The Effciency of Cognitive-Behavioral Therapy in Depressive Old People

Camelia M. Dindelegan*[ii]
*Faculty of Social and Human Sciences,
Psychology Department, University of Oradea, Oradea, Romania

Abstract

Introduction. *Depression is one of the most common and severe mental disorders, with a remarkable share in overall morbidity and mortality. Depression and cognitive impairment are the heaviest burden of an old person (Arehart-Treichel, J. 2001).*

Objectives. *The purpose of this research is to demonstrate the changes in the affective state as a result of an intervention, by pointing out the differences between the two experimental groups and the differentiated compliance of the two groups to the cognitive-behavioral psychotherapy.*

Methods. *This research followed the implementation of a screening interview by administering the SCID I to 10 patients admitted to the acute psychiatric ward of "Dr. Gavril Curteanu" Clinical Hospital Oradea, with a diagnosis of recurrent depressive episode and to 10 patients institutionalized in "Ciutelec" nursing home in Bihor County.*

Results. *There are significant differences in the cognitive style about the future. In the hospitalized elderly diagnosed with depression, we had a Z value of 2.301 at $P = .028 \leq .05$ at the time of testing and retesting; according to Beck's cognitive triad, the negative vision of the future is seen in terms of failure or bankruptcy. A depressed person maintains a weak alignment to the expectations of the future that could be associated with a positive feedback (Abramson et its 1978 cited Dindelegan C., 2008).*

Conclusions. *It can be concluded that cognitive therapy is based on the premise that depression results from the illogical way in which patients think about themselves, about the outside world and the future, which makes them adopt self-locking and self-destructive behaviors (Cottraux, J.2003).*

Keywords: depression, self-locking, self-destructive

[ii] Corresponding author: Camelia M. Dindelegan, Agricultorilor 30, Oradea, Bihor, 410599, Romania. Tel.: 0744119226. E-mail: dindkamy@yahoo.com.

I. Introduction

The theoretical part of this research describes depression and growing older from different angles, the law of protection for this age and the care institutions and services for old people. The research mainly seeks to show how old age people, 60-85 years old, give a feedback to the action of integration in homes for the elderly: nursing homes help them have an active life if their age is accompanied by a series of psychic phenomena such as anxiety, adjustment difficulties or depression. It also identifies whether adherence to cognitive-behavioral therapy is higher in older people who have family support than in those who are institutionalized in nursing homes.

DSM IV includes depression in the category of affective disorders, the predominant feature of which is mood disorder. From this point of view, depression is a broad term that extends from a disorder to a temporary provision to severe mental illness. (Dindelegan, 2012).

Thus, each person can experience in life some sadness or melancholy states that are inherent in human existence and which arise because of failure, losses or frustrations based on a complex situation. The difference between a normal state of sadness understood as a reaction to an aversive situation and depression as a symptom is quantitative and not qualitative. For some people depression is a short-term reaction, a temporary one and has little impact on social and occupational functioning, while for others depressive symptoms are severe and affect them for weeks or even months. Studies show a decrease in age for the onset of depression in younger generations (DSM IV). The evolution of recurrent major depressive disorder is variable. Thus, some people show isolated episodes, separated by long periods of time without any depressive symptoms or the episodes are grouped; there is another category which shows depressive episodes occurring increasingly more often as time goes by. The number of previous episodes can be considered a predictor for the occurrence of a major depressive episode later on. For people suffering from major depressive disorder, the risk of relapse is very high and the remission may be complete (about two-thirds of cases), partial or absent (about one third of cases) (Dindelegan, 2008).

In Beck's theory, the distal contributory causes are the cognitive diathesis and the stress caused by negative life events. According to Beck (1979) there is a cognitive diathesis (provision) which makes some people possess a tendency towards presenting negative cognitive distortions about the self, the world and the future more frequently than other people. Beck believes that depressed patients interpret reality in a distorted way, without relying on "testing the hypotheses" procedures or "predictions" of reality, which does not justify nor confirm the interpretation. Moreover, he argues that individual interpretations of their own experiences are influenced not necessarily by their experienced reality, but mostly by their emotions about that experience. This theory suggests that depressive people have a negative self-schema which generates automatic thoughts and the cognitive triad. Beck defines schema as an organized representation of prior knowledge guiding the actual data processing. The schema represents portions of the information collected during past experiences, which is stored in the long term and works automatically. The depressive schema has a negative content that refers to concepts such as loss, failure, inadequacy (Alloyetal 1985, Beck et al 1979; Kuiperet al., 1988 cited Dindelegan, C., 2008). It selects, filters and interprets information, giving a depressive sense to the events experienced by the subject. Activated by the stress of negative life events, the depressive schema leads to cognitive distortions of the information received by the subject (Beck, 1967 cited Dindelegan, C., 2012).

Cognitive distortions (proximal contributory causes) are considered automatic relative products of the information treatment. Beck claims that people prone to depression achieved illogical, extreme and unrealistic inferences about them and their environment. On the basis of the cognitive theory of emotional disorders, there is the assumption that a dysfunction appears and develops in this area because of the interpretations people give to external events. These interpretations give behavioral responses which in turn maintain the emotional disorder (Dindelegan, 2012).

The status of the elderly is a particular risk factor, which is involved in the complex determinism of the mental disorders. An additional risk factor is the institutionalization in nursing homes. Biological, psychological and social changes that accompany the old age influence the mental illness specific to this period in many ways. It favors the onset of mental illness (Adolphs, R., 2003).

The period of senescence decreases resilience, after reducing a large number of functions and skills. Old age is often a real stressful period, with a large and specific problem. It favors the recurrence and the worsening of previous distress. It determines certain specificity in psychopathological aspects of various mental illnesses. Some authors consider the old age as psycho-traumatic. To better understand the psychogenic model of the disorders in old people from

a nursing home just add the reactions related to impaired physical function, mental function and social change status (all age-specific aspects) and the trauma of institutionalization, as a reaction of hopelessness and helplessness (Balaci, M., 1998).

The decreased ability of old people to adapt is strongly felt, especially in relation to the environmental change - i.e. their new living environment. The most important and best studied disorders are triggered by admission to hospital or in a long-term hospitalization unit (nursing home-hospital). The difference between these two types of institutions is often considered very clear by the old person to be hospitalized.

Old people feel abandoned and isolated. This isolation is a social phenomenon with psychological implications. A study shows that in Romania, the hospitalization of old people is always accompanied by anxiety phenomena. The increasing number of suicidal behavior in the elderly from nursing homes is a testimony itself (Tudose F., 2011).

With multiple manifestation degrees, depression increases with age. Even a slight decrease in the intellectual performance is considered a result of depression (Arehart-Treichel, J. 2001).

Depression is one of the most common and severe mental disorders, with a remarkable share in overall morbidity and mortality. Depression and cognitive impairment are the heaviest burden of an old person (Arehart-Treichel, J. 2001). Unlike conditions such as Alzheimer's disease and vascular dementia in the treatment of which the first steps are being made nowadays, depression is a condition that has been studied for a long time and it has a treatment efficiency in 80-90% of cases (Huber, W.1993). The feeling of sadness does not mean depression, but depression inevitably involves sadness, the intensity of which may vary, affecting the activity and basic functions like sleep and appetite.

Objectives and hypotheses of this study

The purpose of this research is to demonstrate the changes in the affective state as a result of an intervention, by pointing out the differences between the two experimental groups and the differentiated compliance of the two groups to the cognitive-behavioral psychotherapy.

Hypothesis 1: There are significant differences between pre-test and post-test regarding the affective mood (depression) before and after the cognitive-behavioral intervention.

Hypothesis 2: The outcome of cognitive-behavioral intervention significantly lowers automatic negative thoughts, the degree of hopelessness and the negative cognitive style specific to depressive patients.

II. Methods

Initially, this research followed the implementation of a screening interview by administering the SCID I to 10 patients admitted to the acute psychiatric ward of "Dr. Gavril Curteanu" Clinical Hospital Oradea, with a diagnosis of recurrent depressive episode and to 10 patients institutionalized in "Ciutelec" nursing home in Bihor County. The patients were aged 65-85.

Thus, to illustrate the negative thoughts pattern, we highlighted the affective mood (depression) and the automatic negative thoughts, the cognitive style and the degree of hopelessness in the application and interpretation of significant results. It is a quasi-experimental study; the participants answered the questions about their psychological experiences from the questionnaires, excluding the reactions of researchers.

Subsequently, we tested the possibility of diminishing the depressive mood and obtaining emotional and cognitive changes in the two groups of depressed patients through an experiment which included activities of developing skills of self-knowledge by applying the protocol for depression developed by Klasko, S. Jnet & Sanderson, C. William.

Participants

The first experimental group consisted of 10 institutionalized old people in "Ciutelec" nursing home, in Bihor County. Their ages ranged from 65 to 85 years with an average of 76.5. In terms of gender, there were 6 men and 4 women.

For this experimental group, the subjects were assessed based on the estimated GP diagnosis confirmed by the SCID I.

The selection was made after the SCID I. I must mention that depressed patients were under the influence of depressive medication. The participation in this research was on a voluntary basis after they were explained the protocol for depression. Also, the consent of the auxiliary medical personnel engaged in the home setting was asked for. We took into account the religion, the occupation, the educational level and the marital status. There were no other criteria for selecting participants in this study. We used Beck Inventory (BDI II), as a tool for screening the patients in order to check the depressive mood, which can be improved through cognitive- behavioral intervention.

The second experimental group consisted of 10 patients admitted to the acute psychiatric ward of „Dr. Gavriil Curteanu" Clinical Hospital in Oradea, aged between 65 and 85 years. The average age is 74.5 and in terms of gender there were nine women and one man.

For the second experimental group we divided the subjects based on the diagnosis of the treating psychiatrist on the ward, confirmed by using SCID I under my observation.

The selection was made after analyzing the patient's observation chart where their diagnosis and some observations on the disease are mentioned. I must say that depressed patients were under the influence of antidepressant medication. The participation in the research was voluntary, after I explained the purpose of the research and the procedure the patient had to follow. There were no other criteria for selecting participants in the study. We used Beck Depression Inventory (BDI II) for depression.

Instruments

The Beck Depression Inventory – Beck, 1961

BDI is a self-assessment questionnaire. For authors, the overall grade of the questionnaire indicates the depression index, which gives a quantitative estimate of the intensity of subjective symptoms of depression. This questionnaire is not used to diagnose, but to assess the severity of depression. It includes 21 items. Each item contains four statements arranged in the order of severity. The patient is instructed to choose the closest statement to his current status. The scores range from 0-67.

Hopelessness Scale – Beck, 1974

This scale measures the subject's perspective on the future or the degree of despair. The scale was developed by Beck and has 20 items that refer to the future. The answer type is true or false and there is a key dimension. The questionnaire requires constant supervision. A score over 15 points is definitely a suicidal risk and between 9-14 points there is a moderate risk.

Cognitive Style Test – Blackburn, 1986

It was developed by Blackburn in 1986 and adapted and calibrated to Romanian population by Dindelegan, C. in 2008.

The test consists of 30 brief descriptions of some common events. Respondents were asked to choose one of the four possible cognitive responses to the situations. Events are classified into three topics related to Beck's cognitive triad about: the self (interpersonal events, mainly related to self-image), the World (especially action-oriented situations) and the Future (events related to expectations and plans).

The Automatic Thought Questionnaire – Hollon&Kendall, 1980

The Automatic Thought Questionnaire- ATQ was created by Stephen Hollon and Philip Kendall in 1980. This test measures the frequency of automatic negative thoughts associated with depression. The score indicates the frequency of automatic negative thoughts associated with depression.

Procedure

In order to do this research, we performed the following procedure for the two experimental groups. After obtaining the subjects' consent to participate in the study, they filled in Beck Depression Questionnaire (BDI), Hopelessness Scale (BHS), Cognitive Style Questionnaire (CSC) and Automatic Thought Questionnaire – ATQ. Each subject was tested individually in a separate room from the rest of the patients after we explained the working procedure to them. After we offered instruction for the questionnaires, we read the test items and the response options. After choosing the response that best described his/ her present state or the state from the last week, the researcher filled in the answer grid with the corresponding figure.

Tests were applied individually in the paper and pencil manner. The option for the researcher to read the test items is justified by the desire to avoid certain inconveniences related to age and hospitalization in a hospital or a nursery home (or in some cases the absence of glasses); thus, all patients were treated equally.

Experimental design: pre-test and post-test intergroup single-factorial design.

III. Results

The scores of the subjects in the pre-testing and post-testing phase have been introduced in the database and processed in SPSS. The analysis and processing of the results were performed by using nonparametric tests consistent with the research design. Their purpose is to verify the hypotheses of the research, more precisely the statistical testing of differences in multiple ways: pre and post-test in two experimental groups - Wilcoxon test.

Table no. 1: Descriptive statistics, comparison of the depression level, automatic thoughts, degree of hopelessness, negative cognitive style about the future, the self and the world during testing.

	Median Gr.1 institutionalized	Range Gr.1	Median Gr.2 Hospitalized patients	Range Gr.2
Pre_BDI	19.5000		19.000	
Pre_ATQ	76.5000		74.500	
Pre_BHS	11.5000		11.000	
Pre_CSC_VIIT	25.5000		24.000	
Pre_CSC_SINE	24.0000		23.5000	
Pre_CSC_LUME	27.0000		26.5000	
Post_BDI	11.5000		9.000	
Post_ATQ	52.5000		49.500	
Post_BHS	7.5000		65000	
Post_CSC_VIIT	24000		21.000	
Post_CSC_SINE	235000		20.000	
Post_CSC_LUME	265000		255000	

When looking at the table, we can see that, at the beginning of the testing, there was a tendency towards major growth of the automatic negative thoughts in both groups, with an average of 76,500 for the institutionalized old people and 74,500 for patients hospitalized in the ward, leading to physiological, morphological and psychological changes.

The same thing can be said about group 2 (old people hospitalized in the ward); they have a considerable high-level of automatic thoughts - 74.500, but not as high as the one of the other group, fact which we can explain through the presence of the family support.

The analysis of Table 1 also concludes that the two groups exhibited a moderate level of depression at the beginning of the therapy, namely 19,500 - the first group and 19,000 - the second group. After the intervention, the level of depression decreased from an emotional point of view, ranging them from moderate to mild depression level.

There is a slight difference between the two post-test results of the two groups. Thus, the post-test shows that hospitalized patients' results are greater than those of institutionalized old people. This can be explained by the absence of social support and family in the case of the second group. There is a probability that the lack of family creates a lower adherence to cognitive-behavioral therapy.

Table no. 2 Intra-group comparisons (1) between test and retest - institutionalized old people

	z	p
POST BDI PRE BDI	2.207	.027
POST ATQ PRE ATQ	2.023	.043
POST BHS PRE BHS	2.264	.024
POST CSC_FUTURE PRE CSC_FUTURE	2.201	.028
POST CSC_SELF POST CSC_SELF	1.826	.028
POST CSC_WORLD PRE CSC_WORLD	1.953	.068

The pretest and post-test have highlighted some conclusions and by observing the scales and interpreting the meaning of the concepts, we can say the following things about the experimental group No. 1 i.e institutionalized old people:

There are significant differences in the test scores after the cognitive-behavioral intervention protocol applied, which, psychologically, has the following relevance: the scores on the BDI, ATQ, BHS, CSC FUTURE and CSC SELF have decreased significantly, fact which psychologically translates in a significant improvement in cognitive vulnerability.

Data show that out of the six Z reports, five are statistically significant:

We conclude that there are significant differences between pre and post BDI, with a Z of 2.207 at P = .027 ≤ .05, so the chances that the results are due to hazard are very small, institutionalized old people benefitting from cognitive-behavioral intervention. The results show the hypothesis was confirmed; we achieved a reduction of emotional symptoms in the assessed institutionalized old people after depression, with BDI. Using a program to stimulate self-awareness skills and knowing the others leads to an increased self-esteem and a better adapting to the surrounding stimuli.

As for the frequency of automatic negative thoughts in institutionalized old people with depression, we can say that the results are consistent with Beck's model of depression, between pre and post-test, with a Z value of 2.203 compared to a P = .043 ≤. 05. The elderly show the automatic negative thoughts about self, the world and the future in their symptoms. Another explanation for these results is that, in depressed patients, the automatic negative thoughts are part of their symptoms. These are interpretations of events directly related to specific emotional experiences and behavioral responses. These automatic thoughts are persistent, repetitive and cannot be controlled, that is why they appear automatically.

Table no. 3 Intra-group comparisons (2) between test and retest - elderly hospitalized in the psychiatric ward

	z	p
POST BDI PRE BDI	2.107	.027
POST ATQ PRE ATQ	1.923	.043
POST BHS PRE BHS	2.464	.024
POST CSC_FUTURE PRE CSC_FUTURE	2.301	.028
POST CSC_SELF POST CSC_SELF	2.126	.028
POST CSC_WORLD PRE CSC_WORLD	1.753	.048

The pretest and post- test have highlighted some conclusions.

There are significant differences in test scores after applying the cognitive-behavioral intervention protocol, fact which has the following psychological relevance: the scores on the BDI, ATQ, BHS, CSC FUTURE, CSC WORLD and CSC SELF have decreased significantly, which psychologically translates in a significant improvement in cognitive vulnerability.

Database shows that all 6 reports are statistically significant:

We conclude that there are significant differences between pre and post BDI, with a Z of 2.107 at P = .027 ≤ .05, so the chances that the results are due to hazard are very small; the elderly hospitalized in the psychiatric ward benefitted from the cognitive-behavioral intervention. The results show that the hypothesis was confirmed; we achieved a reduction of the emotional symptoms in the elderly hospitalized in the psychiatric ward assessed after depression with BDI. Using a program to stimulate self-awareness skills and knowing the others leads to an increased self-esteem and a better adapting to the surrounding stimuli.

As for the frequency of automatic negative thoughts in the elderly hospitalized in a psychiatric ward with depression, we obtained a Z value of 1.923 between pre and post-test, compared to a P = .043 ≤. 05 and we can say that the results are consistent with

Beck's model of depression. The elderly show the automatic negative thoughts about self, the world and the future in their symptoms. Another explanation for these results is that, in depressed patients, the automatic negative thoughts are part of their symptoms. These are interpretations of events directly related to specific emotional experiences and behavioral responses. These automatic thoughts are persistent, repetitive and cannot be controlled, that is why they appear automatically.

Regarding the experimental group which manifested hopelessness, there are significant differences between the degree of despair determined at pre-test and post-test; we have a Z value of 2.464 at $P = .024 \leq .05$. The verbal expression of despair and the reaction of helplessness experienced intensely are strongly structured in formulas like: "things will never go well for me", "I can't expect anything from the future" or "nobody will ever want me for who I am". The approach regarding the future that was used from the very beginning and the strategies used in this work led to the achievement of hope for the future, thus the patients tolerated more efficiently the depression they had to deal with.

There are significant differences in the cognitive style about the future. In the hospitalized elderly diagnosed with depression, we had a Z value of 2.301 at $P = .028 \leq .05$ at the time of testing and retesting; according to Beck's cognitive triad, the negative vision of the future is seen in terms of failure or bankruptcy. A depressed person maintains a weak alignment to the expectations of the future that could be associated with a positive feedback (Abramson et its 1978 cited Dindelegan C., 2008).

Discussions

After analyzing the data in Table 1, we can say that the pretest scores fell in the pattern of depression; the post-test scores, namely the association between the frequency of automatic negative thoughts and depression, are much lower. This fact shows that people who fall into group 1 (institutionalized elderly) with depression have an increased level of automatic negative thoughts, reinforcing depression. The fact that they are isolated from their loved ones – lack of family support leads to individual vulnerability and to physiological, morphological and psychological changes.

Data in Table 1 can help us conclude that the presence of depression contributes significantly to the emergence of a negative cognitive style. In addition to age characteristics, which I have described in theory, there is also an affective and cognitive disorder with implications on the intellectual and motor activity that generates a negative cognitive style about the self, the world and the future.

The acute sense of hopelessness increases the risk of suicidal ideas and components, fact which was equally present in both groups and included in therapy. So the first group registered an average of 115,000 and the second obtained 11,000 with a small difference of 0.5000. This small difference between the two groups may be due to the fact that the first group can rely on safety in the near future - i.e. they are taken care of, they are provided food and they have a social support until the end of their lives, even if they do not have their family support.

At the beginning of the treatment, we registered a high level of suicide; the post-test assessment presents a 5% lower score, namely 7,500 for the first group and 7,000 for the second group. Even if the post- test presents the feeling of despair regarding their own possibilities and those related to the future, it still does not have the initial level of depressive symptomatology. At the post-test, after therapy, the negative vision of the future remained (due to age particularities) in both groups of patients with small differences, but the desire to die is still present and the suicide attempts are no longer considered a manifestation of the strong desire to escape.

In Beck's view, the depressive old man is perceived as weak, worthless and undesirable in most situations. All these things contribute to the symptoms present in depression such as sadness, passivity, loss of pleasure, resulting in a negative cognitive style. Thus, the different events occurred in patients' lives were considered challenges during the non-depressive period, but now they are seen as unbearable hardships. Therefore, the patients involved in therapy have come to feel so overwhelmed by difficulties that they ended up seeing suicide as their only way out. A. Beck believes that despair is the variable which links depression to suicide.

After administrating the Wilcoxon test – between pre and post-test – to the two experimental groups, we concluded that the statistically significant differences presented the improvement obtained after the cognitive - behavioral intervention. Even if the differences are small, there was a bigger compliance to treatment in group 2 - patients admitted to the psychiatric ward, which may be explained by the presence of family support in this group.

As for the frequency of automatic negative thoughts in institutionalized old people with depression, we can say that the results are consistent with Beck's model of depression; between pre and post-test, we obtained $Z = 2.203$ compared to $P = .043$

≤. 05. The elderly show the automatic negative thoughts about self, the world and the future in their symptoms. Another explanation for these results is that, in depressed patients, the automatic negative thoughts are part of their symptoms. These are interpretations of events directly related to specific emotional experiences and behavioral responses. These automatic thoughts are persistent, repetitive and cannot be controlled, that is why they appear automatically.

Regarding the experimental group which manifested hopelessness, there are significant differences between the degree of despair established between pre - test and post-test with a Z value of 2.264 at P = .024 ≤ .05. The verbal expression of despair and the reaction of helplessness experienced intensely are strongly structured in formulas like – "things will never go well for me", "I can't expect anything from the future" and "nobody will ever want me for who I am". The approach regarding the future that was used from the very beginning and the strategies used in this work led to the achievement of hope for the future, thus the patients tolerated more efficiently the depression they had to deal with.

There are significant differences in the cognitive style about the future. In hospitalized elderly diagnosed with depression at the time of testing and retesting, we obtained a Z value of 2.201 at P = .028 ≤ .05. According to Beck's cognitive triad, the negative vision of the future is seen in terms of failure or bankruptcy. The depressed person maintains a weak alignment to the expectations of the future that could be associated with a positive feedback (Abramson et its 1978 cited Dindelegan C., 2008). Through cognitive-behavioral therapy, we tried to modify their expectations regarding the future, by developing the necessary abilities to have a positive perspective upon the future.

There are significant differences in terms of cognitive style about the self. In institutionalized elderly diagnosed with depression at the time of testing and retesting, we obtained a Z value of 1.826 at P = .028 ≤ .05. According to Beck's cognitive triad which includes the negative view on the self, the negative view on current experiences from the world and the negative view on the future, the cognitive style of the self refers to a self-perception in terms of inability, lack of value, physical or moral deficiency. This view on the self is based on cognitive distortions regarding depressive biases related to past and present.

Regarding the cognitive style about the world, in the case of institutionalized elderly diagnosed with depression, after testing and retesting, we have a Z value of 1953 and a critical threshold P = .068 ≥ .05. We can interpret these values by saying that there are 6% chances for these differences to be due to hazard; they are higher if we consider that the critical threshold required by research is 5 %. Therefore, the study did not reveal an influence of the cognitive-behavioral program on the negative vision on current experiences from the world. These patients see problems more severely than they actually are, but not as severe as they saw them at the beginning of the cognitive-behavioral therapy. This result can be explained by the isolation in nursing homes, where external events are perceived as catastrophic (even if they do not influence them directly): such as media events which are discussed and amplified in the group.

According to the results from Table 3, we conclude that we tried to change the cognitions about the future, developing the skills needed for positive perspective on the future by means of cognitive behavioral therapy.

There are significant differences in terms of cognitive style of the self. In hospitalized elderly diagnosed with depression at the time of testing and retesting, we have a Z value of 2.126 at P = .028 ≤ .05. According to Beck's cognitive triad which includes the negative view on the self, the negative view on current experiences from the world and the view on the future, the cognitive style of the self refers to a self-perception in terms of inability, lack of value, physical or moral deficiency. This view on the self is based on cognitive distortions regarding depressive biases related to past and present.

Regarding the cognitive style about the world in the case of hospitalized elderly diagnosed with depression, after testing and retesting, we have a Z value of 1753 and a critical threshold P = .048 ≥ .05. The negative view on current experiences from the world is revealed in terms of: "overworked", "with obstacles" and "difficult to undertake". The approach from the very beginning of the therapy, the description of the cognitive model of depression and the strategies used to change the negative cognitive style about the world led the awareness of current experiences from the world to a positive level, i.e. life experiences that will not be perceived as obstacles or difficult to undertake.

IV. Conclusions

Thus, it can be concluded that cognitive therapy is based on the premise that depression results from the illogical way in which patients think about themselves, about the outside world and the future, which makes them adopt self-locking and self-destructive behaviors (Cottraux, J.2003).

Aaron Beck developed the cognitive therapy in depression, he hypothesized that negative thoughts had a central role in maintaining depression and that depression could be treated by means of psychotherapy, by helping patients identify and modify negative thoughts. In the light of the cognitive model, depression is defined as the expression of a patient's negative vision about himself, about his future and about his experiences (negative cognitive triad).

Automatic negative thoughts in depression include self-depreciation, sense of failure, rejection, exaggeration of difficulties and very high personal standards.

The objective of the cognitive psychotherapy is to counteract with thoughts, memories and negative beliefs that maintain depression in people who are vulnerable to future depressive episodes. The patient is taught to think more rationally and to find solutions to his problems.

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