treatment Intervention ............................. 18
   Case Information ................................... 19
   Intervention Strategy and Plans ................. 21

IV. PRESENTATION OF FINDINGS ....................... 29
   Graph 1 .............................................. 34
   Graph 2 .............................................. 35
   Limitation of the Study ........................... 36

V. CONCLUSION ........................................... 37
   Implications for Social Work ....................... 38
   Recommendations for Future Research ........... 38

APPENDIX
A. Measuring Scale Used to Conduct the Evaluation . 41

BIBLIOGRAPHY. ........................................... 44
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Severity of Depression</td>
<td>34</td>
</tr>
<tr>
<td>2.</td>
<td>Hopelessness in Depression</td>
<td>35</td>
</tr>
</tbody>
</table>
CHAPTER ONE
INTRODUCTION

Scope of the Problem

While depression is the oldest known psychiatric disorder dating to ancient times, its causes remain unknown. Some refer to it as the "common cold" of emotional problems because it is so widespread, knows no economic, social, cultural, or religious barriers. Approximately forty million Americans suffer from depression at any given time. Depression is a disorder marked by a range of simple to complex feelings and experiences in a variety of life domains. These feelings and experiences are noted as sadness, increase or decrease in appetite, increase or decrease in time spent sleeping, early wakening, feelings of rejection and hopelessness, thoughts of suicide or wanting to die, lack of interest in sex, difficulty concentrating and making decisions, quicker to anger than usual, crying spells, and feeling especially pessimistic. Major Depressive Disorders are twice as common in adolescent and adult females as in adolescent and adult males. Rates of depression in men and women are highest in the 25 to 44 year old age group and lower for both men and women over age

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Thus, more women are diagnosed with depression, specifically women between the ages of 25-44. Depression is more than a feeling of down in the dumps. Depression is accountable for sixty percent of all suicides. The depression constitutes one in 200 episodes of depression. The National Institute for Mental Health reports that one in every five Americans, forty million people, have significant symptoms of depression at any one time. University of Pennsylvania researcher Martin Seligman estimates that Americans lose four billion dollars a year in lost work and medical bills due to depression. The danger of depression is that the longer it goes untreated, the more likely it is to become chronic and seriously damaging. It is evident that depression has an impact on both the individual and society.

A person suffering from depression experiences many repercussions due to their illness. Depression can break up marriages, cost jobs, hamper the capacity to mother, and interrupt friendships. In some instances a bout of

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3"Depression," Newsweek, 4 May 1987, 48.


5Ibid.

6"Depression," Newsweek, 4 May 1987, 48.

7Ibid.
depression may begin with an ordinary response to a situation like the loss of a loved one or a change of job. Feelings of sadness and being "blue" that accompany these events may linger and eventually begin to interfere with daily functioning. At this point, it is valid to label this as depression and seek some professional help. Clinical Depression has been described as experiencing a terrifying aloneness and a sense of being strangely outside, like ghostly spectators of their own lives. Others describe depression as falling into a pit of loneliness, being preoccupied with a sense of despair, feeling tired and sapped of energy. Depression can also be misdiagnosed. This misdiagnosis is due to subjects reporting the physical symptoms such as eating too much or too little, needing more or less sleep, being constipated, having a churning stomach, experiencing impotence or frigidity, headaches, or backaches, instead of the emotional feelings of sadness, hopelessness, and other symptoms previously mentioned. Therefore, it is important to be very aware of the symptoms of depression and to know that it can be treated by counseling, antidepressant drugs, or sometimes, in extreme cases, electric shock therapy.

Thus, there are many components of depression and are perhaps best considered in terms of emotional and accompanying physical states. These include sadness,

hopelessness, sense of failure, dissatisfaction, guilt, expectation of punishment, self-dislike, suicidal ideas, irritability, indecisiveness, self-accusations, crying, social withdrawal, and body image change. The component of depression in this research is hopelessness. There is a vast difference between feelings of sadness and melancholy and feelings of hopelessness. The literature also lists symptoms to look for if one feels they are depressed. It is also very important to look at those depressed individuals who are so stricken that they feel as if they cannot possibly go on day to day. Severe feelings of hopelessness in depression can be immobilizing. Although hopelessness is not always a presenting symptom of depression, and may not occur at all, it is a severe symptom of depression which is closely related to suicide. Hopelessness in depression has been described as feeling so depressed that life is not worth living anymore while also feeling like if they attempted suicide they would "probably mess that up too."

Hopelessness as a symptom of depression can be influenced by self-defeating self schemas and thus can be linked to the cognitive ecological system whereby the role of a self describes factors that demonstrate the relationship between self-schemas and the outside world.\[^{10}\]

\[^{9}\]Ibid.

Self-concept can be thought of as a set of schemas (memories, beliefs, feelings) which one holds about himself. Schemas refer to the manner by which bits of information are organized into meaningful wholes and stored in memory. Schemas are a type of cognitive structure as they are ways in which one views himself. Self-schemas often exert a distorted influence on what one expects, what one sees, how one interprets that view. Within a cognitive ecological frame, a negative self schema will influence how one views himself, reflects how others may view him, and how he views himself in society. If a person develops and maintains a negative self-schema, this will influence and sustain the feeling of hopelessness. Thus, self schemas are grounded in cognitive theory from which cognitive therapeutic techniques are derived.

One technique used to reduce feelings of hopelessness as an aspect of depression is to use cognitive restructuring. To use an individual’s negative and self defeating self schema to explore her view of herself, how she feels others view her, and her place in society. Cognitive restructuring is particularly useful in helping subjects become aware of self-defeating thoughts and misconceptions that impair personal functioning. Cognitive restructuring helps the subject replace these harmful and

\[11\text{Ibid., 52.}\]

\[12\text{Ibid., 53.}\]
negative beliefs with beliefs and behaviors that are aligned with reality and lead to enhanced functioning.\textsuperscript{13} Cognitive restructuring techniques have been found to be particularly useful with people suffering from low self esteem, unrealistic expectations of self and others, irrational fears, anxiety and depression. Thus, cognitive restructuring techniques are appropriate for someone suffering from feelings of hopelessness and depression. Research studies have documented that cognitive/behavioral therapy is one of the two major psychotherapeutic approaches that produces outcomes equivalent to those produced by antidepressant medication.\textsuperscript{14} Thus, use of cognitive restructuring with someone experiencing symptoms of depression, specially hopelessness, has had strong positive results.

Thus, depression is an ancient disorder without known causations. It effects vast numbers of people, most especially men and women between the ages of 25 to 44, with a greater percentage of women than men. Hopelessness is cited as one central symptom of depression. While a number of therapeutic interventions have been constructively practical, cognitive therapeutic techniques have been found to be among the most useful.


\textsuperscript{14}Ibid.
Purpose of the Study

The purpose of this study is to determine the effectiveness of cognitive therapeutic techniques, i.e., cognitive restructuring, in reducing depressive symptoms, specifically hopelessness, in a 23 year old female with a diagnosis of clinical depression.
CHAPTER TWO

LITERATURE REVIEW

The literature review in this research is organized by noting the lengthy known history about depression, reporting research studies on depression and cognitive therapeutic interventions, and defining cognitive therapy and its usefulness in treating subjects with depression.

Historical Perspective

In the fourth century BC depression was first recognized as a medical problem rather than an affliction by the Gods. Hippocrates first attributed mood change to natural rather than divine causes. It was not until the Renaissance that emphasis shifted permanently toward natural causes for mood disorders. The care for people suffering from depression has varied in the quality since this time and until this century, asylums continued to be the principle service system for people suffering from depression.

Today, depression is categorized as unipolar, in which depression is followed by a return to normal mood; and bipolar, in which depression often alternates with episodes of intensely heightened mood, or mania. Unipolar disorder occurs more frequently in women with the lifetime risk for a major depressive episode being 20 to 26 percent, 8 to 12
percent in men.\textsuperscript{1} For purposes of this research, unipolar depression will only be discussed.

Currently it is estimated that at least five percent of the population suffer from unipolar disorder; yet because depression often goes unrecognized, and less than 6 percent of its victims ever seek or receive treatment for their illness, the incidence is probably higher than these figures suggest. Unipolar depression is more severe and prolonged than a simple case of "the blues". Depressed subjects report they are unable to experience pleasure, have a low energy level, ordinary tasks become overwhelming, future becomes bleak, they experience sleep disturbances, weight loss or gain, have a decline in self-esteem, concentration, calculation, and decision making. The overriding characteristic of the illness is the appalling sadness and hopelessness that pervade the subjects life.\textsuperscript{2} As depression is an illness, it can have a disastrous outcome. Depression is linked inextricably with suicide. One person in six with an affected disorder, if untreated, eventually commits suicide.\textsuperscript{3} Analysis of social and psychological factors to depict depression has proven to be fruitless. Character traits, genetic predisposition, and family

\textsuperscript{1}Richard M. Restak, M.D., \textit{The Mind} (Toronto: Bantam Books, 1988), 175.

\textsuperscript{2}Ibid., 169.

\textsuperscript{3}Ibid., 172.
histories cannot determine who gets depression. All that is known for certain is that in at least 60 percent of depressive episodes, no precipitating psychosocial factor can be pinpointed.4

**Research Studies**

In the early 1950’s it became clear that certain medications strongly affected mood. Presently there are two classes of antidepressant medication: tricyclic and monoamine oxidase inhibitors (MAOIs). Both of these antidepressants alter neurotransmitters in the brain in slightly different ways. It is important to note that depression is not limited to neurotransmitter balance and brain function alone. The endocrine and immune systems, which affect every organ system within the body, are also involved in depression. Research in these areas is being pursued but at present, studies of the human brain offer the best "window" for observing the biology of depressive illness.5 A study begun in 1981 compared four treatments of depression: cognitive therapy, interpersonal psychotherapy, drug treatment with the imipramine, and placebos. Two hundred and thirty nine subjects all suffering from unipolar depression, an average age was thirty five, 70 percent were women and all were outpatient.

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4Ibid., 176.

5Ibid., 183-184.
By the end of the trial period there was no significant difference in outcome for any of the forms of the three forms of treatment including cognitive therapy, interpersonal psychotherapy, and drug treatment with imipramine. The untreated subjects showed a slower recovery rate. The findings of this research certainly suggest that talking therapies relieve depression as effectively as drug treatment with imipramine.6

Another study compared cognitive therapy with one of the most widely used antidepressant drugs, Tofranil. Forty severely depressed subjects were randomly assigned into two groups; one group would receive cognitive therapy sessions and no drugs while the second group received Tofranil and no therapy.7 This type of either or research was used as it provided the maximum opportunity to see how the treatments compared. At the end of the 12 weeks, 15 of the 19 subjects treated with cognitive therapy showed a substantial reduction of symptoms. In contrast, 6 of the 25 subjects assigned to the anti-depressant therapy had no known complete recovery as eight subjects dropped out due to medication side effects, and 12 others showed no improvement or partial improvement. The psychological tests and follow-up reports indicated that the cognitive therapy group

6Ibid., 191.

continued to feel substantially better, and these statistics were substantially significant.  

As more women are diagnosed with depression than men, it is important to locate a therapy that works equally well. A study conducted found that both men and women suffering from major depression had generally similar outcomes over a time limited course of cognitive behavior therapy. The depressed male and female study groups generally had comparable outcomes, subjects with higher scores on the Hamilton Depression Inventory had a significantly poorer outcome than did the subjects with less severe depression. This finding indicates that cognitive behavior therapy may be less effective for severe depression and more appropriate for moderate depressive episodes.

Cognitive Therapy and Depression

For this research, cognitive therapeutic techniques were emphasized as it was used to treat the subject. Cognitive therapy is a form of psychotherapy that appears to work well with depressed subjects. A cognitive therapist states that the goal of cognitive therapy is to relieve emotional distress and other symptoms of depression. He

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8Ibid.

9Restak, The Mind, 190-191.

states that the means to this goal is to focus on the subjects misinterpretations, self-defeating behavior, and dysfunctional attitudes. The therapist should be able to identify the linkage between negative thoughts and negative feelings.11

The cognitive therapeutic approach brings to the understanding and treatment of depression the subjects everyday experiences. The subject can regard her disturbances as related to the kinds of misunderstandings she has experienced numerous times during her life. The cognitive therapeutic approach makes sense to a subject because it is related to their previous learning experiences and can stimulate confidence in her capacity to learn how to deal effectively with present misconceptions that are producing painful symptoms. Rather than regard herself as a blind creature with biochemical impulses and unconscious emotional drives as other forms of therapy may suggest, a subject can regard herself as prone to learning erroneous, self-defeating notions and capable of unlearning or correcting them as well. By pinpointing the fallacies in their thinking and correcting them, she can create a more fulfilling life for herself.12


The basic principle of cognitive therapy, according to Dr. David Burns, is that a person’s thoughts determine get moods. Feelings are created not by the events that occur in one’s life, but the way one interprets them. When a person is depressed, her cognitions, or thoughts, are usually negative and reflect a sense of hopelessness that the subject may be reporting as a symptom of her depression. Cognitive therapy combines behavior therapy methods and techniques to change the way the individual thinks about herself and perceptions of events. Aaron T. Beck, a cognitive therapist, suggests that individuals prone to depression have developed a general attitude of appraising events from a negative and self-critical viewpoint. They expect to fail rather than succeed and may tend to magnify failures and minimize successes in evaluating their performance. Also, depressed people tend to blame themselves when events go wrong, even when situations are completely out of their control, such as the weather or other people’s actions. Although there are a number of therapeutic approaches available to treat depression, it is evident that cognitive therapy has been found to be among the most useful. The literature suggests that cognitive

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13Sanchez, "A Practical Approach to Depression," 1.

14Ibid.

Restructuring techniques are useful in treating depressed subjects while dealing primarily with their negative perceptions of self and events surrounding their daily life.
CHAPTER THREE

METHODOLOGY

Research Design

The type of research design employed in this study is the single systems research design. The subject underwent six weeks of cognitive therapeutic techniques at Fayette Counseling Center. Beck's Depression Inventory was administered to rate the severity of depression and hopelessness at the beginning of each session.

Study Design

The design employed in this study is a single symptoms design. An "A-B" was used to rate the severity of hopelessness in depression. Bloom and Fisher refer to the "A-B" design as the simplest logical structure permitting a planned comparison between two elements. The two elements of comparison for this research were depression with specific attention to hopelessness and cognitive therapy.

Design "A", the Beck's Depression Inventory (BDI), was used to rate the severity of hopelessness as a component of depression. Design "B", Cognitive restructuring, was the intervention used to determine its effect on the subject's hopelessness in depression.

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The Beck Depression Inventory is a 21 item measurement used to assess the severity of depression in adolescents and adults. The Beck Depression Inventory was based upon clinical observations and descriptions of symptoms frequently given by depressed psychiatric patients as contrasted with those frequently given by non-depressed psychiatric patients. The observations were consolidated into 21 symptoms and attitudes which could be rated on a 4-point scale ranging from 0-3 in severity. The means, standard deviations, percentages of item endorsement, and corrected item-total correlations of the revised Beck Depression Inventory have been presented in the "Beck Depression Inventory Manual". Reliability estimates based upon Cronbach's coefficient alpha for mixed, single episode major depression, recurrent episode major depression, dysthyemic, alcoholic, and heroin addicted patients are .86, .80, .86, .79, .90, .88, respectively. These estimates are consistent with mean coefficient alphas reported by Beck, Steer, and Garbin (1988) of .88 for the Beck Depression Inventory in a meta analysis with nine psychiatric samples and .91 for 15 non-psychiatric samples. Therefore, the Beck

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Depression Inventory is determined to have high internal consistency in both clinical and nonclinical populations.³

The Beck Depression Inventory has been used in clinical psychiatric settings, hospital emergency rooms, mental health centers, and has been published extensively in books and articles discussing depression. Burns reports that many research studies in the past decade have demonstrated that the Beck Depression Inventory test and similar mood rating devices are highly accurate and reliable in detecting and measuring depression. Further support for the reliability is located in a recent study in a psychiatric emergency room, where it was found that a self-rating depression inventory actually picked up the presence of depressive symptoms more frequently than formal interviewing by experienced clinicians who did not use the test.⁴

**Treatment Intervention**

The intervention used in this research was framed in cognitive restructuring and emphasized that hopelessness in depression can be treated and relieved through cognitive restructuring techniques. Cognitive restructuring emphasizes that a person's cognitions about events determine her emotions, not the actual events themselves. Cognitions

³Ibid., 9.

are defined as either a thought or a visual image that you may not be very aware of unless you focus your attention on it. Since cognitions are automatic, habitual, and believable, the individual rarely assesses their validity. If a person's cognitions are self-defeating and negative, then the person may view herself in a very negative manner, thus resulting in feelings of hopelessness. These feelings of hopelessness are symptomatic of depression.

The developing approaches in cognitive therapy are designed to train the subject to identify and alter the cognitive patterns that are operating to arouse continued feelings of hopelessness. Thus, it is suggested in this study that training in altering distorted cognitions by identifying irrational thoughts and beliefs and teach the subject new ways of restructuring her automatic thoughts would reduce feelings of hopelessness, thereby alleviating feelings of depression, and enhancing a general sense of well being.

**Case Information**

For the purpose of anonymity throughout this research the subject will be referred to as Jane. Jane was a single 23 year old white female. She graduated from high school and completed three semesters of college. Jane sought counseling at the agency because she was experiencing

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depressive symptoms such as lack of appetite, loss of interest in past pleasurable experiences, feelings of hopelessness, sleeping much more than normal for her, lack of motivation, and a severe decrease in self-esteem. Jane reported that there was no specific precipitating reason for the onset of her depressive symptoms. She was currently unemployed and had worked previously as a cashier. She had been in counseling eight months prior for relationship difficulties but discontinued after three visits. During our contacts she lived with her father and stepmother. She had a distant and very turbulent relationship with her mother who lived out of state. Jane had a younger brother who was currently a freshman in college and with whom she was very close. Jane stated that her relationship with her mother had always been chaotic and that her mother verbally abused her for as long as she could remember, planting the seed for a lifelong pattern of decreased self esteem and feelings of hopelessness. She had been in several relationships previously and reported that they were all emotionally and physically abusive. She stated that these relationships built on her low self-esteem and added to her depression. She was involved with a man who was engaged to be married to another woman. Jane had implied that she was in this relationship because she knew it would not work out and she had added to the pattern of low self-esteem and feelings of hopelessness that accompany this.
Jane believed that her depressive symptoms, specifically hopelessness had been a lifelong pattern beginning with her mother and showing up repeatedly in relationships with men. Jane's feelings of hopelessness showed themselves with a negative outlook on the future and the feeling that she would never amount to anything worthwhile. She had a lifelong dream of being a policewoman but had done nothing to work toward this goal as she believed she would never actually be hired. Jane reported that her cognitive distortions came from her mother, when Jane was a child, saying that Jane would never amount to anything and no one would ever love her. Jane reported that she had experienced depression throughout her life after she had been in bad relationships with people who treated her almost identically the way her mother did as a child.

Jane and I met once a week for six weeks. We met in a community mental health setting for one hour each session. During the first session she was introduced to the treatment intervention and the Beck Depression Inventory.

**Intervention Strategy and Plans**

**Preliminary Visit**

The subject was seen in a community mental health setting and was given a complete clinical evaluation that consisted of a mental status, history of present illness and past history. The subject had a fifty minute evaluation with an intake therapist who obtained a verbal picture of
the subject’s needs and situations which brought her to therapy.⁶ In clinical social work treatment, this process is referred to as psychological process in which the caseworker explores outwardly from the problem to areas that one theoretically expects will be related to it.⁷ Other leads may arrive from the content of the initial interview such as illnesses in the family, substance abuse issues, cultural frictions and so on. Psychosocial casework is important as it establishes a presenting problem to be dealt with in the intervention as well as allows for continued assessment of factors that may also be involved in the problem as mentioned above.⁸

First Interview

The therapist established a rapport with the subject by conveying and expressing genuine interest in her well being.⁹ The next step in the first interview was to conduct an inquiry regarding any expectations of the intervention and elicit any negative attitudes regarding self, intervention, or therapist. The therapist administered the Beck’s Depression Inventory at the subject. The therapist explained that this test rated the severity of

⁶Ibid., 409.


⁸Ibid.

depression and would be used at the beginning of each session to determine the severity of depression with specific regard to scores of hopelessness. The client and therapist pinpointed the most urgent and accessible problem with discussed. The problems to be discussed will consist of whatever concerns or problems the subject had stated during the interview. Lastly there was an inquiry to reactions toward present interview.

Interview 3

The third interview began following the same general format as the second interview. The Beck Depression Inventory was administered to rate the severity of depression with specific attention to scores of hopelessness. There was further instruction in identifying negative automatic thoughts (use "induced fantasy" of role playing if indicated). This consisted of asking the subject of any automatic negative thoughts she has experienced. Following was an explanation of how these automatic thoughts represent distortions of reality and are related to other symptoms of depression, such as hopelessness.

Interview 4

This interview followed the same format as the previous interview. The Beck’s Depression Inventory was administered to rate the severity of depression with specific attention to scores of hopelessness. The subject
and therapist reviewed schedule of activities with a special reference to mastery and pleasure as well as reviewed and discussed automatic negative thoughts. Mastery was explained to the subject as a sense of accomplishment when performing a specific task. It was crucial to specify that the judgment of degree of mastery must be based on her present state, not her ideal state. Pleasure refers to feelings of enjoyment, amusement or fun from an activity. Even a mild satisfaction, or pleasure, may help restore subject's morale and produce a sense of hope. The therapist demonstrated to the subject ways of evaluating and correcting cognitive distortions (automatic thoughts) by using the Daily Record of Dysfunctional Thoughts. Instruction began on using the Daily Record of Dysfunctional Thoughts. The Daily Record of Dysfunctional Thoughts is a chart with columns for situation, emotions around the situation, automatic thoughts from situation, rational response to automatic thought, and the outcome rating. The subject was asked to keep this record between sessions so she could follow the flow and pattern of dysfunctional charts. This record was helpful for the subject to become aware of her negative thoughts and distorted thinking patterns.
Interview 5

This interview followed the same format as above. The Beck Depression Inventory was administered to rate the severity of depression with specific attention to scores of hopelessness. The therapist and subject continued to remove psychological blocks to return to a pre-depression level of functioning. Psychological blocks included any defenses, doubts, or unconscious negative feelings the subject had toward therapy that reduced her efforts to move forward.

The subject and therapist verbally discussed any psychological blocks the subject had and worked on removing them through discussion. Specifically this entailed engaging the subject’s attention and interest to the therapist’s attempts to induce the subject to counteract her withdrawal and become involved in more constructive activities. The therapist further demonstrated to the subject rational responses to automatic thoughts by going over the Daily Record of Dysfunctional Thinking with the subject. The Daily Record of Dysfunctional Thinking was examined for logic, validity, adaptiveness, and enhancement of positive behavior versus maintenance of pathology.

Lastly, there was a discussion of Basic Assumptions. Basic Assumptions refer to organization and perception of the world that a person organizes as she furthers through developmental patterns. Basic Assumptions determine how she sets goals, evaluates behaviors and comes to terms with
events in her life. If these basic assumptions are maladaptive, then the subject may be continually perceiving and reacting to her world in a way which does not "work". Basic Assumptions are also termed as a subject's niche and schema as explained in Social Cognition and Individual Change by Brower and Nurius. A niche describes a system of interdependent parts it develops by evolving over time into a system of intricate relationships, where each component has adapted to each other as changes are encountered, and where each component depends on the other for survival. In this niche, one knows the rules, what to expect from others and we are afforded some predictability in our lives. Schemas are essentially or "life stories". Schemas are a reflection of our sense of self, and allow us to interpret events and respond to them based on past experiences. Generally, a depressed individual has a negative self schema and niche. Cognitive restructuring enables an individual to reconstruct these schemas and niches and form new more positive and healthy ones. These basic assumptions, niches, and self-schemas were articulated by the subject and examined by the subject and therapist.

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10Brower and Nurius, Social Cognition and Individual Change, 45-47.

11Ibid., 15.
Closing Interview 6

Preparation began for the subject for termination of therapy. The Beck Depression Inventory was administered to rate the severity of depression with attention to scores of hopelessness. There was an emphasis of practice strategies described in *Coping in Depression* after the termination and emphasis on psychotherapy as a learning process that continues throughout the individual's life. The subject understood that cognitive therapy is a time limited process and that the treatment is of an educational nature. The therapist explained that the subject is learning specialized knowledge, experience and skill in dealing with certain types of problems. Initial goal of therapy was discussed and reinforced to teach the subject that the process has been about handling problems more effectively instead of "curing" her. The subject was encouraged to handle future problems as challenges that will help consolidate her gains and not roadblocks or impossible situations. The most important of the above mentioned is delineating of anticipated problems and rehearsal of coping strategies.

Hepworth and Larsen provide an outline for the preparation and handling of termination with a client in *Direct Social Work Practice*. They state that there are four major aspects of termination which include assessing when the individual goals have been satisfactorily attained, effecting successful termination for the helping
relationship, planning for maintenance of change and continued growth following termination, and evaluating the results of the helping process. All of these aspects were dealt with through talking with the subject about termination, using the educational component of cognitive restructuring for ongoing maintenance, and evaluating goal attainment through testing with the Beck Depression Inventory and subject self reporting of depressive symptoms.

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CHAPTER FOUR
PRESENTATION OF FINDINGS

The following graphs 1 and 2 presented on the following pages represent the findings of this research. The Beck’s Depression Inventory was the instrument used for rating the severity of depression and rating the feelings of hopelessness.

Figure 1 represents the severity of depression which was rated at the beginning of each session for six weeks of the intervention. The first day of the intervention the subject scored a rating of 11 on the Beck Depression Inventory and a rating of 0 on the hopelessness subscale, indicating a moderate mood disturbance. The highest score possible on the Beck Depression Inventory is 40, indicating a Moderate Mood Disturbance and Clinical Depression. The highest score possible on the hopelessness subscale was a 3, indicating suicidal tendencies. The subject never scored above a 1 on the hopelessness subscale, indicating a presence of hopelessness without suicidal ideation.

Subsequent to a discussion of the procedures of the intervention framed in cognitive therapy and urging the subject to read Coping with Depression the client scored a rating of 31 on the Beck Depression Inventory and a score of 2 on the hopelessness subscale on her second visit. She attributed the increase in score to becoming more aware of the symptoms of depression and negative ways in which she
viewed her surroundings. She stated that she became more aware of depression by reading *Coping with Depression*.

As the process of being conscious her daily automatic thoughts began in session 3, the subject began to decrease her depressive symptoms and scored a 10 on the Beck Depression Inventory for an overall severity of depression and a 1 on the hopelessness subscale on her third visit. On the fourth visit the client continued to verbalize a reduction in depressive symptoms and scored an 11 on the overall severity of depression and a 1 on the hopelessness subscale. On the fourth visit, the client was instructed on using the Daily Record of Automatic Thoughts chart. This was done so the subject would be able to chart her every negative thought and assess these thoughts for validity. She reported an increase in mastery over events which, in the past, had been hard for her to achieve such as spending time with her family at home, talking to her mother on the phone without losing her temper and crying, and working four hours a day at a gym. She also reported gaining more pleasure in activities from which she previously reported no pleasure such as spending time with her friends in a casual setting and spending time alone.

One day 5 of the intervention, the subject scored a 9 on the Beck Depression Inventory and 0 on the hopelessness subscale. The subject indicated that she had begun looking for a job on the police force, had scheduled several
interviews for other job possibilities, and was increasing her self-esteem by exercising and being with friends. She continued to use the Daily Automatic Chart to record negative thoughts and identify negative thought patterns. Also during the fifth session, the subject stated that she had talked with her mother and had remained calm while her mother verbally abused her about her weight and lack of a good job. The client stated that she informed her mother that she was not the person her mother was describing and told her mother to call her back when she could talk rationally and with respect to her. This was a huge challenge for the subject and she stated that it felt so good to stand up for herself to her mother. On the final day of the intervention, the subject scored a 16 on the Beck Depression Inventory and a 1 in the hopelessness subscale. The client attributes this slight increase to her being ill with a stomach virus and the past week of rainy weather. The subject was suffering from Seasonal Pattern Specifier, which is the onset and remission of Major Depressive Episodes at characteristic times of the year, such as fall and winter. The prevalence of winter-type seasonal pattern appears to vary, with younger people more at risk. Also, women comprise 60% to 90% of people suffering from this disorder. The high Beck Depression Inventory score and
hopelessness subscale score may be attributed to Seasonal Pattern Specifier Disorder.¹

Although the subject’s scores were increased, she related that she had been verbally abused over the weekend by someone she was in a relationship with and told him that she would not take this anymore and put him on a bus home. This behavior of standing up for herself and taking charge of her life reflects the positive benefits of cognitive therapy the subject had been receiving during the intervention. Her old habits of being verbally abused by people were being challenged by her desire to increase self-esteem and self respect and reduce feelings of hopelessness.

On the final session there was concentration given to using the techniques of charting negative thoughts and keeping an activity schedule as an ongoing process to be aware of cognitive distortions. There was also a discussion of schemas and niches in regard to the subject’s view of herself and the world. We discussed how the techniques focused on in the intervention were educational and can be used to handle future problems.

Figure 1 clearly represents a beginning increase of ratings of severity of depression and then a 3 week period of decreased symptoms. The subject stated that she believes

¹American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., 389.
her depression symptoms will continue to decrease as she applies procedures from the intervention in her daily life. Day 6 depicts an increase in the severity of the subject’s depression. She attributed the increase to her stomach virus and the rainy weather although her behaviors during that week reflected positive change and an increase in self-esteem.

Figure 2 clearly represents a pattern consistent with that of Figure 1. The subject’s feelings of hopelessness were clearly connected to the severity of her depression ratings on the Beck Depression Inventory. Her feelings of hopelessness went up in the second week but tapered off during three weeks of cognitive restructuring only to rise again during her illness and complaints of dreary weather.

The long period of stabilization and low scores on the Beck Depression Inventory and hopelessness subscale are representative of when the subject was doing the most work and using cognitive restructuring methods to treat her depressive symptoms.
FIGURE 1

SEVERITY OF DEPRESSION
FIGURE 2
HOPELESSNESS IN DEPRESSION

HOPELESSNESS SUBSCALE

WEEK
ONE  TWO  THREE  FOUR  FIVE  SIX
Limitation of the Study

The A-B design provides sufficient evidence that the intervention prompted measurable and observed changes in the subject’s social learning with respect to a reduction of depressive symptoms and feelings of hopelessness through cognitive restructuring. However, while the subject provided explanations for change, the A-B design does not permit control of many alternative explanations for why the results occurred as they did. Also, the A-B design is unable to pinpoint what aspect of the intervention was most influential in altering the subject’s behavior.

The subject may have not reported all her depressive symptoms accurately on the Beck Depression Inventory, causing the measurement to be inaccurate. The subject may have inaccurately reported her depressive symptoms because some symptoms such as low self-esteem, sadness, and hopelessness have always been with her and she did not view them as symptomatic of depression. The items on the Beck Depression Inventory are subjective and perceptions are likely to differ. Although the intervention, cognitive restructuring, did provide a time frame of 6 to 15 weeks, the least amount of time was chosen perhaps not allowing as much change to occur as possible given the long history of depression in the subject.
The findings of this study suggest that cognitive restructuring had a positive effect on the subject's feelings of hopelessness and depression. The goal of the study was to decrease depressive symptoms, specifically feelings of hopelessness in someone who was experiencing clinical depression through cognitive restructuring techniques. The subject used charting patterns of negative thoughts, Daily Activities Schedule, and ratings of Mastery and Pleasure over events to decrease depressive symptoms, specifically hopelessness.

The short time effect of cognitive restructuring has proven to be effective as the subject was receptive to cognitive restructuring techniques and expressed genuine desire to continue using cognitive restructuring techniques as a lifelong learning tool. Long term effect cannot be determined in this study, however, due to the enthusiastic approach of the subject and the clear positive effect of the intervention, it is reasonable to assume the long term effect would be congruent with the short term effects. The findings in this study would be valuable for clinicians who are in private or public practice and are looking for short-term therapeutic techniques with a client diagnosed with hopelessness and depression.
Implications for Social Work Practice

As social work practice in private and public sectors are moving toward managed health care and time limited approaches, cognitive therapeutic techniques will prove to be very beneficial. Time limited approaches provide value in the clinical practice arena. It is estimated that a subject will generally attend five to fifteen sessions. By using the cognitive restructuring techniques outlined in this intervention, a clinical social worker will be able to reduce depressive symptoms, specifically those of hopelessness in a focused, time-limited fashion. Social work agencies that use time limited approaches for the treatment of depression will find cognitive restructuring useful as it has potential for reducing depressive symptoms and provides a lifelong educational tool for the client to take with them in their daily life. Social workers in hospitals, public mental health agencies, family counseling centers, and private practice are able to use these techniques to reduce depressive symptoms in clients experiencing unipolar depression. This study has demonstrated that cognitive restructuring techniques has considerable power in reducing depressive symptoms, specifically hopelessness.

Recommendations for Future Research

Future research should caution against using such a short time-limited approach for cognitive restructuring
techniques. The literature suggests anywhere from 6 to 15 sessions and this study suggests that further sessions might have continued to reduce depressive symptoms, specifically hopelessness. Nonetheless, there was a considerable decrease in depressive symptoms, specifically hopelessness, for the major part of the intervention (see Figures 1 and 2). Based upon the Season Pattern Specifier, the subject reflected this behavior and reported an increase in the previously declining depressive symptoms. This suggests that if the intervention had been of longer duration, there might possibly have been another extended decline in the symptoms of depression, specifically hopelessness. Also, a recommendation should be made to use the Beck Depression Inventory to rate the severity of depression and a separate scale, The Beck Hopelessness Scale, to rate the severity of hopelessness.
APPENDIX A

MEASURING SCALE USED TO CONDUCT THE EVALUATION

Beck Depression Inventory

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can’t snap out of it.
   3 I am so sad or unhappy that I can’t stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I don’t get as much satisfaction out of things as I used to.
   1 I don’t enjoy things the way I used to.
   2 I don’t get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don’t feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don’t feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don’t feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don’t feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.
9.  0 I don't have any thoughts of killing myself.
    1 I have thoughts of killing myself, but I would not
        carry them out.
    2 I would like to kill myself.
    3 I would kill myself if I had the chance.

10. 0 I don't cry anymore than usual.
      1 I cry more now than I used to.
      2 I cry all the time now.
      3 I used to be able to cry, but now I can't cry even
          though I want to.

11. 0 I am no more irritated now than I ever am.
      1 I get annoyed or irritated more easily than I used
          to.
      2 I feel irritated all the time now.
      3 I don't get irritated at all by the things that
          used to irritate me.

12. 0 I have not lost interest in other people.
      1 I am less interested in other people than I used to
          be.
      2 I have lost most of my interest in other people.
      3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
      1 I put off making decisions more than I used to.
      2 I have greater difficulty in making decisions than
          before.
      3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
      1 I am worried that I am looking old or unattractive.
      2 I feel that there are permanent changes in my
          appearance that make me look unattractive.
      3 I believe that I look ugly.

15. 0 I can work about as well as before.
      1 It takes an extra effort to get started at doing
          something.
      2 I have to push myself very hard to do anything.
      3 I can't do any work at all.

16. 0 I can sleep as well as usual.
      1 I don't sleep as well as I used to.
      2 I wake up 1-2 hours earlier than usual and find it
          hard to get back to sleep.
      3 I wake up several hours earlier than I used to and
          cannot get back to sleep.
17. 0 I don’t get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven’t lost much weight, if any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

20 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.


"Depression". *Newsweek*, 4 May 1987, 48.


