



Depression, low self-esteem and mindfulness

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Abstract

Negative biases in processing information about the self have long been recognised as a central feature in the development and maintenance of clinical depression. In practice, however, it may not be easy to distinguish between patients whose negative thinking about the self is primarily an aspect of current mood state, and those for whom it represents a reflection of more enduring issues (low self-esteem). The paper speculates that, in both cases, metacognitive awareness (acceptance of the idea that thoughts, assumptions and beliefs are mental events and processes rather than reflections of objective truth) may be an important precursor to active engagement in therapy on the part of the patient, and considers what aspects of cognitive therapy might be used to promote it in clinical practice.

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Prescript

I first met John Teasdale in Oxford in the January of 1979, having travelled down to Oxford on a train whose corridors were adrift with snow. I was instantly struck by how much he reminded me of Woody Allen. Subsequent events did little to dispel this illusion. He invited me into his office, took my coat, and went to hang it on the back of the door. The hook instantly fell off. He offered me coffee, but stopped in the corridor to talk enthusiastically about his new project—a clinical trial of cognitive therapy for depression. As he leaned against the door, his nameplate came unstuck and attached itself to the back of his jacket. I didn't quite like to say anything. We moved to the coffee cupboard. John took down an immense jar of coffee and

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attempted to excavate its depths with a teaspoon. The teaspoon slipped from his grasp and vanished beyond retrieval in the mound of coffee within.

What, I wondered, am I getting myself into here?

What I was getting myself into was the opening steps of a journey in learning that still continues. John's mentorship, his sharp mind and compassion, introduced me to the fusion of theory and practice that creates the enduring fascination of clinical research. He was an informal supervisor for my PhD, and his encouragement prevented me from giving up and calling it a day on many occasions. His pioneering appreciation of the potential value of CBT, combined with a lack of desire to disseminate it himself, created the opportunities for my own development as a teacher and supervisor. Equally, it was through the clinical trial on which we worked together that my interest in low self-esteem and its relation to depression, reflected in this paper, first grew. I have followed the development of his ideas with fascination—though not always with full comprehension (as a colleague said of ICS: “All the words are perfectly understandable; it's only when you try to put them together that you get into trouble”). And now his ability to step outside accepted conceptual frameworks has opened the door to a new adventure: mindfulness meditation. Thank you, John.

1. Introduction

Since the mid-1980s, the nature of the relationship between people and internal events has become an increasing focus of interest, both theoretically and clinically. Researchers have investigated how the interpretations people attach to symptoms they experience can serve to maintain and exacerbate psychological problems. At the same time, they have sought effective ways of helping people to question and test these interpretations, and to formulate credible alternatives, which allow patients to respond to their own thoughts, emotions and body sensations in new and more helpful ways. These developments have been beneficial to the field of cognitive behaviour therapy (CBT) in two main ways. Firstly, they have added new dimensions to our understanding of clinical phenomena. Secondly, they have enhanced the impact of CBT and extended its range, in some cases (e.g. psychosis) in surprising directions.

Models have been developed to describe how people relate unhelpfully to a range of internal experiences, including, for example: physical symptoms and body sensations (e.g. in panic, health anxiety and chronic fatigue); emotions (e.g. Leahy, 2002); shifts in mood and the constellation of thoughts, feelings and physical sensations that accompany them (Teasdale & Barnard, 1993); intrusive thoughts and images (e.g. in obsessive–compulsive disorder and post-traumatic stress disorder); worry in generalised anxiety disorder; and hallucinations in psychosis. Beck himself has acknowledged that these ideas constitute a significant advance in cognitive theory and therapy (letter to the ListServ of the Academy of Cognitive Therapy, 29 September 2003).

A particular theme in these developments is interest in the meanings people attach to cognitive phenomena in their own right, that is, cognition about cognition or “metacognition” (Wells, 2000; Wells & Matthews, 1994). One implication of this work is that, rather than seeking to alter the content of cognitions (the intervention that constitutes the meat and drink of classical cognitive therapy), we should seek to reduce their unhelpful impact by changing the nature of the patient's relationship to them. In some cases, this has meant using the methods of

traditional cognitive therapy to alter propositional beliefs about internal experiences. In others, it involves working to change the way mental events are *experienced*, as they arise (Teasdale et al., 2002).

This idea forms the central pivot of mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002), a radical new approach to preventing relapse in depression. Over a course of eight weekly two-hour classes and intervening homework assignments, MBCT uses insight meditation techniques to teach recovered depressed patients to “decenter” from depressive patterns of thought and the emotional, motivational, physical and behavioural symptoms that accompany them. Meditation leads to enhanced “metacognitive awareness”, that is, an ability to experience thoughts as transient mental events, rather than as aspects of the self or reflections of objective truth (Teasdale et al., 2002). The careful, sensitive and kindly self-awareness promoted by MBCT is intended to increase the chances that future episodes of depression will be “nipped in the bud”, rather than perpetuated and intensified by negative, self-devaluative rumination. Two clinical outcome trials now attest to the effectiveness of the approach with people who have experienced three or more previous episodes of depression (Ma & Teasdale, 2004; Teasdale et al., 2000).

This paper will suggest that cultivating metacognitive awareness may be helpful not only to patients who experience recurrent depression, but also to people with longstanding low self-esteem. It will suggest that, just as MBCT draws on aspects of CBT for depression to provide patients with a range of options when they encounter depressed mood, so CBT for depression and low self-esteem may usefully draw on the shift of emphasis reflected in the metacognitive perspective in general, and MBCT in particular. This would allow therapists to encourage non-judgemental self-awareness, even with patients in an acute state of distress.

2. Depression and low self-esteem: a clinical puzzle

When first confronted by a highly self-critical depressed patient, it is not always clear how to proceed. Specifically, it can be hard to discriminate between: (a) temporary negative biases in thinking about the self, which are largely mood-related and likely to respond to classical short-term cognitive therapy for depression; and (b) enduring negative patterns in processing self-referent information, which are present whether or not the person currently meets criteria for major depression, and may require a rather different approach.

To clarify this distinction, let us consider two patients, both referred by their family doctors for cognitive therapy of depression. Superficially similar, they are nonetheless very different in terms of how they respond to treatment.

2.1. Similarities

2.1.1. Life circumstances

Both patients are women, and both in their late 30s. Both have been depressed for about 18 months, and both have tried anti-depressants without success. Both are married; Mrs A has three children (12, 10 and 6), and Mrs B has two (9 and 5). Both depressions had their onset in encounters with life changes and difficulties. Mrs A's partner is out of work, which has meant

extra responsibilities have fallen on her shoulders. She is juggling work and family commitments, and concerned about her youngest child who is having problems at school. Mrs B used to work as a legal secretary, but has been a full time mother and housewife since becoming pregnant with her first child. Her younger child recently started school. At about the same time, her mother (and main confidant) moved away. Her husband's new job requires him to be absent much of the time.

2.1.2. *Main symptoms*

Both women feel miserable, tearful, tense, anxious and low in energy. Both have lost interest and pleasure in their usual activities, and are having trouble activating themselves, especially first thing in the morning. Mrs A has felt that death would be a relief from her burdens, but would not consider suicide because of her children. Mrs B has already taken two overdoses. Both meet criteria for Major Depressive Episode (DSM-IV-TR, APA, 2000), at a severe level: at the beginning of treatment, Mrs A's score on the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is 32, while Mrs B's is 35.

2.1.3. *Key cognitions*

Both women are highly self-critical, with an identical recurrent self-judgement: "I am useless". Both place high demands on themselves, and admit to perfectionist standards.

2.2. *Differences*

2.2.1. *Response to depression*

Mrs A sees her current state as "not my usual self". She finds it hard to accept how she feels; it feels alien to her and she has put a great deal of effort into trying to "pull herself together and get the show on the road again". Mrs B, in contrast, can only see her continuing low mood as yet further proof of how useless she is.

2.2.2. *Response to the cognitive therapy treatment rationale*

At the end of Session 1, both women respond identically to a description of the cognitive model of depression and to the idea of cognitive therapy: "I see what you mean, but I'm not sure I can do that". As a first homework assignment, both read "Coping with depression" (Beck & Greenberg, 1974), an overview of cognitive therapy for depression. Mrs A's response is: "This was written for me". Mrs B, in contrast, admits that she has not quite finished it yet, and asks if the therapist thinks it might have any relevance to her.

2.2.3. *Engagement in therapy interventions*

As lowered activity levels and loss of interest and pleasure are a difficulty in both cases, treatment begins with activity scheduling. The agreed goal, in each case, is to reintroduce pleasurable and relaxing activities that have been dropped, and to restore some sense of control and competence in daily life. Mrs A makes smooth progress, moving quickly from self-monitoring, to planning ahead, to working with negative automatic thoughts. Mrs B's weekly records of her activities, on the other hand, are not completed or completed only partially. She can move no further than sporadic self-monitoring; planning can be managed in session, with the therapist,

but not at home. This failure to follow through on therapy assignments seems to Mrs B to demonstrate yet again how useless she is.

2.2.4. *The therapeutic relationship*

With Mrs A, there is a real sense of teamwork from Session 1. She is willing to experiment with new ideas, and able to work independently. Rapport is easily established and maintained. As a consequence perhaps, Mrs A's therapist feels competent and worthwhile, and looks forward to their sessions. In contrast, despite apparent rapport in Session 1, there is an increasing sense that Mrs B is unwilling or unable to commit herself to using cognitive therapy and working independently. She repeatedly asks for reassurance. Her therapist feels increasingly frustrated, put upon and incompetent, and begins to dread their sessions.

2.2.5. *Outcome*

Mrs A's BDI score drops swiftly and substantially; within 2 weeks of twice-weekly sessions it is almost within the normal range (c.f. Fennell & Teasdale, 1987). She recovers fully within 12 sessions of cognitive therapy. She formulates more flexible and realistic standards for herself, recognising that her old rules made it difficult for her to accept that she was experiencing difficulty and to ask for help. This increases her self-acceptance, since she need no longer meet rigorous standards in order to experience a sense of self-worth. She can see that the negative judgements about herself which were central to her thinking when her mood was low ("I am useless") were a product of depression, and no longer finds them credible. Her recovery is maintained at one-year follow-up. Her therapist basks in the sense of a job well done. In contrast, Mrs B's depression does not lift—indeed, if anything, she feels even more useless as sessions continue and no sign of progress is seen. In the end, she votes with her feet and ceases to attend. Her therapist feels a mixture of guilt and relief.

3. **Negative self-statements, depression and low self-esteem**

How can the contrast these two women be understood? How is it that straightforward CBT for depression produces such good results with Mrs A, but leaves Mrs B untouched? What accounts for Mrs A's cognitive flexibility, and the contrasting cognitive rigidity of Mrs B? Specifically, what are the nature and function of the apparently identical statements they make about themselves ("I am useless")? Can the relationship between negative self-statements and depression vary from person to person and, if so, what are the implications for cognitive-behavioural treatment?

3.1. *Beck's cognitive model of depression*

3.1.1. *Maintenance*

In his early observations of the cognitions present in depression (Beck, 1967), Beck reported the following themes:

- low self-regard,
- unrealistic downgrading/devaluation of the self,
- magnification of failures and defects,

- minimisation of qualities, resources and past performance,
- extrapolation from minor faults to total worthlessness,
- unfavourable comparisons with other people and
- self-criticism and self-blame.

In short, he identified a systematic bias against the self in the thinking of depressed people. This bias contaminates all three elements of the negative “cognitive triad” that encapsulates the content of depressed thinking (Beck, Rush, Shaw, & Emery, 1979: pp. 11–12), that is, negative, distorted views of the self (as above), experience (including: underestimation of performance; interpretation of specific failure as global; negative comparisons with others; interpretation of others’ comments as critical), and the future (current deficiencies cannot be remedied).

3.1.2. *Vulnerability*

Beck understood cognitive vulnerability to depression in terms of cognitive structures or schemas, based on early experience, and mirroring the negative cognitive triad, that is, enduring negative views of the self, experience and the future. These “persist in a latent state like an explosive charge ready to be detonated by an appropriate set of conditions” (Beck, 1967).

3.1.3. *Sequence at onset*

Situations in some way similar to those under which the schemas were laid down reactivate the constellation of thoughts, feelings, body sensations and behaviour that constitutes depression—including situations leading to a lowering of self-esteem. This leads to a constriction of the field of awareness (preferential processing of negative material), which produces an increasing focus on negative aspects of the self and of experience. A self-maintaining sequence is established: experience, interpreted as failure, leads to self-blame and so to a sense of global worthlessness, and self-condemnation. Since defects are viewed as an intrinsic part of the self, there is no possibility of change, and hopelessness sets in.

Thus Beck’s cognitive model identifies negative self-schemas and negative thoughts about the self as central to the development and maintenance of depression. Subsequent thinkers have reiterated and elaborated this central point (e.g. Ingram, Miranda, & Segal, 1998; Teasdale, 1999), viewing depression as reflecting negative, self-related patterns of information-processing which become accessible in mild, normal depressed mood, and are then fuelled by self-devaluative rumination.

Questioning and testing current negative automatic thoughts about the self has always played a central role in CBT for depression. In terms of reducing vulnerability, however, the focus was originally on modifying conditional dysfunctional assumptions (“if . . . , then . . .” statements, “shoulds”, etc.) rather than on changing absolute negative beliefs about the self, experience (the world), or the future. It was suggested that patients who failed to respond to the recommended course of up to 20 sessions of cognitive therapy for depression should be offered anti-depressant medication or alternative treatment (e.g. Blackburn & Bishop, 1983; Fennell & Teasdale, 1987). We might now speculate that non-responders included patients whose longstanding sense of worthlessness, incompetence, unlovability or failure was untouched by the brief, practical focus of short-term CBT. Fennell and Teasdale (1982) wondered if the experience of lengthy or repeated depressions might alter self-perception, as depressive deficits came to be seen as aspects of the “true self”, rather than temporary aberrations from the “normal self”. They did not

however consider that the converse might also be true: recurrent or chronic depression might be a *product* of enduring negative beliefs about the self. Modifying such beliefs (and beliefs about other people and experience) was incorporated into treatment only later, when cognitive therapists began treating more chronic, severe depressions and depressions co-morbid with personality disorder (see, for example, Moore & Garland, 2003).

3.2. *The function of negative statements about the self*

In the context of depression, negative self-referent statements (such as “I am useless”) can have three different functions (Fennell, 1998). Firstly, they can be primarily a product of depressed mood and die away as mood lifts, whatever the means by which this is achieved (c.f. Hollon, DeRubeis, & Evans, 1996: “surface cognitions”). Secondly, they can be a response to depression itself (“depression about depression”, Teasdale, 1983). So, for example, Mrs A’s assumption that one should always cope gracefully with adversity induced self-criticism when she became depressed following a sequence of negative life events and was unable to come to grips with how she felt. Again, effective treatment of the depression is likely in this case to restore a sense of self-worth, especially if non-judgmental self-acceptance is enhanced by making over-demanding assumptions more flexible and realistic. The third possibility is that negative statements about the self evident while depressed reflect broader cognitive structures or enduring themes (i.e. negative core beliefs or schemas) that outlast episodes, are relatively independent of depressed mood, and contribute to persistent vulnerability to depression and indeed other problems (c.f. Hollon et al. 1996: “depth cognitions”). In this case, it may be hard for patients to engage with any conviction in classical short-term cognitive therapy—as was the case with Mrs B. Equally, simply treating depression may leave low self-esteem largely untouched, so that the patient remains vulnerable to future difficulties even if mood improves in the short term. It is worth noting that these three functions can interact; for example, a person with longstanding low self-esteem will become more harshly self-critical as depressed mood deepens.

These differences in the nature of the relationship between negative statements about the self and depression can be obscured in practice because all three categories are similar in form and content (“I am + global negative self-judgement”), and are maintained by similar patterns in processing self-referent information, including attentional biases (noticing, encoding and recalling information consistent with the negative perspective at the expense of information that contradicts it), ruminative response style (Nolen-Hoeksema, 1991), and attributional style (including the tendency to see negative events as having lasting implications for self-worth, while positive events are viewed as having none) (Abramson et al., 2002). Similarities in form and process may lead therapists mistakenly to treat patients with enduring low self-esteem as if the key problem was depression (as was the case with Mrs B), or conversely to treat patients who are experiencing an episode of depression with methods more appropriate to longstanding low self-esteem (c.f. James, 2001).

4. A continuum of treatment difficulty

It may be helpful to consider patients troubled by depression and concurrent negative views of the self as falling on a continuum of treatment difficulty, whose extremes are illustrated in

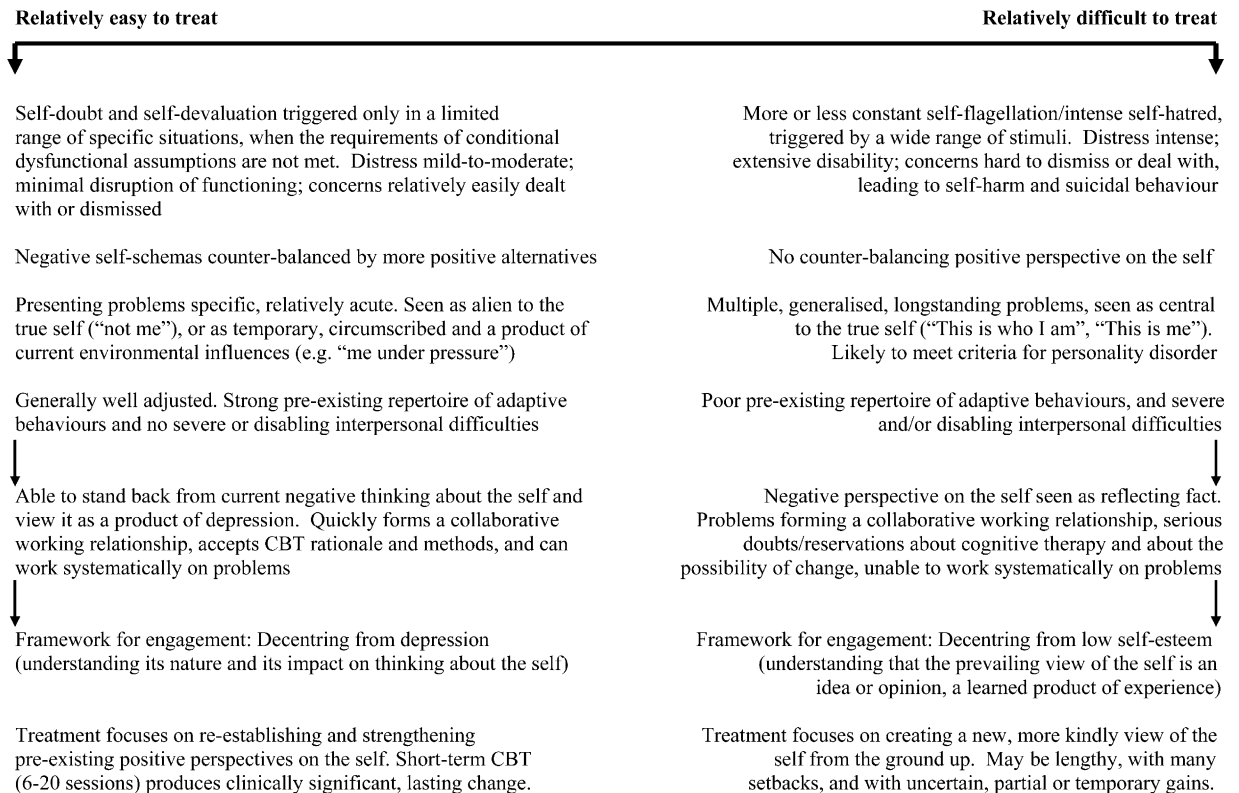


Fig. 1. Depression, low self-esteem and treatment difficulty: a continuum perspective.

Fig. 1. A particular patient might fall at any point on the continuum. Towards the left-hand end are found people whose negative self-statements are primarily an aspect or immediate consequence of low mood (like Mrs A). Such patients will relatively easily reach metacognitive awareness (in this case, an understanding of the personal relevance of the cognitive model of depression, and of the impact of mood on thinking about the self), and be able to participate actively in CBT with good results. Towards the right-hand end are found people like Mrs B, whose negative perspectives on the self are enduring and generalised, relatively independent of mood, not counter-balanced by compensatory positive perspectives, and associated with high levels of distress and disability. For them, identification with negative views of the self will be high, and access to metacognitive awareness (in this case, an understanding that ideas about the self are a product of experience rather than truth) correspondingly low. So active engagement in therapy may be slow to achieve.

Where a particular patient falls on the continuum will be influenced by a number of factors, including: the intensity and consistency of belief in negative self-schemas; the extent to which they have been elaborated and applied to many instances; the degree of associated distress and avoidance; the perceived risk (or impossibility) of change; the height of the threshold for activation; the range of potential activating stimuli; chronicity (the volume of experience, perhaps over a lifetime, that appears to confirm a belief); the level of associated disability in daily life;

the availability of more positive alternative perspectives on the self; the extent to which relevant material is stored in implicit memory (Brewin, Dalgleish, & Joseph, 1996), readily activated by minimal sensory stimuli, associated with high affect, and difficult to access through conscious effort by verbal means; and the power and consistency of malign historical and contemporary environmental influences.

A key feature, highlighted for our purposes here, is the extent of metacognitive awareness, that is, how far patients are able to grasp that beliefs about the self are ideas or opinions, learned and reinforced through experience, as opposed to reflecting objective truth. Beck himself observed at an early stage how difficult such “distancing” could be for acutely depressed patients, and noted how they failed “to make a distinction between thought and external reality, between hypothesis and fact” (Beck, 1970: p. 189). The difficulty is likely to be much greater when (as in enduring low self-esteem) negative perspectives have been rehearsed and reinforced over many years. Successful CBT has been shown to enhance metacognitive awareness (Teasdale et al., 2002). However, I would speculate that some degree of it, however, tentative and primitive, is also a necessary precondition for engagement on the part of the patient—a willingness at least to *begin to entertain the idea* that thoughts and beliefs are not facts, even if only with a percent of a percent of conviction. Otherwise, CBT’s change technology will appear to the patient irrelevant or impossible to implement successfully. If this speculation is correct, then it would be helpful to consider how to foster metacognitive awareness in CBT from the first session on, not only when treating episodes of depression, but also when working with longstanding low self-esteem. In many cases of depression, sharing the cognitive model and outlining its implications for therapy may be enough to encourage the beginnings of active participation and self-help (Fennell & Teasdale, 1987). With severe and enduring low self-esteem; however, patients may be weighed down by a substantial burden of self-denigration and hopelessness, and encouraging systematic, day-to-day application of CBT techniques is a harder task.

5. Metacognitive awareness and CBT

Teasdale, Segal, and Williams (1995) have suggested that a key process in the success of CBT for depression is the extent to which it provides patients with an alternative perspective on the experience and persistence of depression (metacognitive awareness), plus opportunities to put this more helpful perspective into practice and thus increase its credibility, generalisability and ease of access. A similar emphasis on changing the patient’s understanding of and response to internal events is integral to CBT in other problem areas (see for example Salkovskis, 1996). In effect, patients are invited to consider the relative utility of competing ways of understanding their difficulties, and to find out for themselves which is more helpful in practice. Opportunities to do so arise not only through verbal inquiry (guided discovery), but also through direct personal experience (behavioural experiments; Bennett-Levy et al., 2004).

In working with low self-esteem, the competing alternative frameworks could be summarised as

Old perspective	vs.	New perspective
<i>I AM</i> bad/useless/inadequate/unlovable/worthless, etc.		I am a normal human being/OK/no worse than anyone else, but <i>I BELIEVE I AM</i> bad/useless, etc.

Making these alternative possibilities explicit at an early stage in therapy creates a context in which working with specific thoughts, assumptions and beliefs fulfils a number of purposes, of which modifying their content is only one. These are:

1. Creating distance from old perspectives by putting them into words, labelling them, and clarifying how they were learned and what maintains them;
2. Fostering mindful awareness of negative thinking, and of the operation of unhelpful assumptions and beliefs both within and between sessions;
3. Moving from knee-jerk reactions to conscious processing (stepping out of automatic pilot);
4. Encouraging curiosity and flexibility of interpretation by repeatedly reinforcing the message that anything (including the self) can be viewed from a number of different angles. The familiar negative view is only one possibility, and may be neither the truest nor the most adaptive;
5. Altering cognitive content, classically the main thrust of CBT. In working with low self-esteem, this includes testing anxious predictions, questioning self-critical thinking and hopelessness, formulating less stringent assumptions, and identifying and acting in accordance with more accepting and kindly perspectives on the self (Fennell, 1999).

Teasdale et al. (1995) suggest that in CBT all of these except the last are implicit. They speculate that repeated questioning and testing of negative thoughts might lead to a generalised change in perspective where these began to be seen as “passing events in the mind that were neither necessarily valid reflections of reality nor central aspects of the self” (Segal et al., 2002: p. 38). It might be helpful, however, for cognitive therapists to consider what aspects of CBT (if recognised and made conscious use of) might foster this changed relationship to cognition, encouraging patients not only to alter the content of negative thinking, but also to recognise it and interrupt it by responding differently when it occurs. In low self-esteem, the aim is to help patients to move from “This is who I am” to “This is what I do”, from distressing immersion in old, negative ways of viewing the self to interested acknowledgement (“There’s my old war wound playing up again”).

6. Aspects of CBT that encourage metacognitive awareness

MBCT incorporates aspects of cognitive therapy (education about negative thoughts and how to work with them, activity scheduling) in the interests of giving depressed patients an extended choice in how they respond when they encounter low mood. Conversely, importing MBCT’s particular quality of attentiveness—relaxed, compassionate, interested, curious—might increase CBT patients’ ability to open to internal experiences, and to remain with and explore them rather than struggling to dismiss them or fight them off. CBT incorporates a number of elements that lead in the direction of metacognitive awareness. The impact of these might be enhanced if therapists more explicitly used them in such a way as to maximise self-reflection and encourage patients to stand back from internal processes rather than identifying with them. New techniques are not being advocated here; rather a shift of emphasis, taking direction from the central message of mindfulness, is suggested. Potentially helpful elements include:

6.1. Questionnaires

Standard questionnaires are often simply used as a quick and reliable way of assessing initial state and measuring progress. They can also act as a prompt to patients, drawing attention to aspects of experience (for example, assumptions or safety behaviours) of which they have been minimally aware, but which nonetheless contribute to the persistence of the problem. Thus, if carefully examined by therapist and patient, they have direct clinical utility.

6.2. Formulation

Cognitive formulations outline the processes through which problems develop and are maintained (see Fennell, 1997 for a cognitive model of low self-esteem). Sharing the formulation allows the therapist to highlight the central messages on which the patient's engagement in therapy may depend: "This is how you learned to see yourself when you were growing up", "This is what experience has led you to believe", as opposed to: "This is what you are". For patients with longstanding, disabling low self-esteem (like Mrs B), this may be a delicate business: well-rehearsed information-processing biases encourage them to hear the formulation as confirmation of what they have always thought and to screen out, discount or misinterpret the new perspective (Padesky, 1994).

6.3. Treatment rationale

The cognitive therapy rationale (or overview of treatment) communicates another important idea: "Change is possible, and we have practical methods for achieving it". Again, with longstanding problems, patients are unlikely to greet this idea with open arms, or indeed to find it particularly credible. The most the therapist may hope for initially is a willingness, however doubtful, to give CBT a try.

6.4. Written materials

Written materials that the patient can take away, read and reflect on, provide opportunities for cultivating awareness beyond the session itself. These include copies of the formulation flow-chart, handouts about presenting problems and about CBT, lists of useful questions to help in seeking alternatives to unhelpful cognitions, hand-written summaries of sessions or of specific assignments, and end of treatment action plans or "therapy blueprints" (see below).

6.5. "A thought is not a fact"

Cognitive therapists use a number of methods for communicating this idea, including the cognitive model itself, images, metaphors, stories and experiments. For example, the use of video feedback in the treatment of social anxiety (Butler & Hackmann, 2004) allows patients to see for themselves that thoughts such as "I look an idiot" may bear little relation to the reality, even though they feel powerfully convincing at the time. Similarly, Salkovskis's "dog mess" story introduces the notion of multiple perspectives, and illustrates the impact of high emotion, with humour and force (Salkovskis, 1996: pp. 48–49). The story imagines four different people

stepping in dog mess on the way to work. Three are prone to different emotional responses (depression, anxiety and anger), and their interpretations of this unfortunate event are shaped accordingly (failure, imminent catastrophe and blame/vengeance). The fourth is a cognitive therapist, whose response is rather different: “Well, isn’t it good that I remembered to put my shoes on this morning”.

6.6. Illuminating biases in information processing

Padesky’s prejudice model of low self-esteem (Padesky, 1993) provides an engaging framework for exploring the information-processing biases that contribute to the maintenance of negative self-schemas. Padesky asks patients to call to mind someone they know who has a prejudice with which they do not agree, and to consider how that person reacts when they meet someone who fits the prejudice and someone who does not, what they would need to do in order to change, and what would make change difficult. This process is then related back to patients’ own ideas about themselves. Thus, through guided discovery, patients are helped to appreciate how perception, interpretation and memory can all be skewed by dominant perspectives, and to consider how to achieve a more balanced point of view. Similarly, information about cognitive distortions (e.g. Burns, 1980: pp. 32–43) can be used to help people to tune into favourite ways of manipulating incoming information.

6.7. Encouraging in-session awareness of cognitive processes

Therapists can encourage metacognitive awareness by relating patients’ immediate utterances back to the broader framework of a shared cognitive model, e.g.: “Did you notice what you just said about yourself?”, “How does that connect with our formulation?”, “What is that another example of?”, “Is that the voice of your perfectionism speaking?”. Negative self-evaluation arises as readily in response to therapist and therapy as it does to any other experience. This provides golden opportunities to develop awareness of the system in action.

6.8. Developing day-to-day awareness of recurrent cognitive patterns

The 3-column Dysfunctional Thoughts Record (DTR; Beck et al., 1979) is routinely used early in CBT to encourage day-to-day recognition of unhelpful thinking. Worksheets of this kind fine-tune awareness of negative cognitions, the circumstances that trigger them, and associated emotions and behaviour, as a prelude to seeking more realistic and helpful alternatives. The same instruments develop the patient’s sense of recurrent patterns in processing, regardless of content: “Here I go again”. In classical cognitive therapy, patients often reach a stage eventually where this observation alone is enough to defuse a painful train of thought.

6.9. “Compassionate mind”

MBCT is not designed to foster a cold, surgical distance from thoughts and feelings, but rather an interested, kindly and accepting stance in relation to the vagaries of the mind, including the habit of self-criticism and self-devaluation. This is reflected in measures of mindfulness

such as the Freiberg Mindfulness Inventory (FMI; Buchheld & Wallach, 2002), which includes an item category entitled “Non-judgemental, nonevaluative attitude towards self and others”, and statements such as: “I accept myself as I am” and “I see my mistakes and difficulties without judging them”. Within CBT, the concept of “compassionate mind” (Gilbert, 2000) emphasises the healing impact of viewing the self with kindness.

6.10. Enhancing awareness of positive aspects of the self

In CBT for depression, enhancing awareness of positive aspects of experience is a central aspect of treatment, designed to counter the biases in information-processing outlined above. Like mindful awareness of everyday experience, it encourages patients to appreciate the richness of routine experiences, small pleasures and achievements. In CBT for low self-esteem, similar methods (e.g. the Daily Activity Schedule, diary keeping) can be used to bring aspects of the self that are normally ignored or discounted into awareness, and to help patients to notice on a moment-by-moment basis how they maintain outdated perspectives by shutting contrary information out.

6.11. Relapse prevention

With low self-esteem, as with depression, the possibility that old patterns of cognition will recur needs to be taken into account. The “therapy blueprint” (see for example Fennell, 1999, Chapter 9) encourages patients at the end of treatment to reflect on how their problems developed, what kept them going, what they have learned in therapy, what might lead to a setback for them, and how they would deal with it. MBCT’s emphasis on developing detailed relapse signatures and action plans (borrowed from work on psychosis and bipolar disorder) is consistent with this. MBCT also adds an emphasis on the value of regular meditation after classes are finished, giving opportunities for repeated practice at bringing non-judgemental awareness to thoughts, feelings and body sensations. This is seen as a means of fine-tuning awareness of early signs of depression and rehearsing a non-reactive approach to difficulties, so that potential problems can be “nipped in the bud”. Cognitive therapists dealing with other recurrent problems might do well to incorporate similar plans for regular times of non-judgemental awareness in the therapy blueprint.

7. Conclusion

This paper has considered recent ideas on the relationship between the person and aspects of internal experience, in particular the development of MBCT as a means of preventing relapse in recurrent depression. It has suggested that metacognitive awareness (recognising cognitions as events and processes in the mind, rather than reflections of objective truth) might not merely be a consequence of effective cognitive therapy, but a precondition for successful engagement in treatment. Currently, MBCT is seen primarily as a suitable approach for people who suffer recurrent depression, to be undertaken when they are well. Indeed, its originators recommend CBT for those who are actively depressed. Perhaps, however, in time, we shall be in a position

to integrate the two approaches more closely, not only for depression but also for longstanding problems like enduring low self-esteem. After all, they share a common intention: “coming to know ourselves better and becoming more accepting of ourselves, not as we would like to be but as we actually are” (Kabat-Zinn, 1990: p. 70).

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