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Conditional Beliefs of Primary-Care Patients with Treatment-Resistant Depression

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Running head: Conditional Beliefs of Patients with TRD

Abstract

Background: Cognitive behaviour therapy (CBT) for patients with treatment-resistant depression (TRD) aims to reframe underlying conditional beliefs which are thought to maintain depression.

Aim: To systematically explore conditional beliefs expressed by primary-care based patients with TRD, defined as non-response to at least 6 weeks of antidepressants.

Method: Conditional beliefs (stated in an 'If…then…' format) were extracted from a random sample of 50 sets of therapist notes from the CoBalT trial, a large randomised controlled trial of CBT for TRD in primary care. The beliefs were separated into their two constituent parts; the demands ('Ifs') and consequences ('thens'). An approach based on framework analysis provided a systematic way of organising the data, and identifying key themes.

Results: Four main themes emerged from the demand part of the conditional beliefs ('Ifs'): 1. High standards, 2. Putting others first/needing approval, 3. Coping, and 4. Hiding 'true' self. Three main themes emerged from the consequence part of the conditional beliefs ('thens'): 1. Defectiveness, 2. Responses of others, 3. Control of emotions.

Conclusions: Identifying common themes in the conditional beliefs of patients with TRD add to our clinical understanding of this client group, providing useful information to facilitate the complex process of collaborative case conceptualization and working with conditional beliefs within CBT interventions.

Key words: treatment-resistant depression, chronic depression, CBT, conditional beliefs.

Introduction

The burden of depression to patients, health-care systems, and society is well documented (Fostick et al., 2010; Judd et al., 2000) and only a third of patients respond fully to antidepressants (Trivedi et al., 2006). Cognitive behaviour therapy (CBT) is one of the psychological treatments recommended in clinical guidelines (National Institute for Health and Clinical Excellence, 2009). Roughly two thirds of people will no longer meet criteria for major depression following acute-phase CBT (Craighead et al., 2007). However, about half of patients with major depressive disorder who receive acute-phase CBT relapse within two years (Vittengl et al., 2010). It is this highly recurrent and sometimes chronic nature of depression that prompted researchers to identify potential cognitive markers that may represent long-term vulnerability factors, in the hope of enhancing the efficacy of interventions such as CBT (Halvorsen, et al., 2010; Jarrett et al., 2007; Vittengl et al, 2007).

According to Beck's cognitive theory of depression (Beck, 1976; Beck et al, 1979) dysfunctional schemas can represent a vulnerability factor for depression. Dysfunctional schemas consist of negative or unhelpful beliefs and attitudes about the self, the world and others, are generally culturally derived, and represent value judgments and standards. They can remain dormant and largely stable in non-depressed states, but may be triggered by a wide range of stressors or life events that are reminiscent of the early experiences that led to their development (Clark & Beck, 1999; Teasdale 1988). Later texts (Beck et al 1990; Padesky, 1994) argue it is clinically useful to separate the concept of schemas into core beliefs and conditional beliefs (or dysfunctional assumptions), as they require different approaches and techniques in therapy.

Conditional beliefs, also known as 'rules for living' (Fennell 1997), can be stated in an "If…then…" format consisting of a demand and a consequence. For example, "If I am nice to people then they will respect me". This provides a testable statement which can be explored through the use of behavioural experiments (Mooney and Padesky, 2000). CBT involves working collaboratively with patients to identify conditional beliefs, examine their negative effects, and test out alternative, more functional beliefs (Beck, 1995; Fennell, 1997; Padesky, 1994).

Patients with TRD typically report a number of rigid conditional beliefs that govern and maintain unhelpful behavior, influencing the interpretation of events (Mooney and Padesky, 2000). Using the Dysfunctional Attitude Scale (DAS; Weissman, 1979), Riso et al. (2003) found the highest levels of dysfunctional attitudes (conditional beliefs) in people with chronic depression, compared to a group with non-chronic depression and a never-depressed group. People with chronic and persistent depression may have beliefs reinforced over a long period of time, potentially making them more entrenched and difficult to modify. Although beliefs are often not articulated at the start of therapy, they may influence the therapy process (Moore and Garland, 2003). For example, a belief 'If I don't succeed, then I am worthless', may lead someone to be critical of their progress in therapy and negatively affect their level of engagement. Identifying conditional beliefs early on in therapy may help address beliefs that could interfere with therapy and reduce drop-out.

It has also been suggested it is important for CBT to concentrate on conditional beliefs in order to achieve longer lasting change in patients with TRD, (Mooney and Padesky, 2000; Moore and Garland, 2003). Questionnaires such as the DAS (Weissman, 1979) and the

Young Schema Questionnaire (YSQ; Young and Brown, 1990) have been developed to help capture the content and extent of patients' unhelpful beliefs. However, these require patients to rate existing statements, rather than formulating conditional beliefs using their own words and expressions. Such questionnaires can be long, detailed and, anecdotally, used more in research than clinical practice. The CoBalT trial provided a unique opportunity to systematically explore whether there were common themes in the conditional beliefs expressed during CBT by primary care patients with TRD. To the best of our knowledge, there are no other papers that have looked at this. Identifying common themes of conditional beliefs could be useful to CBT therapists in identifying and formulating unhelpful conditional beliefs in therapy.

Method

The CoBalT trial

The material analysed in this study came from CBT sessions with patients participating in the CoBalT trial (Wiles et al., 2013). CoBalT was a multi-centre randomised controlled trial investigating the effectiveness of CBT as an adjunct to usual care (including pharmacotherapy) for primary care patients with TRD. As there is no agreed definition of treatment resistance, the CoBalT trial used a definition of TRD that was inclusive and directly relevant to UK primary care (Wiles et al., 2013).

Eligible patients were aged 18-75 years who had TRD, defined as continuing to have significant depressive symptoms (Beck Depression Inventory (BDI-II; Beck et al., 1996) score of 14 or more, and meeting ICD-10 criteria for a depressive episode assessed using the revised Clinical Interview Schedule (CIS-R; Lewis, 1994; Lewis et al., 1992)) following treatment with an adequate dose of antidepressant medication for at least 6 weeks

(Thomas et al., 2012). Adherence to antidepressant medication was assessed using a self-report measure of adherence that has been validated against electronically monitoring medication bottles (Morisky et al, 1986, George et al 2000) and adequacy of dose of medication based on comparisons with recommended doses for depression in the British National Formulary (Wiles et al, 2013).

Patients in the CoBalT trial were randomised to either treatment as usual (GP care), or treatment as usual plus 12 – 18 sessions of individual CBT based on Beck et al. (1979) with elaborations from Moore and Garland (2003). The latter included techniques that have been found helpful when working with avoidance and resistance, often found in patients with chronic and persistent depression. The treatment protocol for the CoBalT trial encompassed addressing and modifying conditional beliefs. The intervention was delivered by 11 part-time therapists in three sites (Bristol, Exeter and Glasgow) representative of those working in NHS psychological services, with one clinical supervisor per site (Thomas et al., 2012). Therapists kept clinical therapy notes as they would do in usual NHS practice. Information on conditional beliefs was recorded by therapists in therapy notes, formulation diagrams, discharge letters and relapse prevention plans. This study was based on conditional beliefs extracted from a random sample of therapy notes.

Selection of therapy notes

In total, 234 patients were randomised to the intervention arm of the CoBalT trial. Of these, 152 (Bristol: n=63; Exeter: n=54; Glasgow: n=35) completed a course of CBT and gave consent for both their therapy recordings and medical records to be used for research purposes. A random sample of 50 therapy notes (stratified by age (<50 years; ≥50 years) and gender) from the three research sites was selected for the purposes of this study

(Bristol: n=20, 5 per stratum; Exeter: n=20, 5 per stratum; Glasgow: n=10, 2 per stratum and 2 at random). An initial hypothesis was that there may be differences in the conditional beliefs of men and women, as well as between different age groups. Stratifying by age and gender allowed any differences to be explored. If there were no recorded conditional beliefs within a set of therapy notes, the next randomly generated patient within that stratum was used in order to ensure a final sample of n=50. This replacement procedure was used on five occasions. If there was an insufficient number of patients within the relevant stratum (age/gender), the next patient was selected from a randomly generated alternative stratum. This procedure was used on three occasions.

Extraction of data from therapy notes

The selected therapy notes were examined thoroughly to extract recorded underlying conditional beliefs. The two researchers examining the notes (AB and SG) were CoBalT trial CBT therapists and therefore familiar with formulating conditional beliefs. Conditional beliefs were identified as extreme statements in the form of 'If…then…', 'Unless…then…' and 'I should/must/need…'. With all these, after data extraction, we imposed an 'If…then…' format to simplify the analysis. The two researchers worked together at this stage of data extraction to ensure agreement about the data being collected. Conditional beliefs were typed verbatim into a spreadsheet, resulting in a long list of conditional beliefs, each marked with the unique patient ID number.

Data analysis

The list of extracted conditional beliefs was cut into strips so there was one conditional belief per strip. This allowed the beliefs to be manually sorted and grouped into themes.

This process identified many beliefs started with the same 'demand' but ended with a different 'consequence'. For example:

'If I don't do things perfectly, then I am a failure.'

'If I don't do things perfectly, then others will reject me.'

To capture these idiosyncrasies, and limit researcher interpretation, it was decided to cut the conditional beliefs in half, sorting the demands ('Ifs') and the consequences ('thens') separately. It was also decided that the two researchers would initially sort all of the data independently before comparing groups and refining themes. This allowed the researchers to discuss each other's interpretations of the data and produce a more rigorous analysis. Overall, there was considerable agreement over the grouping of beliefs. Further discussion enabled greater refinement of the groups and agreement on theme labels.

An approach based on framework analysis (Ritchie and Spencer, 1994) was used to organise the data. Using this approach, data was placed into tables with patient ID numbers down the side and the labels of themes across the top. This provided an overview of the data aiding the process of making comparisons across and within themes, leading to further refinement, and an initial exploration of any gender or age differences. Investigator triangulation was undertaken with a third researcher (GL) who examined the content and grouping of the emerging themes in order to comment on the face validity of the analysis.

Once final themes for the demands and consequences were agreed, the number of patients who held beliefs within each theme were counted. At this point it was possible to explore frequencies by age and gender. Themes of demands and consequences were cross-tabulated to link them together as complete conditional beliefs and derive frequencies for the various combinations. The majority of patients held more than one conditional belief

and hence chi-squared tests were conducted for each of the possible combinations to identify any that occurred more frequently than expected by chance.

Results

Study participants

The final sample consisted of therapy notes relating to 29 women and 21 men with a mean age of 48.8 years (SD 12.5). The average number of CBT sessions attended was 14.3 (SD 3.5). All 11 CoBalT trial therapists were represented.

The characteristics of the patients whose notes were sampled reflected those of the main CoBalT trial (Wiles et al., 2013; see Table 1). Most participants reported severe (mean BDI-II score = 30.2) and chronic depression (56% reported their current episode of depression lasting more than 2 years). Many (n=33, 66%) had been on their current antidepressants more than 12 months, with a minority (n=7, 14%) having taken their medication for less than six months. Forty-six percent reported 5 or more episodes of depression. Most (n=40, 80%) had previously been treated with antidepressants. All but one patient had a secondary diagnosis of an anxiety disorder on the CIS-R.

Insert table 1 about here

Conditional beliefs

A list of 284 conditional beliefs was generated by examining therapy notes. The number of beliefs found per patient varied from 1 to 19 (mean = 5.68, SD = 3.6). In many cases, the

greater number of beliefs reflected the development and refining of conditional beliefs as therapy progressed, rather than lots of distinct beliefs.

Four main themes emerged from the demands ('Ifs') (Table 2). Three main themes emerged from the consequences ('thens') (Table 3). Some of the main themes contained sub-themes which are described below. The final column in Tables 2 and 3 show the number (and percentage) of patients for whom this theme was present.

Insert tables 2 and 3 about here

Themes to emerge from the demands ('Ifs')

1. High Standards

The most frequent theme to emerge from the first part of the conditional beliefs (found in 80% of notes examined) related to having 'High standards'. Within this, three sub-themes were identified; 'Working hard/keeping busy', 'Perfectionism', and 'Achieving goals'. The first of these statements concerned keeping busy and doing as much as possible, often to keep up with perceptions of others or trying to do as much as they believed they used to do before they became depressed, which for many, was a number of years ago. The sub-theme of 'Perfectionism' was based on statements that suggested they needed to do things 'perfectly' or 'just so'. The final sub-theme reflected statements that suggested the individual set themselves goals, which *had* to be achieved. These goals were usually unrealistic or extremely ambitious.

2. Putting others first/needing approval

The second most frequent 'demand' theme to emerge (found in 60% of notes) included statements that reflected a strong sense of *always* putting others first, having to do what they believed was expected by others, not upsetting others, trying to be kind and considerate at *all* times and needing to gain the approval of others.

3. Coping

The third most frequent 'demand' theme (found in 48% of notes) included statements about the importance of being strong, capable, and independent. There were three sub-themes within this main concept of 'Coping'; 'Not asking for help', 'I should be able to cope', and 'Not showing emotion'. The first of these reflected a desire not to rely on others or burden them in any way. The second often involved people comparing themselves to others or expecting themselves to manage just as well as they would have before experiencing depression. The third captured statements about hiding emotions from others and having to be in control of one's feelings at all times.

4. Hiding 'true' self

The final theme to emerge from the 'demands' (found in 22% of notes) included statements that referred to keeping others at a distance to prevent them seeing or finding out about the 'real me'.

Themes to emerge from the consequences ('thens')

1. Defectiveness

The most frequent theme to emerge from the second part of the conditional beliefs (found in 82% of notes examined) included statements about being defective in some way or a fear of becoming defective if conditions were not met or standards were not upheld. Six

sub-themes emerged in the way that people described 'defectiveness'. These sub-themes were 'Stupid, useless, failure', 'Bad', 'Lazy', 'Selfish/burden to others', 'Weak/others can hurt me', and 'Worthless'. People also took these characteristics to mean it was their fault when things did not go 'right'.

2. Responses of others

The second most frequent theme to emerge from the 'consequences' (found in 56% of notes) included statements relating to fears about the reactions of others. There were two distinct sub-themes; 'Others will think badly of me' and 'Others will reject me'. The first of these highlighted fears that others would disapprove and lose respect for the person (whilst not necessarily showing this outwardly). The second sub-theme included statements that others would explicitly ridicule or reject them.

3. Control of emotions

The final theme to emerge from the 'consequences' (found in 18% of notes) included statements reflecting fears about one's own emotions being overwhelming and the consequences of 'losing control' either for themselves or for others.

Linking demands and consequences

Table 4 shows how the main themes identified during the analysis can be linked back together in twelve possible combinations. An example quote is provided for each combination. The numbers show how many participants' therapy notes contained a belief that fitted within each theme. The most commonly held beliefs were around 'achieving high standards' and 'being defective', and in 35 out of 50 people these were linked, e.g. *"I must get 100% in everything, otherwise I am useless, stupid" (F37).*

Insert table 4 about here

The majority of participants had more than one conditional belief. Therefore, the frequencies of demands and consequences were compared for each of the twelve combinations using chi-squared tests. Four combinations of demands and consequences were more common than would have been expected by chance: (1) 'If I don't achieve high standards, then I am defective' ($p = 0.04$); (2) 'If I don't appear to be coping, then I will be thought badly of/rejected' ($p = 0.002$); (3) 'If I don't appear to be coping, then I will lose control' ($p = 0.001$); and (4) 'If I don't hide my true self, then I will be ridiculed/rejected' ($p = 0.008$) (Table 4).

Differences by age and gender

Examining frequencies by age and gender revealed few differences. The largest difference noted in the 'demands' was around the theme of 'Coping' where 33% of women *under* 50 held beliefs about coping compared with 71% of women *over* 50.

Within the 'consequences', some differences emerged in the theme 'Responses of others'; 33% of women *under* 50 held beliefs that others would think badly of them or reject them, compared to 71% of women *over* 50. This age difference was reversed in men; 90% of men *under* 50 held these beliefs about others, compared to just 38% of men *over* 50.

Discussion

Many commentators have argued that a key aspect of CBT for TRD is identifying and reframing conditional beliefs because they maintain the disorder and, even when symptoms remit, the presence of dysfunctional conditional beliefs increases the risk of relapse (Kuyken, Padesky & Dudley, 2009). This study developed following an observation in CBT supervision that common themes were being identified in the conditional beliefs of patients with TRD.

This study investigated the content of conditional beliefs that were recorded in the CBT notes for 50 patients with TRD, most of whom had chronic and persistent depression. Beliefs were explored by breaking them down into two constituent parts and looking at the links between these. Four overarching themes emerged from the 'demand' section of the conditional beliefs ('Ifs') and three from the 'consequence' part ('thens'). The most commonly held beliefs were around a demand of having to achieve 'high standards' and a consequence of being 'defective'. Both of these themes were found in 80% or more of the sample. In 35 participants (70% of the sample) these were linked. The other themes found to link together more commonly than expected by chance were: 'If I don't appear to be coping, then I will be thought badly of/rejected', 'If I don't appear to be coping, then I will lose control', and 'If I don't hide my true self, then I will be thought badly of/rejected'. However, caution is necessary in interpreting these findings due to the small numbers and multiple testing, which may have produced a significant result by chance.

Interestingly, this study only found minimal differences in the conditional beliefs of men and women, and those aged over and under 50 years old. The main differences found reflected a trend for older women to be more concerned than younger women about 'Coping' and 'Responses of others'. Younger men appeared to be more concerned about the 'Responses of others' than older men were.

Identifying themes of conditional beliefs that may interfere with engagement in therapy, e.g. having high standards or a sense of defectiveness, may be clinically beneficial in allowing the therapist plan how to manage this during therapy. For example, patients who hold beliefs concerning 'High standards' may have high expectations of therapy, the therapist, and/or themselves. The qualitative study of CoBalT trial participants found that a key factor in patients' dissatisfaction with therapy was having to undertake homework tasks and a fear of failing at these (Barnes et al., 2013). Some participants reported pressure to get therapy tasks 'right'. Addressing unrealistic expectations of therapy and their own 'performance' could be important to prevent disengagement or confirmation of unhelpful conditional beliefs, for example, being a failure. Currently there is a lack of research predicting patient drop-out from CBT for depression (Schindler et al., 2013), the influence of conditional beliefs may be an important factor for future research to consider.

A limitation of this study was the post-hoc design and reliance on information recorded during therapy. Data quality was therefore constrained by different styles of formulation and note-keeping. However, therapists were broadly representative of those working in the NHS and the clinical note-keeping was consistent with professional standards. Researchers (AB and SG) were confident that the data extracted from therapy notes reflected conditional beliefs as conceptualized in cognitive theories of depression. Where multiple conditional beliefs were recorded in a patient's notes, in some cases, this appeared to reflect the process of refining these over the course of therapy ensuring that the belief most accurately reflected that held by the patient. The variation in the number of conditional beliefs recorded may also reflect differences in note keeping or the focus of therapy sessions.

Caution should be exercised in generalizing these findings because participants reflected a population recruited in UK primary-care. It is possible that holding certain types of beliefs may discourage people from entering a research trial or completing therapy. Further, these findings may not be specific to patients with TRD. However, one of the strengths of this study is that the participants were recruited from primary-care and relate to a highly prevalent, difficult-to-treat group (Thomas et al., 2013). The main themes that emerged reflected existing literature around conditional beliefs and TRD. For example, four of the main themes described in this study ('High standards', 'Putting others first/gaining approval', 'Coping' and 'Control of emotions') are similar to the 'Achievement', 'Dependency' and 'Self-control' dimensions in a factor analysis of the DAS by Power et al. (1994). Two 9-item versions of the DAS have also been designed to identify the central themes of 'Perfectionism' and 'Need for approval' (Beevers et al., 2007). In this study perfectionism (unlike ordinary striving for realistic goals) was a sub-theme of 'High standards' and has previously been identified as a key variable to consider in CBT for chronic depression (Riso and Newman, 2003).

In conclusion, this study found key themes in the conditional beliefs of primary-care patients with TRD. These add to the clinical understanding of this client group and provide useful information to facilitate the complex process of collaborative case conceptualization within CBT interventions for this client group. Future research is needed to investigate whether similar themes of conditional beliefs are also found within other clinical populations, e.g. acute first episode depression. If individuals with TRD are more likely to hold particular conditional beliefs, these may be important targets for earlier intervention in order to prevent the development of chronicity.

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Conflicts of interest

CW has been a past president of the British Association for Behavioural and Cognitive Psychotherapies (BABCP), a workshop leader and author of texts on depression and self-help resources and is a Director of a company that markets CBT self-help resources. WK is Co-Founder of the Mood Disorders Centre, teaches nationally and internationally on CBT

and co-authored a cognitive therapy book (Collaborative Case Conceptualization, published by Guilford Press). The other authors have no conflicts to declare.

Ethical approval

Ethical approval for the study was given by West Midlands Multi-Centre Research Ethics Committee (NRES/07/H1208/60) and site-specific approvals were obtained from the relevant Local Research Ethics Committees (LRECs) and Primary Care Trusts (PCTs)/ Health Boards covering the three trial sites. The trial was registered under ISRCTN38231611.

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Table 1: Characteristics of the 50 patients whose notes were examined

Socio-demographic variables	n	(%)
Marital status:		
Married/living as married	27	(54.0)
Single	6	(12.0)
Separated/Divorced/Widowed	17	(34.0)
Employment status:		
In paid employment (full/part-time)	24	(48.0)
Not in employment	9	(18.0)
Unemployed due to ill health	17	(34.0)
Highest educational qualification:		
A level, Higher grade or above	27	(54.0)
GCSE, Standard grade or other	16	(32.0)
No formal qualifications	7	(14.0)
History of depression	n	(%)
Number of prior episodes of depression:		
0-1	9	(18.0)
2-4	18	(36.0)
≥5	23	(46.0)
Current depression and co-morbidity		
BDI-II score: mean (SD)	30.2	(8.8)
PHQ-9 score: mean (SD)	15.8	(4.7)
ICD-10 primary diagnosis: *n (%)*		
Mild	7	(14.0)
Moderate	34	(68.0)
Severe	9	(18.0)
Duration of current episode of depression: n (%)		
<1 year	10	(20.0)
1-2 years	12	(24.0)
> 2 years	28	(56.0)
Secondary diagnosis on CIS-R: n (%)		
Generalised anxiety disorder	24	(49.0)
Mixed anxiety and depression	12	(24.9)
Panic disorder	5	(10.2)
Specific (isolated) phobia	5	(10.2)
Agoraphobia	3	(6.1)
None	1	(2.0)

Table 2: Main themes to emerge from the demands (the 'Ifs')

Main themes	Examples*	Number in sample for whom this theme was found
		n (%)
1. High standards	*"If I don't achieve (my standards)…" (F21)* *"If I don't do things right…" (F52)* *"If I'm not good at everything…" (F57)* *"If I am not superwoman/perfect…" (F69)* *"If I'm not successful…" (M24)* *"If I don't achieve my goals…" (M61)*	**40 (80%)**
2. Putting others first/needing approval	*"I must always put other peoples' needs before mine…" (F59)* *"If people don't like me…" (F54)* *"If I let people down…" (M47)*	**30 (60%)**
3. Coping	*"If I can't deal with things…" (M32)* *"If I ask someone for help…" (F66)* *"If I say what I really feel…" (F49)*	**24 (48%)**
4. Hiding 'true' self	*"If people get to know me…" (M37)* *"If people see the real me…" (M66)* *"If people knew what I was really like…" (F49)*	**11 (22%)**

**Brackets after the quote give details of the gender and age of the participant*

Table 3: Main themes to emerge from the consequences (the 'thens')

Main themes	Examples*	Number in sample for whom this theme was found
		n (%)
1. Defectiveness	*"…then I am useless…stupid" (F55)* *"…then I am bad" (F40)* *"…then I am a failure" (F21)* *"…then I am worthless" (M49)*	**41 (82%)**
2. Responses of others	*"…then I will be thought badly of" (F66)* *"…then I'll be rejected, alone" (M52)* *"…then I have failed them and they won't respect me" (F43)* *"…then other people will think less of me and ridicule me" (M47)*	**28 (56%)**
3. Control of emotions	*"…then I will lose control of my feelings and can't cope" (F52)* *"…then I will lose control and not be able to cope" (F60)* *"…then I don't know what I'll do…I'll explode, hurt someone" (M52)*	**9 (18%)**

**Brackets after the quote give details of the gender and age of the participant*

Table 4. Frequencies of combinations of demands and consequences, with an example of a conditional belief including that combination. Individuals (N=50) could hold more than one belief.

	Then I am defective **n = 41**	**Then I will be thought badly of/rejected** **n = 28**	**Then I will lose control** **n = 9**
If I don't achieve high standards… **n = 40**	n = 35 *"I must get 100% in everything, otherwise I am useless, stupid" (F37)* p = 0.04	n = 21 *"If I don't do things well then others will criticise me and reject me and be disappointed" (F60)* p = 0.32	n = 8 *"Something needs to be done a certain way and anything that falls short of that makes me feel emotional, stressed, anxious" (F41)* p = 0.46
If I don't put others first / gain approval… **n = 30**	n = 26 *"If I inconvenience others then I'm a time waster/selfish" (F28)* p = 0.29	n = 19 *"If I don't do what others want, I'll be criticized" (F49)* p = 0.20	n = 7 *"I should always be approachable and compassionate in order that I should not upset other people" (M61)* p = 0.23
If I don't appear to be coping… **n = 24**	n = 20 *"If I don't appear to be coping then I am a failure" (M47)* p = 0.81	n = 19 *"If I ask others for help they will reject me" (F66)* p = 0.002	n = 9 *"If I feel anxious then I have no control, it will overwhelm me and I'll be embarrassed" (F41)* p = 0.001
If I don't hide my true self… **n = 11**	n = 9 *"If people get to know me then they'll find out I'm different/odd and reject me" (M37)* p = 0.99	n = 10 *"If people knew the real me (disgusting, worthless, unlikeable, dirty, fat, emotional) they would pity me or worry and not want to know me" (F40)* p = 0.008	n = 3 *"If I let other people know about my sadness/upset then it will hurt them"(F59)* p = 0.37

Brackets after the quote give details of the gender and age of the participant