

**Depression and Suicidal Behavior:
A CBT Approach for Social Workers**

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Because of its prevalence in our society, depression is often referred to as the “common cold” of mental illness. Social workers will certainly encounter clients with a variety of mood related disorders, regardless of the setting in which they choose to work. As common as depression may be, as professionals we are challenged by the complexity of client presentations, whose vulnerability and resilience will be determined by medical issues, the schemas formed in childhood, current cognitive style, and coping skills, and available social support. The challenge lies not only in correctly assessing factors that contribute to dysfunction, but also in formulating a treatment plan that includes interventions that will result in positive outcomes for the client’s disturbance.

Although the notion of external causation is a popular view regarding depression, a cognitive-behavioral therapy (CBT) conceptualization is less likely to create a state of helplessness and blame, and is more likely to support empowerment of the individual. Key elements of empowerment, as defined by Chamberlin (1997) include access to information, ability to make choices, assertiveness, and self-esteem. A CBT conceptualization leads the client away from a negative view of the future and external circumstances, and instead emphasizes an internal locus of control, where internal resources of empowerment and strength are discovered, regardless of the existing external circumstances.

Of course a wide variety of external events or life circumstances that generate stress can be contributing factors in precipitating a depressive episode. Nonetheless, despite an association between stress and depression, many people who are subjected to high levels of stress do not develop depression, and ongoing stressful experiences, do not lead inevitably to vulnerability, failure to adapt, and psychopathology (Bernard, 1993).

Cognitive behavioral theory attempts to deconstruct individual differences in vulnerability, adaptation, and development of psychopathology, through systematic assessment of a client's thoughts and behaviors, and use of empirically validated interventions. This chapter will present an overview of depression, demonstrate empirical support for CBT, and clarify its potential usefulness in social work settings. Assessment and managing suicide risk will also be addressed as important components of a complete treatment package.

Depression: Description of Symptoms

In order to begin a thorough assessment, it is important to gain a clear understanding of the severity of symptoms, as well as formulating a hypothesis about the factors which might be maintaining and perpetuating the patient's problems. While affective, cognitive, and behavioral symptoms are widely recognized as main problem areas for depressed clients, Dobson and Dozois (2004) also emphasize somatic symptoms and social functioning as areas requiring assessment. In a study done by The World Health Organization, common elements of depressive experiences were identified in subjects across four different countries: Iran, Japan, Canada, and Switzerland. The symptoms included sad affect, loss of enjoyment or pleasure (anhedonia), anxiety, tension, lack of energy (lethargy), loss of interest, inability to concentrate, and ideas of insufficiency, inadequacy and worthlessness. Depressive experiences around the world appear to share a common foundation. Some components of assessment that are useful to consider are provided in the following list adapted from Dozois & Dobson (2004).

Affective symptoms are those symptoms that inform the therapist about the patient's mood. These may include depressed mood, guilt or a sense of worthlessness,

loss of interest, hopelessness and suicidal ideation. Severity of the depressive state can be measured with specific instruments such as the 21-item *Beck Depression Inventory-Second Edition* (BDI-II, Beck, Steer, & Brown, 1996), or through self-report using *Subjective Units of Disturbance Scale (SUDS)*. A weekly SUDS measure of self-reported depression can be requested from the patient by asking how they feel on a scale of 0-10 in terms of depression, with 10 being the most depressed they have ever been and 0 as no depression. It can be helpful to ask the client, as a measure of expectation, where they would like to be most of the time when they near their goal in treatment. Most of the clients we work with report 2.5-4 as a reasonable goal. Explaining to the client that most people are not a 0 or 1 most of the time can affirm realistic treatment goals.

Cognitive symptoms consist primarily of negative or irrational thinking. Although depression is associated with a preponderance of negative thinking, the overwhelming lack of positive thinking appears to also be specific to depression (Dozois & Dobson, 2001). Themes of hopelessness about the future, guilt about past behaviors, blame, worthlessness, disinterest, and sometimes death can permeate the inner thinking lives of depressed clients. These cognitive symptoms are powerful factors in terms of perpetuating dysfunction, particularly from the perspective of a cognitive model. If a depressed individual can become increasingly competent at identifying and restructuring cognitive distortions, the dark cloud of depression will often lift. The key to interventions directed at distorted, dysfunctional or irrational cognitions is to challenge the client to change the cognitions related to environmental stressors, life's daily struggles, self-evaluations, and predictions about the future.

Behavioral symptoms that might help the therapist in assessing improvement over the course of treatment include the appearance, movements and mannerisms of the client, as research demonstrates that depressed individuals make less eye contact, speak slower than non depressed individuals and exhibit a decrease in overall body and hand movements (Schelde, 1998). Many clients become tearful or cry during the initial sessions. The time spent crying usually lessens once the therapy begins to take effect. Observing the intensity and time spent crying, in session, can be another behavioral symptom that can indicate progress in the early stages of treatment. Having clients monitor crying episodes outside of sessions will also serve as another behavioral indicator of improvement or lack thereof. Depressed individuals might also tend to stay in bed and not engage in activities that they found pleasurable before the onset of the depressive episode. Subsequently, the client will benefit from an assessment of daily activities that could include attention to personal appearance and other self-care issues. Leahy and Holland (2000) emphasize reward planning and activity scheduling as components of behavioral intervention. Reward planning can include buying something new or having a manicure. The client can be encouraged to complete a pleasurable activities inventory by listing things he used to do before he was depressed that were associated with a pleasant outcome. He can begin to reintegrate some of those activities into his schedule. Activity scheduling can be as simple as taking a short walk alone or with a friend. Because of the low energy and concentration impairment often associated with depression, tasks that were routine in the past, may feel overwhelming. Therefore, it is reasonable to break down tasks into smaller steps (for example, if the laundry needs to be done, an acceptable step for the day might be to sort the laundry). Persons, Davidson

and Tompkins (2001) believe it is imperative to facilitate behavioral change and thus introduce behavioral interventions, before cognitive interventions. The rationale for this is that “so long as the patient is not functioning, the lack of functioning serves as compelling evidence to support the depressed patient’s negative cognitions (“I can’t do anything”).

Somatic symptoms are physical symptoms that include complaints such as headache, constipation, back pain, chest pain, dizziness, musculoskeletal complaints, and weakness (Simon, VonKorff, Piccinelli, Fullerton, Ormel, 1999). These aches and pains can sometimes be emphasized by the client over affective symptoms. Therefore somatic symptoms are an important piece of the assessment for depression, as specific cultures demonstrate an elevation in somatic complaints as evidence of depression. Chinese immigrants, for example, may not report the emotional issues directly, but will express their distress by describing more physical symptoms (Mak & Zane, 2004). When working with individuals from unfamiliar cultural groups it may be important to ask specific questions concerning somatic complaints.

Social Dysfunction or maladaptive interpersonal behaviors can be another area of concern. Coyne’s (1989) interpersonal reward model postulates that depressed individuals begin to complain, which gains reassurance and attention. Initially these individuals receive positive reinforcement because of the complaining, but then the self-preoccupation eventually leads others to reject them, which and further reinforces their negative self-image (Leahy & Holland, 2000). A lack of meaningful interpersonal interactions or pleasurable activities can certainly negatively impact the course of a depressive episode. Assessing the client’s social skills deficits and implementing

interventions to address these deficits can be part of a complete treatment plan for individuals with depression. Assertiveness training, boundary setting, and interpersonal problem solving may be useful in increasing social competency and success. Such skills may also decrease the chances for relapse.

Issues for the Beginning Phase of Treatment

Because a client's self-talk contributes to a construction of reality and consequential behaviors and feelings, it is important for the clinician to distance herself from the pessimism and negative predictions about circumstances and outcomes. For beginning practitioners it can often be difficult not to buy into the client's negative view. In addition, the first few sessions are a time when the client needs to feel understood, and accepted. Psychomotor retardation as a symptom of depression will cause the client to need more time to respond; therefore patience is essential on the part of the clinician during this time. One productive way to begin the treatment process is to ask the client about any past treatment, and to discuss what aspects of that treatment were helpful or unhelpful.

Practitioners who adhere to a CBT framework, work to socialize clients into the model. This often begins by informing the client of the structure of sessions, and the process of efficient information gathering in order to alleviate any anxiety or feelings of rejection, when the therapist interrupts or changes the course of the assessment session. The primary focus of the first few sessions will be assessment, so the clinician will be asking many questions in a short period of time, thus it is helpful to ensure that clients are made aware of this. Clients who have engaged in other types of therapy are often

surprised at the directive style of the clinician, and quick pace of cognitive behavioral therapy.

In order to create an effective treatment protocol, making a correct diagnosis during assessment is essential. Research demonstrates that depression has a high rate of co-morbidity with other Axis I disorders. Although depression appears to be relatively simple to diagnose, clinicians can make two common mistakes when evaluating clients (Morrison, 1995). The first is that the therapist may focus on a client's anxiety, substance use or psychotic symptoms, and ignore underlying symptoms of depression. Thus, the practitioner may fail to recognize depression as an important issue due to the presence of other psychopathology. The second error is not adequately diagnosing other problems because of the presence of depressive symptoms. Complex co morbidity patterns, such as the presence of personality disorders, when overlooked, can interfere with treatment adherence and progress. Several case examples are provided below to highlight these assessment issues.

Case Example 1

Geri, a 14-year old female, has been in treatment since an early age. She was in a variety of foster homes until age five, and was subsequently adopted. She is described by her adoptive parents as a nice young lady who has difficulty focusing in class, and on occasion engages in impulsive behaviors. She has many friends who she enjoys spending time with, and does not present with irritability or obvious sadness. She has been treated with stimulants for ADHD, which was diagnosed at age 8. On initial screening with the *Beck Depression Inventory* (BDI), she had a score of 31, which indicates a depression of severe intensity. She

was not able to articulate her feelings, nor her thoughts until she completed the BDI. No one had considered depression, because she didn't present in the typical way that most adolescents present with depression.

Case Example 2

Victor is a 47-year old with a history of depression. He has been on a variety of medications including the tricyclics, SSRI's, and MAO inhibitors, and none has made any significant difference in his feelings of depression or his ability to function. Victor reports that every clinician he has seen has focused on his depression, and he presents as severely depressed with a 33 on the *Beck Depression Inventory* (BDI). Currently he has difficulty sleeping, because he reports that he takes a long time to eat, then he lets the cat out, gets ready for bed, and can't figure out why the night goes by so quickly and suddenly it is 5:00 am. Victor begins to slowly and shamefully report that he does some weird things. Victor's primary diagnosis is Obsessive Compulsive Disorder (OCD). He engages in rituals and compulsions that prevent him from functioning adequately. The OCD symptoms interfere with his life to such a significant degree that he subsequently feels depressed.

Another issue to consider at the beginning phase of treatment is *client suitability*. Cognitive-behavioral therapy may not be suitable for certain individuals. The client must be willing to be active in treatment and to understand that the process may at times be challenging. Those clients, who are simply exploring their past, and have no specific behavioral issue to address, may do better with another treatment modality or a generally supportive therapist. Upon further exploration and careful listening, the therapist will

find that even among clients with vague complaints, some degree of cognitive distortions and difficulties with emotional regulation will exist and may potentially be addressed with CBT interventions. Recent studies demonstrate that even psychotic patients can benefit when the focus of the therapy is on issues of daily living, rather than on the psychotic thinking. For obvious reasons, patients with organic brain disease or trauma to the brain may or may not benefit depending on their level of impairment.

Basic Cognitive and Behavioral Concepts and Assumptions

Behavior therapy is founded on the premise that when environmental consequences are linked to particular behaviors, the consequence either increases (reinforce) or decrease (extinguish) the likelihood of a person responding in the same manner when confronted with similar stimuli in the future. This theory of change is also based on the client's prior learning history, and the ability to integrate new learning experiences.

While Beck was developing his cognitive theory, in the mid 1970s, Peter Lewinsohn was developing a behavioral theory of depression. According to Spett (2005), Lewinsohn argued that the essence of depression is a low rate of behavior, and this low rate of behavior causes all the other symptoms of depression. Lewinsohn hypothesized that the low rate of behavior was secondary to a lack of reward from the environment. If we can teach the depressed patient how to elicit higher rates of reward, the depressed patient's rate of behavior will increase, and the depression will lift. If the patient increases activities that she enjoys, improves social skills so that she won't be rejected as often, and gets out of bed even when she doesn't feel like it, she will likely experience improvement in depressive symptoms. As noted earlier behavioral activation is often an

important first step in any CBT treatment program for depression and is recommended in several treatment manuals (Freeman & Gilson, 1999; Leahy & Holland, 2000).

Cognitive models of depression assume that individuals respond to life events behaviorally and emotionally based on their interpretation of those events. Therefore the cognitive model of therapy does not attempt to change the trigger, but rather focuses on changing the individual's perception of the trigger or activating event in order to decrease disturbance. The thinking of the client must be revealed and be open to restructuring by the therapist, the client or both. A major premise of cognitive theories is that dysfunctional cognitions can be accessed and restructured in order to effect behavioral and emotional change. Cognitive theory also acknowledges that aspects of depression are rooted in reciprocal causal relationships, and that change in one area such as emotions, will likely produce change elsewhere (Persons, Davidson & Tompkins, 2001).

Although cognitive-behavioral therapists are sometimes viewed as unempathic and unemotional because of the focus on method, protocol, and active therapist involvement, in reality, the therapist client relationship is highly valued (Young, 2003; Ellis, 1987; Beck, 1995). A genuine relationship that includes respect, caring, and acceptance forms the foundation for using CBT skills. Other important assumptions included in most CBT models is the value of empiricism, a focus on functioning better in the present, and the efficient use of time (Young & Mattilla, 2002)

Both behavioral and cognitive models have their foundation in learning theories. Learning occurs when an individual is able to do or think something new or different. The goal of getting better, as opposed to simply feeling better, is attained through techniques that assist the client in learning new ways of thinking and practicing

behavioral assignments that increase overall competence. New skills become integrated into the client's daily life. Thus, CBT can be framed within a developmental learning model rather than a linear medical model.

For example, take a client who finds herself in a phase of life where developmentally she is challenged to move forward and lacks the skills or knowledge to do so. The client lacks the skills, not necessarily because of deficient chemistry, but because this difficult situation has not been encountered before. When one meets such a challenge, by definition the individual is *unconsciously incompetent*. The client may be confused and shamed by the inability to be effective without help and may begin to have thoughts that she is stupid, worthless, and unable to function. The client becomes aware of the lack of knowledge, by virtue of feeling helpless, hopeless, and overwhelmed, and subsequently the client feels *consciously incompetent*, as she admits that she cannot get beyond the issues at hand without professional help. The social worker, or other mental health professional will provide the client with the opportunity to find ways to start working on getting better, or becoming more competent, rather than just feeling better. As the client learns and practices the skills presented within the context of CBT, she becomes *consciously competent*. She must still concentrate on what she is doing in order to meet with some level of success. As her skills become more automatic with practice, she becomes *unconsciously competent*. The client no longer has to think about what she is doing. She is now thinking more consciously, managing her emotions more appropriately, problem solving more effectively, and seems to have a better handle on life. This process can be compared to learning to speak a new language. Practice will

increase the chances for success. This is the primary reason why homework is such an important component of CBT.

In their text, *Direct Social Work Practice: Theory and Skills*, Hepworth and Larsen (1986) present a conceptualization of social work practice that is consistent with the assumptions of cognitive behavioral practice:

“Though it is the primary source of information, verbal report is vulnerable to error because of possible faulty recall, distorted perceptions, biases and limited self-awareness on the part of clients. It is thus vital to avoid the tendency to accept client’s views, descriptions, and reports as valid representations of reality. Similarly it is important to recognize that the feelings expressed by clients may emanate from faulty perceptions or may be altogether irrational.”

Cognitive therapists attempt to facilitate their patient’s awareness of distorted thinking patterns, or cognitive distortions, and provide interventions that help to change the distortions but also understand that when dealing with humans, the process of discovery must be supportive and affirming of the individual’s emotional status.

Historically, there has been significant debate over whether interventions based on purely behavioral models or cognitive models are most effective for helping clients. The battle of behavior therapy versus cognitive therapy is similar to the nature versus nurture struggle for which we will also likely never have a satisfactory answer. The interrelatedness of behavior and cognition is so strong as to warrant a change of name for an organization previously known as *Association for Advancement of Behavior Therapy*, which was recently changed to *Association of Cognitive and Behavioral Therapy*. Regardless of which side we choose, Leahy and Holland (2000) report that the behavioral

model is a useful part of cognitive therapy, as behavioral assignments are essential to examining and testing the patient's cognitive distortions. The patient's response to a behavioral assignment will provide insight into the distorted automatic thoughts. For example, suggesting that a client have a manicure might elicit a response that informs us of her self-view of worthlessness or undeservingness. From a practical standpoint practitioners need to consider both thinking patterns and behaviors and how they typically go together for a specific client.

Empirical Support for CBT and Depression

Numerous studies support the efficacy of CBT for the treatment of depression (Beck, 1976; Blackburn & Bishop 1979; Dobson, 1989; Rush, Beck, Kovacs, & Hollon, 1977). Cognitive therapy can be effective for treating severe forms of depression and in combination with anti-depressant medications is sometimes more efficacious than either treatment alone (Reinecke & Didie, 2005). Many qualitative and quantitative reviews now conclude that cognitive therapy: (a) is effective for reducing depressive symptoms, (b) is at least comparable, if not, superior to medication treatment, and (c) is associated with lower rates of relapse in comparison to medication treatments (Dobson, 1989; Hollon & Beck, 1985; Hollon & Najavits, 1988; Hollon et al., 1991; Miller & Berman, 1983). Confirming Dobson's results, Gloaguen et al., (1998) in their meta-analysis found that cognitive therapy (CT) was significantly better than no treatment, antidepressant medication, and a group of miscellaneous therapies. However, in contrast to Dobson's finding of a clear superiority of CT over BT, Gloaguen and colleagues found that CT was comparable to behavior therapy alone (BT). A more recent meta-re-analysis completed by Wampold, Minami, Baskin and Tierney (2002) also supports the effectiveness of

cognitive therapy for depression. However, this study concluded that all bona fide psychological treatments for depression are equally efficacious. In order for a treatment to fit the criteria of bonafide it had to meet the following criteria: (a) the therapist had to be trained in the specific therapy at a graduate level, (b) the sessions were face to face and treatment was individualized for the patient, (c) treatment contained psychologically valid components (as evidenced by two of the following- a citation made to an established approach, a description was contained in an article and the description contained a reference to an established psychological process, or a manual existed to guide delivery of treatment). Gloaguen, Cottraux, Cucherat, and Blackburn (1998) completed a meta-analysis that resulted in demonstrating that CT and behavioral therapy are equally efficacious.

In the midst of what may be perceived as a cognitive revolution, a debate has arisen stemming from the highly visible results of the National Institute of Mental Health Treatment of Depression Collaborative Research Program study (NIMH TDCRP), which concluded that cognitive behavior therapy was not effective in the treatment of severe depression (Elkin, Shea, Watkins, et al., 1989). The issues present on both sides of the debate are of a methodological nature. Criticisms of the studies include researcher allegiance, lack of stringent selection criteria, exclusion of some studies while including others, and use of the BDI as the only measure of depression. When taken together, CBT seems to have a relatively large base of support for treating clients with depression. However, it is certainly not the only approach that is empirically supported but nonetheless remains an important option.

Albert Ellis's Rational Emotive Behavior Therapy (REBT) Model

Albert Ellis's rational emotive therapy was developed in the 1950's. Ellis was becoming disillusioned with the process of psychoanalysis, and proposed that people have a biological and social tendency to easily and naturally raise their healthy preferences and desires into unhealthy and self-defeating demands (Ellis, 2003). Ellis has demonstrated three ways in which people do this. If they do not perform well, or as they *should*, then they are worthless. If other people do not treat them fairly, then the other people are damnable. Third, if their lives are not stress free, then they simply cannot be happy at all (Ellis, 2003) .

Albert Ellis's REBT model uses cognitive restructuring to change irrational thoughts. He distinguishes between two types of evaluations. In his REBT model he states that clients can evaluate life's difficulties and challenges either rationally or irrationally. He also addresses the validity of the thought as well as the utility. Is the thought logical and grounded in reality and is it helpful? Ellis and other rational emotive behavior theorists, writers, and practitioners make up a major school of thought regarding the importance client's evaluations (McMullin, 2000). Ellis uses several quotes in the REBT resource book for Practitioners to demonstrate his philosophy:

Epictetus: *People are disturbed not by things, but by the views they take of them*"

Shakespeare: *"There is nothing either good or bad, but thinking makes it so."*

Milton: *"The mind is its own place, and in itself can make a Heav'n of Hell, and a Hell of Heav'n."*

The Bible (Proverbs 23:7): *"As a man thinketh in his heart so is he."*

REBT focuses on four major types of irrational beliefs that create disturbances (Dryden, 2003):

- Demands (DEM): Elevating personal desires to moral dictates or rules that are imposed on the self, others, or the world. This type of thinking is often verbalized in words like *must*, *ought*, and *should*.
- Awfulizing (AWF): Exaggerating the consequences or level of hardship associated with aversive events. This type of thinking is often indicated by client statements like “It’s awful, terrible, horrible, etc.”
- Low frustration tolerance (LFT): Underestimating one’s own ability to deal with discomfort or adversity. Often heard in statements such as “I can’t stand it or tolerate it.”
- Depreciation beliefs (DEP): Blaming or condemning people “in total” for specific behavioral acts. For example if another doesn’t conform to my desires, he or she is “bad or worthless.”

Below are some sample distinctions between irrational (IR) and rational (RB) beliefs related to the four major categories:

Demands

(IR) *I must have my boyfriend’s love or He should love me.*

(RB) I would like to have my boyfriend’s love, but there is no law that exists that says he has to love me.

Awfulizing

(IR) *It would be awful not to be loved by him.*

(RB) I would be disappointed and sad if he didn't love me, but it certainly is not the end of the world.

Low Frustration Tolerance

(IR) *I can't stand the idea of ever being separated from my boyfriend.*

(RB) I don't like thinking about being apart, but I have certainly tolerated other breakups.

Depreciation Belief

(IR) *My boyfriend would be a rotten person if he breaks up with me.*

(RB) I may feel frustrated because I can't control his choices, but exercising his free will doesn't make him a globally bad person. REBT theory states that when confronted with negative events, we have a choice of feeling bad, but not becoming depressed and disturbed (DiGiuseppe, 2002). REBT differentiates between healthy and unhealthy negative emotions. It is healthy to experience some level of negative emotion in response to a negative activating event, rather than feeling indifferent to the event. Irrational thinking is likely to intensify and prolong negative emotional experiences.

A basic part of the REBT model is the A-B-C assessment. Although real life situations are far more complicated than such a theory may encompass, it is a simple way to have the client begin to focus on and structure their thinking in more rational ways. In this model the A represents *an activating event* which can be external or even a thought itself. The B is the *belief* about A. The C is the *consequence* that results from B about A. Most people with disturbances believe that the activating event cause the resulting C, feeling or behavior. According to A-B-C theory, it is the B about A which drives C. We often hear someone saying, "He insulted me (A) and that made me so angry (C)". The A or activating event is someone insulting. The illusion is that this event created angry

feelings or C. The question is then, why do some people react negatively to being insulted, while others walk away? The answer is based in their belief about some aspect of A.

Clinical example:

CLIENT: All week I have been thinking about all the problems that I have, and I am getting more and more depressed. I don't know if I can ever change.

THERAPIST: What were you telling yourself when you were making yourself depressed?

CLIENT: I'm not sure

THERAPIST: Well do you see the musts and shoulds you are putting in there? I must feel better, I should not be feeling this way. I should change.

CLIENT: I have to get better right away. Yes I am using *demandingness* a lot.

THERAPIST: That's correct. It also sounds like you are saying that you should not have so many problems. If you said, I would prefer not to have so many problems, but I do and I will work on them without putting so many demands on myself particularly in the area of immediate changes, then you wouldn't get so depressed about your problems. You would feel like you could stand it, not feel so bad about yourself and perhaps agree that you didn't like the situation but could certainly tolerate it.

Readers interested in a more detailed description of REBT theory and practice are referred to Walen, DiGiuseppe, and Dryden (1992).

Beck's Cognitive Therapy

As originally formulated in the 1960s, the emphasis in Beck's cognitive therapy was to help clients identify *distortions in thinking about the reality of life events*, and to

replace those distortions with more *accurate and realistic perceptions and appraisals*.

While this is still a major focus, the Beck model has evolved to include three levels of cognitions: automatic thoughts, assumptions, and core beliefs.

Automatic Thoughts. Human beings are constantly thinking and making evaluations about the world around them. Automatic thoughts are part of this ongoing inner dialogue that naturally occurs with everyone. They are *spontaneous and fleeting*, and are thought to exist *just below the level of conscious awareness*. They may also take the form of images or memories. With minimal effort, most people are able to tune into this inner dialogue and identify specific thoughts as they occur moment to moment. In terms of working with depressed clients, it is important to identify those automatic thoughts that are negative, distorted, and associated with periods of low mood. Initially, the focus is on helping clients notice the thinking that takes place when they feel most down. Again, it is important to assess the automatic thoughts exactly as they are experienced when sadness or a sudden change in mood occurs. Initially, it may seem as though clients report a wide variety of automatic thoughts related to their sadness and depression. However, in a short time you're likely to notice recurring patterns. In addition, once the other underlying cognitions (assumptions and core beliefs) are identified, the content of automatic thoughts becomes more understandable and easier to predict.

Assumptions. Assumptions can be conceptualized as *rules* or *attitudes* that guide daily actions and also set expectations (Greenberger & Padesky, 1995). These assumptions are often not directly expressed verbally by clients, as they may themselves be unaware of them, and therefore they are not easily accessible to the practitioner. Since

assumptions give rise to the automatic thoughts, one way to identify them is to make *inferences from recurring themes* found in automatic thoughts. Assumptions, when stated, typically take the form of “if-then” statements, or “should” or “must” statements. For example, “If I try to get close to others then they will reject me,” or “Even if I try hard, (then) I probably won’t succeed anyhow.” Assumptions can be problematic to the extent that they are exaggerated, distorted, and are maladaptive when applied rigidly across situations. Assumptions are believed to develop in response to early childhood experiences and interactions with others. Persistently negative or even traumatic experiences can lead to negative assumptions about oneself and result in negative expectations or attitudes regarding others and the future. Maladaptive assumptions actually are a coping skill developed to deal with the negative schema.

Core Beliefs. Core beliefs are proposed as the “deepest” or most abstract level of cognition. Core beliefs contain the most centrally held ideas related to self, other people, and the world. These are rules that are held with great conviction. Negative core beliefs underlie maladaptive assumptions and distorted automatic thoughts. For example, one may believe at a fundamental level that he is worthless and does not measure up favorably when compared to others. Thus, core beliefs may determine the way an individual automatically interprets reality, especially in ambiguous or stressful situations. The advantage for practitioners in conceptualizing maladaptive assumptions and core beliefs lies in the larger roadmap that it provides to help direct interventions in the most effective manner. For example, using Judith Beck’s (1995) cognitive conceptualization model, let’s take a look at a specific *client*. *Carmin* is a 27 year old college graduate beginning work at a new job.

A. The cognitive model as applied to Carmine

1. Typical current problems

Writing reports, volunteering for overtime, social withdrawal, lack of assertiveness

2. Typical automatic thoughts

I can't do this, I am a failure, I will never make it here->sad

I should be more involved and doing more->guilty

What if they don't like my work; What if they fire me-> anxious

3. Core beliefs

I am inadequate and incompetent

4. Assumptions or Conditional beliefs

If I fail at this job then I am a failure as a person

If I ask for help, then I am weak

5. Rules

I must work harder than everyone else

I should excel

6. Therapist's Goals

Decrease, self criticism, teach basic cognitive tools to dispute dysfunctional automatic thoughts and restructure negative thoughts, do problem solving around improving written reports, and address social skills that will improve social withdrawal.

One can begin to see that Carmine's beliefs, which likely developed earlier in his life, predisposed him to interpreting events in a negative way. He did not question his beliefs, but rather accepted them as absolute and true. The thoughts and beliefs did not cause the depression, but once the depression took hold, these thoughts supported the maintenance of the depression.

Suicide Risk Assessment: When Depression Becomes Dangerous

Despite extensive research into variables that might contribute to suicidal behaviors, evaluating suicide risk continues to be both clinically difficult and scientifically imperfect for mental health providers. Studies that have attempted to categorize individuals and construct a suicide profile have been, for the most part, inconclusive, as assessing suicide risk is not a static process. In spite of the best efforts of family and professionals, suicide took the lives of 30,622 people in 2001 (CDC 2004). One in seven patients hospitalized for major depression will die by suicide (Powell, Geddes, Deeks, Goldacre, & Hawton, 2000). Although depression is strongly associated with suicide, most depressed individuals do not commit suicide and many non-depressed individuals make suicide attempts. Depression is not a necessary nor a sufficient cause (Reinecke & Didie, 2002)

There are risk factors outside of the symptoms of the disorder that indicate a greater probability for potential fatal behavior. The most critical risk factors for suicide completion (in order of their seriousness), are: (a) the medical seriousness of previous suicide attempts, (b) history of suicide attempts, (c) acute suicidal ideation, (d) severe hopelessness, (e) attraction to death, (f) family history of suicide, (g) acute overuse of alcohol, and (h) loss/separations (Peruzzi, & Bongar, 1999). A history of serious suicide attempts may be the single best predictor of completed suicide (Moscicki, 1997). From a purely cognitive perspective, hopelessness may be a helpful short-term and long term predictor of suicidal risk among adults and thus feelings of pessimism may be an important target for therapy (Freeman & Reinecke, 1993, Reinecke, 2000). A cognitive model considers maladaptive cognitions to be a central pathway to suicidal behavior (Rudd, Joiner, & Rajab, 2001). Most researchers agree that motivation towards

suicidality comes from a belief that the problem the individual is facing is too large and overwhelming to ever be solved, and that suicide is the only solution or escape. The individual has essentially run out of options. At this point a formal risk assessment is in order.

Treatment of suicidal patients is systematic, strategic, and problem focused with an initial emphasis on challenging beliefs that support feelings of hopelessness (Reinecke & Didie 2002). Marsha Linehan has published a suicide crisis protocol in pocket form, which can be obtained at www.behavioraltech.com. Her risk assessment format in basic form is as follows:

- Summarize the problem. What precipitated the crisis?
- Emphatically instruct not to commit suicide. Give advice and make direct suggestions.
- Generate hope
- Validate and soothe while focusing on affect tolerance
- Reduce high risk environmental factors by removing lethal means. Increase social support
- Address function of current suicide ideation
- Get a commitment to a plan of action
- Trouble shoot the action plan
- Anticipate recurrence of the crisis and reassess suicide risk

Berk, Henriques, Warman, Brown and Beck (2004) have developed a ten session treatment protocol specifically for suicidal individuals. The key element in the early phase of treatment is teaching the patient skills in order to become their own therapists

outside the session. Many people who have not had CBT treatment have no idea that their behaviors are often driven by their thoughts. Teens who are hospitalized for a suicide attempt will often report that when they had thoughts of suicide, they didn't realize that they had a choice to not follow through on the attempt. The middle stage of treatment, sessions 4-7 focus on cognitive restructuring and behavioral change. What are the recurring themes in the individual's automatic thoughts? These themes can be addressed using Socratic questioning or dysfunctional thought records. The later sessions address relapse prevention. This relapse prevention piece explores any possible future crisis and solidifies the patient's coping skills. Beck et al recommends that booster sessions be offered to the client whenever they might feel the need to reconnect.

Finally, Leahy and Holland (2000) provide a structured interview format for practitioners to use in evaluating suicidal risk. Their approach consists of 38 questions regarding current and past behaviors. We recommend this format for those who are unfamiliar with how to conduct a risk assessment interview.

Summary

In an effort to demystify depression and empower clients, CBT offers a structured approach to dealing with the negative thought patterns and reduced behaviors present in most depressed clients. The beginning phase of treatment includes a thorough assessment of client symptom patterns, the development of a supportive and collaborative therapeutic relationship, and a process of socializing the client into the CBT model. Once treatment begins, clients are exposed to a variety of cognitive and behavioral techniques designed to increase skills that become integrated into the client's life. In addition, several models of CBT exist from which practitioners can choose, the most common

being the theories of Beck and Ellis. Finally, consideration must be given to assessing and intervening with clients who may be at risk for suicide.

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