

[Experience Sharing Forum]

**Application of Cognitive Therapy
to Hopelessness Depression**

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Hopelessness depression is a subtype of depression. Due to hopelessness, this subtype of depression has distinctive symptoms of retarded initiation of voluntary responses, apathy, and mood-exacerbated negative cognition. Hence, hopelessness depression patients have motivational defects and strong dysfunctional thinking. These are unfavorable factors for cognitive therapy because cognitive therapy requires patients' participation in identifying and modifying their dysfunctional thinking and it has limitation for modifying strong dysfunctional thinking. This article shows that undermining hopelessness is a necessary preliminary step before cognitive work on their dysfunctional thinking when treating hopelessness depression patients, and it can be done by cognitive treatment focusing on self-esteem enhancement. A successful case experience of applying cognitive therapy to hopelessness depression is illustrated.

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Depression is a prevalent mental problem in Hong Kong. According to *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision), depression has the symptoms of depressed mood, loss of interest or pleasure, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feeling of worthlessness or inappropriate guilt, inability to think or concentrate, and recurrent thoughts of death or suicide (American Psychiatric Association, 2000). However, it is now found that depression is not a single disorder but comprises several subtypes which have distinct symptom complex (Ingram, Scott, & Siegle, 1999). One of the subtypes of depression is hopelessness depression (HD). It was first proposed by Abramson, Metalsky, and Alloy (1989), and its existence is supported by later research findings (e.g., Abela, 2002; Metalsky, Joiner, Hardin, & Abramson, 1993; Stockum, 1999). This depression subtype has symptoms of retarded initiation of voluntary responses, sad affect, suicidal attempts or ideation, lack of energy, apathy, psychomotor retardation, sleep disturbance, difficulty in concentration, and mood-exacerbated negative cognition (Abramson et al., 1989).

Among various forms of psychotherapy to treat depression, cognitive therapy is very much welcomed by practitioners in Hong Kong because of its efficiency and effectiveness. However, HD has different cognitive diathesis factor from that of general depression, and has distinctive symptoms of retarded initiation of voluntary responses, apathy, and mood-exacerbated negative cognition. Are there any special concerns when applying cognitive therapy to HD? This article discusses about the application of cognitive therapy to HD and shares the counselor's experience in applying cognitive therapy to an HD patient.

Cognitive Therapy in the Treatment of Depression

Cognitive Model of Depression

Cognitive therapy is developed by A. T. Beck (1996), based on his cognitive model in understanding human behavior. A. T. Beck first proposed that cognition dominated emotion and behavior. However, with increasing knowledge from clinical, evolutionary, and cognitive psychology, he has refined his cognitive model and now posits that cognitive system works together with affective, motivational, and behavioral system of an individual as a mode. Modes are networks of the schemas of different systems that compose personality. The cognitive system deals with the ways that individuals perceive, interpret, and assign meanings to events. It contains the schema of core beliefs with high stability, and the core beliefs give rise to assumptions. When an individual faces an event, the assumption would bring an automatic thought into the individual's mind instantly. The automatic thought is accompanied by a corresponding emotion (A. T. Beck & Weishaar, 2005). The modes are designed to deal with specific demands or problems. There are two types of modes, namely primal modes and minor modes. Primal modes are autonomous and are related to survival reactions whereas minor modes are related to prosaic activities and are under conscious control (A. T. Beck, 1996).

Depression can be conceptualized as a primal mode (A. T. Beck, 1996). The cognitive system in depression mode contains the schema of negative cognitive triad which includes three core beliefs: (1) negative view toward self (people believe that they are defective, deficient, and worthless); (2) negative view toward the world (people believe that the world is making unreasonable demands upon them); and (3) negative view toward their future (people believe that their problem would not be solved). The negative cognitive triad causes negative biased information processing, and makes the individual prone to identify a situation as loss

(A. T. Beck & Weishaar, 2005). The individual would easily have depressive automatic thoughts and emotion.

Strategies

Cognitive therapy aims to adjust information processing and initiate positive change in all systems by acting through cognitive systems (A. T. Beck & Weishaar, 2005). It is by the conscious control system to gain perspective over the basic cognitive reaction. The system plays the role of evaluating the products of the primal cognitive processing by applying more adaptive, flexible, and mature thinking (A. T. Beck, 1996). The therapist helps a depression patient to identify and modify their dysfunctional thinking including the automatic thoughts, assumptions, and core beliefs arising from the patient's negative cognitive triad. Cognitive therapy has a variety of intervention techniques of which the therapist can make use (J. S. Beck, 1995).

Cognitive Therapy in the Treatment of HD

Cognitive Model of HD

The cognitive diathesis factor of HD is depressogenic attributional style (DAS). When facing negative events, HD patients use this style to make inferences about the consequences, the causes, and the self. These three inferences lead to a verdict of hopelessness, an expectation that highly desired outcome will never occur or highly aversive outcome would surely occur. Hopelessness engenders the symptoms of HD (Abramson et al., 1989).

The operation of DAS is analogous to that of core beliefs. DAS gives rise to the three inferences. When facing a negative event, the three inferences would bring an automatic thought with the content of hopelessness, accompanied by the emotion of hopelessness. In fact, the effect of DAS is similar to the part of "negative view toward the future"

in the negative cognitive triad of depression; they both deprive the patient from seeing the possibility of positive change in future. Besides, research findings have shown that DAS, like core beliefs, has high stability (Hankin, Fraley, & Abela, 2005; Voelz, Walker, Pettit, Joiner, & Wagner, 2003).

Strategies

When proposing HD, Abramson et al. (1989) suggested that treatment to HD should, firstly, undermine hopelessness and, secondly, modify the cognitive diathesis. Apparently, in treating HD patients, the preliminary job of undermining hopelessness is necessary. Hopelessness causes resistance from HD patients to cognitive work on their dysfunctional thinking in two ways. Firstly, HD patients have motivational defects arising from the distinctive symptoms of apathy and retarded initiation of voluntary responses. These two symptoms are derived from the helplessness expectancy component of hopelessness. If an individual expects nothing from the outcome, he would have no incentive to pay any effort (Abramson et al., 1989). Hence, HD patients have difficulty to fulfill the requirement of cognitive therapy that patients have to participate in examining the validity of their thinking and doing experiments for finding out the real facts. Secondly, the effect of cognitive therapy in a case depends much on the intensity of the dysfunctional thinking held by the patient. Patients who have very strong dysfunctional thinking have difficulty to gain awareness of the problems with their dysfunctional beliefs (Fennell, 2004). HD has the symptom of mood-exacerbated negative cognition, which means that when the patient is becoming sad, his cognition would become even more negative (Abramson et al., 1989). Thus, being affected by hopelessness, HD patients have very negative cognition and would resist change in their thinking. Hicks (2003) found that hopelessness is an important cognitive factor affecting the outcome of cognitive therapy for depression.

Cognitive Work Undermining Hopelessness

What can be done to undermine the patient's hopelessness, and to prepare the patient for the subsequent cognitive work on his/her dysfunctional thinking? Hopelessness has been found to be very much related to the psychological construct of self-esteem. In the two studies about the test of the hopelessness and self-esteem theories of depression (Abela, 2002; Metalsky et al., 1993), self-esteem was found to be a crucial factor determining the hopelessness effect of DAS. High self-esteem individuals with DAS are less likely to develop hopelessness when facing negative events, comparing with low self-esteem individuals. There are two possible reasons. Firstly, though DAS causes pessimistic inference about causes and consequence, high self-esteem encourages individuals to adopt riskier approaches or enhancing strategies in which they call attention to their strengths and abilities (Kirkpatrick & Ellis, 2004), resulting in higher chance of success. Secondly, though DAS causes pessimistic inference about self, high self-esteem prevents people from making generalization from failure experience to other areas of the self-concept (Brown, 1998), resulting in better views of self. As self-esteem can serve as a buffer against hopelessness in individuals with DAS (Metalsky et al., 1993), enhancing the self-esteem of HD patients may help them combating hopelessness.

Fennell and Jenkins (2004) illustrated the cognitive model of self-esteem and pronounced that cognitive therapy can enhance an individual's self-esteem by promoting positive self-evaluation and helpful problem-solving in difficult life situations. Nevertheless, while HD patients have tendency to infer negative characteristics about themselves from the occurrence of negative events, therapists should put the emphasis on neutral or positive life events when promoting positive self-evaluation. This would avoid resistance from HD patients.

Cognitive Work on Cognitive Diathesis

After undermining the patient's hopelessness, therapists can proceed to work on the patient's dysfunctional cognition arising from DAS. While the operation of DAS is similar to that of core beliefs, the strategies of cognitive therapy in modifying dysfunctional cognition in general depression can be applied to that in HD.

Case Sharing

The counselor had an experience of applying cognitive therapy to a case of HD. Before identifying the client as a case of HD, the counselor rendered cognitive work on her dysfunctional thinking directly. The client showed great resistance and proclaimed that her thinking was absolutely true and should not be disputed about. As a result, the treatment could not proceed.

The following gives the information of the case background, presenting concerns, conceptualization, formulation of treatment plan, treatment process, and outcomes. Lastly, personal experience of the counselor in the treatment process is shared.

Case Background

Madam X was a middle-aged woman. She was married and was a full-time housewife. Her husband was a driver earning limited income. They had two adolescent children, the younger one being a mentally retardate. Madam X became severely depressed when her younger child was diagnosed as suffering from mental retardation at the age of two over ten years ago. Madam X was diagnosed as suffering from major depression. She attended outpatient psychiatric treatment and had regular drug compliance. She had no suicidal thoughts but her mood was persistently low.

Presenting Concerns

Madam X had the belief that “as life would inevitably end in death, life is totally hopeless.” She started to have this belief when her beloved father died shortly after being diagnosed as suffering from cancer some twenty years ago. Besides, she ruminated about the question of “why people have to die.” She could not concentrate on her daily tasks, and that greatly affected her child-care and housework performance. Her husband was disappointed with her and that caused her marital relationship problem.

Conceptualization

Madam X was suffering from HD. Her DAS was activated by negative events in her life, which included her beloved father’s death, her giving-birth to a mentally retarded child, as well as her depression, child-care and marital problem.

Formulation of Treatment Plan

Madam X had deep hopelessness which caused her resistance to cognitive work on her dysfunctional thinking. Cognitive therapy would be first rendered to enhance Madam X’s self-esteem to undermine her hopelessness. After she had improvement in her hopelessness, cognitive therapy would be rendered to modify her dysfunctional thinking. The treatment program would last for three months, consisting of twelve sessions scheduled once in two weeks. A follow-up session would be arranged one month after the treatment program to review her progress.

The contents of interview sessions would be summarized in written form, so that Madam X could read them at home for rehearsal between the sessions. Written materials that the patient can take away provide opportunities for cultivating awareness beyond the session (Fennell, 2004). After the treatment, these written materials would be compiled

into a book with illustrations as a compliment to Madam X for her completion of the treatment program.

Treatments to enhance Madam X's self-esteem would include:

1. Encouraging Madam X to keep daily record of five completed tasks with rating of pleasure and achievement level on a scale of 1–5 for self-monitoring. This homework would help Madam X to see that she was more active and successful than she thought, and was more able to recognize her accomplishments (Emery, 1988). Daily record sheets with tables of five rows and three columns would be given to Madam X for keeping the record. The three columns were for recording the completed tasks, and the respective rating of pleasure and achievement.
2. Helping Madam X to have positive self-evaluation on her characters and also on her performance in her social roles. This would help Madam X to see her strengths and contributions.
3. Helping Madam X to identify her life problems and enhancing her problem-solving ability to solve these problems. This would increase her sense of mastery and competence. The Chinese translation of the problem-solving worksheet in J. S. Beck's (1995) *Cognitive Therapy: Basics and Beyond* would be used. The items on the worksheet would guide Madam X to find out solutions to her problems step by step.

Treatments to modify Madam X's cognitive diathesis would include:

1. Helping Madam X to identify the problems with her dysfunctional thinking and make due modifications.
2. Enhancing Madam X's skill in coping with her negative rumination.

Treatment Process

At the beginning of each session, Madam X's homework (the daily record of five completed tasks with rating of pleasure and achievement) was reviewed. Then, the treatment activities that followed would depend on the focus in the sessions. The treatment for the first to fifth sessions focused on self-esteem enhancement. Madam X reviewed her past and present life, and identified her strengths and weaknesses. Besides, Madam X identified her depression problem, child-care problem, and marital relationship problem, and devised solutions to solve them. The treatment for the sixth to twelfth sessions focused on the dysfunctional cognition. Madam X examined her thinking and rumination, and devised means to cope with them.

Outcomes

Rosenberg Self-esteem (RSE) Scale and Beck Depression Inventory (BDI) Measurement

Madam X's RSE score rose from 20 to 27 and her BDI score dropped from 29 to 23. This showed that Madam X had improvement in her self-esteem and depression after the treatment program.

Madam X's Responses

Madam X's had gradual increase in her positive self-evaluation and problem-solving behavior. At the beginning, Madam X commented herself as being unlovable and inadequate. However, she later was able to see her good appearance and characters, her strengths in communicating with her children and in her care-giving role, as well as her contributions to her family. Besides, she could gradually identify her life problems and make some successful problem-solving attempts. This showed that she had improvement in her self-esteem.

Since the sixth session, Madam X was gradually able to see that her dysfunctional belief of “life is hopeless” did not reflect the reality but an outcome of her DAS. She made up her mind to cope with her dysfunctional belief and rumination constructively. Madam X tried to think more positively about life. When the rumination intruded into her mind, she tried to modify it or ignore it by engaging herself in pleasurable activities. Subsequently, she was less affected by her dysfunctional thinking and had improved mood. In the last treatment session, the counselor invited her to name the book which would be given to her after compilation. Madam X gave the title of “Never Give Up” to denote her readiness and volition to face her future life difficulties. In the follow-up session, Madam X reported that she had maintained her good condition. This showed that she had improvement in her depression.

Comments From the Counselor’s Supervisor

The interview sessions were video-taped for comments from the counselor’s supervisor. The counselor’s supervisor remarked that the treatment outcome was satisfactory. Madam X gained insight into her cognitive problem and developed means to cope with it, leading to the improvement in her depression.

Madam X’s Feedback

In the last treatment session, Madam X was invited to give feedback on the treatment program. Madam X said that after the treatment, she had much better self-understanding and self-acceptance. She saw her strengths and learned to appreciate them; she saw her weaknesses and learned to improve them. Besides, she gained the awareness of her DAS, her dysfunctional belief, and her negative rumination, and learnt means to cope with them. She reported that she had improvement in

her depression problem and had better performance in her child-care and household duties.

Counselor's Personal Experience in the Treatment Process

Before identifying Madam X as a case of HD, the counselor made great effort in modifying her dysfunctional cognition. However, Madam X showed great resistance, and the counselor was not able to progress and felt stuck. Gradually, the counselor realized that Madam X was overwhelmed by hopelessness, and decided to change the focus of cognitive work to self-esteem. Nevertheless, the counselor bore in mind that the ultimate target of change was Madam X's dysfunctional thinking. The counselor saw Madam X's gradual improvement in her emotion. After confirming her readiness for discussing her cognitive problem several sessions later, the counselor returned the focus of cognitive work to her dysfunctional thinking. Subsequently, Madam X gained insight into her cognitive problem and learnt to cope with her dysfunctional thinking. The counselor knew that the ultimate treatment goal had been achieved.

Discussion

The present case experience shows that for treating HD patients, undermining hopelessness is a necessary preliminary step to cognitive work on their dysfunctional thinking, and cognitive treatment focusing on self-esteem enhancement is effective in undermining hopelessness.

Nevertheless, this case experience has limitations. Firstly, BDI was used to measure the outcome of the treatment. However, as the symptoms of HD are not exactly as that of general depression, the Hopelessness Depression Symptom Questionnaire (Metalsky & Joiner, 1997) would be a better measurement tool in this case. Secondly, the counselor got the data from Madam X only. There might be bias due to

the experimenter expectation effect. The counselor's tone and gesture might hint Madam X to give higher RSE and lower BDI item ratings as well as positive feedback in the evaluation in order to prove the effectiveness of the treatment program. It would be much better if the counselor can also ask Madam X's husband about her change.

There are three suggestions about the use of this cognitive treatment to enhance patients' self-esteem. Firstly, HD patients have motivational defects due to their symptoms related to hopelessness. Hence, therapists have to adjust the task difficulty when assigning homework to patients. This would avoid resistance from patients and encourage their participation. Secondly, materials recording the positive cognition gained in the treatment sessions allow HD patients to make rehearsal at home, and that contributes to the treatment process. If the patient is illiterate, video or audio record form can be considered. Thirdly, self-esteem is an important topic in psychology and there are many studies coming up in this topic, for example, the variability of self-esteem by Hayes, Harris, and Carver (2004). Therapists can make use of new study findings to design self-esteem enhancement cognitive treatment program for the benefit of HD patients.

Conclusion

Though the operation of DAS in HD is analogous to that of cognitive negative triad in general depression, the use of cognitive therapy in HD warrants special attention. Undermining hopelessness in HD patients is a necessary preliminary step to cognitive work on their dysfunctional thinking.

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認知治療在無望抑鬱症的應用

無望抑鬱症是抑鬱症的一種，無望感令患者有遲滯的自發反應、冷漠，且因低落情緒而出現嚴重的消極認知等獨特症狀。故此，無望抑鬱症的病人往往欠缺動機，並有強烈負面思想。這些問題不利於進行認知治療，因為認知治療要求病人參與識別和改變他們功能不良的思想；況且，認知治療對處理頑固功能不良的思想亦有其限制。本文引用一個個案，指出使用認知治療醫治無望抑鬱症病人時，首要工作是減輕病人的無望感，而這又可以透過重點提升病人自尊的認知治療來達成。