Mental Health and Society week 8
Models of depression and therapies for depression

Behavioural models: Depression as a lack of reinforcement
Associated with the work of Lewinsohn (e.g. Lewinsohn et al, 1984; Lewinsohn & Arconad, 1981) who suggests that depression can be caused by a reduction in positive rewarding experiences. As they become more depressed they have fewer sources of reward and thus enter a vicious circle of depression. Even in family settings, depressed people may receive fewer reinforcing comments from family members than nondepressed people (Libet and Lewinsohn, 1973; Lewinsohn & Schaffer, 1971). Depressed people report fewer reinforcing events when asked to keep a 'pleasant events schedule' diary (Lewinsohn et al, 1979). Moreover, depressed people report more negative events in the field of health, finances, professional and academic activities, social activities (Lewinsohn, 1975) Depressed people may actively avoid pleasureable events (Carvalho and Hopko, 2011).
The role of social reinforcement: Evidence for the vicious circle idea of depression comes from findings such as Boyce et al (1993) where depressed people had greater difficulty than nondepressed people with self disclosure, worried about separation from loved ones, feared rejection and misread social situations. In addition Coyne (1976) found that people who had a phone conversation with a depressed person felt worse than usual. In a study by Gottlib and Robinson (1982) people interacting with a depressed person became less verbal, less supportive and less cheerful.
This evidence is *correlational* rather than *causal.*
Implications for therapy: As a result of this theory and evidence Lewinsohn and his colleagues have tried a number of therapies with depressed people. These may involve
1) Reintroducing pleasurable events: This begins with the client completing schedules of pleasant events and selecting a set of these which the client is then encouraged to engage in each week by means of a 'contract'. There is some evidence that this does indeed lead to greater participation in the activities and an improved mood (Teri and Lewinsohn, 1986; Lewinsohn & Graf, 1973).
2) Reinforcing non-depressed behaviour, such as talking, going to work, and ignoring depressed behaviours like complaining, crying and self-deprecation. People's family members can be enlisted in this (Liberman & Raskin, 1971).
3) Teaching social skills: Depressed people are liable to act despondently in social settings, so other people are likely to keep their distance. Depressed people can be taught to exercise effective social

skills. This is often done by means of role play, where clients practice eye contact, tone of voice, facial expression, posture and other interactive skills. This seems to improve clients' interactive skills (Hersen et al, 1984; King et al, 1974)

On their own these therapeutic techniques do not necessarily result in improvement, but combining several of them can be effective, especially with mild or moderate depression (Lewinsohn et al, 1982; 1984; 1990). Lewinsohn's therapy has developed to include classes, textbooks, and homework assignments. The programme typically lasts eight weeks and Lewinsohn reports improvements in 80% of clients. More recently a review by Barrera (2009) argues that the behavioural components of a therapy programme are more effective than the cognitive ones.

Cognitive models: Depression as a kind of distorted thinking

This is associated with the work of Aaron Beck (e.g. 1967; 1991) who sees depression as involving negative thoughts. These he breaks down into:

1) Maladaptive attitudes: Originates in childhood, and is based on the way children learn to perceive themselves as a consequence of how others perceive them. Children may come to believe that their worth as a person is tied to every task they perform. Thus, life's failures and setbacks may come to take a heavy toll. The negative attitudes become a kind of schema against which the child evaluates all experiences (Beck et al (1992)

2) The cognitive triad: This involves people making negative interpretations of i) their experiences - often interpreted as burdens, ii) themselves - as deficient, undesirable or worthless, and iii) their futures - as bleak and full of hardships, frustrations and failures.

3) Errors in thinking: These were broken up further by Beck into i) Arbitrary inference - negative conclusions based on little evidence. ii) Selective abstraction - focusing on failures in an otherwise satisfactory situation. iii) Overgeneralization - forming a generally negative view of oneself from a single failure. iv) Magnification and minimisation - underestimating the significance of positive experiences and overestimating the importance of negatives ones. v) Personalisation - seeing oneself as the cause of problems.

4) Automatic thoughts: many of these aspects of thinking become habitual, so that the depressed person is constantly giving themselves reminders of their failures.

5) The totality of depressing thoughts can form a **feedback system** or vicious circle. Experiencing the symptoms will be self confirming.

Research and therapy on the cognitive model

Beck's model has stimulated a great deal of research and therapy since his development of it in the early 1960s. E.g. Garber et al (1993) found that depressed people regularly expense negative automatic thoughts. Reading statements to oneself which resemble automatic thoughts makes one increasingly depressed (Strickland et al, 1975). People who were inclined to ruminate about their mood were more inclined to experience depression for longer periods (Nolen-Hoeksema et al, 1993). In another study by Rush et al (1986) the researchers studied 15 depressed women who were interviewed after their depressive symptoms had started to decline. Those who still had maladaptive attitudes were more likely to have a relapse within six months.

Cognitive Therapy for depressed individuals may involve:

1) Increasing activities and elevating mood. This is a common feature with behavioural therapies (see above). The therapist may help the client prepare a schedule of activities for the coming week. As therapy proceeds, the weekly schedule becomes more demanding and more active.

2) Examining and invalidating automatic thoughts. This may involve 'homework' of recognising and recording negative thoughts. These can then be reviewed in the subsequent therapy session. The therapist can question the validity of the thoughts. This is sometimes referred to as collaborative empiricism, where the client and therapist try to get at the reality behind the thoughts and conclude that they are groundless.

3) Identifying distorted thinking and negative biases. As clients begin to detect the fallacies in their automatic thoughts therapists can help them identify other illogical features in their thinking. That is, people might be engaging in 'dichotomous thinking' where e.g. anything less than perfection is an abject failure. With self blaming clients therapists might use 'reattribution techniques' to guide their clients to identify other possible causes of problems.

4) Altering primary attitudes. This might involve questioning the primary attitudes that got the client depressed in the first place. By encouraging clients to test their attitudes the therapist can encourage further change in a positive direction.

Evaluating the effectiveness of cognitive therapy.
There are a number of studies which show that cognitive therapy can be successful compared with a placebo group (Hollon & Beck, 1994; Pace and Dixon, 1993; Hollon et al, 1993). In the case of chronic episodes, CBT appears to be more effective than interpersonal therapies (Schramm et al, 2011). Moreover, clients who do respond to this therapy tend to show steadily more positive feelings about themselves.

However, there is some scepticism about why it works. There may be a whole range of non-specific factors at work, which are not particular to CBT, but are to do with the interpersonal relationships fostered in the therapeutic process. A sceptical review by Parker & Fletcher (2007) suggests that a key ingredient is 'therapeutic allegiance' – whether the therapist believes in the therapy being offered.

Cognitive and cognitive behavioural therapies have proved popular with therapists yet there are some questions of a broader philosophical and political kind left unanswered. Many philosophers (e.g. Derrida, 1973) are suspicious of the idea that we necessarily have an inner self conscious core that we can discover by ourselves or with the help of others. Whereas the likes of Beck can identify features of these 'cognitions' no one is really sure what they are (Parker et al, 1995). There is some scepticism of the idea that what happens in the individual's head determines or frames what happens in the social world. There is also the implied optimism of the therapeutic view - negative thoughts are almost by definition *wrong* ones.

Moreover as Smail (1993) argues, understanding and itemising the distress does not necessarily lead to a change in the conditions that brought it about. Although the cognitive approach makes use of the idea of attitudes and beliefs it does not generally analyse how they might have come about in the first place. This is because when cognitive therapists talk about them they are usually cut off from the environmental context that makes them intelligible.

Much cognitive therapy and research thus falls under the heading of philosophical nominalism, the idea that the individual exists before society, and society was created subsequently as a result of a social contract between individuals. Thus, we have the origins, says Emerick (1996) of this disparate collection of individuals seeking self centred personal assistance. It is this view that has pervaded the literature on depression.

What happens to clients whose distress can't be brought under control by keeping diaries or challenging their cognition

Befriending, listening, self-help and depression

Harris et al (1999) describe an intervention with depressed women who were recruited through a postal questionnaire. Out of 4000 people who were screened a total of 104 were found who had depressive symptoms, were not seeing another therapist and were interested in being in a befriending scheme. Half of them were given befrienders. Of those given befrienders 65% got better, compared with a 'spontaneous

remission' rate of 39% in the control group. Similar results have been reported in studies of elderly people being visited by a community nurse (Blanchard et al, 1995) where 55% of depressed elderly clients who were visited regularly improved compared with 20% of those who did not receive visits.

Listening visits in pregnancy were advocated by Clement (1995) as a way of reducing the incidence of postnatal depression - these visits can be undertaken prior to the birth, during pregnancy. Postnatal depression is relatively widespread, affecting between 12% and 15% of those who have babies (Cox et al, 1982, Kumar and Robson, 1984; Watson et al, 1984). However, it does seem to respond to 'listening visits. In a study by Holden et al (1989) a series of 8 listening visits were made to postnatally depressed women. After 6 months only 31% of those who were visited were still depressed, compared to 62% of those who were not. Listening visits were also determined to be useful by Turner et al (2010) and Barnes et al (2009).

The effectiveness of the befriending and listening strategies seems to be comparable to antidepressant treatment, according to Harris et al (1999).

Naylor et al (2010) describe a primary care intervention of bibliotherapy, where patients showing signs of depression were invited to read 'Feeling good: the new mood therapy' by David Burns (1999). 'This study provided empirical evidence that a behavioural prescription for Feeling Good may be as effective as standard care, which commonly involves an antidepressant prescription' (Naylor et al, 2010: 258).

Computerised prevention programmes were evaluated favourably by Christensen et al, 2010).

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