

Chapter 1

THE COGNITIVE MODEL OF PERSISTENT DEPRESSION

In this chapter, you will find information on:

- The standard cognitive model of acute depression
- Problems encountered in applying this model in persistent depression
- Three kinds of avoidance that obscure the relationship between negative automatic thoughts and negative emotions
- The nature of overt negative thinking and important underlying beliefs in persistent depression
- Social factors that can trigger or maintain persistent depression
- Early experiences that can contribute to the formation of maladaptive belief systems
- How beliefs, overt negative thoughts, avoidance processes and social adversity combine to manifest in low self-esteem, helplessness and hopelessness
- The implications of the model for the overall conduct of cognitive therapy

Cognitive therapy for depression is based on the theoretical and clinical model described by Beck, Rush, Shaw and Emery in their influential book *Cognitive Therapy of Depression* (1979). This model describes the negative thinking characteristic of depression and how this relates to the symptoms and to other emotional, behavioural and situational aspects of the illness. Factors contributing to the manifestation of negative thinking are also considered. These factors include early experiences that influence the development of beliefs and attitudes, and subsequent situations or events that trigger the disorder in vulnerable individuals. The model is used as a guide for the therapist in formulating how depression is maintained in a particular case.

The application of the standard cognitive model in cases of persistent depression can result in confusion and frustration for both patient and therapist. In this chapter, we discuss how the cognitive model for acute depression needs to be adapted in order to apply it to persistent depression. In outline, we propose that the crucial cognitive characteristics in persistent

depression are low self-esteem, helplessness and hopelessness. Vulnerability to these thinking patterns arises from the enduring and rigid nature of patients' negative beliefs about themselves and their social world. The persistent threat of distress results in the adoption of maladaptive coping styles, which exacerbate the problems that patients face. Once depressed, patients' experiences, shaped by their beliefs and coping style, confirm and entrench low self-esteem, helplessness and hopelessness. As we have described in the introduction, persistent depression is not a homogeneous problem. Patients' histories, course of current episode and presentation can vary widely. The model describes factors that potentially contribute to the maintenance of depression and help to account for some of the variation in presentations of persistent depression. These factors then need to be considered in constructing a cognitive formulation and treatment plan for each individual case.

THE COGNITIVE MODEL OF ACUTE DEPRESSION

Automatic Thoughts

The standard cognitive model of Beck and colleagues (1979) describes negative thinking in depression at three levels: negative automatic thoughts, thinking errors or biases and underlying beliefs or assumptions. Firstly, many of the spontaneous or automatic thoughts of people with depression are manifestly negative. Such negativity focuses on the self, the world and the future: the negative cognitive triad. People suffering from acute depression tend to see themselves as defective or inadequate, and see the world as presenting them only with insuperable obstacles and difficulties. They see such problems persisting indefinitely into the future and are pessimistic to the point of hopelessness and perhaps suicidal wishes. When these negative automatic thoughts come to mind, they trigger feelings of misery and despair or exacerbate an existing low mood state. Negative emotions or low mood can prime these negative thoughts, making them more likely to come to mind and more believable when they do. As low mood primes the negative thoughts, which then further exacerbate low mood, a vicious circle is set up whereby the person's mood can spiral downwards. This can also lead to procrastination and inactivity, which further feed into the vicious circle, as illustrated in Figure 1.1.

Cognitive Biases

The negative content of thinking manifest in these negative automatic thoughts results in part from certain biases or distortions in the processing

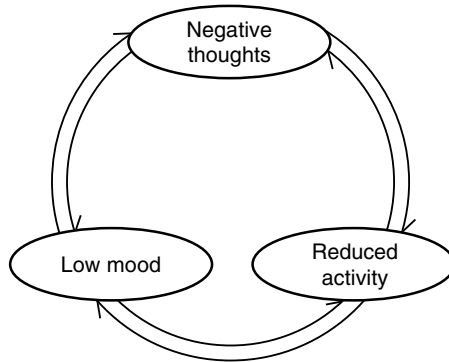


Figure 1.1 The vicious circle in depression

of information. These biases include all-or-nothing or ‘black and white’ thinking, personalisation and jumping to conclusions. Dichotomous or ‘black and white’ thinking is central, whereby the person sets unrealistically high standards for their own performance. If these standards are not met, negative judgements ensue. For example, this processing bias could readily be identified with one patient, *Elizabeth*, from the early stages of therapy and was a target for intervention. If something did not meet Elizabeth’s exacting high standards it was dismissed as substandard and of no value. Elizabeth saw no shades of grey, so that even an adequate outcome was seen as not making the grade. Black and white thinking can lead to a mental filter, such that positive or neutral aspects of a situation are ignored, whereas negative aspects are selectively focused on and dwelt on at length. Having such high standards served to focus Elizabeth continually on her shortcomings. Her expectation of failing to meet her standards accounted in large part for the avoidance and procrastination that had pervaded her life since the onset of her depression. Elizabeth’s thinking biases are evident in the following discussion that took place while reviewing one of her homework assignments.

T: How did you get on with keeping your diary of automatic thoughts?

E: Not very well.

T: Have you got it with you?

E: Yes. It’s a mess.

T: Could we take a look at it together?

E: Okay (*shows completed diary to therapist*).

T: Right. Mmm . . . You’ve written down three examples. What makes you say you have not done it very well?

E: My handwriting is very untidy.

T: I can read it though, isn’t that the most important thing?

E: It looks awful.

T: Anything else you are unhappy with?

E: I don't think I've done it properly.

T: Mmmm. . . We've spoken about your sense of not doing things properly before. How are you defining properly in this instance?

E: I haven't written down all the thoughts I intended to. I'm bound to have missed some important thoughts, I'm so forgetful these days. Also, I didn't always write them down immediately as you suggested. I waited half an hour or so.

T: Okay let's summarise. You have very ably identified what you see as your shortcomings in completing the diary. You see your handwriting as untidy and as far as you are concerned it has not been done properly. Can I ask—even if it has not met your exacting standard, is it of no use to us today in our session?

E: Mmmm. . . I see what you're saying.

T: So if this is the black and white position are there any shades of grey here?

E: (*sighs*) I suppose. I guess I did write down three thoughts and like you said you can read it, which is the point really.

In addition, depressed people frequently personalise any negative outcomes, by assuming the blame for things that go wrong or seeing personal rejection in any uncomfortable social situation. Thoughts that exemplify this kind of bias include 'It's all my fault' or 'I should have stopped this happening'. Personalisation pervaded *Jean's* thinking in most interactions with other people. For example, if she argued with her partner she invariably concluded it was her fault. This was sometimes taken to the extreme that if someone refused a request, Jean took this as evidence that she had offended them in some way or that they were exacting revenge for some past misdemeanour on her part.

Negative biases may also be in the form of arbitrary inferences, where the depressed person jumps to the most negative conclusion about a situation in the absence of any evidence. Patients often predict quite catastrophic outcomes for future events, while perfectly plausible benign or beneficial outcomes are never conceived or are dismissed as highly unlikely. This way of thinking is particularly characteristic of depressed patients who present with significant anxiety symptoms. *Marion* tended to predict that any event from making a request of her daughter to attending a social gathering or therapy session was likely to end in absolute disaster. In the early stages of treatment, Marion asked to end the therapy. After some discussion, it transpired that before each treatment session Marion's mind was bombarded by negative thoughts regarding the fact she had not completed her homework. This typically began with thoughts such as 'I'm too tired' and 'It won't help' and then turned to predicting that the therapist would

think that she was lazy. This thinking quickly got out of proportion to such an extent that she would picture the therapist shouting at her and telling her she was a waste of space. She imagined the therapist writing to her psychiatrist to tell him the same, resulting in the psychiatrist washing his hands of her. Her request to be discharged helped her to exert some control over what she perceived with absolute certainty would be the inevitable outcome of the non-completion of homework assignments. Marion had no evidence to support these predictions, but when depressed and anxious her thinking was dominated by this kind of negative processing.

Dysfunctional Assumptions

The third level of negative thinking is that of longstanding cognitive structures that predate the onset of the episode of depression and whose activation results in cognitive biases and automatic thoughts. In cases of acute depression, conditional beliefs or assumptions are thought to confer the cognitive aspect of vulnerability. These conditional beliefs typically set out the conditions that must be satisfied for the person to adopt a sense of worth, fulfilment or happiness. *Elizabeth's* rule 'If you can't do something properly then there is no point in doing it at all' was manifest in the above example. If rigidly applied, such a belief increases the likelihood of depression when those high standards are not met, whether this is due to internal or external factors. The limitations imposed by the symptoms of depression prevented Elizabeth living up to her standards and so caused her much distress. Other common conditional beliefs in depression are 'If anyone criticises or rejects me, it shows I am an unlikeable person' and 'I cannot be happy unless I am loved by others'. These conditional beliefs are similar to quite functional beliefs held by many people, in that most people would prefer to be loved and not to be criticised or rejected. However, they are unhelpful in their extremity or the rigidity with which they are applied to situations where the conditions are perceived as not being met.

In the cognitive model of depression, these conditional beliefs are thought to develop in many cases through early life experiences. Where parents have been excessively critical, the child may internalise the implicit rule that being valued only comes from perfect performance, as was the case for Elizabeth. This assumption may become latent or silent during parts of adult life where any endeavours are met with a reasonable degree of success. Thus, prior to becoming depressed, Elizabeth had, by unrelenting hard work, managed to live up to the excesses of her conditional belief. However, any notable failures activate the latent assumption and the person becomes sensitised to any signs of falling short of their perfectionistic

standard. The onset of Elizabeth's depression was triggered by public criticism from her coworkers for dutifully following company procedures that were commonly flouted. The demand she placed on herself always to do things 'properly' (in this instance, stick to the rulebook) led to her being criticised. This criticism was perceived by her as a failure to live up to others' expectations of her. However, had Elizabeth decided to flout the rules along with everyone else, she would in her eyes have failed in the expectations she set for herself. This illustrates the impact of stringent adherence to inflexible rules, which in this instance put Elizabeth in a no-win position.

PROBLEMS APPLYING THE COGNITIVE MODEL IN PERSISTENT DEPRESSION

In using this model of depression with acute cases, pertinent negative thoughts are often self-evident. Once the patient is socialised to the cognitive model, automatic thoughts can readily be identified and are often amenable to cognitive interventions. It would seem reasonable to expect that persistent depression would be characterised by a thinking style in which these negative automatic thoughts, processing biases and structures would be chronically manifest. Indeed this is often the case, and the therapist is assailed by a barrage of self-criticism and overwhelming negativity from the patient. A chronic cognitive triad (see pages 55–59) of low self-esteem, helplessness and hopelessness is often manifest in overt negative thoughts about the self, the world and the future. The extremity and rigidity of this negative thinking can be difficult to contain and manage, as was the case with Elizabeth. However, this barrage of negativity is not the only notable thing in the experience of therapists working with resistant depression. A number of common features of presentation in these patients can make it hard to see immediately how the cognitive model applies. These include a reluctance of some patients to discuss their problems or thoughts; globality of thinking that is hard to relate to particular problems; and an apparent lack of relationship between the patients' negative thoughts and low moods.

Firstly, with some chronically depressed patients, it can be hard to gain from them any idea of what their problems are or even that they have any problems. In the early stages of contact, some patients are reluctant to talk about any problems they are having. Although some reluctant patients will assent to direct questions about their problems, others may explicitly refuse to discuss certain issues. Even where an initial assessment has seemed fairly innocuous to the therapist, the patient may express reluctance to continue with the therapy during or after the initial contact.

The therapist's difficulty applying the cognitive model does not always stem from this reluctance of patients to discuss their problems. Plenty of patients with persistent depression have many problems that they wish to discuss and on occasion the therapist can be faced with an apparent tidal wave of different problems affecting every area of a patient's life. Patients may indicate various relationships in which they have been slighted, rejected or let down and various endeavours that have failed or been incomplete. As they flit from one to another of an apparently vast array of problems, the patient's moods may be quite turbulent. However, the negative cognitions described in the standard cognitive model may still be hard to identify. It can be difficult to focus a patient on one particular problem for long enough to identify the related meanings and interpretations. Having been hit by this wave of various problems, the therapist can still be left with a lack of clarity as to the nature of the patient's difficulties. Importantly, the cognitions crucial to applying the model may not be immediately apparent.

Other patients respond to the therapist's questions about their problems quite readily, but show or describe little sign of upset or distress. Where patients do not readily provide information about their problems or feelings, the therapist is often left with a description of symptoms but little information about other aspects of the cognitive model with which to build a formulation. For example, at his first session *Stan* complained of a number of symptoms of depression, particularly memory loss, which he worried was due to dementia or a brain tumour. However, he did not think he had any other problems, although he acknowledged in response to the therapist's questioning that being unemployed and various family situations might be problems. Although he said he did not like talking about these things, Stan did not appear to be upset. Similarly, when any overt negative thinking was apparent, such as when he described himself as pathetic, this was accompanied by an air of resignation rather than any sign of acute distress.

AVOIDANCE IN PERSISTENT DEPRESSION

A common factor that interferes with the application of the cognitive model in these apparently disparate presentations of persistent depression is avoidance. In persistent depression, avoidance can serve to mask negative thinking patterns or inhibit the effects of negative thoughts on mood. On occasions, negative thinking may not be overt or apparent due to such avoidance. Pinpointing such avoidance in persistent depression is often a prerequisite to identifying negative thoughts. To understand the ways that

negative thinking manifests in and contributes to persistent depression, it is important first to consider different forms of avoidance and their effects.

In acute depression, avoidance is often plain to see and is frequently acknowledged by the patient. It is manifest in gross behaviours, such as staying in bed all day or steering clear of particular work or social situations. The patient is usually willing and able to describe the negative feelings and thoughts that result when their attempts to avoid these situations are not successful. In chronic depression, the avoidance is often more subtle in nature. It can take three interrelated forms: behavioural avoidance of certain external circumstances, cognitive avoidance of certain mental ideas or images and emotional avoidance through the direct suppression of emotional experiences. Each of these forms of avoidance can obscure the distressing feelings and thoughts that are crucial in constructing a cognitive formulation of the patient's problems.

Behavioural Avoidance

Patterns of behavioural avoidance associated with depression have to be sustainable within the patient's lifestyle. Because in chronic cases the depression is of some duration, the gross withdrawal seen in acute depression is usually not sustainable and is encountered relatively rarely. Although some patients avoid whole classes of situation, such as work or social situations, in many cases the avoidance is of more subtle aspects of the situation. Thus, patients with persistent depression may not acknowledge or may not be aware that they are avoiding certain situations. Some patients may appear to be keeping up a good level of social contact. However, it may emerge that all their relationships are concerned with providing practical help to other people, and that in fact they become highly anxious about unstructured situations. For example, at assessment it appeared that *Rosemary* was maintaining a busy social life with friends and family. However, it emerged that most of her contacts involved helping others in some way, by cleaning or childminding for neighbours and by ferrying people in her car to shops or hospital appointments. At family gatherings and social activities, she would avoid mixing with people by engaging in activity, such as cooking or tidying up. Through managing the precise nature of social interactions in this way, patients like *Rosemary* can minimise the levels of distress they experience. Importantly for the cognitive therapist, overt negative thoughts may rarely be triggered and tend to emerge only when the patient is unable to manage in their usual way. For example, when *Rosemary* did have to engage in social interactions without recourse to helping people, she thought that people would see her as a miserable person and want nothing more to do with her.

Subtle avoidance is also commonly encountered in the form of routines that patients develop for carrying out activities of daily living. Some patients appear to be carrying out many activities, such as shopping or looking after themselves and their home, with little difficulty. This may be accomplished through a strict routine in which particular activities are carried out at a particular time on specific days of the week in a particular place. Any deviation, such as going to a different shop than usual, or doing something at a different time, represents an insuperable break from routine. As with overt withdrawal, this adherence to routine is often an attempt to manage the depression, and any variation is seen as risking a worsening of symptoms. For example, *Graham's* lifestyle included aspects of overt avoidance and routinised activity. Having experienced two very disabling episodes of depression, he had made a conscious decision 'not to rock the boat' by overstretching himself. His routine involved getting up at 9.30 a.m., then slowly having breakfast, watching television and getting washed and dressed, which took him until lunchtime. After lunch, his afternoon activities included a five-minute walk to the local shop for a paper and the evening would involve preparing a meal and watching more television. He made expeditions to the local supermarket (10 minutes' walk away) and visits to his neighbours on a weekly basis. Based on his fear of overstretching himself, Graham actively avoided exercise, working on his computer and making trips to the pub, cinema or town (to which he received frequent invitations from friends). The development of rigid routines can help patients to adapt their lifestyle to the depression and can successfully limit the acute distress experienced on a day-to-day basis.

Cognitive Avoidance

Many chronically depressed patients not only try to avoid being in certain situations but may also try to avoid thinking about them. Cognitive avoidance can manifest itself in a number of ways. It can be seen in the general reluctance to discuss or acknowledge problems described above. Some patients will discuss their problems in general terms but try to avoid thinking certain specific thoughts. This can influence not only their internal mental life, but also their reaction to the therapist's attempts to engage them in describing their problems. Some of the difficulties relating a patient's presentation to the cognitive model can be accounted for by this coping strategy and are manifest from the first meeting with the patient.

A general reluctance to discuss problem areas is sometimes evident from the very outset of any assessment. In some patients this is reflected in attempts to engage the therapist in discussions about issues of tangential relevance, such as the weather or a news item. Some chronically depressed

patients will not spontaneously raise problems they wish to discuss, but will answer direct questions about their symptoms or problems that the therapist has gleaned from the referral, such as unemployment or social isolation. They may play down the impact of these problems or respond in an unrealistically positive way. Other patients may be more explicit about their desire not to discuss certain topics. In *Peter's* case, this desire was reinforced by his wife, who asked to attend his first session to ensure that the therapist did not ask Peter anything about the circumstances that had led to his depression. She explained that whenever Peter attempted to talk about this subject he cried, which was humiliating for him. She wished to protect him from this humiliation by preventing him having to talk about issues that might upset him.

Some patients readily describe their symptoms or problem situations, but the therapist may find it hard to elicit any negative thoughts associated with their current distress. This was the case for *Marion* who complained of being constantly tired and of her lack of motivation to engage in even the basic activities of daily living. Attempting to focus Marion on how her inactivity impacted on her view of self met with statements such as 'I don't know' or 'It doesn't'. In cognitive therapy, part of the therapist's brief is to help the patient to identify the negative thoughts that may be contributing to their distress. Patients' reluctance to focus on negative thoughts can lead them to react to therapy in an irritable or prickly fashion. When the therapist attempts to enquire about particular thoughts, the patient can become extremely upset. This can be manifest as anger at and disparagement of the therapist ('You don't understand' or 'You must be incompetent to be making me feel like this') or therapy ('I can tell right now this is not going to work for me'). When *Julie's* therapist asked what was upsetting her most about the fact that her 14-year-old son was currently in a remand centre, Julie initially responded, 'Isn't it obvious? Anyone would be upset.' Although on one level this seems a valid response, it did not clarify exactly what the situation meant to Julie. The therapist asked whose fault it was that her son was in such trouble. Julie then became quite irritable with the therapist and replied, 'I suppose you're blaming me.' Although tempted to apologise and back off, the therapist persisted, 'There may be a range of possible answers to the question and I was interested in how you see the situation.' Julie replied that her husband said it was her fault. The therapist then asked her how much she believed that. At this point, Julie began to cry and said, 'It is my fault—I'm his mother.' This suggests that her initial irritation at the therapist was a result of her attempt to avoid her own thought that she was to blame for this unfortunate situation. She remained unable to see that some of her distress was caused by her attributions of self-blame, and instead attributed her difficulties entirely to the events that occurred in her life.

Even when patients complain of a tidal wave of problems in a turbulent fashion, as described on page 27, this can be a reflection of cognitive avoidance. The patient may be trying to describe a problem situation, but as they start to think about aspects of the situation that make them feel particularly uncomfortable, they 'jump ship' only to hit on another area of their life that is not going well. Again, they may describe the situational aspects of the problem but shy away from focusing on the painful thoughts and feelings that accompany those situations. At assessment, Julie described a plethora of problems accompanied by a moderate degree of distress, but moved from one problem to the next in a somewhat chaotic fashion. This left the therapist initially overwhelmed and somewhat at a loss about where to start treatment.

Cognitive avoidance in persistent depression can also take the form of deliberate suppression of specific thoughts, memories and images. The role of cognitive avoidance of specific thoughts and images in persistent depression may be similar to its role in cognitive models of other disorders (e.g. Borkovec & Inz, 1990; Wegner et al., 1987). Many chronically depressed patients report experiencing intrusive thoughts and memories. When they notice a distressing intrusion, they try to eliminate the intrusion from their mind or to control the rumination by attempting to distract themselves. The consequence of this can be a rebound effect, which results in a recurrence of the intrusion or a reinstatement of the ruminative process, often with a worsening of the accompanying affective state. The individual may then intensify their efforts to rid themselves of the distressing thought, resulting in a processing loop accompanied by increasing distress and a decreasing sense of control over mental processing. Such unsuccessful attempts to suppress distressing memories were manifest in Julie's strategy of cognitive avoidance. She reported intrusive memories of episodes of physical violence and sexual assault that had occurred over ten years previously during her first marriage. Julie took the occurrence of these intrusions as evidence that she should really still be with her first husband and that she was being punished for divorcing him. She also saw the intrusions as evidence that she was losing control of her mind and feared a complete mental breakdown. She invested a great deal of mental energy in attempting to keep control by pushing her intrusive memories out of her mind.

Emotional Avoidance

It is striking when working with patients with persistent depression that many describe having 'no feelings'. Indeed therapy sessions can proceed for long periods with little sign of the mood shifts so common in acute depression. Many patients appear to be able to talk about apparently

distressing situations and describe apparently disturbing or disparaging thoughts with little outward sign of emotional disturbance. Apparently positive events can be described in the same flat monotone in which negative events, such as redundancy or the threat of losing invalidity benefit, are greeted. Indeed, many of these patients show very little sign of acute emotional arousal about anything, presenting instead with a dull flatness of mood. For example, at assessment *Stan* described, in an even tone with no sign of distress, his redundancy two years previously from a job he had held for many years. He elaborated equally cheerlessly that it might have been quite a good thing, as it saved him the hassle of getting to work every morning. In a subsequent session he relayed news of the birth of a grandchild in a similarly flat tone. As well as responding to events in an emotionally flat way, patients can describe cognitive themes that would be expected to be associated with great distress in a matter of fact fashion. *Stan* described how he was unable to tell his wife that he did not wish to accompany her on various outings with her friends. He said that he knew that this was a sign of being pathetic and weak, but his tone of voice was mild, there was no sign of distress and he denied being upset.

This damping down of expected affective responses can reflect a form of direct emotional avoidance. Some patients report that suppressing or distancing themselves from their feelings is an intentional strategy. This is most often the case for men who are socialised to value emotional control and to see expressions of emotion (either positive or negative) as indicative of weakness or irrationality. The degree of effort involved in such emotional suppression seems to vary considerably. If questioned, some patients acknowledge directing a great deal of effort towards vetting and controlling their emotional experience. Although *Graham* would discuss potentially upsetting issues with no overt sign of distress or discomfort, it transpired that internally he experienced a range of emotional reactions. He believed these responses to be abnormal and unacceptable, and took them as evidence of his inadequacy. As a result, from his childhood onwards he had developed strategies for ensuring that these emotions were never publicly displayed. These included tensing his body, in particular 'pushing down' in his stomach, in order physically to suppress his feelings. Interestingly, *Graham* was not averse to letting his feelings out in private and had on occasions cried at upsetting events in the privacy of his bedroom or when alone reading a moving book or watching a film. Thus it was the public display of emotions that was most unacceptable to him rather than experiencing them *per se*.

For many other patients, the control of emotions seems to have become so automatic that it requires little effort. Such patients often have great difficulty identifying any acute emotional experiences at all. The lack of acute

negative experience may explain patients' failure to consider manifest difficulties as problems in the way described above. Even the most grievous external circumstances, including redundancy or personal losses, may not be viewed as problems. The lack of emotional experience can impact on a patient's view of depression itself, such that some persistently depressed patients do not see themselves as depressed. For example, at the beginning of therapy Stan kept asking the therapist over and over again whether he was depressed, and seemed unable to take on board the therapist's assurance that he did indeed have many of the common symptoms of depression. This made it difficult at the beginning of therapy to gain an accurate picture of the history of depression and its relation to his other life experiences. Stan thought that he had been like this for the two years since his initial referral by his general practitioner, which was shortly after he had lost his job. He also thought it possible that he may have been like this for some 20 years, as he had not seemed to be the same as other people over that time.

CONSEQUENCES OF AVOIDANCE

Adaptive Consequences

With many patients, the adoption of a range of avoidant coping strategies for dealing with unpleasant events, thoughts and feelings can be traced back to an early age. These avoidance strategies were often adaptive, given the context in which they emerged, and enabled the individual to deal with highly aversive experiences. This was the case for *Marion*, who as a child was treated as a pawn in the ongoing conflict between her alcohol-dependent father and depressed mother. She quickly learned that she could exert little control over the behaviour of either parent and frequently became highly anxious. Her own emotional needs were neglected and she learned to ignore these to such a degree that as an adult she had no real sense of what these needs were and how to meet them. Avoidance as a coping strategy may also be learned from the models presented in certain cultures. For example, male patients' concerns that the expression of emotions will lead to ridicule and humiliation are not entirely unfounded in many parts of the UK. In this environment, men are socialised to view open expression of any emotion (positive or negative) as a lack of inner strength and control. Cultural attitudes about the experience and expression of emotion may lead to the reinforcement of emotional suppression both within and outside the home.

These forms of behavioural, cognitive and emotional avoidance can all be seen as strategies the patient has evolved for dealing with the distress

provoked by difficult events and thoughts. Successful use of such strategies in the avoidance or relief of anxiety and distress over many years will have been highly reinforcing. With the onset of depression, these same avoidant strategies can then be applied to dealing with depression itself. Patients who have experienced depression over a number of years learn that if they can avoid stressful situations or painful thoughts and feelings, then their depression will just grumble along in the background in a way that can be endured. Clearly, developing skills to regulate affect is a crucial aspect of psychological development, which facilitates adaptation to change or challenging situations. However, the avoidance strategies described here seem maladaptive in that they do not simply serve to make unpleasant affect more manageable to enable those problem situations to be addressed effectively. Rather, they seem to be intended to eliminate unpleasant emotions from conscious awareness. This has a number of self-defeating consequences.

Maladaptive Consequences

With increasing avoidance, patients' tolerance of upsetting emotions can become severely limited and the development of alternative ways of managing affect compromised. Problem situations frequently remain unaddressed and problem-solving skills may not be developed or practised. Through avoiding articulating or working towards personal goals, patients may be chronically deprived of the satisfaction this can bring. Where avoidance is intended to conceal perceived inadequacies from others, it may in fact serve to prevent erroneously negative self-evaluations from being re-evaluated.

Different styles of avoidance can have different consequences for patients' current behaviour and mood. Behavioural and cognitive avoidance of upsetting situations and thoughts entails engaging in particular physical and mental activities to manage mood. Where this active avoidance is the predominant way of coping, patients' moods can be highly labile. When not confronted by any particular problems, the person's mood can be good and they may present themselves as happy and coping well. However, when avoiding or ignoring problems becomes impossible to sustain, their mood may quickly crash and extreme negative thinking may become evident. This style of coping is often exhibited from assessment onwards. For example, *Kate* began her first therapy session saying that she felt quite well and could not think of any problems that she wished to discuss. When the therapist suggested reviewing different areas of her life in order to get to know her better, it soon emerged that she was jobless and facing

considerable financial problems. In addition, she had suffered in a string of apparently abusive relationships and had recently fallen out with one of her neighbours. As the elucidation of all these problems progressed, Kate became extremely distressed, berated herself as a horrible person and left the room saying she did not want to carry on the therapy. It took considerable persuasion in a quiet corridor outside before she agreed to return to the therapist's office and discuss how therapy might be able to help her. In many patients, when their avoidance breaks down, the negative cognitions expected within a cognitive model are all too evident and the associated mood shifts quite overwhelming.

In contrast, where emotional avoidance is predominant, the patient's mood will tend to be flat and the outward appearance is of passivity. Whereas behavioural avoidance leads to an outward focus on controlling events, emotional avoidance focuses the patient's effort inwards on the control of emotional experience. Patients for whom this strategy predominates seem to show little initiative, instead going along with what seems to be expected of them. In this way, *Stan* had few friends of his own and never arranged any social contact. When confronted with gatherings of his wife's friends, which he found quite awful, he would go along with an air of resignation. For some patients, the elimination of emotions has become so pervasive that they have great difficulty identifying or expressing any desires or preferences at all. Although this coping style tends to prevent overwhelming mood shifts, this lack of emotional immediacy can be problematic in itself. Where patients have become very able to limit or distance themselves from their feelings, they often remain in situations that they find aversive or fail to take any action to bring about satisfying results. The constancy of undesired outcomes then feeds an increasing sense of gloom and hopelessness, which even further emotional suppression cannot alleviate.

Consequences for Therapy

Importantly, the processes of avoidance have major implications for the conduct of cognitive therapy, which are discussed in detail in the remainder of this book. The subtle and often successful implementation of behavioural avoidance can mean that important negative thoughts are not triggered. Cognitive avoidance can make it difficult for the therapist to focus on specific problems or to identify specific negative thoughts in therapy. The lack of emotional arousal which results from emotional suppression impedes the psychotherapeutic process generally and means that any negative thoughts that are identified are not 'hot' and are thus harder to work

with. Even when patients have grasped the idea of recognising and identifying negative thoughts, avoidance may then affect subsequent attempts to develop new ways of dealing with them. Having successfully identified a negative thought, patients may then apply their usual coping strategy of pushing thoughts out of their mind rather than going through the process of examining the content of the thought itself and looking for a more balanced view.

A further effect of patients' avoidance on therapy is that initial cognitive therapy interventions frequently result in patients feeling worse in the short term. If this reaction is not expected and discussed as part of the initial treatment rationale, the patient can experience the emotional arousal provoked in therapy as aversive and unhelpful. This in turn can feed into beliefs about the perceived uncontrollability of depression as an illness. It can also lead the patient to perceive that the therapist is 'out to get them' in some way. This can explain the sometimes hostile or angry responses when it is suggested to patients with chronic depression that they should start therapy. It is important that the threat this presents to the establishment of a therapeutic alliance is anticipated and the potential for premature termination of treatment reduced. Ways of adapting the style of therapy (Chapter 2), the socialisation of the patient into therapy (Chapter 4) and the use of behavioural (Chapter 5) and cognitive (Chapter 6) techniques to lessen the adverse impact of these avoidance processes on therapy are discussed in detail in subsequent chapters.

LEVELS OF COGNITION IN PERSISTENT DEPRESSION

Addressing the thinking of patients with persistent depression can often seem like the unenviable task of stripping wallpaper in an old house. With considerable effort one layer of wallpaper is removed small strip by small strip, only to reveal another layer of paper of an even more unsuitable design bonded to the wall by an even stronger layer of adhesive. The thoughts that are easiest to identify often turn out to be manifestations of more deeply entrenched and more widely generalised beliefs. For example, some patients appear to attribute their perceived inadequacy to being depressed but, when questioned, attribute their inadequacy to having been repeatedly depressed, and when this is questioned they attribute their inadequacy to their make-up, viz. 'It's just me—the way I am'. In providing an account of cognition in persistent depression, the cognitive model must first describe the characteristics of overt negative thinking that are most immediately apparent. The belief systems underlying overt negative thinking must then be examined.

Overt Negative Thoughts

In the cognitive model of acute depression, Beck and colleagues (1979) described how negative thoughts impinge on conscious awareness in a spontaneous or automatic fashion. Such negative automatic thoughts are commonly associated with depressive affect shifts. As with the cognitive triad in acute depression, negative thinking in persistent depression manifests in low self-esteem, helplessness and hopelessness. However, the processes of cognitive and emotional avoidance in persistent depression influence the nature of the thoughts that are apparent to the therapist. In many cases of persistent depression, the evasion or suppression of shifts in affect limits the occurrence of spontaneous, 'hot' automatic thoughts.

The negative thoughts that are reported in chronic cases seem less affectively charged and are often quite stereotyped or habitual. Patients may say the same things over and over again, using the same negative descriptions of themselves and the situation each time. Thus, *Marion* repeated the phrase 'It's hopeless' like an incantation; *Catherine* would respond to any therapeutic intervention with 'It won't make any difference'; and *Stan's* comment on most situations was 'I'm just pathetic'. These repetitive negative thoughts are often global in nature and may be divorced from reference to any specific situation. They often contain the same thinking biases as in acute depression, with black and white thinking patterns and personalisation particularly common. Although accompanied by a general mood of gloom, such thoughts are often not associated with changes in emotional state. Perhaps because of the lack of accompanying emotional arousal, such thoughts can not only be repetitive and held quite rigidly, but also seem somewhat immune to tried and trusted modes of questioning, as will be discussed in Chapter 6. Attempts to question these negative thoughts often lead to rationalisation at a superficial level with little improvement in the patient's affective or motivational state. This global negative thinking may reflect an avoidance of thoughts about specific negative situations that may be inherently more emotional or 'hot'.

However, when avoidance processes break down, the negative thoughts driving that avoidance tend to become apparent. Such thoughts are accompanied by overwhelming levels of affect. This was true for *Jean*, who in the face of actual or perceived criticism from others would become simultaneously anxious, angry and guilty. At such times, she spontaneously proffered a stream of automatic thoughts in which she assumed others were viewing her in a negative light, which she believed would lead them to withdraw all attention and affection forever. She would become enraged at the injustice of this but would also blame herself and assume the burden of responsibility for making peace.

Not only was the situation itself blown out of proportion in this way, but her high levels of affect were then catastrophised as a total loss of control, thus further exacerbating her distress. Such outbursts of emotion were difficult to contain and manage for both therapist and patient, so in some respects it was understandable that Jean used avoidance as a means of managing her negative affect. In these circumstances, the high levels of affect coupled with the rigidity of her thinking made conventional efforts to question Jean's negative thoughts extremely difficult.

Thinking Style

In many cases of persistent depression, the style of the patient's way of thinking may be as important as its negative content. The global style of thinking is reflected in the kinds of cognitive biases or thinking errors seen in persistent depression. The negative thinking of patients with persistent depression is often categorical and extreme. This extremity of black and white thinking can make the thinking biases of acutely depressed patients seem moderate. For example, *Rosemary* could concede that other depressed people would benefit from making some allowance for the depression, but drew the line at the possibility that she might give herself more time to do things. To her, even to consider this possibility would be categorically 'selfish', as it would limit the time she had available to do things for others. Thinking biases such as overgeneralisation, jumping to conclusions and personalisation are also common in persistent depression. In acute depression, these thinking biases often reflect excessively negative inferences drawn from particular situations. Patients with persistent depression often seem to arrive at similar negative conclusions without any reference to any particular negative situation or trigger.

An overgeneral style of processing has been described as an important feature of cognition in depression that is associated with chronicity (Williams et al., 1997). Patients with persistent depression often seem to have great difficulty recounting particular incidents, whether from the recent or more distant past. They may be certain about some state of affairs at an abstract level, but be unable to back up their general view with specific instances. This applies to both positive and negative events, although the difficulty may be more marked when attempting to recall positive memories. For example, at one session when discussing the previous week, *Julie* reported that she had failed at just about everything she had attempted, but was unable to give any examples. She also said that the only thing that had gone well in the week was that her niece had made some kind remarks to her, but she could not think of the day on which this had occurred or the content of what had been said. It is likely that such overgeneral

memories have less affective impact than more specific memories. As this overgeneral recall does not seem to be under conscious control, it may be different in nature to the forms of cognitive avoidance described above. It may result from a detrimental influence of an avoidant style of processing on the ability to access and elaborate specific memories at the time of recall (Kuyken & Brewin, 1996). Alternatively, it may reflect cognitive disengagement from situations at the time they are encoded into memory, which interferes with the registration of specific information about those situations.

This abstract style of processing may interfere with the accomplishment of particular tasks. For example, at one stage *Elizabeth* described having considerable difficulty completing a particularly complicated report at work. When the therapist asked for more details, Elizabeth could describe in general terms what the report was about but was unable to elaborate on its format or the more specific issues involved. This resulted in her difficulty in breaking the overall task down in order to tackle specific aspects of the report in a step-by-step fashion. Interestingly, this kind of clinical observation is supported by research suggesting that the difficulty depressed patients have in recalling specific memories contributes to their poor problem solving (Williams et al., 1997; Garland et al., 2000).

The overt negative thinking observed in patients with persistent depression is often ruminative in nature. Such rumination involves patients repeatedly focusing on the fact that they are depressed; on the symptoms of depression; on its causes and its persistence. Recent research has suggested that rumination may influence both the duration and severity of low mood (Nolen-Hoeksema, 1991). Importantly, this ruminative response style may reflect different cognitive processes to the negative automatic thoughts in depression. This processing style can reflect a deliberate or habitual strategy, rather than reflecting automatic differences in accessibility of emotionally toned material. It is frequently encountered in patients for whom the theme of control is a central concern, and it may represent part of a strategy for managing affect. Its presence can be detected when the patient's attention shifts in the session from the issue at hand to questions of the symptoms of depression or the likely duration and course of the illness.

Underlying Beliefs

The overwhelming affect occasionally triggered by some thoughts in persistent depression results from the profound personal significance of the thoughts. The thoughts that are accessible in awareness at times of acute

distress may directly reflect the activation of deeper level assumptions and beliefs. The repetitive and flat nature of much of the thinking observed can be seen as a consequence of protecting against such activation of deeper beliefs. Whereas in acute depression it is often possible to treat cases by addressing behaviours and automatic thoughts with relatively minimal understanding of or attention to beliefs, this is less so in persistent depression. Beliefs relevant to persistent depression concern negative representations that patients have of themselves, their relationship to others and the world in which they live. Rather than being transient ideas that are to a large extent coloured by the mood state in which they arise—as in the automatic thoughts seen in acute depression—beliefs are of an enduring nature. The person gives them credence at different times, in different situations and in different mood states. In applying the cognitive model to persistent depression, it is helpful to consider three types of underlying beliefs: beliefs about depression, conditional beliefs or assumptions and unconditional or core beliefs.

BELIEFS ABOUT DEPRESSION

The beliefs that are often most immediately evident when working with cases of persistent depression are those concerning the depression itself. Beliefs about depression, its causes and its controllability may be fashioned by the patient's repeated or prolonged experience of being depressed and undergoing treatment. These beliefs about depression can have important implications for the persistence of depression.

Depression as a Sign of Inadequacy

The symptoms of depression, including lack of energy and motivation, entail reductions in what the person is able to accomplish compared to usual. As a result of such limitations, patients often view being depressed as a sign of weakness or inadequacy. For many patients, the specific belief that depression is a sign of weakness is guided by a pre-existing general belief that emotions are a sign of weakness (see below). When the symptoms persist, such weakness is viewed as characterological, rather than as a temporary or partial state. This view is then often reinforced by changes in role that may accompany the persistence of depression, such as being retired on medical grounds. Prior to his illness, Peter saw himself as strong, capable and in control of himself and his life. In his eyes, not having eradicated the depression at an early stage constituted a definitive failure.

He believed quite rigidly that 'my depression shows what an inadequate person I am' and he discounted as applying only to other people the view that depression is an illness.

An unsuccessful treatment process can reinforce the belief that depression shows a weakness of character. When first presenting with depression, patients are often told that their depression is treatable and are informed of the range of effective treatments that are available for depression. When such 'effective' treatments are tried and found to be ineffective, perhaps several times over, an attribution that the illness reflects a defect in character rather than being a treatable illness is reinforced. The explanation is often lent further weight by other aspects of the treatment process. For example, the clinician whose initial attempt at treatment has been unsuccessful may refer the patient on. Although to those who understand the health care system this is eminently sensible, patients who are forming a view that their depression proves that they are inadequate may see this as a sign that the clinician has given up on them. Similarly, if, as is often the case for psychiatrists in training positions, the treating doctor is moved to another position after an unsuccessful course of treatment, then this may again reinforce a patient's view that they are untreatable as a result of some fundamental inadequacy. Things are made even worse if the clinicians themselves, having initially approached their new patient with optimism and enthusiasm, become transparently discouraged and even disinterested when the patient fails to make a good response despite the clinician's best efforts. For example, *Catherine* had had several experiences of being referred on by different mental health professionals after their efforts to treat her depression had met with little success. She interpreted this lack of success of treatments that she had been told were effective as evidence of her own fragility and weakness. However, she continued to believe that there were effective treatments available, and so also believed that the various treating clinicians must be withholding these from her. Bitterness and resentment at the failure of the treatment system were thus mixed in with her own poor self-esteem.

Depression as a Biological Problem

As well as confirming a view of depression as a sign of personal inadequacy, past unsuccessful treatments can reinforce other beliefs about depression that affect the person's engagement in cognitive therapy. The majority of patients have initially been prescribed antidepressant medication as a first-line treatment for their illness. The treatment rationale provided for this usually involves presenting depression as a biological problem. Depression

may be described as a chemical imbalance or as a hereditary complaint for which medication is the treatment of choice. Subsequent lack of treatment response may also have been explained in terms of biological disturbances in the brain. The view that depression is biological is reinforced by evident physical symptoms, especially lethargy and muscular aches or weakness. The apparent lack of relation between low mood and obvious stressors can also feed the idea that the problem is entirely biological. This idea can be integrated with the characterological view described above in a belief that depression is 'stamped in my genes'.

The strength of patients' attributions of their problems to character or to biology limits their expectations of cognitive therapy. The idea that a few hours of talking will alleviate flaws in a person's character is seen as implausible. It can seem similarly illogical to expect a psychological approach to change the nature of the brain or affect levels of neurotransmitters. Cognitive therapy is firmly expected to be the latest in the long line of failed treatments. This can result in therapy being commenced with an attitude of scepticism or overt antipathy towards the therapist, but an air of passive resignation seems at least as common. As we discuss in Chapter 4, in presenting the rationale for cognitive therapy, it is helpful to discuss the interrelationships between biological changes and psychological changes. To encompass patients' beliefs about depression, explaining the maintenance of their problems using a psychobiosocial model is preferable to using exclusively psychological explanations.

CONDITIONAL BELIEFS

Beliefs about depression can be quite firmly held and have significant impact on engagement in therapy, but nevertheless represent only the outer layer of cognitive content (or 'wallpaper') in persistent depression. At the next layer, conditional beliefs are rules and assumptions that govern behaviour. Such rules stipulate that if certain conditions are satisfied, self-esteem is preserved. These rules can often be articulated as 'if . . . then' statements ('If I do everything perfectly, then I am a worthwhile person') or should statements ('I should always put the needs of others before my own'). Some examples of beliefs typical in persistent depression are: 'If I can't do something properly, there is no point in doing it at all' (*Elizabeth*); 'If I don't do what other people want, I will be criticised and rejected' (*Jean*); and 'If I can't control my emotions, it is a sign of weakness' (*Peter*). These beliefs can be viewed as values that confer some benefits, but also entail disadvantages. The rigidity with which such beliefs are adhered to by patients with chronic depression prevents them, to a greater or lesser extent, from functioning effectively.

Beliefs about Emotions

As discussed above, the belief that depression is a sign of personal inadequacy is often a specific application of a more general belief that emotions are a sign of weakness. The different forms of avoidance discussed above often result from negative beliefs about the experience and expression of emotion. The idea that open expression of any emotion reflects a lack of self-control prevails in many parts of British and other cultures. Control of emotions may be reinforced and viewed as strong or brave, whereas emotional display may be punished or derided as weak. Many patients with persistent depression firmly and wholeheartedly endorse the view that emotions are a sign of weakness and should be overcome or kept under control. As a result of such beliefs, many patients adopt a rule that their feelings should be hidden from others at all times. Any display of emotions is predicted to lead to ridicule and humiliation. This idea often leads to overt behavioural avoidance of upsetting situations. For example, since his business had gone into receivership, *Dave* had seen little of his extended family. He knew that he would feel embarrassed, predicted that he would be unable to hide his upset and believed that for others to see this would result in complete humiliation. He thus tried to avoid all situations where he thought that people might ask personal questions. Many patients believe that emotions should not only be kept hidden, but should be stamped out internally too. Where patients' rules entail overcoming their emotions completely, attempts at emotional suppression become mandatory. For example, *Stan* shared *Dave's* belief that any outward sign of emotion would lead to ridicule and humiliation, but also believed that any feeling inside rendered him weak and vulnerable. His view was so absolute that he did not allow any feelings even about major positive events, such as the birth of his grandchild.

Beliefs about Work

Negative beliefs about emotions are often accompanied by beliefs about the importance of being productive. Many patients derive their sense of worth from being productive and see emotions as irrelevant to or interfering with this goal. The importance of productivity is often reflected in beliefs about work, which are endorsed by many men (and, increasingly, women) in Western society. Individually, work can provide a sense of purpose and meaning in life. Socially, work is important in defining roles, particularly masculinity, and can be the means through which status and respect (in the eyes of self and others) are conferred. Work is also the means through which someone becomes able to provide materially for others, which can

be important in maintaining self-worth. In persistent depression, such attitudes are frequently encountered in the form of beliefs such as, 'In order to have respect and worth I must work'. For some individuals, simply working in itself confers acceptability and respectability, and being hard working is seen as a virtue. For others, it is vital to achieve particular status and respect through being outstanding in the work role. For example, prior to becoming depressed, *Dave* worked long hours striving to make his business the most successful in its field. When the conditions of these beliefs are satisfied, and the person has gainful employment, then there are no grounds for depression. Many patients, whose persistent depression followed their being made redundant, claim that they had never had a moment's depression before in their life. Examination of the person's history bears out that when they have worked there has indeed been no problem with self-confidence or esteem.

However, for patients with these beliefs, being unable to work is a devastating blow. Its effect on perceived self-worth is crippling, even when not working is a result of redundancy that is obviously not the patient's fault. For example, *Peter* was retired on grounds of ill-health due to depression at age 50. As a man in his fifties still battling with his illness in an area of high unemployment, it was unlikely that Peter would work again. As he was no longer working or providing materially for his family Peter saw himself as worthless and avoided most social activities because he felt so ashamed. He saw himself as a 'scrounger from the state' and worried that this was how others also perceived him. Although Peter did not hold any belief that was radically different to any other man of his generation and social class, his belief that his worth depended on working and nothing else was categorical. Peter believed with an extreme degree of conviction that work was his only measure of worth and applied this belief rigidly. Although he now devoted time to his family, house and garden, he saw this contribution to family life as of absolutely no significance to his self-worth. Attempts at encouraging Peter to consider voluntary work as a means of deriving a sense of purpose were defeated by the fact that part of his definition of worth was how much an individual earned. Far from improving his self-esteem, for Peter to consider his worth as depending on family or voluntary work represented in his eyes a loss of respect and dignity. As a result of its extremity and rigidity, the effects of his conditional belief on his self-esteem were as pernicious as those of an unconditional belief.

Other Common Conditional Beliefs

As in acute depression, conditional beliefs in persistent depression often focus on the standards the patients should maintain in their personal

and social behaviour. Patients commonly apply rules about perfectionism and meeting high standards to performance of any tasks. For example, *Elizabeth* maintained that it was essential to her always to do everything to the highest possible standard and to ensure that this standard was met by 'always doing things properly'. This meant that she was continually vigilant for any shortcomings in any of her efforts and viewed any such shortcomings in a highly self-critical fashion. As with many patients, she saw such a self-critical attitude as essential to maintaining an adequate standard of performance. She endorsed a belief that 'Unless I push myself constantly, things I do will not be of an acceptable standard'. For other patients, concerns about pleasing others and gaining approval in their relationships are more important in maintaining self-esteem. For example, *Rosemary* adopted a rule that she should always please others. She believed that 'If I do not do what other people want, they will criticise or reject me'.

As well as determining a person's view of their self-worth, conditional beliefs can also describe that person's view of the world. Beliefs about fairness, such as 'if you are fair to others they will be fair to you in return' are commonly encountered in working with patients with persistent depression. For example, *Peter's* way of life had been greatly influenced by the principle that 'if you work hard you will be rewarded'. When he was made redundant, not only was his sense of worth as an individual eroded, but his sense of justice in the world was severely compromised. This destruction of the contract he had always assumed existed between him and the outside world left him believing that life was pointless in an unfair world. Other changes in working practices, such as a shift from a perceived emphasis on quality of work to an emphasis on profit, can also infringe beliefs about fairness and result in the elimination of job satisfaction. Beliefs about fairness can also influence people's expectations in relationships and importantly affect their reaction to events such as perceived let-downs or injustices.

The Rigidity of Conditional Beliefs

Beliefs that are similar in content to these may be apparent in acutely depressed patients or in the population at large. As with beliefs about work, it is the extremity and rigidity with which conditional beliefs are applied in chronic depression that makes their effect particularly disabling. The extremity of black and white thinking can be striking. For *Elizabeth*, the slightest blemish in anything she undertook could render it completely useless in her eyes. For *Rosemary*, even to consider not doing something that someone else wanted would cast her as a 'horrible person'. The particular rigidity of these beliefs can be highlighted when the patient has been

exposed to conflicting demands. Rosemary frequently found herself in the position of trying to satisfy conflicting demands from different members of her family. Her rule that she should please all other people all of the time was sometimes impossible to satisfy. When having to turn down a request from members of her family because of some prior commitment, she was unable to see this as an inevitable consequence of the situation. Instead, she would blame herself for being unable to meet all the demands, and would greatly fear the anger of whomever she had been unable to please.

The rigidity with which beliefs are applied can also lead to particular difficulties in situations where more than one belief is activated simultaneously. For example, Elizabeth's belief that 'if you don't do something properly there is no point in doing it at all' would often make her anxious about the tasks that confronted her. To attempt these tasks would then activate another belief that 'if I am emotional, it shows I am not in control of my faculties'. Her inability to suspend or tone down one rule in order to satisfy the conflicting demands of another resulted in her being in a state of almost constant dissatisfaction with herself. Where conditional beliefs are applied in an absolute and rigid fashion, their detrimental effects can be as inevitable as those of unconditional or core beliefs that often form the most fundamental layer of negative cognition in persistent depression.

UNCONDITIONAL BELIEFS

The cognitive model proposes that the chronic cognitive triad (low self-esteem, helplessness and hopelessness) in persistent depression is underpinned by unconditional beliefs about the self, other people and the world. These generalised negative beliefs are tacitly held as unquestionable truths and so guide the processing of information in a distorted or prejudicial fashion (Padesky, 1990). Unconditional beliefs about the self most commonly cluster around two main themes: that of weakness and that of unacceptability. Beliefs about weakness include 'I am inadequate or weak', where the person considers that they fundamentally lack the resources to meet external or internal challenges, and 'I am vulnerable', where the person has an enduring expectation of harm either from ridicule by others or from being overwhelmed by emotions. Beliefs about unacceptability include 'I am bad', where the focus is on selfish impulses and feelings seen as morally unacceptable, 'I am horrible or unlovable', where the person believes that they can only ever be criticised or rejected by others, and 'I am no good', where the person believes that they can never meet the standards required to gain the approval of others. Other common beliefs

are 'I am a failure', 'I am worthless', 'I am inferior', 'I don't count' (insignificance) and 'I am neglected or deprived'. To the patient, the experience of these unconditional beliefs being activated is of the awful truth about them being cruelly exposed, so such activation can trigger overwhelming affect. Behavioural, cognitive and emotional avoidance can be understood as strategies to prevent such activation or limit its consequences. In some patients with persistent depression, these unconditional beliefs are evident from the earliest stages of therapy. For others they become clear only after considerable effort at cutting through the 'smokescreen' of avoidance.

Prejudicial Processing

Unconditional beliefs are maintained by cognitive and behavioural processes, which have been well described in previous texts (Beck et al., 1990; Padesky, 1994; Young, 1990). At a cognitive level, such beliefs serve as prejudices, such that only experiences consistent with the negative view get noticed and remembered. When positive information that could disconfirm the belief is encountered, it is ignored, dismissed or discounted in some way. This cognitive bias in the way that information is processed reinforces the unconditional beliefs. For example, *Marion* saw herself as 'unlovable' and so always expected that other people would reject or abandon her. An incident early in therapy suggested how biases in her processing of information might have served to maintain this belief. Marion was 15 minutes late for an appointment on a cold, snowy December day. The bus had been late and she had walked a mile to the session, where she arrived flustered, shivering and soaking wet. She apologised profusely and repeatedly for being late. The therapist hung Marion's coat on the radiator to dry off, offered her some paper towels to dry her hair and face, and then offered to make her a hot drink. Marion started to cry and when asked what was upsetting her, she replied 'You are being kind to me. It doesn't seem right—I was late. I don't deserve it'. This interaction was subsequently used to illustrate how experiences inconsistent with her view of herself as unlovable could not be processed. The therapist's reaction to her being late made no sense to her. She elaborated that it would be dangerous to trust the therapist's kindness because ultimately she would be discharged from therapy and the potential for future kindness would be lost. Similar processes operated outside the therapy setting: when anyone seemed to like Marion, she believed that this was only because she complied with their wishes rather than because they liked her as a person. In contrast, she considered any negative reactions to be truly reflective of her real, unlovable self. The idea of unconditional beliefs as self-prejudices is discussed in more detail in Chapter 7.

Schema Maintenance Processes

As well as being reinforced by these cognitive biases, unconditional beliefs are further reinforced by their reciprocal relationship with conditional beliefs and the behavioural strategies associated with them. Young (1990) has described these processes as schema compensation, schema avoidance and schema maintenance. Conditional beliefs can specify compensatory strategies, whereby the individual tries to make up for the deficiency defined by their unconditional belief. For example, *Kate* believed that she was a bad or 'horrible' person. To prevent people discovering this, Kate took great pains to try to please others. She believed that 'Unless I please other people, I will be rejected' and so had great difficulty asserting her own needs in relationships. Whenever Kate did receive positive feedback, she attributed it to having done everything she could to please. She saw this simply as maintaining a façade, and thus continued to believe she was horrible in essence. If she ever perceived someone reacting negatively to her, she would become distraught as she believed that they had seen through her façade to her real character. The compensatory strategy specified by her conditional beliefs thus left her unconditional negative view of herself untouched. This strategy had a number of other effects, which only served to reinforce her view of herself as horrible. Always doing what others wanted often resulted in her becoming silently resentful, which she interpreted as further evidence of being horrible. When on occasion her bottled up resentment exploded into poorly controlled displays of anger, commonly at innocent parties, this confirmed her horribleness. Further, her acquiescence to others' wishes meant that she had landed in a succession of relationships with men who had treated her in an abusive fashion. She believed that these relationships were indicative of what someone like herself could expect and that for the abuse to keep repeating itself must mean that in some way she deserved it. Thus, far from mitigating or weakening unconditional beliefs, conditional beliefs or compensatory strategies often serve to reinforce them.

Where unconditional beliefs concern unacceptability, conditional beliefs often specify compensatory actions that aim to achieve some external goal. Thus, someone who believes that they are unlovable will try to prevent this being noticed by pleasing other people. An individual who believes that they are no good will try to succeed in everything they undertake. The person's emotional state depends on the extent to which their compensatory strategies succeed in masking the unconditional belief. Thus, when beliefs about unacceptability are most dominant, patients will generally be vulnerable to experiencing high levels of affect. In contrast, unconditional beliefs about weakness are often associated with conditional beliefs about

maintaining control over emotions. *Stan's* view of himself was summed up in therapy as an unconditional belief 'I am weak'. This resulted in his endorsing a rule 'I must never allow myself to get emotional'. As described above, this led to his suppressing all feelings, negative and positive. Thus, where beliefs about weakness predominate, emotional flattening tends to result. This prevents the acute emotional arousal that the patient is most likely to interpret immediately as weakness. However, it can still lead to the beliefs about weakness being reinforced. For *Stan*, as his gloomy state was so unvarying, it came to seem that he was unable to control it. The resulting sense of helplessness fed into his view of himself as weak. In addition, his suppression of his wishes and desires resulted in inertia and passivity. In comparison to this, when he saw other people satisfying their personal goals or desires, he interpreted it as further evidence of his weakness.

Conditional beliefs and the ensuing compensatory strategies are thus used to prevent activation of unconditional beliefs, but may also have the effect of maintaining or reinforcing those very beliefs. In a similar fashion, avoidance may also be used directly to prevent such activation and may also serve to maintain the beliefs. Where patients have core beliefs about unacceptability, a common strategy is to prevent other people from realising this by avoiding certain types of people, relationships or interactions. To return to *Marion*, her view of herself as 'unlovable' led her to avoid social contact as much as possible in order to avoid the possibility of rejection. Where she could not avoid social contact altogether, she would try to keep any contact on as superficial a level as possible. As a result, *Marion's* network of social relationships was indeed impoverished: she had few friends and those relationships she had were not close. She interpreted this state of affairs as a sign that she was not loved as much as others, which reinforced her belief that she was unlovable. Avoidance can also reinforce beliefs about weakness. For example, *Stan's* view of himself as weak meant that he believed himself to be incapable of making decisions and unable to cope with the consequences of making the wrong one. He thus tried to avoid making any. The result of this was that others tended to make any decisions for him and he would go along with things that would patently not have been his choice. He then interpreted being subjected to these undesired situations as evidence of powerlessness, which again reinforced his view of himself as weak.

A process of schema maintenance can also occur, where the person behaves in ways that are directly consistent with the schema. Believing that they are inherently unlovable can induce some people to behave in ways that are unpleasant or uncaring. By behaving in a hostile or rejecting fashion, the person can avoid appearing to have been rejected. This

can give the sense of having decided to act this way and hence of having some control over the perceived inadequacies. However, this course of action reinforces a negative self-view. The patient is likely to interpret their own negative behaviour as confirmation of their unacceptability as well as in fact alienating other people and inviting hostile responses. This was sometimes true of Kate (described above). Although she usually attempted to compensate for her view of herself as 'horrible' by pleasing others, on occasion she would instead adopt a cynical and dismissive tone towards others. This tended to occur in relatively impersonal situations where she perceived that she had little chance of eliciting a good reaction however she acted. At her doctor's surgery, for example, she had acquired a reputation for being rude and aggressive over the way she handled requests for appointments or prescriptions. Although in these situations she appeared haughty and overconfident, she saw the ensuing reluctance of the staff to help her as further evidence of just how horrible she was.

Beliefs about Others and the World

Rigid, unconditional beliefs shape not only patients' views of themselves, but also of other people and the world around. Patients with a view of themselves as weak often have an exaggerated and fixed view of the infallibility or 'normality' of others. They believe that others always deal smoothly with any real problems that they encounter and are never subject to any unexplained mood swings or irrational reactions. For example, when asked to describe how he saw other people, *Stan* replied that they were 'normal'. As well as believing that other people's feelings always made sense and were in proportion to events, *Stan* believed that others had no difficulty expressing themselves and getting what they wanted in life. Patients who view themselves as unacceptable often have a complementary view of others as critical and judgemental. For example, *Marion* expected other people to demean or reject her at every turn. It was described above how she tended to interpret others' kindness or sympathy as patronising or, in the case of her therapist, as a purely professional reaction. Patients who see themselves as worthless or not good enough frequently express a view of self-in-relation-to-others that is hierarchical in nature. Underlying interactions with others, there is a comparison drawn in which patients usually see themselves as less than others in some way. Within this hierarchy, some patients at times attempt to bolster their fragile self-esteem by viewing themselves as superior to some others. In such instances the patient may be overtly critical of another or seem to bask in the misfortunes that have befallen someone else.

In considering patients' view of the world or life in general, the most common theme in persistent depression is that of harshness. Patients do not expect life to treat them well, either in terms of good fortune or from the results of their own efforts. One patient summed it up as 'Life has got it in for me'. The particular slant put on this view of the world as harsh depends on its interaction with beliefs about self and others. Patients with the hierarchical view of self and others described above talk about a competitive 'dog eat dog' world. Those with high levels of anxiety view the world as particularly dangerous and unpredictable, whereas a view of the world as unfair is common in those with anger as a dominant feature. These negative views of the world can be particularly associated with the helplessness of persistently depressed patients. Patients' beliefs that the world is harsh can be self-referent in that they may believe that the world is particularly cruel to them. However, this is not always the case. Some patients are sensitive in general to any signs of suffering or injustice in the world, whether on a small scale or a global level. In some patients, poring over news reports of every tragedy or attending to every sign of misfortune that they encounter, from the weather to bad driving, reinforces this sensitivity. In others, the view that the world is too awful to be faced is fed by avoiding or minimising contact with the world as far as possible.

SOCIAL FACTORS IN PERSISTENT DEPRESSION

Maintaining Factors

From the above descriptions, it is clear that persistent depression is maintained not just by beliefs held inside the person's head. These beliefs manifest themselves behaviourally, often with detrimental consequences for the nature of the social environment in which patients find themselves. Whatever the precise nature of their beliefs, most patients with persistent depression drastically restrict the kinds of situations or experiences in which they participate. Whether their beliefs are of weakness, badness or worthlessness, patients tend to hang back from social contact and to behave in self-effacing and placatory ways when in social situations. They may have few social relationships and those they have, whether with partners, friends or acquaintances, often seem to be with people they do not particularly like. Similarly, this reluctance to express or assert themselves limits the chances of fresh social and occupational opportunities. The result is that patients are often underemployed or stuck in jobs they do not like or to which they are not suited. The consequent lack of positive feedback or reinforcement from the environment clearly serves to maintain the depression and the negative beliefs. The interaction between negative

beliefs and negative life situations thus forms a vicious circle that is crucial in the current, ongoing maintenance of persistent depression.

Triggering Factors

Negative events or situations also have an important role in the initial development of persistent depression, sometimes through triggering the onset of depression. The role of events in triggering onset is evident in cases where rigid conditional beliefs are apparent. Loss of or disruption in relationships has long been recognised as a common trigger for depression, particularly in those whose self-esteem depends greatly on being liked or approved of. In comparison, patients who believe that their work determines their personal worth are more susceptible to events that disrupt their working life. Redundancy is the most obviously depressogenic type of event, but more subtle changes in working practices can also be devastating to those with rigid beliefs. In business, recent examples of changes in the working culture include change from an emphasis on mutual support to an emphasis on profit and change from an emphasis on quality of product to an emphasis on presentation. In the public services, changes in the working culture have included changes in emphasis from caring to efficiency and from clinical judgement to standardised protocols. Particularly where such changes are imposed suddenly, such as when a company that has provided employment for many years is taken over, this can lead to unaccustomed pressure and conflict, which are not well tolerated (as was the case for Peter and Graham described in this book). The resulting stress results in the person taking time off for physical or mental ailments and consequently feeling more guilty and ashamed. When low mood and loss of motivation then set in, the patient is diagnosed as depressed, the sense of weakness or worthlessness deepens and the cycle of persistent depression is underway.

Predisposing Factors

In the cognitive model, as well as contributing to the triggering and maintenance of current depression, situational factors also have a longer-term influence on vulnerability to depression. In particular, events or circumstances play a crucial role in the development of maladaptive beliefs. Important beliefs about the self and others are often formed through learning from experiences during childhood and adolescence. The impact of early loss, trauma or abuse on the development of negative beliefs has been extensively considered in cognitive therapy (e.g. Beck et al., 1990). In

patients with persistent depression, overt trauma is often absent and other factors, such as neglect or being subject to rigid standards or rules across a variety of situations, may be most important in the development of beliefs.

Some patients with persistent depression report histories of harsh or abusive upbringings, as would be expected. Repeated experiences of being harshly criticised, punished, beaten or, more rarely, sexually abused, result in a view that abuse is all that can be expected. As no alternative view is apparent, the child forms a view that such treatment is deserved and so develops a view of self as being inherently unacceptable or bad. The violence does not necessarily have to be directed at the future patient. Many patients with persistent depression report an aggressive atmosphere between their parents, where either they were given or they assumed responsibility for trying to maintain a fragile peace. For example, *Marion's* mother would use Marion as a barrier to prevent her being hit by her alcoholic husband. Even when there was no imminent threat of violence, Marion was petrified of provoking any trouble. She quickly learned to be quiet and not to ask for anything, but despite this was not successful in preventing the violent outbursts. Her thinking that her own needs were unacceptable and that she was in some way to blame for not preventing the violence contributed to her developing a view of herself as unlovable.

Neglect does not always occur in such obviously violent or abusive circumstances. It can occur through parents modelling an overemphasis on the value of achievement, productivity and work over caring, kindness or family values. Through observing such role models, the future patient comes to adopt beliefs that they only have any worth as long as they achieve things. For example, *Elizabeth* described her mother as a strict woman with very high standards. She expected Elizabeth also to meet the standards that she set and restricted Elizabeth's opportunities to do things in any other fashion by continually monitoring her activities. It was not surprising that Elizabeth saw herself as worthless unless she continually met these very high standards.

Although abuse or neglect are common in the backgrounds of patients with persistent depression, it is not uncommon for negative beliefs to develop in a context that is more ambiguous and less readily identified as negative. Indeed in many cases, the strength of the person's negative view of themselves seems inconsistent with their reports of a trouble-free childhood. On closer examination, it sometimes seems to be the extreme 'normality' and lack of any observable ructions that has been pathogenic. Certain families seem to emphasise a view that life proceeds smoothly at all times and that even when things go wrong, no one gets upset. Disagreements and anger are never expressed. When children who grow up in this family 'culture'

experience upset, they perceive themselves as something of an oddity and start to form the view that they are weak compared to others. This was the case for *Stan*, who described both his parents in terms of being kindly and calm, but perhaps somewhat distant. He remembered repeatedly being teased as a little boy at school, for example about his ears sticking out, and becoming very upset. At home, he found himself unable to express his upset to his family and instead pretended he was fine. Because he knew he was not fine, he felt ashamed of his reaction and started to see himself as weak. Although thoughts about the particular taunts about his ears did not now bother him, the sense of weakness for being upset by it had persisted. Such a view of self as weak may be wittingly or unwittingly reinforced by the reactions of other members of the family to the child's upset. Whether told forcefully or gently not to be upset, the implicit message is that, if you are upset, there is something wrong with you. This can then form the template or schema that is fertile ground for later pathology.

Particular circumstances at home or at school can thus have a strong influence on the formation of negative beliefs. For some patients, the uniformity in the attitudes encountered across different situations may reinforce negative beliefs or foster their being rigidly applied. For many people, being subjected to some pernicious influence in one situation, for example at home, may be balanced by a supportive influence in another sphere, for example at school. Even traumatic or repeated negative experiences frequently do not seem to lead to the global or rigid negative beliefs often seen in persistent depression. Conversely, the imposition of relatively innocuous conditions across different situations is sometimes central to understanding the development of maladaptive beliefs. For example, *Graham* described being vigorously encouraged by his parents to strive for excellence. There was nothing exceptional about this, but Graham was sent to a church school that propounded similar attitudes. Graham's social life as a child revolved around home, school and church and so he experienced limited exposure to different attitudes and encounters with people outside of and disapproved of by his milieu. In the face of the constancy of this striving for perfection, the strength of his view of himself as inadequate became understandable. Similarly, if a child sees any display of emotions being scorned both within their family and in wider social circles, their view of emotions as a sign of weakness may be particularly firm. For example, *Peter's* upbringing in a working-class family in Scotland helped to explain his belief that showing emotions was a sign of weakness. In this wider culture, control over emotions generally is an important part of being seen as strong or masculine, but displays of joy or grief are often deemed acceptable 'behind closed doors'. That Peter's family did not display emotions even in private made his view of emotions as weak particularly categorical.

THE CHRONIC COGNITIVE TRIAD

In acute depression, the concept of the negative cognitive triad is helpful in conceptualising patients' problems. Negative thinking about the self, the world and the future can usually be identified with suitable prompting. In persistent depression, the negative thinking in each domain is not necessarily linked to specific triggers or to changes in emotional state. In some patients, negative thinking may be immediately apparent, whereas in others overt negative thoughts may be evaded or denied. The model proposes that the negative thoughts central to persistent depression are enduring in nature and have become more closely interwoven with associated behavioural strategies and their social and environmental consequences. The chronic cognitive triad encompasses the domains of low self-esteem (self), helplessness (world) and hopelessness (future). The chronicity of negative thinking in each domain is a result of three factors. Firstly, negative beliefs confer enduring vulnerability to negative thinking in each domain. Secondly, avoidance and compensatory processes are used to handle the distress that would otherwise be constantly present when the beliefs were activated. Thirdly, the recurrence of negative situations and events, which are made more likely by those avoidance and compensatory strategies, confirms and entrenches the beliefs.

Low Self-esteem

Although low self-esteem is virtually ubiquitous in chronic depression, it is manifest in different ways in different patients. In many patients with persistent depression, negative thinking about the self is overt and is evident in their persistent self-criticism or self-blame. For some patients, such as *Elizabeth*, each attack on the self is experienced as depressing, so chronic low self-esteem is a painful experience. For her, engaging in any task once she was depressed entailed almost certain failure to live up to her high standards, and resulted in a barrage of self-criticism and consequent upset. Some patients take responsibility for any actual or perceived problem they encounter, and are constantly racked by guilt. In many other cases, negative thinking about the self may not always be evident, but any apparent self-esteem is fragile. For example, *Kate* kept negative thoughts from her mind and denied thinking negatively whenever possible. However, even when she seemed well, she was highly vulnerable to any event that triggered any negative self-evaluation. As the negativity was often extreme, her self-esteem was very fragile. Whenever her self-esteem crashed down, it had devastating consequences for her mood. For other patients, self-criticism has a more ritualistic quality and, although set in a background of low

mood, does not itself evoke distress. *Stan* tended to keep negative thoughts from his mind by avoiding any challenging situations. However, when challenged or presented with negative possibilities, he would endorse them in a resigned fashion. His passivity and emotional suppression protected him from any acute sense of devastation.

Whether chronically low or fragile in nature, low self-esteem needs to be formulated at a number of levels. For patients with persistent depression, underlying beliefs define the fundamental experience or truth about themselves as inherently negative. These negative beliefs provide the grounds for low self-esteem that is then cemented by the effects of avoidance, compensatory strategies, overt negative thinking and life changes once depressed. For example, beliefs about weakness and inability in patients like *Stan* often result in self-protective strategies. Thus, *Stan* rarely even set himself any goals or articulated any wishes for fear of not satisfying them. This led to a blanket lack of initiative and the suppression of any distressing feelings. However, the lack of pleasure, satisfaction or achievement and the dominance of others in his life provided constant proof of his negative self-image. In this way, beliefs about weakness and emotional control are often associated with chronic low self-esteem, which is characterised by a lack of self-confidence. Negative self-evaluative beliefs about badness and unacceptability are associated with more acutely painful low self-esteem, as is experienced by patients like *Kate*. When her belief that she was horrible was activated, she was subject to self-critical and self-punitive thinking and intentions, leading to intense self-hatred. When these beliefs had successfully been deactivated through avoidance or compensation, her low self-esteem was less evident. The fragility of self-esteem in such cases may be seen in lability over time or in the patient's self-protective prickliness or hostility when in a less depressed state.

Most patients attribute their difficulties—whether with persistent depressive symptoms, with never getting any satisfaction, or with flare-ups of extremely painful feelings—to their make-up or character. These characterological attributions for their difficulties provide further confirmation for their negative beliefs about themselves and their lives. Thus, patients who have difficulty initiating any satisfying activity may interpret this in terms of weakness; patients who have mood swings see them as unacceptable; patients who are subject to many unfortunate events see themselves as responsible or even as cursed. Importantly, patients do not see that they have any role in making these interpretations or attributions, but experience their view as 'the way I am'. This certainty that any ongoing difficulty reflects some inherent flaw or defect means that low self-esteem is continuously confirmed, reconfirmed and then entrenched.

Helplessness

Most depressed patients see the world as an unrewarding or hostile environment affording only unpleasant outcomes that cannot be prevented. In acute depression, perceptions of helplessness can result from the biasing effect of low mood on judgements of control or from overgeneralised conclusions drawn from particular events. In persistent depression, helplessness results from a more complex interplay of beliefs and coping strategies. It can be manifest in different ways in different patients. For patients with beliefs about weakness and incapability, helplessness arises mainly through seeing positive outcomes as unattainable and manifests itself in passivity. Other patients are helpless in the face of the consistent failure of their often frantic efforts to prevent negative outcomes, such as the surges of overwhelming distress that occur when attempts to conceal presumed inadequacies break down. Either way, the result is that patients see good reasons to believe that they cannot get what they want from life.

Passivity is one of the most striking features in the presentation of many patients. It is a particularly common manifestation of helplessness in patients for whom emotional suppression is strongly evident. Such passivity is often based on the perception that no activity could have any desirable effect. Taking *Stan* as an example, his passivity and reluctance to initiate action resulted in his life being lacking in sources of reward or reinforcement. Rather than setting goals or working towards the satisfaction of any desires, he simply tended to suppress any wishes. Even when apparently desirable outcomes arose in his life—for example, when his family were pleased with anything he had done for them—he did not allow himself any pleasure in case it did not last. This reinforced his view that there was nothing he could do to feel any better. Helplessness in such cases arises from the unremitting flatness of the emotional landscape. Helpless passivity can also result from life events that shatter the person's view that their life has some value. For *Peter*, redundancy was a severe blow to his self-esteem. Moreover, it wiped out the value of any of his remaining social and leisure activities. While he was working, activities such as socialising and playing sports served to confirm that his life had value and were thus reinforcing. His redundancy undermined any reinforcement from these activities. To him, there seemed to be nothing he could do to restore the overall value to his life, which was previously conferred by working. His helpless outlook was therefore a result of the combination of his rigid belief about the value of work combined with the event of redundancy.

In other patients, helplessness focuses on inability to control negative outcomes, rather than from the impossibility of attaining any positive outcomes. For some patients, the chronicity of material and social adversity

in the external environment is the key factor in triggering helplessness. For *Julie*, the initial onset of her depression was related to her divorce from her first husband, and since then she had experienced several bereavements, had entered into an unhappy second marriage and her teenage children were having serious problems. This series of major life events, some of which may have been made more likely by her depression, undoubtedly contributed to her view that there was nothing she could do to stop bad things happening. Moreover, her inability to avert these events confirmed her longstanding belief that she was responsible for bad things. For other patients, it is the uncontrollability of negative emotions that forms the focus of their helplessness. For *Kate*, lapses in her behavioural or cognitive avoidance of difficulties led to surges of overwhelming emotion. Whenever these struck, she saw them as entirely beyond her control and felt extremely helpless and frantic. Even in her better moments, she had a sense that emotional disaster could strike at any time. Her constant efforts to prevent or relieve distress through keeping painful thoughts and feelings out of her mind could not prevent these crises. She did not see the possibility that her avoidance was contributing to her problems and concluded that she was helpless to avert this overwhelming distress. In such patients, each crisis feeds back into their underlying view of themselves as unacceptable, confirming the view that they will not be able to prevent further disasters.

Hopelessness

Most patients with persistent depression believe that things cannot get better for them. They tend to see their depression stretching ahead indefinitely into the future and believe that any treatment is doomed to fail. In part, such hopelessness may be based on the person's current experience of low mood, as in acute depression. However, as with low self-esteem and helplessness, there are usually additional factors contributing to hopelessness in persistent depression. Again, patients' ongoing experiences, the influence of their avoidance and compensatory strategies on those experiences and their long-held underlying beliefs can all contribute to their hopeless perspective. The failure of previous treatments to produce the desired alleviation of the depression is usually the most obvious factor supporting the patient's hopelessness. Especially where such treatments have initially been presented as 'effective', the persistence of symptoms despite treatment results in a view that nothing will work. Patients often view such lack of response to treatment as showing that the depression has become part of their make-up. This feeds into both their low self-esteem and into their hopelessness about the chances of things ever improving.

In many cases, while these recent experiences of treatment are important contributors to hopelessness, they often serve to confirm and solidify a previous tendency to view life from a hopeless standpoint. Some patients endorse a long-held belief that always assuming the worst will protect them from disappointment. Such a pessimistic outlook is often part of an overall strategy of emotional suppression and control. For example, *Stan* had always believed that by not allowing himself any expectation of any positive outcome he could keep the potential for failure or disappointment to a minimum. He described going into most endeavours in his life, including his marriage and his job, with this attitude. Since he had become depressed, he viewed his symptoms and their lack of response to treatment in similar terms and thought it best not to let anything raise his hopes. Thus, his long-term tendency to adopt a pessimistic outlook had become entrenched in his hopelessness about his depression ever improving. In such patients, pessimism can be seen as a strategy that has been adopted pre-emptively in order to avoid or control negative emotions.

For other patients, pessimism is a consequence of repeated experiences of external setbacks or recurrences of depressive experiences. Some patients are desperate to avoid experiences of failure, rejection or depression that will reconfirm their negative view of themselves. However, they have learned 'the hard way' that no matter how much they try to succeed, be liked or stay in control, things will always go wrong. Patients such as *Kate*, who are highly avoidant of the possibility of failure or rejection, become extremely sensitive to any signs of the outcomes they fear. Whenever they encounter any sign of failure or rejection, it seems like another disaster and confirms to them that things in their life will never improve. Attributing any ongoing difficulties to inherent defects of character not only maintains low self-esteem, but also means that patients can see no possibility of things improving. As with low self-esteem and helplessness, the hopelessness of persistently depressed patients becomes more and more entrenched as ongoing difficulties are interpreted in terms of long-held negative beliefs.

A SUMMARY OF THE COGNITIVE MODEL OF PERSISTENT DEPRESSION

The cognitive model of depression is represented in Figure 1.2. The main pathways contributing to the model of acute depression are shown as bold lines. In acute depression, the centre of the action is at the level of the negative automatic thoughts that trigger or maintain negative emotions. These thoughts are specific to certain situations or times of low mood and are fuelled in the main by conditional beliefs. As the beliefs are conditional,

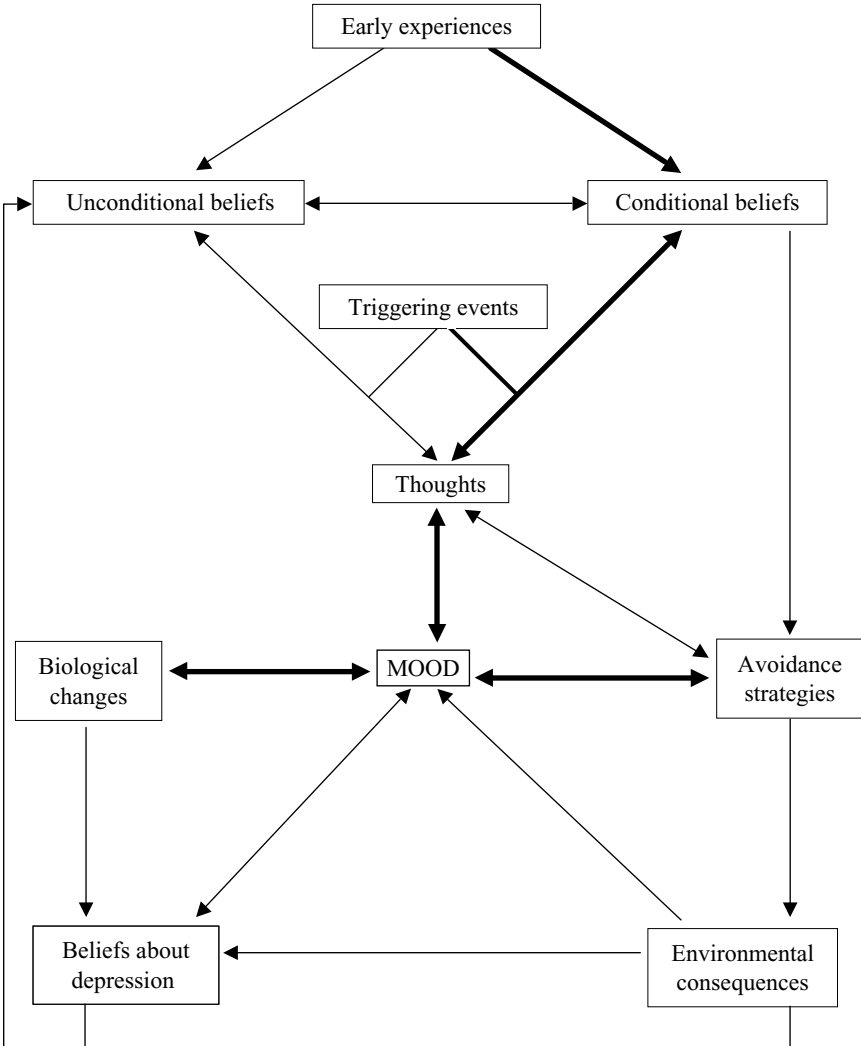


Figure 1.2 The cognitive model of persistent depression
 ➡ Main pathways in cognitive model of acute depression
 —➡ Additional main pathways in persistent depression

thinking errors and specific negative thoughts arise under certain conditions and are then sustained by the low mood they provoke. Low mood can also result in avoidance, which also feeds into the vicious cycle.

A number of additional factors contribute to the persistence of depression, as shown in the pathways indicated by fine arrows. The cognitive

triad cannot be described simply in terms of automatic negative thoughts. Rather, low self-esteem, helplessness and hopelessness reflect more enduring and deeply held beliefs. These beliefs are closely interwoven with patterns of behaviour and their social consequences. In many cases, unconditional beliefs about the self, others and the world are evident. Furthermore, rigid conditional beliefs are often applied inflexibly across many different situations. The unconditional nature and rigid application of these beliefs renders the person pervasively vulnerable to low mood. However, the actual experience of low mood is mitigated by the employment of various avoidance strategies driven by these beliefs. Whereas in acute depression, avoidance tends to be gross in nature and triggered by low mood, the avoidance in persistent depression is subtle and ubiquitous. Subtle forms of behavioural, cognitive and emotional avoidance can all be identified, and can be related to the precise nature of underlying beliefs. Aggressively negative views of the self as unacceptable tend to be associated with behavioural and cognitive avoidance of situations and thoughts associated with those beliefs. Views of the self as weak and vulnerable are more likely to result in a blanket restriction of emotional experience. These attempts to limit acute emotional distress lead to dysfunction in the regulation of affect, resulting in either overwhelming, unregulated distress or in the suppression of much vital experience.

Beliefs and avoidance strategies are thus seen as important in rendering patients vulnerable to the persistence of low mood. The environmental and psychological consequences of long-term use of avoidance are then important in reinforcing and maintaining low mood. One result of avoidance is that patients restrict the range of activities in which they engage. Failure to express their own wishes or to work towards desired goals results in their becoming trapped in unfulfilling situations at best. At worst, a patient's passivity or acquiescence to undesirable situations culminates in extremely aversive outcomes, such as exploitation or abuse. Life becomes devoid of any positive rewards that could lift the person's low mood. Environmental changes arising as a result of the depression, such as medical retirement or divorce, further deprive the patient of sources of pleasure or satisfaction. The constant influx of negative information reinforces the negative beliefs. Persistent low mood states may then be reinforced by the constant activation of negative beliefs through these negative experiences, and this can lead to an intensification of avoidance strategies and further deterioration of the environmental conditions.

Whether the depression has persisted lifelong or has been triggered by a life event such as redundancy, its persistence results in the emergence of beliefs about the depression itself. When attempts to control depressive feelings and symptoms are unsuccessful, this supports the view that the depression is entirely beyond the patient's control. This belief that the depression

is uncontrollable increases the sense of helplessness and exacerbates the patient's passivity. Further, the lack of response of the depression to assuredly effective treatments confirms beliefs of inadequacy and intrinsic defectiveness. The beliefs about the depression itself thus feed back into the central negative beliefs, which in turn serve to maintain the depression. As can be seen in Figure 1.2, a long-term vicious circle arises, whereby the environmental consequences of the avoidance and depression reinforce the negative beliefs which feed back into the depression.

An important factor that differentiates persistent depression from acute depression, as may seem obvious, is the timescale over which these vicious circles operate. In acute depression, the vicious circles of automatic thoughts and negative feelings are instantaneous. Changes in the extent to which activities are engaged in or avoided also occur across timescales of days or weeks and have concomitant effects on emotions within this timescale. By comparison, the vicious circles in persistent depression reflect patterns occurring across months and years. Central beliefs, dysfunctional affect regulation, behavioural passivity, and unsustaining or aversive environments may also have gradually and cumulatively fed into each other for many years.

VARIATIONS IN CLINICAL PRESENTATION

The Introduction outlined the heterogeneous nature of persistent depression, and a number of subgroups of patients with persistent depression were identified. These include:

- (1) patients who have suffered from at least low-grade depressive symptoms for most of their adult life;
- (2) patients who have experienced multiple, recurrent depressive episodes, with incomplete recovery from the most recent;
- (3) patients whose symptoms persist following treatment of a first acute major depressive episode, often following a major life event.

Genetic, neurochemical or even changes in the structure of the brain may play a role in the persistence of symptoms in any of these groups. However, the nature of the central beliefs and the predominance of different processes of avoidance can make important contributions to understanding differences in the presentation of cases. In grouping different kinds of chronically depressed patients, two factors are particularly important: history of depression and the variability of emotional experience. In terms of the history of depression, some patients report always having had problems with depression, whereas others can identify a clear onset. In terms of the variability of depression, the emotional experience of some patients

is intense and highly labile, whereas for others, emotional experience is depleted and flat.

Patients who report always having had problems with depression have often been described as having a depressive personality (group 1 above). In these patients, the model supposes that unconditional beliefs will be important. Some patients, such as *Stan*, describe continuous, usually low-grade depressive symptoms throughout their adult life. Because of the lack of variation in the patient's mood state, it is often hard to date the onset of any particular depressive episodes and the course of disorder tends to be one of gradual deterioration. In these cases, the self-concept is usually of being lacking in some essential qualities that others are perceived to possess. Stan thus perceived himself to be weak compared to others, who he saw as normal, and he saw the world as a daunting place. In common with many other patients, he saw unpleasant feelings as inevitable, and so coped with them by suppression and control. In his attempt to clamp down on all negative feelings, his positive motivation and initiative were also eliminated. Such patients' lives become socially impoverished or dominated by external demands and the wishes and desires of others. Stan's low mood resulted in part from a lack of much vital experience and in part from his surrender of external control to others. In this group of patients, it is often hard to identify specific problems. Patients often do not complain of depression itself, but focus on symptoms such as tiredness or memory problems. They have often been persuaded to seek treatment by others. Figure 1.3 illustrates some of the main features in the presentation of patients where beliefs of weakness and coping through suppression and control are predominant.

For other patients, such as *Kate*, the lifelong pattern is of intense mood swings rather than flatness of mood (group 2 above). During spells of depression, they experience intense combinations of self-hatred, anxiety and rage. With *Kate*, the difficulty in establishing the precise history of the depression arose from the sheer number of episodes, which lasted for periods of days, weeks or months. As with many patients, *Kate* described days or weeks of being well, sometimes exaggeratedly so, in between these episodes. Such chronic instability of mood is often associated with central beliefs about the self as unacceptable or bad. *Kate* saw herself as horrible, expected other people to be critical and rejecting, and saw the world as hostile. For such patients, their mood state depends on the success of strategies to mask these beliefs or avoid their activation. Behavioural and cognitive avoidance and compensatory strategies, such as subjugation to others or striving for achievement, are marked. The active nature of compensation and avoidance strategies tends to result in many projects and relationships initiated and abandoned, rather than a

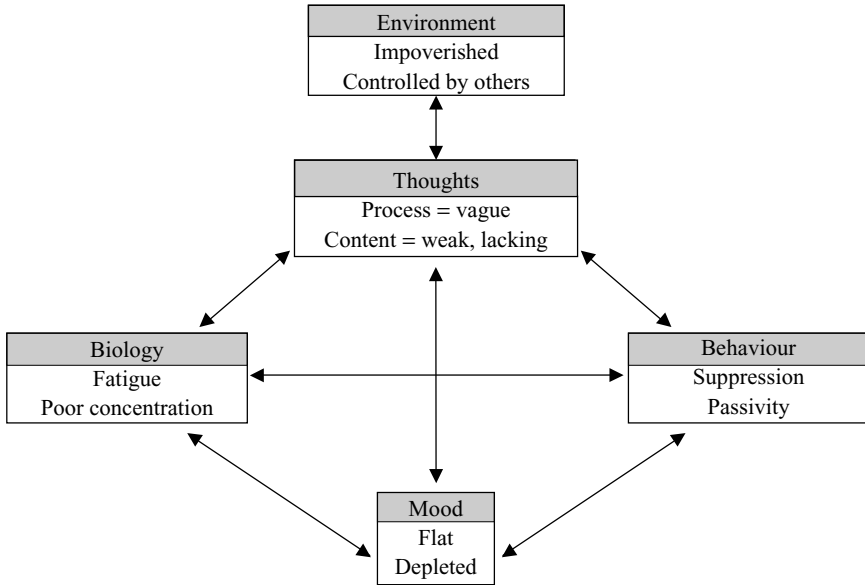


Figure 1.3 Relationships between factors in the cognitive model for patients with predominant beliefs about the importance of emotional control

blanket lack of initiative. Kate's intense low moods resulted whenever she could not avoid the latest in a long line of setbacks and problems, which confirmed her extreme negative views. Figure 1.4 illustrates relationships between key features in patients where compensation for beliefs about unacceptability and badness is central.

In many cases there is a specific onset of the persistent episode of depression after extended periods of apparently good functioning (group 3 above). The cognitive model here supposes that the conditional beliefs have previously been satisfied or unconditional beliefs successfully compensated for. Some event or change of circumstance then violates an important assumption or exposes an unconditional belief. The crucial change can be an external event, such as a major loss, redundancy or divorce, or the experience of illness or depression itself. The precipitating event or change explodes the basis for the person's self-worth because the rigidity of the belief system renders the impact of the event catastrophic. Subsequently, even when mood or symptoms are temporarily boosted by medication, there are no convincing alternative sources of self-worth to which the patient can resort.

For many of these onset cases, it appears to be the violation of beliefs about the importance of control that shatters self-esteem. Many patients with longstanding low-grade depression, such as Stan, see themselves as

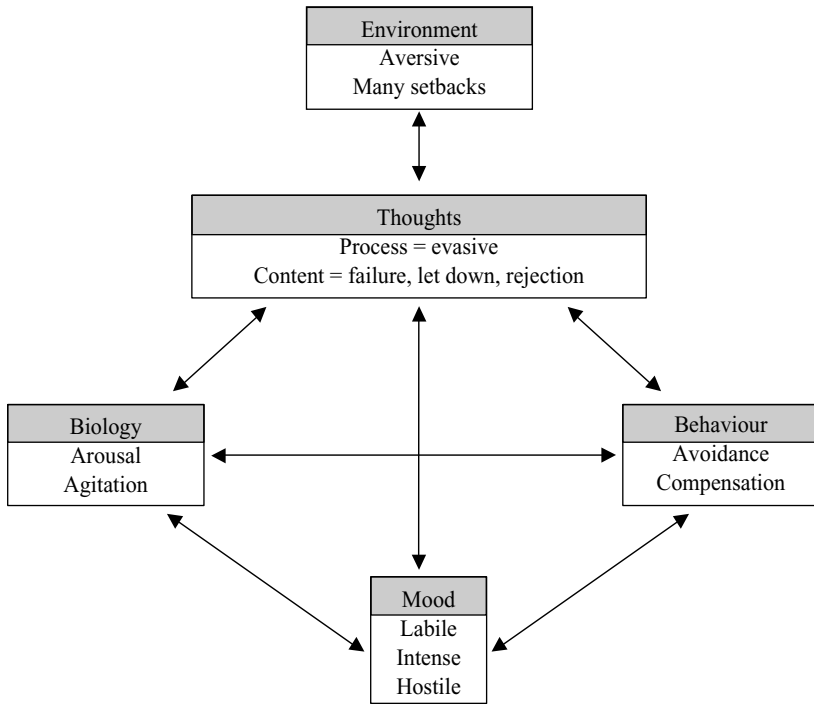


Figure 1.4 Relationships between factors in the cognitive model for patients with predominant beliefs about unacceptability and badness

striving to maintain control of their emotions. In comparison, many cases with more recent onset of depression, such as *Peter*, perceive themselves to have lost control. This may be due to an external event, most commonly the stresses in the field of work described previously. Importantly, the experience of illness, including depression itself, can also do this. Thus, in some patients, an initial experience of depression, which may result from a combination of biological or psychological factors, is so devastating to the person's self-image that recovery is not possible. For Peter, both external and internal factors were important: his redundancy was devastating and resulted in the onset of his depression. The depression itself was experienced as a total loss of control, which then compounded all his other concerns. His attempts to cope focused on controlling his unpleasant moods and emotions, for example by attempting to keep upsetting thoughts out of his mind. As these attempts rarely result in the elimination of low mood, patients like Peter tend to experience the depression as unpredictable and out of control. For other onset cases, the crucial events are those that trigger devastating negative self-evaluations, most commonly

experiences of failure or rejection. Subsequent experiences that have previously been associated with self-worth, such as being liked or achieving things, may lead to lifts in mood. However, these tend to be short-lived as the patient is likely to have become highly sensitive to signs of failure or rejection, which cause mood to crash back down.

In presenting these groupings, it is not intended to imply that there are distinct and easily discernible subtypes of persistent depression. Some patients do exemplify quite clearly one of the different types presented here. In many, particular constellations of features described here predominate, but other features are mixed in. For example, it would be rare indeed to encounter a depressed patient who coped exclusively by emotional suppression with no behavioural avoidance or whose beliefs exclusively related to weakness and self-control with no sign of negative self-evaluation. Weighing the relative predominance of direct suppression of feelings versus compensation for perceived shortcomings or the relative influence of beliefs about control versus acceptability can prove helpful. Although most patients present in such a way that some particular features can be seen to predominate, some patients seem to have a cocktail of the different types of presentation described here. This can render formulation and treatment particularly complicated. Beyond this, these groupings of patients by different factors in the model do not seem readily to lead to the identification of differences in overall 'difficulty' or response to the therapy. Clinical impressions abound of people who seem deeply damaged but who respond surprisingly well, and of those who seem to be suffering relatively minor impairment but do not seem to change in the slightest degree. These are backed up by research data supporting the difficulty of predicting response from a variety of measures (see Chapter 12).

IMPACT OF THE MODEL ON THE NATURE OF COGNITIVE THERAPY

The model described has implications for each aspect of cognitive therapy as conventionally practised. The style of therapeutic relationship, the formulation, the strategies and techniques employed, and the structuring of the therapy all need to be amended in the light of this model. These changes are to be described in detail in the rest of this book. Two of the most crucial differences in the conduct of therapy relate to the attention paid to the regulation and management of affect and to the relative emphasis on automatic thoughts versus central beliefs.

In therapy with acute cases, the regulation of affect tends to take care of itself as long as the other tasks of therapy are being addressed. Focusing

on problem areas and identifying the associated negative thoughts can usually be expected to provoke the appropriate negative affect. Questioning and reality testing those thoughts then usually results in modulation of excess negative affect. As we have described, these processes of activation and modulation of emotion cannot be assumed to occur naturally during therapy with chronic cases. In some instances, a combination of behavioural avoidance and emotional suppression result in a paucity of acute affect in the sessions. Although negative thoughts can be identified, the absence of affect renders attempts to question them ineffective. At other times, the breakdown of the patient's attempts to avoid painful affect results in overwhelming levels of emotion. Even when the patient does not blame the therapist or therapy for this, the high levels of affect and extremity of thinking are not conducive to re-evaluation or new learning. Thus when working with persistent depression, the therapist has to pay more deliberate attention to the regulation of affect, either by encouraging or provoking emotional experience when it is absent or by taking steps to stem its flow when it is overwhelming. This emphasis pervades all stages of the therapy. Particular effects on the style and structure of the therapy are described in Chapter 2 and effects on the implementation of standard behavioural and cognitive techniques are described in Chapters 5 and 6.

For many patients with persistent depression, automatic thoughts are few and far between, and for the rest automatic thoughts seem to reflect long-held beliefs. Therefore, working at the level of automatic thoughts presents considerable difficulty. In acute depression, working at this level is often sufficient to achieve considerable relief of symptoms and may even provide strategies to lessen the likelihood of relapse. In persistent depression, working at the level of automatic thoughts rarely accomplishes sufficient change in thinking or symptoms in itself. However, this level of work remains a vital precursor to the endeavour of modifying key underlying beliefs directly. Work on automatic thoughts is important in increasing patients' awareness that their thoughts are just thoughts, not reality (so-called meta-awareness, Moore, 1996, see Chapter 12). In addition, it introduces patients to skills in regulating affect. Any cognitive changes achieved at the level of automatic thoughts may also have effects at deeper levels of cognition. Thus, in working with persistent depression, the aim of intervening with automatic thoughts is not only to modify those thoughts themselves, but also to facilitate modification of underlying beliefs. At all stages of therapy, therapists working with chronic cases need to be constantly aware of the potential impact of core beliefs and, once therapy is underway, to be able to employ techniques for their modification. Working with automatic thoughts is the focus of Chapter 6 and, with more central beliefs, of Chapters 7 and 8.

SUMMARY POINTS

- In the cognitive model of acute depression, negative automatic thoughts, cognitive biases and dysfunctional assumptions contribute to the onset and maintenance of depression.
- In persistent depression, patients use subtle behavioural, cognitive and emotional forms of avoidance to limit negative affect.
- Avoidance can make specific negative automatic thoughts hard to identify and can obscure the link between negative automatic thoughts and negative feelings.
- When avoidance breaks down, patients can experience extreme negative thinking and intense negative emotions.
- Overt negative thinking in persistent depression is often global and repetitive, and is not always accompanied by acute affect shifts.
- Thinking style and conditional beliefs in persistent depression are often characterised by rigidity and extremity.
- Unconditional negative beliefs can be self-perpetuating through a prejudiced style of information processing.
- Common themes in the beliefs of patients with persistent depression are those of weakness/control and unacceptability/compensation.
- In addition to early trauma and abuse, less evidently malign factors, such as rigidity or lack of emotional expression by caregivers, may contribute to the formation of underlying beliefs in persistent depression.
- Patients' attempts to avoid or compensate for their underlying beliefs often have negative consequences, such as getting overwhelmed by trying to please others or gaining little pleasure, which maintain depressed mood.
- Beliefs about depression itself, such as the belief that depression is a sign of inadequacy, can feed the persistence of depression.
- The combination of negative beliefs, overt negative thinking, avoidance and their negative consequences results in enduring low self-esteem, helplessness and hopelessness, which are the cognitive hallmarks of chronic depression.
- In conducting cognitive therapy for patients with persistent depression, the prominence of avoidance and beliefs mean that processes for regulating affect and modifying beliefs are important developments from standard cognitive therapy.