



Specificity of cognitive and behavioral variables to Positive and Negative Affect

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ABSTRACT

The Tripartite Model proposes that a combination of greater Negative Affect (NA) and reduced Positive Affect (PA) contributes to depressive symptoms. The purpose of this study was to test a model of affective experience in which cognitive variables (i.e., negative cognitions and appraisals) are uniquely related to NA but not PA, and in which behavioral variables (i.e., activity participation) are uniquely associated with PA but not NA. Participants included 88 spousal Alzheimer caregivers (mean age = 74 years). Multiple regression models, in which negative cognitions (i.e., helplessness, blames self, and negative appraisals) and activity participation (i.e., frequency of engaging in social and recreational activities) were used to predict depressive symptoms, PA and NA. Results indicated that while helplessness, blaming oneself, negative appraisals, and activity participation all significantly predicted depressive symptoms, only negative cognitive variables significantly predicted NA, and only activity participation significantly predicted PA. These data confirm that depressive experience consists of two relatively independent components – increased Negative Affect and reduced Positive Affect – which have unique correlates in negative cognitions and activity participation. If confirmed, the findings suggest the utility of focusing interventions on each of these components in the management of depressive symptoms.

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Introduction

Although depression and anxiety have been traditionally conceptualized as two distinct entities, with depression relating to emotions such as sadness and anxiety relating to emotions such as fear (Izard, 1972; Watson & Kendall, 1989), empirical evidence has not typically supported a clear distinction of these constructs (Clark & Watson, 1991). Given the high comorbidity between the two syndromes (Mineka, Watson, & Clark, 1998) and high correlations between questionnaires assessing depressive and anxious symptoms (Clark & Watson, 1991; Watson, Weber, et al., 1995), several models have been proposed as a means of distinguishing the experience of depression from anxiety. Elucidating the components that constitute each specific syndrome not only improves assessment and diagnosis, but also helps improve treatment in that intervention targets can be made more precise. One such model is the Tripartite model (Clark & Watson, 1991).

The Tripartite Model of anxiety and depression

In a seminal review of psychometric evidence examining the properties of anxiety and depression measures, Clark and Watson

(1991) concluded that individuals with anxiety and depression seemed to share an underlying non-specific affective state (i.e., general affective distress) known as Negative Affect (NA). This underlying distress is characterized by increased experience of emotions such as fear, sadness, guilt, and anger. However, depression appeared to have an additional underlying state characterized by diminished Positive Affect (PA), or feelings of joy, energy, enthusiasm, and interest, which were not typically diminished in anxiety. Therefore, in what came to be known as the *Tripartite Model* (Clark & Watson, 1991), depression seemed uniquely characterized by a diminished experience of PA combined with increased NA.

Since the introduction of the Tripartite Model of anxiety and depression, accumulating research on this 3-factor model (Brown, Chorpita, & Barlow, 1998; Chorpita, Albano, & Barlow, 1998; Joiner, Catanzaro, & Laurent, 1996; Teachman, Siedlecki, & Magee, 2007), and its individual components (Joiner et al., 1999; Kiernan, Laurent, Joiner, Catanzaro, & MacLachlan, 2001) has supported its validity. In a two-part series investigating the validity and structure of a tripartite structure of these syndromes, Watson and colleagues tested their model in five samples: 3 students, 1 adult, and 1 patient (Watson, Clark, et al., 1995; Watson, Weber, et al., 1995). Participants completed the Mood and Anxiety Symptom Questionnaire (MASQ), which was constructed specifically to test the Tripartite model. The authors found that the MASQ anxious arousal and anhedonic depression subscales did indeed discriminate between

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anxiety and depression and demonstrated excellent convergent validity (Watson, Weber, et al., 1995). Furthermore, a 3-factor structure of the MASQ (General Distress, Anhedonia vs. Positive Affect, and Somatic Anxiety) emerged in each of the 5 samples, consistent with the Tripartite Model (Watson, Clark, et al., 1995).

Additionally Teachman et al. (2007) and colleagues examined the structural invariance of the Tripartite Model in young, middle-aged, and older adults and found that the 3-factor (Tripartite) model best fit each age group, compared to 1- and 2-factor models tested. Evidence also generally supports the tripartite model in culturally diverse populations in children (Kiernan et al., 2001; Yang, Hong, Joung, & Kim, 2006) and adults (Philipp, Washington, Raouf, & Norton, in press). Although minor discrepancies to the model may include differences in emotional expression across cultures, lack of cross-culturally validated measurement tools, and varying measurement and data analytic techniques (Burns & Eidelson, 1998), the overall pattern of data to date suggests that the central principles of the model are consistent across several populations.

Unique correlates of Positive and Negative Affect

In 1988, Watson proposed that a unique set of patterns could be observed between certain constructs and the two primary domains of depressive symptoms, that is, Positive (PA) and Negative Affect (NA). Specifically, Watson proposed that health complaints and perceived stress would be related to intraindividual changes in state NA and unrelated to state PA, and that daily social activity and physical exercise would be related to intraindividual fluctuations in state PA, but not to state NA. Moreover, previous work has supported similar hypotheses in between-subjects analyses (Watson & Pennebaker, 1989), and therefore, this study aimed to replicate those findings in their sample. While the individual findings were not overwhelming, the resulting pattern that emerged was that PA was more strongly related to social activity and exercise, while NA was more strongly related to perceived stress. These results suggested that certain endogenous and exogenous factors may be uniquely associated with PA and NA. Indeed, Mausbach and colleagues found that intraindividual fluctuations in social and recreational activity were significantly correlated with fluctuations in PA but not NA (Mausbach, Coon, Patterson, & Grant, 2008). Given the unique importance of PA and NA to the experience of depression, demonstrating unique correlations with PA and NA has theoretical and clinical implications because it may suggest that certain targets of psychotherapy might differentially influence depressive symptoms via their relations to its two components (i.e., PA and NA). Further, it raises the question of whether greatest influence on depressive symptoms is achieved via targeting both the PA and NA domains, as opposed to simply targeting one domain.

Cognitive–Behavior Therapy and Positive and Negative Affectivity

Cognitive–Behavior Therapy (CBT) for depression, which combines both cognitive and behavioral intervention techniques, has received a great deal of attention as an empirically supported treatment for depression. Several meta-analytic reviews have supported the efficacy of CBT interventions in the reduction of depressive symptoms in several populations such as children and adolescents (Lewinsohn & Clarke, 1999), older adults (Pinquart, Duberstein, & Lyness, 2007), and depressed inpatients (Stuart & Bowers, 1995). Many of these studies have found large effect sizes. Notably, it has been shown that patients receiving telephone-administered CBT demonstrated a greater reduction in depression and a greater increase in PA compared to those receiving

a telephone-administered supportive emotion focused therapy (Mohr et al., 2005).

CBT's unique integration of both cognitive and behavioral techniques may constitute a comprehensive treatment that may differentially operate to reduce NA and increase PA. A compelling 2007 study by Kring and colleagues (Kring, Persons, & Thomas, 2007) examined change in PA and NA via administration of a CBT intervention to patients diagnosed with a mood and/or anxiety disorder. Results indicated that while depressive symptoms decreased during treatment, change was most notable in NA but not PA. Indeed, PA only increased during treatment for those who demonstrated significant and enduring (without depression for over 20 weeks) decreases in depression. A revealing conclusion by the authors was that PA was not a central focus of treatment. That is, the therapy was heavily influenced by the *cognitive* theory of Aaron Beck (Beck, Rush, Shaw, & Emery, 1979) and less focused on *behavioral* theories of increasing pleasure or engagement in social and recreational activities (Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972).

These findings appear to suggest a unique pattern of correlations between behavioral constructs and PA on the one hand, and between cognitive constructs and NA on the other. Specifically, examining the findings of Watson (1988), we see that that behavioral constructs (e.g., social activity, exercise) may be more strongly related to PA (Watson, 1988). The findings of Kring et al. (2007) suggest that cognitive factors may more strongly relate to NA.

Despite these interesting findings, little research has examined the unique relations of the cognitive and behavioral components of CBT with PA and NA. However, Jacobson et al. (1996) have conducted one of the most detailed analyses of the individual components of CBT for depression. In their study, they enrolled depressed patients to receive a purely behavioral therapy (i.e., behavioral activation), a therapy focusing on both behavioral activation and negative cognitions (i.e., automatic thoughts), or pure Cognitive Therapy for depression, which included components of the previous 2 treatments but also examined core schemas. Interestingly, all three therapies significantly reduced symptoms of depression, but none was more effective than the others. The authors conclude that if these findings are true, they raise questions about the conditions for change in cognitive therapy and the potential need to revise cognitive theory and cognitive therapy.

Current study

This study had several aims based on findings in the extant literature. Our first aim was to establish the validity of the Tripartite Model of depression within a sample of Alzheimer's caregivers. Family caregivers to patients diagnosed with Alzheimer's disease are known to experience substantial psychological morbidity, including depressive symptoms (Cohen et al., 1990; Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999; Schulz, O'Brien, Bookwala, & Fleissner, 1995). Indeed, caregivers are estimated to be at twice the risk for depression compared to non-caregiving older adults (Baumgarten et al., 1992). Therefore, Alzheimer's caregivers provide an excellent sample for examining variation in not only depressive symptoms, but also in affective experience (e.g., PA and NA). Indeed, during the course of providing care, caregivers adjust their own engagement in activities in response to providing greater care for their loved ones (Mausbach, Patterson, & Grant, 2008). Various caregiving demands, such as problem behaviors of the Alzheimer's patient that are often unpredictable, can lead to variability in NA (Mausbach, Coon, et al., 2008). Therefore, caregivers might be considered an ideal population for testing our first aim, for which we hypothesized that both Positive and Negative Affect will be significantly associated with depressive symptoms.

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