

Depression

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Introduction

Depression is so frequent that it has been called ‘the common cold of psychiatry’ (Seligman 1975). The World Health Organisation estimates that by 2020 it will be second only to cardiovascular disease in terms of worldwide burden of ill health (Murray and Lopez 1998). In mild or short-lived forms, depression is an almost universal experience; in more severe forms it can become a crippling disorder.

For a diagnosis of major depression DSM-IV-TR (APA 2000) requires five or more of the following symptoms: depressed mood; pervasive loss of interest or pleasure; significant weight change or change in appetite; sleep disturbance; observable agitation or retardation; loss of energy; feeling worthless or unnecessarily guilty (not just about being depressed); poor concentration or decision making; and recurrent thoughts of death or suicide. At least one of the first two symptoms (mood, anhedonia) must be present. This pattern must be present most of the day, nearly every day, during a continuous period of at least two weeks, and must cause significant distress or impairment of functioning.

DSM-IV-TR also recognizes a chronic low mood state, dysthymia, in which there may be fewer symptoms than in major depression, but which persists for at least two years. Finally, depression often does not present in the ‘pure’ form described above; for example, 50% of depressed patients also have an anxiety disorder. This chapter focuses on unipolar depression (see Chapter 11 for bipolar disorder).

Cognitive model

The cognitive model of depression was A.T. Beck’s (1967) first well-articulated model of a specific disorder, and remains influential. It proposes that early loss leads to the formation of enduring cognitive structures, which render the person vulnerable to depression in the event of future losses. Thus, core beliefs derived

from early experience (e.g. ‘I am stupid’), together with related conditional assumptions (e.g. ‘If I can maintain a very high standard, people may not notice my stupidity’), predispose a person to depression. Events that evoke core beliefs and contravene underlying assumptions (e.g. a challenging new job) then trigger depression. Once activated, the system colours the process and content of thinking in such a way as to perpetuate low mood and other symptoms of depression.

Cognitive therapy first tackles negative thinking (undermining cognitive and behavioural maintenance factors), and then re-evaluates underlying assumptions and beliefs so as to reduce future vulnerability (Beck *et al.* 1979). Classically, patients are offered up to 20 sessions (moderately to severely depressed outpatients on average recover within 15). The treatment has a well-established evidence base (Hollon *et al.* 2002).

Key cognitions

Three facets of cognition are important in understanding the development and persistence of depression: the *content* and *process* of negative thinking, and *cognitive vulnerability*.

Content

Themes of loss, self-devaluation, and hopelessness pervade the thinking of depressed people. Beck’s ‘cognitive triad’ is a central feature: distorted, negative views of the self (e.g. ‘I am useless’), the world (e.g. ‘Nothing ever goes right for me’), and the future (e.g. ‘It will always be like this’). Depression about depression (e.g. ‘This just proves how useless I am’) may also be prominent. Suicide may seem to be the only solution (e.g. ‘There’s no other way out’).

These thoughts play a critical role in the maintenance of depression. A system of reciprocal feedback develops, where negative thinking intensifies low mood and physical depletion, undermines motivation and energy, and reduces engagement in satisfying activities. These changes in turn appear to confirm negative thinking. Thus the system feeds upon itself.

Process

Thinking in depression is characterized by pervasive biases, which incline the person to notice and recall information congruent with depressed mood, and to screen out and forget information inconsistent with it. The result is an apparent absence of positive experiences, past and present. This perceptual bias is complemented by biases in interpretation (Abramson *et al.* 2002). Negative events are explained in terms of factors that are internal (me, rather than external circumstances or other people) and stable across time and place. Such events are seen as having implications for the future, and for self-worth. In contrast, positive events are attributed to factors that are external (not me)

and specific to the time and the place, and are not seen as having implications for the future or for self-worth. A similar attributional style has also been found to characterize people at risk of future depression.

Other cognitive processes contributing to the persistence of depression include:

- ◆ Errors in logic such as overgeneralization (drawing general conclusions from specific events), selective attention (paying attention only to negative aspects of experience), and all-or-nothing thinking (Beck *et al.* 1979)
- ◆ ‘Ruminative response style’ (Nolen–Hoeksema 1991)
- ◆ ‘Overgeneral memory’ (inability to access specific memories, especially of positive events) (Williams *et al.* 2000)
- ◆ Reduced ‘meta-cognitive awareness’ (inability to see thoughts as thoughts, rather than as reality) (Teasdale *et al.* 2002)
- ◆ Cognitive aspects of depression itself, such as problem-solving deficits, concentration problems, and mental slowness.

Cognitive vulnerability

As outlined above, Beck’s model suggests that vulnerability to depression can be understood in terms of the environmental activation of negative core beliefs about the self, the world, and the future, together with unhelpful assumptions which guide day-to-day thinking and behaviour (Ingram *et al.* 1998).

More recently, an alternative way of explaining cognitive vulnerability to future depressions in people who have already experienced an episode has been put forward—the ‘differential activation hypothesis’ (Segal *et al.* 2002). This suggests that recurrent depression occurs when normal depressed mood, by a process of association, triggers a constellation of negatively toned thoughts, feelings, body sensations, and behaviours. These are perpetuated by ruminative thinking (Nolen–Hoeksema 1991), creating a ‘depressive interlock’, which becomes increasingly independent of environmental triggers and difficult to interrupt. This perspective suggests that low mood of the kind that anyone might experience is toxic for people with previous experience of depression.

Behavioural experiments

Behavioural experiments are used to test negative automatic thoughts and to re-evaluate underlying beliefs and assumptions, and so reduce future vulnerability. In addition, they counter the cognitive processes outlined above. That is, they encourage conscious processing and enhance memory of positive experiences, they interrupt rumination, and they promote decentering from negative thoughts, so that these come to be viewed as something the depressed person does, rather than a reflection of objective truth.

The experiments that follow are organized in the order in which they are usually carried out in treatment. They reflect the step-by-step acquisition of cognitive-behavioural skills. Starting with the specific and concrete, they only subsequently move to more generalized and abstract themes. There are a number of reasons for this:

- ◆ Negative statements about the self, the world, and the future are plentiful in depression, and can tempt therapists to assume a need for schema-focused interventions. In fact, many will turn out to be a reflection of depressed mood, and disappear once the patient has recovered (see Chapter 20).
- ◆ Even genuinely unhelpful assumptions and core beliefs are not usually appropriate early treatment targets. Low mood and cognitive deficits characteristic of depression make analysis at high levels of generality painfully hard, whereas being able to make small changes in thinking and behaviour fosters hope (e.g. ‘There *is* something I can do’) and enhances the credibility of the cognitive model.
- ◆ Research shows that positive outcome in cognitive therapy for depression is predicted by the extent to which early sessions focus on specific, concrete interventions (Feeley *et al.* 1999). For many people, these are the sessions in which most change occurs.

Throughout the experiments listed below, the pervasive themes (self, world, future) identified above will be evident, as will the cognitive processes that maintain depression:

- ◆ **Engagement**

Experiment 10.1: introducing the cognitive model

- ◆ **Activity scheduling**

Experiment 10.2: checking out perceptions of activity

Experiment 10.3: checking out perceptions of pleasure and mastery

Experiment 10.4: changing patterns of activity

- ◆ **Testing negative automatic thoughts (the cognitive triad)**

Experiment 10.5: negative thoughts about the self

Experiment 10.6: negative thoughts about the world

Experiment 10.7: negative thoughts about the future

- ◆ **Reducing vulnerability to depression: testing assumptions and beliefs**

Experiment 10.8: perfectionism

Experiment 10.9: belief about poor judgement

Experiment 10.10: sense of failure

- ◆ **Relapse and recurrence: planning for the future**

Experiment 10.11: short circuiting depression and hopelessness

Engagement

The first step, once assessment is completed and cognitive therapy appears to be the treatment of choice, is to introduce the cognitive model of depression. Depressed patients are not likely initially to absorb a full longitudinal case conceptualisation, but a simple vicious circle illustrating the links between negative thinking and mood is relatively easily communicated.

Experiment 10.1: introducing the cognitive model

Problem Mike believed his depression was an illness. He doubted that psychological treatment would have anything to offer him.

Target cognition Talking therapy won't help.

Alternative perspective It may be worth a try.

Experiment The therapist had already developed a problem list with Mike. She asked him to rate how depressed he felt 'right now' on a scale of 0–100 (0 = not at all depressed; 100 = as depressed as he possibly could be). She asked him to focus for a few moments on the problems he had described, and then to re-rate how depressed he felt. She then asked him to focus on what he could see out of the consulting room window. She asked detailed questions to help him to become absorbed in what he saw. After a couple of minutes, she asked him to rate his mood again.

Results Mike's depression intensified when he focused on his problems. In contrast, when he was able successfully to absorb himself in the view from the window, his mood lifted somewhat.

Reflection Mike could see that the results of the experiment fitted with a vicious circle linking mood and thinking. That is, when he pondered on his difficulties, he felt worse; when he distracted himself from them, he felt a little better.

Further work Mike remained doubtful, but agreed to give cognitive therapy a try. The therapist did not attempt to convince him that it would work, but suggested trying it as an extended experiment. Approaching the methods with an open mind and carefully tracking progress would provide a chance to discover if it suited him.

Tips Distraction experiments can be useful in demonstrating the mood–thinking link. Distraction (attentional redeployment) also interrupts depressive rumination, and is a helpful tool in the depressed person's mood management kit. However, it does not resolve the issues underlying depression. Therapists should be careful to ensure that it is not used to avoid issues that should be faced.

Activity scheduling

Activity scheduling (monitoring and modifying patients’ activity levels) is a vital component of cognitive therapy for depression. Therapists sometimes view it as boring, trivial, or simplistic and move swiftly on to more obviously cognitive territory. This deprives patients of a powerful intervention.

Used within a cognitive framework, activity scheduling becomes a rich source of behavioural experiments. It offers an incomparable opportunity for identifying and testing a wide range of negative thoughts, as well as counteracting unhelpful cognitive processes (rumination, overgeneral memory, selective attention to the negative, etc.). The following sequence of experiments with a single patient illustrates this. It uses a key tool from cognitive therapy for depression, the weekly activity schedule (WAS) (Fig. 10.1)—an hour-by-hour diary on which activities are recorded and planned (Beck *et al.*, 1979; Fennell, in press). It shows how the WAS can be used flexibly to test a series of negative automatic thoughts.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6–7 a.m.							
7–8 a.m.							
8–9 a.m.							
9–10 a.m.							
10–11 a.m.							
11 a.m.–12 p.m.							
12–1 p.m.							
1–2 p.m.							
2–3 p.m.							
3–4 p.m.							
4–5 p.m.							
5–6 p.m.							
6–7 p.m.							
7–8 p.m.							
8–9 p.m.							
9–10 p.m.							
10–11 p.m.							
11–12 p.m.							

Fig. 10.1 Weekly activity schedule (WAS) (see text).

Experiment 10.2: checking out perceptions of activity

Problem Doreen had been depressed for 18 months. She was low in mood, energy, and motivation. Right from the beginning of therapy, she was critical of herself for being so lazy.

Target cognition I'm not doing anything.

Experiment The therapist explained that inactivity is a normal symptom of depression. She introduced Doreen to the WAS and explained how it could be used to get a clearer idea of how she was spending her time. If Doreen recorded what she did on the sheet over the next three days, they would look at the results together when they met again. Doreen said she thought the sheet would be empty. The therapist suggested that, in order to get started, they work through today together, writing down what Doreen had done, hour by hour.

Results Prompted by the therapist to recall the day in detail, Doreen was surprised to see that in fact she had been quite busy. She had done a little cleaning at home, been shopping for the day's food, made a phone call to the town council about the family home, and arrived on time for her session on the other side of town.

Reflection When the therapist asked how this fitted with her idea that she was 'not doing anything', Doreen said, 'It doesn't look that way, does it?'

Further work Feeling encouraged, Doreen agreed to check out her original thought by keeping a record of what she did until the next session. She discovered that her prediction that the WAS would be empty was incorrect: she was more active than she had thought.

Tips It is particularly important in depression to prepare for and rehearse homework assignments, identifying negative thoughts that might stop the person from carrying them out successfully, and finding ways of tackling them. These can be written on a flashcard for the patient to consult; at this stage, patients are unlikely to be able to work out alternatives to negative thoughts by themselves.

Experiment 10.3: checking out perceptions of pleasure and mastery

Problem Doreen was doing more than she thought, but she still felt that she was not getting satisfaction from what she did.

Target cognition Everything's a bore.

Alternative perspective I could be mistaken about that too.

Experiment The therapist suggested that it might be useful to find out whether this thought accurately reflected what was really happening. She suggested

continuing the written record, with an addition—each activity was to be rated for pleasure (‘How much did you enjoy it, out of 10?’) and mastery (‘How much of an achievement was it, out of 10, *given how you felt at the time?*’). Doreen predicted ratings of 1 or 2 out of 10. Again, the therapist suggested working through today so as to be sure that the task was clear. Doreen would then complete the record and the ratings for herself over the few days until their next session.

Results Reviewing the day so far once again illuminated Doreen’s biased perceptions. Although some of her activities were neither pleasurable nor satisfying, she had enjoyed a conversation with her husband, had noticed the blossom in the park on her way to the session, and conceded that arriving on time again, given how tired and slow she felt, could count as an achievement.

Reflection Doreen realized that she was getting more out of what she did than she thought.

Experiment Doreen agreed to keep an open mind about how much pleasure and mastery there was in her day, and to continue with the record. She discovered that, before starting to observe her life more closely, she had either not noticed or forgotten things she enjoyed. As they came into focus, she began to feel less depressed and better about herself.

Tips People usually readily understand the concept of pleasure, but have more trouble with mastery. They tend to assume that only major achievements can be given ratings for mastery. In fact, when a person is depressed, the simplest activities are real achievements. Failing to recognize this helps to maintain depression.

Experiment 10.4: changing patterns of activity

Problem Monitoring her activities showed Doreen that she was doing more than she thought, and deriving some satisfaction from what she did. It was also clear though that she was spending a lot of time in bed or just sitting doing nothing. Her ratings of pleasure and mastery showed that these were not rewarding activities. Indeed, they provided space for rumination and tended to make her more depressed. However, Doreen did not feel she had the energy to do more.

Target cognitions I’m too tired. It would be better to wait until I feel better.

Alternative perspective This policy hasn’t got me very far up until now.

Experiment Doreen would compare two strategies when she felt tired. On one occasion, she would retreat to bed for as long as she wanted. She would record how she felt after doing this, and rate it for pleasure and mastery. On a second occasion, she would engage in an activity that might be pleasurable or

give her a sense of achievement. Again, she would record her feelings afterwards, and rate the activity for pleasure and mastery. To make sure that Doreen had a range of possible activities available (nothing might come to mind at the time), she made a list in session.

Results Doreen did not carry out the experiment as planned. She realized, when she came to do it deliberately, that going to bed would only make her feel worse. So she did something pleasurable instead (made a cake for her little granddaughter's birthday).

Reflection Doreen felt really pleased with herself. She enjoyed making the cake—and her granddaughter enjoyed eating it.

Further work Doreen began planning each day in advance, drawing on an extended list of activities that might provide pleasure and mastery. She continued over several weeks, until she felt that her pattern of activities suited her, and that she was enjoying what she did and giving herself credit for it without needing the record sheet.

Tips In some cases, patients' activity levels at the beginning of treatment are extremely low. If they have been depressed for some time, it may be difficult to think of things to do to fill the day. The therapist will have to be ingenious, creative, and persistent in helping the patient gradually to build up a repertoire of satisfying activities. Ideally, a combination of pleasure and mastery is the goal. It may be necessary along the way to work repeatedly with a wide range of negative thoughts, and the therapist must guard against being contaminated by pessimism and lack of confidence.

Testing negative thoughts (the cognitive triad)

Experiment 10.5: negative thoughts about the self

Problem Rosie had got depressed shortly before college exams and dropped out of college. She had gone back to live at her parents' home and felt too depressed to see her friends. She had not seen them for five months.

Target cognition My friends will think I'm thoughtless and selfish and won't want to know me. Belief rating 90%.

Alternative perspective One or two of my friends may be missing me. Some have tried to contact me and I've made excuses. Maybe they'll understand. Belief rating 20%.

Predictions Tamsin, my best friend, will be really angry. She'll think I'm pathetic, and won't want to know me anymore. If we do meet, I'll probably cry all night and feel really foolish.

Experiment The experiment was for Rosie to phone Tamsin and suggest meeting up for coffee or dinner.

Results It took several weeks before Rosie felt ready to pick up the phone. She needed two further preparatory sessions with her therapist during which she recognised that although she *felt* like Tamsin would think she is pathetic, it was actually rather more likely that Tamsin would be relieved and happy to see her. When she did ring, Tamsin expressed surprise and delight. They made a date to go out and the evening went really well. Far from feeling foolish and crying all night, Rosie had the best evening she had had in a long time.

Reflection Rosie realised that Tamsin did still want to know her and had felt greatly relieved that she had got back in touch. At their next meeting, Rosie checked with Tamsin whether she thought other friends would react in a similar way. After further experiments with other friends, Tamsin belief that her friends wouldn't want to know her dropped to 10%, and that they would be understanding climbed from 20% to 80%.

Tip Making a clear distinction between what depressed patients *feel* might happen, and what they think is objectively most likely to happen can be important in building confidence to take the first step.

Experiment 10.6: negative thoughts about the world

Problem John had become increasingly depressed since the death of his wife Georgina, three years ago, from breast cancer. He was now off work, and his low mood and irritability were affecting his teenage children. Despite being popular with his colleagues and friends, he had become more and more socially withdrawn, even though he knew that Georgina would have wanted him to enjoy himself, as she always had done when she was alive.

Target cognitions Life is wretched. Without Georgina, there's no point in trying to go out and enjoy myself.

Alternative perspective Time moves on. She would say: 'Go out and enjoy yourself'. She would want this for me, and for the children.

Prediction Two Christmas functions were coming up—an office party and a dinner with colleagues, some of whom were also good friends. John predicted that there was only a 50% chance that he would attend these functions (going seemed pointless) and that his enjoyment would not be rated as more than 3 out of 10.

Results John attended both the party and the dinner. He rated his enjoyment of the party 8 out of 10, the dinner 6 out of 10. He noted how warm and pleased to see his colleagues were, and was surprised by how much he had laughed. At the office party he was even able to talk about how low he had been when he left work. The dinner with colleagues was more awkward: several junior colleagues were sitting near him, which inhibited him from talking about recent experiences.

Reflection John felt ‘liberated’. Finding out how much his friends cared for him, and hearing from his children how delighted they were to find ‘the person we used to enjoy’ again, convinced him of the value of his new perspective. He reflected that Georgina would never go away and would always occupy a special place in his heart.

Further work This was such a breakthrough that John invited 12 friends to lunch shortly after Christmas. In the New Year, he initiated an evening out with a group of friends from university who met intermittently every few years. His mood improved dramatically, and he was ready to return to work six weeks after Christmas.

Tips If bereavement is seen as having enduring implications for the self, the world, or the future, grief can shade into depression over time. Therapists need to be sure, however, that depression is the problem, and not pure grief.

Experiment 10.7: negative thoughts about the future

Problem Jenny suffered chronic, severe depression associated with emotional and physical abuse during childhood. She had had several admissions to psychiatric hospital and had been unable to work for over a year. She had, however, done some voluntary work as a teacher’s assistant at a local primary school. This went well for a while, but when her mood dipped again she felt unable to continue. The school was aware of her problems and willing for her to work when she felt able to.

Target cognition There’s no point in my going to the school; it’s better for me and them if I don’t go.

Alternative perspective Discussion revealed considerable evidence that Jenny had been successful in her role in the school; in fact there was often a queue of children wanting to work with her. However, she had had no formal feedback from the teacher with whom she worked. On the basis of this discussion, Jenny formulated an alternative possibility: ‘It is worth continuing because (a) I am probably reasonably good at it, (b) I might still enjoy it, and (c) I could ask the teacher how she thinks I am doing?’

Predictions If my thoughts are right, then if I go back to school, I will not enjoy it at all. No one will have missed me or want to talk to me. The teacher will be unenthusiastic or negative if I ask for feedback. On the other hand, I may not enjoy it as much as I used to (because I’m more depressed), but it may be all right. The teacher’s feedback might be positive. If it is negative, I can consider whether I need to make any changes.

Experiment Jenny decided to try at least one more school session. She would rate how much she enjoyed the session, and note what kind of response she got from the children. If a suitable opportunity arose, she would ask the teacher for feedback on her performance.

Results As soon as Jenny arrived, several children immediately asked where she had been, saying they had missed her. She felt very anxious at first, but settled down to some degree, and rated her enjoyment as 4 out of 10. She had no opportunity to ask for feedback but, buoyed by what had happened, returned for another session. She talked to the teacher, who said that she valued Jenny's help, and that she had been missed.

Reflection Jenny had been very sure that going back to school would be a negative experience. She realized how easy it would have been never to discover how much she was appreciated.

Tips Expectation of negative outcomes is central to depression. It leads to hopelessness, and if sufficiently generalized, to suicidality. Behavioural experiments are a powerful means of discovering that even very convincing predictions can be wrong. Sometimes, however, they are correct. In this case, therapy turns to helping the patient to cope constructively with whatever has happened.

Reducing vulnerability to depression: testing assumptions and beliefs

Experiment 10.8: perfectionism

Problem Lisa had a history of falling into 'holes'. Suicidal thoughts had been prevalent for about 10 years, and she made one serious attempt five years ago. She was highly competent, but felt unable to get on top of her job. She recognized that she had perfectionist standards and, if they were not met, could sink precipitously, feeling that she had let everyone down.

Target cognition Irrespective of how much gets thrown at me, I should be able to cope. If I can't do everything perfectly by myself, I'll feel a complete failure. I'll be letting everyone down.

Alternative perspective It's perfectly OK to ask for help if there's too much work. That's what I'd tell another person to do. It's nothing to feel ashamed or guilty about. The boss will probably agree with anything constructive I suggest—he has a lot of respect for me. (This was worked out with the therapist; Lisa found it difficult to find an alternative on her own.)

Prediction If I hand over any tasks, my boss will think less of me.

Operationalize prediction Lisa predicted that, if she continued to believe that she should be able to cope with anything, she would feel 80% disappointed and 90% deflated after seeing the boss. He would show clearly that he was disappointed in her (frowning, sighing, avoiding eye contact). However, if she could accept that asking for help was reasonable, she would only feel 20–30% disappointed and 20% deflated. Her boss would be helpful.

Experiment Lisa went to see the boss to negotiate handing over some tasks and prioritizing others.

Results Her boss questioned why she needed to hand over parts of the job in rather more detail than Lisa had expected, but he accepted her reasons. She did not feel as bad about this as she had expected: 60% relieved, and only 20% disappointed and 10% deflated. When she told some colleagues, they were sympathetic. One even said: ‘Why not give other things up?’

Reflection Lisa felt pleased that she had made this breakthrough without any adverse consequences. It helped her begin to entertain the idea that she did not have to do everything perfectly all the time, and that others did not expect it.

Further work Lisa had been a perfectionist for a long time. She needed to practise applying her new standards over time in a range of different situations (e.g. no longer having to make the family holiday ‘perfect’).

Tips See Chapter 20 for further ideas on perfectionism and low self-esteem.

Experiment 10.9: sense of failure

Problem Alan, a family doctor, was depressed for the second time in five years. His depression was partly maintained by occasional mistakes he made at work. Alan distinguished between ‘mistakes’ (such as forgetting to return a phone call) and ‘clinical errors of judgement’ (misdiagnosing a patient in circumstances where the accurate diagnosis would be apparent to any competent doctor). He viewed both as unacceptable. Minor mistakes were evidence of incompetence, which would inexorably lead to serious clinical errors.

Target cognitions Alan’s distress reflected a disabling core belief (‘I’m a failure’) which derived from his sense that he had never lived up to the advantages his upbringing had bestowed on him. This was supported by an associated assumption: ‘To be worthy of this privilege, I must be successful at everything I do, at all times’. Making mistakes, to his mind, confirmed the core belief and contravened the assumption.

Alternative perspective Following detailed discussion, Alan tentatively concluded: ‘Everybody makes mistakes. They are not evidence of incompetence

which will lead to significant clinical errors. Nor do they mean that I am a failure.’

Prediction Alan thought that the most meaningful test for him would be to ask other family doctors if they ever made mistakes. He predicted that no one else would make the kind of errors that he made, and that they would share his view that small mistakes could easily lead to clinical errors of judgement.

Experiment Alan and his therapist agreed to test this prediction with a survey. Alan thought the survey might be biased if he did it himself with his own colleagues. The therapist therefore agreed to conduct audiotaped interviews with eight family doctors Alan did not know. She briefed them about the nature and format of the interview, and then asked the following questions:

- ◆ How long have you been practicing as a family doctor?
- ◆ What do you consider to be the most difficult aspects of your job?
- ◆ Do you ever worry about relatively minor errors such as forgetting to return a telephone call?
- ◆ Have you ever made minor errors? If yes, how frequently?
- ◆ Do you ever worry about making significant clinical errors of judgement, which may lead to misdiagnosis?
- ◆ Have you ever made such an error? If yes, how did you cope with it?
- ◆ Why do you think mistakes happen?
- ◆ What strategies have you found helpful in managing worry about making mistakes?

Results After identifying possible negative biases in how he might respond to what he heard, Alan listened to the audiotape in the session. The answers were very clear. All the doctors worried about making significant errors to some degree. Only one worried about minor mistakes, although everyone acknowledged that they happened with monotonous regularity. Two candidly admitted making more significant errors of judgement, the reasons why they thought these had occurred, and the impact on their confidence. Alan listened attentively to the tape, making notes.

Reflection Alan commented that the respondents must be exceptionally competent, to disclose their imperfections so freely. His new belief (‘Everybody makes mistakes’) strengthened, and he was able to begin to break the link between minor mistakes, serious errors of judgement, and personal failure. This began the process of undermining his excessively demanding assumption,

thus reducing the pressure he placed on himself at work, which had contributed to triggering his depression.

Further work Alan still expressed concern that others might make ‘lesser’ mistakes than he did. Comparing mistakes he had made with mistakes mentioned in the survey helped to address this. He began to practice being more tolerant of his human imperfections.

Tips Alan’s difficulties illustrate how negative core beliefs and related dysfunctional assumptions fuel depression. He took some time to feel comfortable with less demanding standards and to view himself less critically. (See also Experiment 10.5 and Chapter 20.)

Relapse and recurrence: planning for the future

Depression is a recurrent condition. Cognitive therapy has been shown to reduce relapse rates in the year following treatment by about 50%, but a continued risk remains (Hollon *et al.* 2002). Patients should be prepared from the outset to experience setbacks, and at the end of treatment it is important to identify possible triggers for relapse and to formulate an action plan detailing how to manage future episodes. Even so, patients can still slip into depression.

Experiment 10.10: short circuiting depression and hopelessness

Problem Christine came for cognitive therapy after being depressed for two years. She had also experienced depression in the past. Christine recovered with 12 sessions of therapy. However, three years later, she began to get depressed again. As her mood dipped, old patterns of thinking emerged (hopelessness and self-blame). She began to consider suicide as the only realistic option. Fortunately, she recognized this as a danger signal and re-contacted her therapist, albeit with little confidence that further sessions would help.

Target cognitions Here it comes again. I might as well give up—nothing will work, so what’s the point of trying? I’ve failed again.

Alternative perspective In fact, Christine had good reason to feel low. Her husband had defrauded the company he worked for, and they had lost their house and their social circle. In the course of a long and painful session, a more hopeful alternative perspective was formulated: ‘My depression is an understandable reaction to my circumstances, not a personal failure. The only way to find out if cognitive therapy will help again is to try it.’

Prediction If I try what worked last time, it might work again.

Experiment Christine hunted for the action plan she had prepared at the end of therapy. Along with the plan was an audiotape she had made—a message to herself which reminded her that she was likely to underestimate what cognitive therapy might do for her, and urged her to give it a try. She began activity scheduling to reduce rumination and increase access to enjoyable activities, and started the step-by-step process of tackling the real problems she faced.

Results Within a few days, Christine was feeling less depressed and hopeless.

Reflection Christine still had to face the major changes that had taken place in her life, but she felt in a better state to do so, with her therapist's continuing help and support.

Tips The onset of a new episode of depression can be insidious. Patients may not recognize what is happening until they are well down the road. It is crucial that end-of-treatment action plans incorporate ways of helping patients to be alert to early warning signals of depression and to avoid intensifying it by slipping into familiar patterns of negative thinking.

Distinctive difficulties

The nature of depression

Depression can make cognitive therapy a tough assignment. Patients are expected to engage actively in treatment, to carry out between-session self-help assignments, etc. Hopelessness, inertia, low energy, and lack of interest and motivation make this difficult. Labelling these problems as symptoms of depression is helpful. Associating them with specific negative thoughts reinforces the patient's grasp of the cognitive model of depression, encourages distance from thoughts and symptoms ('That's the voice of depression speaking—it may not be true'), and opens up opportunities for experiments.

Therapist contamination

Depressive negativity can make it hard for therapists to maintain optimism. Depression is an infectious disease: by the time a patient has repeated 20 times that nothing can possibly help, it may be hard for the therapist to remain convinced that cognitive therapy could make a difference. Again, keeping the model in mind is crucial.

Session frequency

Traditionally, sessions are twice weekly for the first 3–4 weeks, and once weekly thereafter. In moderate to severe depression, it is hard to carry the effects of a session forward over a whole week: the power of depression may overshadow

initial interventions. Therapists are recommended to see patients twice weekly at the beginning of treatment. This may be difficult to organize, but patients are more likely to be able to transfer what they learn in session into their own lives, thus encouraging speedier recovery.

Cognitive deficits

Therapists must take cognitive deficits into account. Particular emphasis should be put on clear structure and action plans, being specific, and writing down predictions and the results of experiments. Otherwise, the value of the learning experience may be quickly dissipated by concentration and memory problems, and by pervasive negative biases.

High frequency of ‘Yes, but . . .’

Depressed patients can always find reasons why an experiment will not (or did not) work, and is not (or was not) worth doing. Even what appear to the therapist to be positive results may be discounted (e.g. ‘Yes, but anybody ought to be able to . . .’; ‘What’s so special about that?’). Therapists should expect this and, rather than being disconcerted, use it to consolidate the patient’s understanding of the cognitive model (e.g. ‘Look, there’s another one of those’). ‘Yes, but . . .’ can be tackled in the same way as any other negative thought.

Suicidal thoughts/hopelessness

Therapists working with depressed clients must always be alert to suicidal thinking and the possibility of suicidal behaviour. Hopelessness about the future is a crucial cue, and should be routinely monitored. If suicidal thinking is present, it must be tackled as a priority. Particular care should be taken in setting up behavioural experiments with people vulnerable to suicidal thinking, to ensure that tasks are manageable and that things that might go wrong are predicted and prepared for. Otherwise, apparent ‘failure’ can increase hopelessness.

Environmental reinforcement of negative thinking

Patients’ friends and family may wittingly or unwittingly reinforce negative perspectives. A patient finally geared herself up to carry out a domestic task after weeks of procrastination. Her husband’s response was, ‘Well, that’s very nice dear, but what about all the other things you’ve not got round to yet?’ Taking over depressed people’s responsibilities (out of a genuine wish to be helpful) may have a similar impact, magnifying their sense of uselessness. The solution to these problems depends on the reasons for them. Often meeting the people concerned, for an educational session or to involve them more closely in therapy (with the patient’s agreement), is enough. Sometimes, however, such difficulties reflect serious problems in the relationship, which require attention in their own right.

Chronic/severe/inpatient depression

Activity scheduling is usefully enhanced with more chronic and severe depressions. Sessions may be shorter and more frequent, behavioural activation may continue for longer as the prime intervention, and tasks designed to undermine negative thoughts are likely to be smaller in scale than they would be with less distressed and disabled outpatients (e.g. five minutes of a single planned activity in a 24-hour period, to investigate ‘I can’t do anything’, as opposed perhaps to planning half a day). These tasks may seem trivial, compared to the weight and scope of the depression, but ‘a journey of 1000 miles starts with a single step’. Small steps can improve mood and help the patient move towards tackling bigger issues and life problems.

Related areas

Readers may find it useful to consult Chapter 11 (bipolar disorder) and Chapter 20 (low self-esteem).

Further reading

- Beck, A.T., Rush, A.J., Shaw, B.F. and Emery, G. (1979). *Cognitive therapy of depression*. Guilford Press, New York.
- Fennell, M.J.V. (in press) Depression. In: K. Hawton, P. Salkovskis, J. Kirk and D.M. Clark (ed.), *Cognitive behaviour therapy for psychiatric problems: a practical guide* (2nd edn). Oxford University Press, Oxford.
- Gilbert, P. (2000). *Overcoming depression* (2nd edn). Constable & Robinson, London.
- Padesky, C.A. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy*, **1**, 267–78.
- Segal, Z.V., Williams, J.M.G. and Teasdale, J.T. (2002). *Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse*. Guilford Press, New York.

Tales from the Front Line

Not for the faint-hearted

Sandra, who had a blood-injury phobia, worked excellently with her trainee therapist to learn the skills involved in applied tension, so as to reduce the chances of fainting at the sight of blood or injury. She decided she was ready to experiment with putting these skills into practice, and her therapist arranged for them both to visit the local hospital to have a blood sample taken. Sandra used her new skills so successfully that she felt fine – but her therapist fainted, suddenly and dramatically. She needed recovery time before they could return to base, feeling as if their roles had been reversed.

Subsequent discussion enabled this therapist to make excellent use of the experience. Sandra, who had been teased for fainting by her brothers, had a fundamental belief that she was stupid. However, she also believed that her therapist was not stupid, and seeing her faint changed her belief about herself at once. For herself, the therapist drew two conclusions: first “Don’t assume that it’s all going to go well”, and second, “It’s important to know where your limits are”. On a second visit both of them were fine.

