

What Changes in Cognitive Therapy for Depression? An Examination of Cognitive Therapy Skills and Maladaptive Beliefs

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This study examined effortful cognitive skills and underlying maladaptive beliefs among patients treated with cognitive therapy (CT) for depression. Depressed patients ($n = 44$) completed cognitive measures before and after 16 weeks of CT. Measures included an assessment of CT skills (Ways of Responding Scale; WOR), an implicit test of maladaptive beliefs (Implicit Association Test; IAT), and a self-report questionnaire of maladaptive beliefs (Dysfunctional Attitude Scale; DAS). A matched sample of never-depressed participants ($n = 44$) also completed study measures. Prior to treatment, depressed patients endorsed significantly more undesirable cognitions on the WOR, IAT, and DAS compared with never-depressed participants. Patients displayed improvement on the WOR and DAS over the course of treatment, but showed no change on the IAT. Additionally, improvements on the WOR and DAS were each related to greater reductions in depressive symptoms. Results suggest

that the degree of symptom reduction among patients participating in CT is related to changes in patients' acquisition of coping skills requiring deliberate efforts and reflective thought, but not related to reduced endorsement of implicitly assessed maladaptive beliefs.

Keywords: cognitive therapy; depression; skills; maladaptive beliefs

COGNITIVE THERAPY (CT) FOR DEPRESSION (Beck, Rush, Shaw, & Emery, 1979) is a well-studied treatment with substantial evidence for its efficacy (DeRubeis, Webb, Tang, & Beck, 2010). While cognitive change has long been suggested as important to the therapeutic benefits of CT, the nature of the cognitive changes produced by CT remains unclear. Clarifying the nature of these changes is important to advancing a basic understanding of depression as well as elucidating the process by which therapeutic gains are achieved in CT.

As Barber and DeRubeis (1989) suggested, different kinds of cognitive change might explain the therapeutic benefits of CT. First, CT could help patients develop skills to cope with negative thoughts when they occur. Such cognitive change would involve deliberate, ongoing efforts to employ cognitive and behavioral strategies. These efforts require patients to understand, practice, and generalize a variety of skills during appropriate situations (Jarrett, Vittengl, Clark, & Thase, 2011). Alternatively, CT could help patients change their underlying maladaptive beliefs (e.g., If others do not approve of me, I am worthless) through therapeutic procedures that allow them to see that these beliefs are not reasonable, accurate, or

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adaptive. If patients changed their beliefs, they would be unlikely to have future negative thoughts related to their self-worth and therefore have less need to engage in ongoing effortful cognitive strategies to cope with their negative thoughts. The purpose of this study was to evaluate cognitive change in CT by clarifying the role of effortful (i.e., skill acquisition) and underlying (i.e., maladaptive beliefs) cognitive processes.

Assessment of CT Skills

In CT, patients learn skills to apply when experiencing negative moods that allow them to handle these experiences in more adaptive ways. Much of the skills taught in CT are related to identifying negative automatic thoughts and evaluating the accuracy of these thoughts. However, CT also involves other skills, including behavioral strategies such as how to engage in certain kinds of activities to improve one's mood. Therapists providing CT continually help patients develop new skills and enhance their use of existing skills to cope with negative moods. While several efficient measures of CT skills have been developed recently (e.g., Skills of Cognitive Therapy [Jarrett et al., 2011]; Cognitive-Behavioral Therapy Skills Questionnaire [Jacob, Christopher, & Neuhaus, 2011]), these measures each rely on patients' ability to report on their own mastery and use of CT skills (for a review, see Hundt, Mignona, Underhill, & Cully, 2013).

Barber and DeRubeis (1992) developed the Ways of Responding Scale (WOR) to assess patients' mastery of the coping strategies taught in CT. The WOR presents respondents with six hypothetical scenarios and some initial negative thoughts one might have in each situation. Using an open-ended response format, the WOR asks respondents to describe what their further thoughts and actions might be in each scenario. Responses are parsed into thought units and coded for whether each thought unit reflects a positive or negative coping strategy. A total score is calculated as the difference between the number of positive and negative responses.

The WOR has been used to examine change in coping skills over the course of psychotherapy in several studies. Barber and DeRubeis (2001) found that patients who participated in 12 weeks of CT for depression showed significant pre- to posttreatment improvements in WOR total scores ($d = .70$). Furthermore, greater changes in WOR total scores were related to greater improvements in self-reported depressive symptoms ($r = .54$). Across both cognitive and dynamic psychotherapies, Connolly Gibbons et al. (2009) found that patients experienced positive changes in WOR total scores ($d = .47$). Consistent with Barber and DeRubeis's (2001) findings, change

on the WOR was related to concurrent change in depressive symptoms (partial $\eta^2 = -.23$ for the Beck Depression Inventory [BDI] and $-.33$ for the Hamilton Rating Scale for Depression [HRSD]). While these studies suggest that the acquisition of CT skills is related to depressive symptom reductions in CT, they do not address the possibility that changes in underlying maladaptive beliefs may also occur during CT. In fact, evidence of improvements in WOR scores could be due to changes in maladaptive beliefs that reduce patients' tendency to report negative coping strategies because they are less likely to experience negative thoughts.

Assessment of Maladaptive Beliefs

Assessing changes in underlying maladaptive beliefs in a way that is not likely to be contaminated by individual differences in CT skills requires careful consideration of the available methods of measurement. Self-report questionnaires, which are often used to assess depression-related beliefs, can be susceptible to self-presentation and expectancy biases. For example, a patient who has completed a course of CT has likely learned what types of beliefs his or her therapist views as adaptive. We suspect that some patients may be motivated to endorse these desirable responses even though they do not fully believe them. In this case, self-report measures would fail to capture important individual differences in underlying beliefs that are not contaminated by the desire to give adaptive responses. A number of researchers have developed methods of assessing implicit cognition that minimize or eliminate these potential self-presentational biases (see Petty, Fazio, & Brinol, 2008). One promising method of assessing implicit cognition is the Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998). IATs are computer-based tasks that measure the ease with which individuals can associate two concepts. Participants' rapid categorization provides an indirect assessment of beliefs, even though the task does not involve a direct query regarding the belief of interest (Greenwald, Poehlman, Uhlmann, & Banaji, 2009). For example, an IAT assessing gender stereotypes might ask participants to categorize words into the categories of male versus female or science versus liberal arts—but do so using only one of two response keys. By altering the response mapping across blocks of the task, the gender-IAT examines whether participants are faster to respond when the keys are labeled “male/science” and “female/liberal arts” than when they are labeled “female/science” and “male/liberal arts.” Differential latencies across the response mappings provide an estimate of participants' beliefs regarding the association of gender with science or the liberal arts—beliefs that some people may hold but be

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