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# COGNITIVE THERAPY OF DEPRESSION

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Chapter 7

# APPLICATION OF BEHAVIORAL TECHNIQUES

## Cognitive Change through Behavioral Change

The cognitive *therapy* of depression is based on the cognitive *theory* of depression. By working within the framework of the cognitive model, the therapist formulates his therapeutic approach according to the specific needs of a given patient at a particular time. Thus, the therapist may be conducting cognitive therapy even though he is utilizing predominantly behavioral or abreactive (emotion releasing) techniques.

In the early stages of cognitive therapy and particularly with the more severely depressed patients, it is often necessary for the therapist to concentrate on restoring the patient's functioning to the premorbid level. Specifically, engaging the patient's attention and interest the therapist attempts to induce the patient to counteract his withdrawal and to become involved in more constructive activities. The rationale for this approach is based on the clinical observation that the severely depressed patient, and often the important people in his life ("significant others"), believe that he is no longer capable of carrying out the typical functions expected in his role as a student, wage earner, homemaker, spouse, parent, etc. Furthermore, the patient can see no hope of gaining satisfaction from those activities that had previously brought him pleasure.

The severely depressed patient is caught in a vicious cycle in which his reduced level of activity leads to labeling himself as ineffectual. This labeling, in turn, leads to further discouragement and ultimately to a drift into a state of immobility. He finds it difficult to carry out intellectual functions (such as reasoning and planning motor activities—even walking and talking spontaneously as well as performing complicated acts requiring specialized skill and training.

These forms of behavior are generally instruments for achieving satisfaction and maintaining one's self-esteem and the esteem of others. The disruption of these functions as a result of diminished concentration, fatigability, and low mood produces dissatisfaction and a reduction of self-esteem.

The role of the therapist is clear. There is no easy way to "talk the patient out" of his conclusions that he is weak, inept, or vacuous. He can see for himself that he simply is not doing those things that once were relatively easy and important to him. By helping the patient change certain behaviors, the therapist may *demonstrate* to the patient that his negative, overgeneralized conclusions were incorrect. Following specific behavior changes, the therapist may show the patient that he has, in fact, not lost the ability to function at his previous level, but that his discouragement and pessimism make it difficult to mobilize his resources to make the necessary effort. The patient thereby comes to recognize that the source of his problem is a cognitive error: He *thinks* (incorrectly) that he is inept, weak, and helpless, and those beliefs seriously restrict his motivation and behavior.

The term *behavioral techniques* may suggest that the immediate therapeutic attention is solely on the patient's overt behavior; that is, the therapist prescribes some kind of goal-directed activity. In actuality, the reporting of the patient's thoughts, feelings, and wishes remains critical for the successful application of the behavioral techniques. The ultimate aim of these techniques in cognitive therapy is to produce change in the negative attitudes so that the patient's performance will continue to improve. Actually, the behavioral methods can be regarded as a series of small experiments designed to test the validity of the patient's hypotheses or ideas about himself. As the negative ideas are contradicted by these "experiments," the patient gradually becomes less certain of their validity and he is motivated to attempt more difficult assignments.

Many of the techniques described in this chapter are also part of the repertoire of the behavior therapist. The impact of the therapeutic techniques derived from a strictly behavioral or conditioning model is limited because of the restriction to observable behavior and selective exclusion of information regarding the patient's attitudes, beliefs, and thoughts—his cognitions. Hence, even though the behavior therapist induces the patient to become more active, his



pessimism, self-disparagement, and suicidal impulses may remain unchanged. For the behavior therapist, the modification of behavior is an end in itself; for the cognitive therapist it is a means to an end—namely, cognitive change.

It is important to note that cognitive changes *do not necessarily* follow changes in behavior. In contrast to the typical findings in the social-psychological studies of normal subjects, we find that depressed individuals do not readily alter their hypervalent, negative cognitions despite distinct behavior changes. This point is illustrated in the following example.

A 36-year-old depressed woman had withdrawn from participating in the tennis games she had previously enjoyed. Instead, her daily behavior pattern consisted of "sleeping and trying to do the housework I've neglected." The patient firmly believed that she was unable to engage in activities as "strenuous" as tennis. Her husband arranged for a private tennis lesson in an attempt to help his wife to overcome her depression. The patient reluctantly attended the lesson and appeared to be "a different person" in the eyes of her husband. She stroked the ball well and was agile in following instructions. Despite her good performance during the lesson, the patient concluded that her skills had "deteriorated" beyond the point at which lessons would do any good. She misinterpreted her husband's positive response to her lesson as an indication of how bad her game had become—because *in her view*, "He thinks I'm so hopeless that the only time I can hit the ball is when I'm taking a lesson." In essence she rejected the obvious reason for her husband's enthusiasm in favor of an explanation derived from her negative image of herself. She also stated that she didn't enjoy the tennis session because she wasn't "deserving" of any recreation time.

This vignette illustrates the importance of placing the behavioral changes into perspective for the patient. The negatively biased cognitions are not necessarily altered simply by a change in behavior. Rather the change in behavior allows the identification of such negative appraisals. Behavior change is important insofar as it provides an opportunity for the patient to evaluate empirically his ideas of inadequacy and incompetence. The therapist has to base the rationale for his therapeutic procedure on an understanding of the patient's frame of reference. In this case, although the husband initiated an appropriate plan of action (a tennis lesson), his ignorance

of his wife's belief system prevented him from helping her to solve her cognitive problem. In fact, his effort backfired in that she misinterpreted the entire experience. Later in the chapter we will describe the therapeutic strategies of defining and dealing with the cognitions related to mutually agreeable behavioral goals and behavior change.

## SCHEDULING ACTIVITIES

Many depressed patients report an overwhelming number of self-debasing and pessimistic cognitions at times when they are physically and socially inactive. They criticize themselves for being "vegetables" and for withdrawing from other people. Paradoxically, they may justify their withdrawal and avoidance on the basis that activity and social interaction are meaningless or that they are a burden to others. Thus, they sink into increasing passivity and social isolation. Furthermore, it is not unusual for the depressed patient to interpret his inactivity and withdrawal as evidence of inadequacy and helplessness and thereby complete a vicious cycle.

The prescription of special projects is based on the clinical observation that depressed patients find it difficult to undertake or complete jobs which they accomplished with relative ease prior to the depressive episode. They are prone to avoid complex tasks, or, if they do attempt such tasks, they are likely to have considerable difficulty achieving their objective. Typically, the depressed patient avoids the project or stops trying soon after he encounters some difficulty. His negative beliefs and attitudes appear to underlie his tendency to give up. Patients often report, "It's useless to try," for they are convinced they will fail. When they engage in goal-directed activities they tend to magnify the difficulties and minimize their ability to overcome them.

The use of activity schedules serves to counteract the patient's loss of motivation, inactivity, and his preoccupation with depressive ideas. The specific technique of scheduling the patient's time on an hour-by-hour basis is likely to maintain a certain momentum and prevent slipping back into immobility. Furthermore, focusing on specific goal-oriented tasks provides the patient and therapist with concrete data on which to base realistic evaluations of the patient's functional capacity.

As with other cognitive techniques, the therapist should present the patient with a rationale. Often the patient is aware that inactivity





is associated with an increase in his painful feelings. The patient can generally accept the idea that inactivity increases his negative ruminations and dysphoria. At the very least, the therapist can request the patient to engage in an "experiment" to determine whether activity diminishes his preoccupations and possibly improves his mood. The therapist and patient determine specific activities and the patient agrees to monitor his thoughts and feelings while engaged in each task. In every difficult cases, the therapist may seriously question the patient, "What have you got to lose by trying?"

The therapist may choose to provide the patient with a schedule to plan his activities in advance and/or to record the actual activities during the day. A "graded task" hierarchy should be incorporated into the daily plan.

Planning specific activities in collaboration with the patient may be an important step in demonstrating to him that he is capable of controlling his time. Severely depressed patients often report a sense of "going through the motions" with the sense that there is little purpose in their activities. By planning the day with the therapist, they are often able to set meaningful goals. Later, the patient's record of the actual activities (compared to what he planned for the day) provides the therapist and patient with objective feedback about his achievements. The record also provides a reference to self-ratings of mastery and satisfaction for successful goal-attainment (see Figures 1 and 2).

It may tax the therapist's ingenuity to get the patient sufficiently involved in the idea of carrying out a program of activities or even filling his activity schedule retrospectively. Thus, the therapist explains the rationale (for example, that people generally function better when they have a schedule), elicits the patient's objections, and then proposes making a schedule as an interesting experiment. It should be emphasized to the patient that the immediate objective is attempting to follow the schedule rather than seeking symptomatic relief: Improved functioning frequently comes before subjective relief is apparent.

It is important for the therapist to stress the following principles to the patient prior to using a schedule to plan daily activities.

1. "No one accomplishes everything he plans, so don't feel bad if you don't realize all of your plans."

**WEEKLY ACTIVITY SCHEDULE**

**NOTE: Grade activities *M* for Mastery and *P* for Pleasure**

| | M | T | W | Th | F | S | S |
|---|---|---|---|---|---|---|---|
| 9-10 | | Go to grocery store | Go to Museum | Get ready to go out | | | |
| 10-11 | | Go to grocery store | Go to Museum | Drive to Dr.'s appointment | | | |
| 11-12 | Doctor's Appointment | Call friend | Go to Museum | Doctor's Appointment | | | |
| 12-1 | LUNCH | LUNCH | Lunch at Museum | | | | |
| 1-2 | Drive home | Clean front room | Drive home | | | | |
| 2-3 | Read novel | Clean front room | Washing | | | | |
| 3-4 | Clean bedroom | Read novel | Washing | | | | |
| 4-5 | Watch T.V. | Watch T.V. | Watch T.V. | | | | |
| 5-6 | Fix dinner | Fix dinner | Fix dinner | | | | |
| 6-7 | Eat with Family | Eat with Family | Eat with Family | | | | |
| 7-8 | Clean kitchen | Clean kitchen | Clean kitchen | | | | |
| 8-12 | Watch T.V., Read novel, Sleep | Call sister, Watch T.V., read novel, sleep | Work on rug. Read novel, sleep | | | | |

FIGURE 1. Assigned Activity Schedule for Patient A.





**WEEKLY ACTIVITY SCHEDULE**

**NOTE: Grade activities *M* for Mastery and *P* for Pleasure**

| | M | T | W | Th | F | S | S |
|---|---|---|---|---|---|---|---|
| 9-10 | | Went to grocery store M3 P0 | Back to bed M0 P0 | Ready to go out M2 P0 | | | |
| 10-11 | | Went to grocery store M3 P0 | Back to bed M0 P0 | Drove to town | | | |
| 11-12 | | Went to grocery store M3 P0 | Called repairman for dishwasher M3 P0 | Appointment | | | |
| 12-1 | LUNCH M0 P1 | LUNCH M0 P0 | LUNCH M0 P1 | | | | |
| 1-2 | Drove home M0 P0 | Called friend M0 P3 | Washing M4 P0 | | | | |
| 2-3 | Read P1 | Watched T.V. M0 P1 | Washing M4 P0 | | | | |
| 3-4 | Cleaned Room M5 P2 | Watched T.V. M0 P1 | Washing M4 P0 | | | | |
| 4-5 | Cleaned Room M5 P2 | Watched T.V. M0 P1 | Watched T.V. M0 P2 | | | | |
| 5-6 | Fixed Dinner M4 P2 | Fixed Dinner M3 P0 | Fixed Dinner M2 P0 | | | | |
| 6-7 | Cleaned kitchen M4 P0 | T.V. M0 P0 | T.V. M0 P1 | | | | |
| 7-8 | Watched T.V. M0 P1 | T.V. M0 P0 | T.V. M0 P1 | | | | |
| 8-12 | Watched T.V. Sleep M0 P1 | T.V. M0,P0 Clean kitchen M3,P0 Sleep | T.V. Sleep M0 P1 | | | | |

FIGURE 2. Completed Activity Schedule for Patient A.

2. "In planning, state what kind of activity you will undertake, not *how much* you will accomplish. What you accomplish often depends on external factors you can't plan, such as interruptions, mechanical failures, and weather, as well as subjective factors such as fatigue, concentration, and motivation. For example, you say that you wish the house was cleaner. Plan to do housework for one specific hour each day, say 10–11:00 a.m. The actual number of hours you will need to finish cleaning the house can be predicted after you have followed the schedule for several days."
3. "Even if you don't succeed, be sure to remind yourself that *trying* to carry out plans is the most important step. This step provides useful information for setting the next goal."
4. "Set aside time each evening to plan for the next day; write your plans for each hour of the next day on the schedule."

These principles are important since they are designed to counter negative ideas about attempting the scheduling task.

The activity schedule serves to structure the day and it provides information to assess the patient's daily activities. In making this assignment, the therapist clearly states that the initial purpose of the program is to *observe* and not to *evaluate* how well or how much the patient does each day.

The following table is taken from the schedule reported by a depressed 40-year-old male. The patient was asked to rate on a scale from 0 to 5 the degree of mastery (M) and pleasure (P) associated with each activity.

| Monday | | M | P |
|---|---|---|---|
| 6–7 a.m. | Woke up, stayed in bed | 0 | 0 |
| 7–8 a.m. | Dressed, washed | 0 | 0 |
| 8–8:30 a.m. | Read paper, drank coffee | 0 | 0 |
| 8:30–10 a.m. | Back to bed—couldn't sleep | 0 | 0 |
| 10–12 a.m. | Watched TV | 0 | 1 |
| 12–1 p.m. | Paid bills | 0 | 0 |
| 3 p.m. | Friends visited | 0 | 3 |
| 3–4 p.m. | Watched TV | 0 | 0 |
| 4–5 p.m. | Tried to wash car | 0 | 0 |
| 5–6 p.m. | Ate dinner with family | 0 | 1 |
| 6–7 p.m. | Did dishes with wife | 0 | 0 |



The daily record activity provided the basis for testing the recurrent idea expressed by the patient that "I don't do *anything*." Without such specific evidence, the therapist cannot realistically and constructively refute the patient's belief that he did things and wasn't capable of doing anything.

The daily activity schedule also induces the patient to become aware of the activities which provided even slight relief from the feelings of depression. In this case, the therapist asked, "Did you feel better or worse when you were in bed and not sleeping compared to when you visited friends?" To his surprise, the patient realized that the social interactions had relieved his dysphoria. Thus, with an activity schedule and the associated therapist questions, the patient learned that his depression does fluctuate depending on his behavior and on external circumstances. Ideas such as, "Nothing makes any difference" or "I feel equally terrible all day" can be altered to the more reasonable view that "Sometimes I can do something which will provide relief for me." Even the most depressed, retarded patients seem to feel better when involved in an activity—if for no other reason than the distraction it provides. Furthermore, by rating the degree of satisfaction associated with each activity, the patient becomes "sensitized" to feelings of satisfaction and thus is more likely to experience and recall pleasurable sensations. Such experiences counteract his belief that he is incapable of experiencing any gratifications. (For further elaboration, see the section on Mastery and Pleasure techniques.)

If the patient is unable to decide what to plan, the therapist suggests various possible projects which the patient wishes he could carry out (for example, housework, shopping, paying bills, etc.). Once a job has been selected, a time slot is picked and the scheduled plans are recorded on the Activity Schedule form at the appropriate times (for example, cleaning the house 10–11 a.m. Monday and Wednesday; one hour of shopping Tuesday 10–11 a.m.). The actual details of carrying out the plans are discussed in a step-by-step manner and may be facilitated by the Cognitive Rehearsal technique discussed later in this chapter. The patient should be encouraged to observe and report any negative ideas that occur while trying to carry out the plan. These ideas should be dealt with in the same way as any other dysfunctional cognitions.

The flexible application of the principle of scheduling activities is illustrated in the following example.

A 42-year-old unemployed depressed male complained of inertia which he defined as "an inability to do anything." In the session, the patient indicated particular difficulty in deciding what task to start since, as he described it, he was overwhelmed with jobs around the house. The therapist decided to use an activity schedule and set out with the patient to plan a "reasonable" day using the graded task concept in addition to outlining an hour-to-hour schedule. The therapist emphasized the value of the patient's planning his day so he would have a concrete set of guidelines. The guidelines were formulated so that the patient would not view the schedule as something which "must" be followed. As with all behavioral assignments, the therapist elicited the patient's reactions to the proposed schedule. In this case, the patient was relieved that he was not expected to follow the schedule rigidly and agreed to *attempt* each item.

The items on the agenda included getting up, washing, etc., making breakfast, scanning the newspaper for job opportunities, beginning to mow the lawn (the emphasis being on initiating the activity, not completing it), preparing a resume for a job, and watching television. The patient reported the schedule to be extremely useful as it helped to break his day into discrete units. He continued the scheduling throughout therapy and established a system of planning his day in the prior evening since the mornings were the most difficult decision-making times for him.

The next example demonstrates how the therapist elicited a general sense of hopelessness about a specific task—shopping. Then, each of the problems raised about the task was specified, assessed, and answered. Finally, the therapist and patient constructed a schedule to accomplish an aspect of the goal, recognizing that "everything" could not be accomplished in one trial.

A 48-year-old severely depressed mother of five reported, "I can't do the shopping. I can't plan one meal to the next." Her reasons for not being able to shop included these: (1) "My five children are all on weird diets and I can't keep them all in mind," (2) "I can't tell when my husband's coming home so I don't know what to buy," (3) "I forget what I wanted to buy when I get to the store."





THERAPIST: If you shop for the next day's menus, would you consider that useful?

PATIENT: Yes, but I used to shop for a month at a time.

T: Shopping for one day is not as "efficient" as you used to be—I understand. But by comparing yourself to your best performance, you overlook the value of accomplishing at least one day's shopping now.

P: That's true. I see that.

T: Let's plan one hour a day for shopping. Which hour is best?

P: Eleven to twelve.

T: Okay. Let's mark "shopping" into the 11–12 block for the three problems you know about shopping: (1) forgetting, (2) many individual menus, and (3) an unpredictable number of people for dinner. First, how would you solve the problem of forgetting?

P: I try to make a shopping list.

T: So one thing you'll need to do is make a list during the 11–12 period each day.

P: Right.

T: Next. Are there any foods which all the various diets have in common?

P: Yes, hamburgers, cottage cheese, and salads. But I am tired of fixing and eating those foods.

T: Changing the diets is one issue. Shopping is another. Let's stick to shopping for now. We'll get onto other issues when we're ready. (Note: The therapist did not bring up the patient's probable assumption that she must please everyone in order to be a good mother. When her depression was reduced, the idea was discussed.)

P: Okay. I could plan on hamburger and salads each day.

T: Next, since you're buying the same things for each meal, it doesn't matter how many are present at dinner each night. You can save any extra food for the next day.

P: (smiles): That's true.

T: Do you have enough ideas to plan on working on shopping each day for the one hour? Be sure to record exactly what you do in that hour when it comes and to record any negative thoughts you have while you're trying to shop.

## MASTERY AND PLEASURE TECHNIQUES

Some depressed patients engage in activities but derive little pleasure from them. This failure to derive gratification often results from either (a) an attempt to engage in activities which were not plesurable even prior to the depressive episode, (b) the dominance of negative cognitions which override any potential sense of pleasure, or (c) selective inattention to sensations of pleasure.

In the first instance, patients undertake generally unexciting activities, such as housework, with the result that they do not find that successful completion is gratifying. The patient may hold back from participating in pleasurable activities or he may not readily recall past activities which were pleasurable. The therapist's first objective is to elicit the patient's reasons for not engaging in pleasant activities. A reason such as "I don't deserve to have fun because I have not accomplished anything" is commonly heard from depressives. To counteract this type of thinking, the therapist could describe one purpose of increasing pleasurable activities, namely, to improve the patient's mood even if temporarily.

Activities which are likely to be pleasurable may be assessed with the Reinforcement Survey Schedule (Cautela and Kastenbaum, 1967) or the Pleasant Events Schedule (MacPhillamy and Lewinsohn, 1971). The therapist may assign the task of undertaking a particular pleasurable activity for a specified number of minutes each day and request that the patient note changes in mood or reduction of depressive ruminations associated with the activity. When the patient engages in various activities, it is useful to have him record the degree of Mastery (M) and Pleasure (P) associated with a prescribed activity (see section on Scheduling Activities). The term Mastery refers to a sense of accomplishment when performing a specific task. Pleasure refers to pleasant feelings associated with the activity. Mastery and Pleasure can be rated on a 5-point scale with 0 representing no mastery (pleasure) and 5 representing maximum mastery (pleasure). By using a rating scale, the patient is induced to recognize *partial successes* and *small degrees* of pleasure. This technique tends to counteract his all-or-nothing thinking.

It is often valuable to explain the concepts of Mastery and Pleasure to the patient. "Mastery" may not be directly related to the



completion nor to the magnitude of the task. Patients tend to compare how well they complete the task to their predepression level of achievement. He or she may say, "What's the big deal about calling up a friend? I used to be able to make a dozen calls without thinking about it." Or, "So what if I did some housework. I *should* be able to do that. It's what's expected of me." The therapist explains to the patient that judgment of current performance (degree of mastery) is logically based on the difficulty of the task in his *present* state and not his ideal state: Because of his depression, he is "carrying a 100-lb. weight on his shoulders" or is "dragging a heavy anchor"; in this context, reaching even a minimal goal can be judged a major achievement.

Pleasure refers to feelings of enjoyment, amusement, or fun from an activity. Sometimes even a mild satisfaction that patient attributes to his own actions may help to restore his morale and produce a sense of optimism.

Thus, Mastery and Pleasure may be totally independent. A patient should be encouraged to regard any Mastery as a forward step even though he may not experience any Pleasure. The failure to score either Mastery or Pleasure after successfully engaging in a prescribed activity is likely to be related to a negative interpretation of the event. For example, a patient reported that reading the newspaper had been pleasurable in the past and yet he obtained no pleasure from it when depressed. An inquiry about the loss of pleasure produced responses such as, "I thought of how I lost my job" and "The world seems to be falling apart from the newspaper reports." Similarly, he did not have any sense of mastery from washing the car. He reported, "I couldn't get the whitewalls clean" or "I did not have enough energy to clean the upholstery." By focusing on what he did not accomplish, the patient misses what he *did* accomplish. The therapist points out how this all-or-nothing thinking prevents the patient from having any perspective regarding his present capacity and achievements.

Thus, scheduling activities and rating each for mastery and pleasure provides data with which to identify and correct cognitive distortions. Furthermore, activities which are no longer sources of pleasure can be isolated and, with further experimentation, replaced. The following clinical example demonstrates how an activity schedule is used to identify and correct negative thoughts. Assignments

often elicit absolutistic or perfectionistic standards. Thus, further assignments are designed to elicit and "work through" these thinking problems.

While severely depressed, a 38-year-old executive returned his Activity Schedule with the following ratings of Mastery and Pleasure on a 0–5 scale.

| *Saturday* | | M | P |
|---|---|---|---|
| 8–9 a.m. | Awoke, dressed, ate breakfast | 1 | 1 |
| 9–12 noon | Wallpaper kitchen | 0 | 0 |
| 12–1 p.m. | Lunch | 0 | 0 |
| 1–3 p.m. | Watched TV | 0 | 0 |

The report indicates that although breakfast provided some pleasure and just getting up was rated as achievement, the remainder of the day provided no sense of pleasure or mastery. Yet the patient did wallpaper a kitchen while very depressed. How did he discredit this apparent achievement?

THERAPIST: Why didn't you rate wallpapering the kitchen as a mastery experience?
PATIENT: Because the flowers didn't line up.
T: You did in fact complete the job?
P: Yes.
T: Your kitchen?
P: No. I helped a neighbor do his kitchen.
T: Did he do most of the work? (Note that the therapist inquires about any other reasons for a sense of failure which might not be offered spontaneously.)
P: No. I really did almost all of it. He hadn't wallpapered before.
T: Did anything else go wrong? Did you spill the paste all over? Ruin a lot of wallpaper? Leave a big mess?
P: No, no, the only problem was that the flowers did not line up.
T: So, since it was not perfect, you get no credit at all.
P: Well . . . yes.

[Note that the irrational belief "If I don't do everything perfectly, I am useless, inadequate, and a failure," is implied by this reasoning. However, the correction of this assumption will be left to a later phase of therapy when the patient is less depressed. For now, the correction of the cognitive distortion is the objective.]



T: Just how far off was the alignment of the flowers?
P: (holds out fingers about ⅛ of an inch apart): About that much.
T: On each strip of paper?
P: No . . . on two or three pieces.
T: Out of how many?
P: About 20–25.
T: Did anyone else notice it?
P: No. In fact, my neighbor thought it was great.
T: Did your wife see it?
P: Yeh, she admired the job.
T: Could you see the defect when you stood back and looked at the whole wall?
P: Well . . . not really.
T: So you've selectively attended to a real but very small flaw in your effort to wallpaper. Is it logical that such a small defect should entirely cancel the credit you deserve?
P: Well, it wasn't as good as it should have been.
T: If your neighbor had done the same quality job in your kitchen, what would you say?
P: . . . pretty good job!

The therapist initially reviewed the reported activities and tried to identify apparent discrepancies between what was accomplished (the activity) and what was felt (feelings of mastery and pleasure). Next, by careful inquiry, the therapist sought the reasons for the discrepancy. Then, he elicited the data for the cognition, "The flowers didn't line up." The data were examined objectively by (1) putting the patient's evaluation into perspective with other data (the patient did the bulk of the work, others didn't notice the flaws, etc.) and (2) asking the patient to assess the data from an objective point of view ("What would you say if someone else wallpapered your kitchen in that way?"). Thus, the patient began to see his selective attention to minimal flaws and to reassess the actual facts of the situation.

## GRADED TASK ASSIGNMENT

After successful completion of a series of tasks, depressed patients generally experience some (even though transient) improvement in their mood. They then feel motivated to tackle more difficult

tasks, provided the therapist is vigilant to detect and rebut the patient's inclination to disparage his achievement.

An example of the Graded Task Assignment was described by Goldfried (personal communication, 1974), who independently arrived at this technique. Interestingly, his technique and rationale were similar to those used by our group. While treating a depressed outpatient, Dr. Goldfried reported:

> Working from the assumption that the depression might be construed as a perceived inability of the patient to control her environment, I assigned her a number of specific tasks such as making the beds, getting dressed in the morning, and straightening out rooms around the house, to demonstrate to her that she could, indeed, control the world around her. As she became more adept at these lower level tasks, she was assigned more complex ones. As a significant part of the treatment, I had her continually stand back to evaluate her performance and particularly note that the changes occurring in her life resulted from her own efforts.

The key features of the Graded Task Assignment are:

1. Problem definition—for example, the patient's belief that he is not capable of attaining goals that are important to him.
2. Formulation of a project. Stepwise assignment of tasks (or activities) from simpler to more complex.
3. Immediate and direct observation by the patient that he is successful in reaching a specific objective (carrying out an assigned task). The continual concrete feedback provides the patient with new corrective information regarding his functional capacity.
4. Ventilation of the patient's doubts, cynical reactions, and belittling of his achievement.
5. Encouragement of realistic evaluation by the patient of his actual performance.
6. Emphasis on the fact that the patient reached the goal as a result of his own effort and skill.
7. Devising new, more complex assignments in collaboration with the patient.





The use of graded assignments is illustrated in the following case:

The therapist visited a 40-year-old woman patient on the first day of her hospitalization. Instead of following rather loose instructions by the ward personnel to be involved in ward activities, she was lying in her bed and was ruminating about her problems and "feeling miserable." She did not believe she could get satisfaction from anything.

The therapist was able to determine that in the past, she had enjoyed reading. She stated, however, "I haven't even been able to read a headline in a newspaper for the past couple of months." Despite her doubts regarding whether she would be able to concentrate, she was willing to make an effort to read a few lines. The therapist selected the shortest story in a collection from the library and urged her to read it while he was with her. She said, "I know I won't be able to read it." He replied, "Well, try reading the first paragraph *out loud.*" She responded, "I may be able to mouth the words but I won't be able to concentrate." He then suggested, "See whether you can read the first sentence."

She read the first sentence aloud and continued until she had completed the paragraph. He asked her to read some more but to try reading to herself. She gradually became engrossed in the short story and spontaneously continued onto the next page. He told her to keep reading and that he would return later. About an hour later, the therapist received a call from the psychiatric resident who said, "I just saw the patient whom you *claim* is depressed." When he returned to the ward, the therapist observed that her depression had indeed lifted (temporarily). He encouraged her to undertake a regimen of reading progressively longer short stories; by the end of the week, she was reading a long novel. Within ten days after admission and with continued treatment, she was well enough to return home.

As illustrated in this case, the therapist should elicit the patient's reactions to undertaking a simple project. Most often, the patient's ideas center around a belief that he can't do anything or can't do the specific task. It is important for the therapist to divide a large task into small parts or steps and then to start with a relatively easy first step that he is reasonably certain the patient can complete. As the patient finishes each step, he goes on to the next part. After successful completion of a few tasks during the therapy session, the therapist suggests "homework assignments." The assignments proceed

step by step, for example, from boiling an egg to the eventual goal of preparing a meal.

The therapist is careful to set modest goals to avoid the patient's strong tendency to give up because of his automatic thought, "I can't do it." After a successful attempt the therapist discusses the achievement with the patient and tries to provide an opportunity for the patient to assimilate the success. After the successful experience, the patient usually feels motivated for the next step, but still has to work against the resistance caused by self-doubt and cynicism. Repeated successes generally undermine the patient's belief that "I can't do it." As the patient continues to master each problem, his attitudes such as, 'I can't do anything" or "It is all meaningless" are gradually eroded.

A poorly designed Graded Task Assignment is likely to result in failure. The patient is likely to magnify a failure and use it to confirm his attitude of "I can't do anything." For this reason, a preliminary exercise in carrying out graded tasks may be used in the therapy session and subsequently graded tasks may be assigned as homework. The therapist should formulate the assignment in such a way as to avoid the appearance of failure. For instance, if the therapist suspects that the patient is likely to fail at a task, he should break it into smaller, more easily accomplished steps. The therapist should initially suggest they attempt to determine *how much* the patient can do; "Even if you don't get very far, it will give us important information." In this way, even a "failure" may be construed in a positive way by the therapist; namely, as a source of data for devising other projects.

An important source of error in the application of the Graded Task Assignment is the therapist's failure to check with the patient about his evaluation; that is, how well he *thought* he did in carrying out an assignment. Although depressed patients are likely to do better than they expected, they are also prone to disqualify an accomplishment after the task is completed. A patient may think, for example, "I would have done this in half the time before I was depressed." "Of course I accomplished this, but I am still depressed."

It is crucial to elicit such disclaimers and qualifications from the patient and to provide reasonable answers to them. For example, in response to the first objection, the therapist may respond, "The question we tested with the task was whether you could do it at all. You predicted you couldn't. Yet you did *in fact do it.* You lost sight of





the original purpose of the project by noting you didn't do it at top efficiency. That's a completely separate question." The therapist may respond to the other objection with the explanation, "The project wasn't designed to relieve your depression. It was to see whether your prediction about your inability to do it was accurate. Do you now believe that your prediction was right? . . . We don't expect relief of your depression until we have finished a number of steps. However, your mood does change depending on whether you think you can influence your feelings of depression by carrying out an assignment and then evaluating your success accurately.'

## COGNITIVE REHEARSAL

One of the difficulties in treating depressed patients is the fact that, once depressed, they have problems in carrying out well-learned tasks. A number of psychological factors may interfere with their normal behavioral repertoire. Difficulty in concentration may impede the formulation or execution of normally automatic, habitual behaviors. A housewife may wander into the kitchen to get a glass of water and then forget what she came for. Her problem was not amnesia, but obsessive ruminations; she simply failed to focus on the purpose of the trip to the kitchen. Such an unpleasant experience intensifies her belief that something is seriously wrong with her mind.

"Cognitive rehearsal" refers to the technique of asking the patient to imagine each successive step in the sequence leading to the completion of the task. This procedure forces the patient to pay attention to the essential details of the activities and counteracts the tendency of his mind to wander. Further, by rehearsing the sequence of steps, the patient has a preprogrammed system to carry out the assignment.

Another aim of cognitive rehearsal is to identify potential "roadblocks" (cognitive, behavioral, or environmental) which might impede the achievement of the assignment. The central plan of the therapist is to identify and develop solutions for such problems before they produce an unwanted failure experience. Interestingly, some patients report that they feel better simply as a result of the completion of the assigned task in imagery.

Identification of the psychological barriers by using cognitive hearsal is illustrated in the following example.

The patient was a 24-year-old single unemployed female who ter some discussion agreed to attempt to attend her neglected xercise classes.

THERAPIST: So you agree that it would be a good idea to go to an exercise class.
PATIENT: Yes, I always feel good after them.
T: Okay, well I'd like you to use your imagination and go through each step involved in getting to the class.
P: Well, I'll just have to go the way I've always gone.
T: I think we need to be more specific. We know that you've decided to go to class before but everytime you've run into some roadblocks. Let's go over each step and see what might interfere with getting to class. I'd like you to go through all the steps needed to get to your class. Go over each step in your imagination and tell me what they are.
P: Okay. I know what you mean.
T: The class starts at 9 a.m. What time should we start?
P: About 7:30. I'll wake up to the alarm and probably be feeling lousy. I always hate starting the day.
T: How can you handle that problem?
P: Well, that's why I'll give myself extra time. I'll start by getting dressed and having breakfast. Then, I'll pick up my equipment . . . (pause) . . . Oh, oh, wait, I don't have a pair of shorts to wear. That's one roadblock.
T: What can you do to solve that problem?
P: Well, I can go out and buy some.
T: Can you visualize that? What comes next?
P: I picture myself all ready to go and the car isn't there.
T: What can you do about it?
P: I'll ask my husband to bring the car early.
T: What do you picture next?
P: I'm driving to the class and I decide to turn round and go back.
T: Why?
P: Because I think I'll look foolish.
T: What's the answer to that?
P: Well, actually, the other people are just interested in the exercise, not in how anybody looks.

[By preparing herself with coping techniques for each of those "obstacles" the patient was able to get to the class—in fantasy. She





was then asked to rehearse the entire sequence again and this time was able to imagine the various steps without any interfering cognitions. Subsequently, she indeed drove to the class and did not experience any difficulties. In the event that unexpected problems did arise, she had been instructed to write them down, attempt to master them on the spot, and discuss them at the next session.]

## ASSERTIVE TRAINING AND ROLE-PLAYING

The procedures which form the basis of the assertive training have been well documented. In general, the training focuses on specific skills and includes techniques such as modeling, coaching, and behavior rehearsal. The efficacy of the treatment package and the relative contribution of its components have been reported elsewhere (McFall and Twentyman, 1973).

Role-playing simply involves the adoption of a role by the therapist, the patient, or both, and the subsequent social interaction based on the assigned role. Assertive training and role-playing can be effectively employed in the treatment of depressed patients. As with other techniques with a behavioral focus the therapist attempts to clarify self-defeating or interfering cognitions. Role-playing may also be employed to demonstrate an alternative viewpoint to the patient or to further elucidate the factors which interfere with appropriate emotional expression. (For a list of such cognitive factors see Wolfe and Fodor, 1975.)

A 20-year-old female patient reported a "humiliating experience" in which she became flustered while buying some clothes in a large department store. She was preoccupied with thoughts that her purchase may not have been suitable and that she gave the clerk less money than was requested. When the clerk asked for more money, the patient concluded, "She must think I'm a fool. I'm so clumsy and inept." The therapist asked the patient to take the role of the clerk and to draw some conclusions from her observations.

PATIENT: (in role of clerk) Well, I see a woman who is obviously flustered and embarassed to have given me the incorrect change. I would try to console her by saying, "Everyone makes mistakes."

THERAPIST: Do you think it's possible the clerk also came to a similar conclusion with the exception that she did not console you?

P: Well, if she had tried to console me, I would have been shocked. No, she couldn't have been so understanding . . . I know what it's like to be a klutz, so I can put myself in the other person's shoes.

T: And what evidence do you have that the clerk didn't understand your mistake? Did she make any comments? Did she act disgusted?

P: No, actually she was quite patient. She even smiled but that made me feel more like a fool.

T: Well, without much data it's difficult to draw definite conclusions about her reactions. So let's work on your tendency to view yourself as a fool when you make mistakes. Later we can rehearse how you could have responded if she had acted critically to you.

Role-playing may be used in similar manner to elicit a "self-sympathy" response from the patient. The therapist may take the role of the patient in an attempt to change the patient's cognitive set from self-critical to sympathetic. It is common for depressed patients to be more demanding and critical of themselves than of others in the same situation.

One of the essential aspects of cognitive therapy is the evaluation of cognitions which may interfere with behavioral performance. Some depressed patients behave nonassertively because of the negative beliefs rather than as a result of a deficiency of behavioral skill.

A 29-year-old depressed male had returned to a university after a 10-year period during which he worked as a factory worker. He came to a therapy session particularly disturbed by the behavior of his 20-year-old chemistry laboratory partner. The younger student persistently left their shared equipment dirty and disarranged with the result that the patient spent time every week cleaning the equipment. The patient clearly outlined a way of discussing the problem with his lab partner but changed his mind each time he was about to confront him. The therapist pursued the patient's cognitions related to his attempts at self-assertion.

PATIENT: Well, even though I know what to say and when to say it, I always get the thought, "He'll think I am overmeticulous."





THERAPIST: And what would it mean to him if you were "overmeticulous."

P: He'd think I was a rigid, conservative type.

T: Are you a "rigid, conservative type."

P: No. You know what? I'm concerned that he might rebel and I'd be causing even more trouble.

From this point, it was apparent the patient was not behaving in an assertive manner because of his desire to avoid "causing trouble," particularly since he was "considerably older." His lack of assertiveness resulted in further concern about his decision to return to university. When the therapist and patient were able to list the "pros and cons" of his being assertive in this instance, the patient decided to speak to the other student and had no difficulty accomplishing his objective.

This example illustrates the vital importance of an individual's negative cognitions in interfering with assertive behavior.

## BEHAVIORAL TECHNIQUES: RATIONALE AND TIMING

It is extremely important that patient understand the rationale for the various behavioral assignments. The therapist faces a considerable challenge with depressed patients since they are prone to distort the purpose of the tasks *post facto*. It is the therapist's responsibility to insure that the patient interprets the results of an assignment within the confines of the initial objective. The initial objective, therefore, must be made clear from the beginning.

One helpful strategy to evaluate the patient's understanding of a task is to use a role-reversal (the patient takes the role of the therapist). The patient can then review the reasons for the assignment (for example, recording daily activities) and the therapist can subsequently correct any misconceptions.

When outlining a behavioral assignment, the therapist needs to avoid making generalized statements which may imply that the completion of one task will make the patient feel better. The therapist should simply underscore that the patient is "moving in the right direction." Positive expectations of the patient are helpful, of course, but the patient should be guided away from the absolute ("all or nothing") evaluation of the results of any one assignment.

*Note:* The utilization of a "significant other" (spouse, other relative, or close friend) is often very helpful in setting and implementing behavioral assignments. In addition to encouraging the patient in initiating and completing projects, the significant other can provide valuable feedback to both patient and therapist.

Some patients respond to success in a behavioral assignment by dramatically increasing their activity. While this result is generally desirable, the patient may overextend himself to the point of failure or may experience anxiety from undertaking new projects before he is prepared for them. A reminder that the initial goals of therapy involve testing negative ideas and gradually increasing activity, rather than making tremendous accomplishments, may be indicated.

As previously noted, most of the behavioral techniques are employed in the initial therapy sessions. The appropriate targets include passivity, avoidance, lack of gratification, and an inability to express appropriate emotions (such as anger and sadness). While these symptoms may be evident across the range of depressed patients, the behavioral techniques are clearly indicated with severely depressed patients. An individual with severe depression commonly has considerable difficulty focusing on more abstract conceptualizations. His attention span may be limited to well-defined concrete suggestions. Research findings in the area suggest "success" experiences on concrete behavioral tasks are most effective in breaking the vicious cycle of demoralization, passivity and avoidance, and self-disparagement.

Homework assignments also need to be graded to the patient's level of understanding. In general, homework is not assigned in the initial stages of treatment until the patient completes a form of the assignment in the session. Obviously, it is impossible to comply absolutely with this rule since many assignments require the patient to be in his natural environment. Nevertheless, cognitive rehearsal and telephone conversations between patient and therapist will circumvent many problems. We have found that the agreement to call the therapist when the patient is "stuck" in carrying out an assignment is very helpful. This practice enables the patient to identify and master his problems in the "real life situation" and also motivates him to continue with his assignments. "Reporting in" to the therapist by telephone when the patient has completed a series of assignments also provides a powerful motivation to carry out the projects.





Once the patient understands the rationale and application of the behavioral techniques, therapy proceeds to more "purely" cognitive approaches. If behavioral symptoms or problems reappear, the patient may need a "refresher course" or may simply reinstitute the behavioral techniques. In times of stress, many former patients return to activity scheduling or recording. Since the techniques have already been mastered, they are easily used to prevent incipient regression.

In summary, behavioral techniques are useful insofar as they improve level of functioning, counteract obsessive thinking, change dysfunctional attitudes, and give a feeling of gratification. By observing changes in his own behavior, the patient may then be more amenable to examining his negative self-concept. An amelioration of the negative self-concept then leads to more spontaneous motivation and an improvement in mood.