Cognitive Behavioral Intervention in the Major Depressive Episode

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Abstract

Establishing a diagnosis of depressive disorder in its chronic form implies the existence of several depressive episodes. The states of irritability, sadness, melancholy, sleep-wake cycle disturbances, fatigue, and pronounced impairment of social and personal life are present and represent signs and symptoms of major depressive episodes. A major depressive episode may be difficult to detect due to comorbidity with other medical conditions such as diabetes, morbid obesity, cardiovascular disease, and the socio-cultural context in which the individual functions (DSM-5, 2013).

A psychiatric investigation is required in the case of depressive disorder and medication is often needed and even more so, essential in sustaining psychotherapy. Also, suicide risk assessment is mandatory to address, especially when patients report suicidal thoughts or suicidal tendencies (Oquendo, et al., 2004). To a large extent, it is important to note that the success of therapy depends on the patient's willingness to cooperate.

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I. INTRODUCTION

When you wish for something, when you experience pleasure, pain, aspirations, desire, power, faith, hope, new, old, everything next to you, flavors, colors, memories, future, stories, dreams, play, song, joy, forgiveness, trial, acceptance, they slowly fade into nothingness until they fade away and along with them, you as well, even though you are breathing, you are still alive. They then re-appear, but seem foreign to yourself.

These experiences were yours; they were a part of you, even though they seem part of a movie based on someone else's life. The only obvious thing for you now is the attentive but heedless instance of nothingness, that certain something that is so hard to wear, so difficult to define, that something that gradually and cunningly engulfs you, paralyzes and feeds on your pain and silent cry. With each day that goes by and you silently refuse confrontation, it weaves its cocoon of sadness around your soul, sinking deeper into the silk of pain, splitting yourself from the rest of the world and, most importantly, from yourself. Each day when you are not present in your life, this thing settles in, and you seem to be tacitly agreeing with the role of a cast out spectator of your own life, you feel guilty, weird, punished, embarrassed, incomprehensible, agitated or numb.

How many of us have felt this at a certain point, or at least had fleeting experiences like those mentioned above? Probably each of us, at a given moment in an existing context, has experienced a deep state of sadness that is sometimes too deep to simply call it sadness. Yet for how many of us do the aforementioned experiences reflect the everyday reality... how many of us live their lives under the siege of this Hydra of the contemporary world, depression?

Statistically, if we take into account the World Health Organization (WHO) reports, the figures are colossal, namely 4.4% of the world's population and about 300 million people worldwide are affected by depression, a condition that, since 2012, ranks as the second cause of suicide worldwide for individuals aged between 15 – 29 years.

There are 40.27 million cases of depressive disorders in Europe, and 1 out of 10 Romanians are affected by depression and anxiety disorders, with suicide rates ranging from 10.5 to 12.2 per 100,000 inhabitants in the year 2016 (Ionescu, 2005; Olesen, 2012; World Health Organization, 2017).

The steps that need to be taken may seem easy, but in reality it is very difficult for one in such a situation. Asking for help, if you can get access to specialized services or are willing to accept the need to receive help is not easy for the one in question, especially in the Romanian socio-cultural context. From every perspective, regardless of the therapeutic approach, the process of alleviating symptoms is arduous, due to the fact that for a depressed person, to want is not the same as to be able to.

Depression is not a fad, a hint or a simple fit, depression hurts and exhausts day by day, around the clock. During the major depressive episode, the symptoms are global on an affective, cognitive and physiological scale (Beck, 2008). The depressive disposition assumes, on an emotional level, the existence of a subjective sense of sadness for a long period of time, anhedonia - inability to feel pleasure, experiencing social withdrawal, feelings of excessive guilt, uselessness, lack of motivation, difficulty in concentration and making decisions, impoverishment of content of thought and speech, and sometimes, depending on the type of depression, delusional ideas, congruent with the mood (Treadway, & Zald, 2011; Lykouras et al., 1986). There are also physiological factors present - excessive fatigue and energy depletion, insomnia or increased sleepiness, headache, fatigue, weight gain or loss, lack of appetite, or appetite for a certain type of food (Holdevici, & Crăciun, 2013).

II. COGNITIVE BEHAVIORAL TECHNIQUES

Intervention techniques of cognitive-behavioral therapy that are successfully used in the treatment of major depressive episode include cognitive restructuring, identification of automatic negative thoughts, testing the validity of negative thoughts and beliefs, behavioral tasks, psychoeducation, relaxation, assertive training, optimization of problem solving and other abilities, narrative technique, imagery techniques and mindfulness (Clark, Beck, & Alford, 1999; Holdevici, & Crăciun, 2017).

Depression is the result of a combination of bio-psycho-social factors, but negative thoughts are essential in triggering and sustaining a depressive episode (Sheldon, 2011; Morgan, 2003). Looking from the perspective of cognitive-behavioral psychotherapy, the depressive episode has an important contribution to the emergence of negative states. This is the reason why automatic negative thoughts are a starting point for psychotherapeutic intervention. It is worth mentioning that they derive from cognitive structures called central beliefs reunited in the cognitive system in the form of cognitive schemes (Beck, 1979; Leahy, 2017). We can recall certain specific cognitive distortions found in depression:

- Magnification (Catastrophizing): “I will embarrass myself”;
- Global Labeling: “Everyone thinks I am a loser and a fool”;
- Predicting: “I will certainly do not pass the exam”;
- Polarized thinking, all-or-nothing: “I have no way out”, minimizing the success: “Anyone would have succeeded”;
- Always being right: “I should be accepted by everyone, I should stop feeling bad, I have too many failures, so I'm a loser” (Beck, 1976; Burns, 2012).

In order to achieve the goal of eliminating negative automatic thoughts and maladaptive behaviors within the therapeutic process, the patient and the therapist need to go through the following steps:

1) Identifying maladaptive behaviors achieved by detecting certain repetitive patterns that lead to the emergence of nonadaptive behavior (Beck, 2011);
2) Recording the sequence of negative thoughts and interrupting them by distracting and replacing them with rational thoughts;
3) Analyzing the accuracy of maladaptive assumptions; this can be done by following the truthfulness of the hypotheses issued by the patient, the detection, the repetition and the highlighting of the existing breaches in the dysfunctional thinking (Kovacs, & Beck, 1986);
4) Identifying the automatic thoughts that intertwines between the external situations and the emotional reaction of the depressed, namely an internal dialogue of the patient in relation to certain events or activities (Turner, & Swearer, 2010);
5) Testing automatic thoughts, this is done by checking their exaggerated or inadequate validity;
6) Changing the attribution of responsibility and culpability by using Socratic techniques, as the patient with depression tends to feel guilty due to the negative consequences of his actions, situations or events (Ellis, 1980);
7) Role play can be successfully used in decreasing the catastrophizing of negative events;
8) Identifying alternative solutions to help the patient with depression in thinking about the most appropriate explanations for negative situations and also in learning to verify their conclusions before automatically accepting them as univocally undesirable;
9) Training self-confidence consists in stimulating and encouraging the patient with depression to become more optimistic and self-confident by performing simple, day-to-day and useful activities, which are appropriate to the patient's preferences: reading, shopping, cooking, gardening etc.

III. CONCLUSIONS

Cognitive-behavioral psychotherapy for patients with depressive episode involves the development of therapeutic processes over a period of 16-20 sessions, one hour twice a week in the first three to four weeks, then a weekly security session. However, for those with severe depression that have a hard time concentrating, the length of a session may be 20 minutes. A clinical interview must seek the information that is needed in order to start the therapeutic

process and establishing a plan, assessing the onset, evolution and current life context, associated negative thoughts, suicide risk; establishing the therapy goals; drafting a list of issues and objectives; detailed presentation of the therapy plan and explanation of the cognitive model generating and supporting the depressive state; stressing the importance of performing behavioral experiments and homework (McKay, & Fanning, 2016).

More valuable than the bundle of techniques that may successfully lead to the therapeutic intervention is the therapeutic relationship (Hubble, Duncan, & Miller, 1999; Saunders, 1999). Without the patient trusting that he or she can be open and accepted without feeling judged, the therapeutic process cannot be carried out.

By offering one acceptance, as one is here and now, the patient will allow him or herself the freedom of being, accepting, forgiving, fully understanding himself, accessing, using and growing unpredictable resources that he was not completely aware of and ultimately, the freedom to be here and now in his own life.

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