Particularities of Depressive Symptomatology and Cognitive-Behavioral Interventions

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Depression represents an inherent human suffering of whose manifestations present the same characteristics around the world. Within the depressive symptomatology tableau we may find apathy, lack of interest, emphasized sadness, lack of capacity of emotional reasoning, along with insomnia, decreased appetite, decreased self-esteem and libido, fluctuations of weight, all being correlated with a series of somatic symptoms (Allen, & Badcock, 2006; DSM 5, 2013).

Depression generally evolves in episodes which may present duration between six months and one year and a half, followed sometimes by spontaneous remissions (DSM-IV-TR, 2000). Not treating depressive episode means increasing the probability that another episode might occur at lower time intervals, with periods of recovering which will need more time.

Beck observed the way in which depressive patients evaluate events from a negative and self-critical point of view. Depressive patients expect mostly failure instead of success and present a tendency of amplifying failure and minimizing success in evaluating their performance. When things events work badly the depressive patients tend to blame themselves (Beck, 1976; Clark, & Beck, 1999).

Beck suggested that negative thoughts of depressed individuals are rapidly installed and automatically, as a reflex, as they are not consciously controlled. Such thoughts are followed many times by unpleasant emotions (despair, sadness), of which patients are aware, even if they have been less conscious about previous automatic thoughts.

On the other hand, in order to explain cognitive phenomena related to emotional disorders, Williams and Moulds (2007a) refer to a hypothesis which states that the existence, at any level, of decisional mechanisms, capable of judging the affective valence of information. In the case of depression it is assumed that the elaboration starts as a decisional mechanism which evaluates the affective valence of the stimuli, the affective decision output representing the input of mechanisms of allocating resources, establishing whether or not new resources shall be

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allocated to the stimuli processing (cognitive avoidance).

Subjects with „depressive" traits such as self-criticism, perfectionism, negative attribution style, have the general tendency of responding to the decisional style in a certain direction (Williams, & Scott, 1988). It seems that people with such traits present whether resources allocation or retracting them. Pathological manifestations will not be presented if the negative disposition is weak, but its modifications will exacerbate the tendency of allocation/retraction of resources, as the subjects will manifest exaggerated reactions to minimal perturbations of disposition and even prolonging them after the stimuli has been removed (Williams, Barnhofer, Crane, Hermans, Raes, Watkins, et al., 2007).

The interaction of biological and psychological treatments in the case of depression represented a clinical challenged from the beginning. Along with the discovery of the first neuroleptic drug, chlorpromazine, a new science has emerged – psychopharmacology – which proposes to modify behavior; because of its interdisciplinary character, its activity is mostly conducted in the area of what we call the psyche-soma. Genetic, biochemical and clinical data accredit the idea that types of depression form a relative heterogeneous group of affections. In the case of depressive symptomatology there is an etiology, pathogen, clinical manifestations and also different ways in which patients respond to treatment.

We may assert that anti-depressive substances take action predominantly on somatic manifestations of depression, while psychotherapy positively influences cognitive-behavioral dysfunctions. Psychotherapy can be applied after the symptomatology content of depression has been diminished or put out.

Empirical studies conducted during the past 40 years show that Cognitive-Behavioral interventions are recognized as presenting efficiency in obtaining positive results among depressive patients (Taylor, & Marshall, 1977; Jacobson, Dobson, Truax, Addis, Koerner, Gollan, & Prince, 1996; Butler, Chapman, Forman, & Beck, 2006).

Cognitive-Behavioral therapy is a generic term for therapeutic interventions which incorporates cognitive and behavioral techniques. Directions which define such interventions can be resumed as follows: molecular, metacognitive and constructivist approach.

Molecular approach is oriented only on the irrational thought which is conceptualized as a mediator variable for the behavior (Lyddon, 1990). The main assumption is that the thought affects the emotion. This type of approach is found in the first stages of cognitive-behavioral interventions.

The metacognitive approach is a direction oriented on cognitive structures and process, as the main purpose of the therapy sights the acquisition of general strategies and modifying central schemas, not consequences. Beck's cognitive therapy (Beck, 1976), but especially its concept regarding personality disorders (Beck, Davis, & Freeman, 2015), is best included within this

approach. Overcoming the level of the cognitive event (the irrational thought), introducing the history of development, emphasizing the dynamic interaction between the organism and the environment, replacing peripheral modifications with more general reconstructions offers the approach a high predictive and explanatory power (Alford, & Beck, 1998).

The constructivist approach brings a new set of assumptions: reality is not invariant and a given, it is created by the subject even while one perceives, as the causal relationship has a circular nature (Neimeyer, 2009). The constructivist elements assume building new models or interpretation of reality, in a more functional way compared to the existing ones (Caro, 2002; Cottraux, & Blackburn, 2006).

Based on etiopathogenetic assumptions, cognitive-behavioral interventions in depression have the main objective of identifying the invoked issue as a cause of the affective disorder by the depressive patient, on one side (Grant, Townend, Mills, & Cockx, 2008); identifying solutions of solving problems and applying them with the purpose of recovering functionality of individuals, on the other side (Clark, & Beck, 1999).

A series of characteristics of the patients, together with the experience of the therapist will thus facilitate the development of a specific matrix.

In the end, the mixed medical and psychotherapeutic treatment will be a personalized one, according to the requests imposed by the symptomatology, environment and personal values of the depressive patients.

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