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The use of safety behaviours to manage intrusive memories in depression ☆

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Abstract

Cognitive models of clinical disorders conceptualise cognitive and behavioural safety-seeking behaviours as central to symptom persistence because they prevent disconfirmation of key maintaining beliefs. Despite growing evidence of the role of negative beliefs about intrusive memories in depression, it remains unclear why such beliefs persist. Accordingly, we examined whether safety behaviours in response to unhelpful beliefs about intrusive memories might play a role in their maintenance. Eighteen high dysphoric (i.e., BDI-II $\geqslant$12) individuals who reported an intrusive negative autobiographical memory in the past week completed a battery of measures about their memory, associated negative beliefs and safety behaviours adopted in response to their beliefs. The most commonly endorsed beliefs reflected themes of wanting to control memories (e.g., 'I should be able to rid my mind of this memory') and self-deprecation about experiencing them (e.g., 'Because I can't control this memory, I am a weak person'). The beliefs prompted a range of safety behaviours, with cognitive distraction being the most common. The findings demonstrate that safety behaviours are common in response to maladaptive beliefs about intrusive memories. Treatment developments in this area are needed, and should incorporate strategies to challenge beliefs about memories, reduce the use of safety behaviours, and promote processing of intrusive memories.

Keywords: Depression; Memory; Intrusive memories

Introduction

A growing literature has established that intrusive memories of negative autobiographical events commonly feature in the cognitive profile of major depression (e.g., Brewin, Hunter, Carroll, & Tata, 1996a, 1996b; Kuyken & Brewin, 1994). For example, as many as 86% (Kuyken & Brewin, 1994) and 87% (Brewin et al., 1996a, 1996b) of depressed samples experience intrusive memories. Not only are such memories experienced in depression, in addition, their presence and intrusiveness is positively associated with cognitive correlates of depression such as poor self-esteem and a negative attribution style (Kuyken & Brewin, 1999). Longitudinal

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studies have also highlighted the predictive role of intrusive memories in the course of depression (Brewin, Reynolds, & Tata, 1999).

As a core symptom of PTSD, the characteristics and management of intrusive memories have primarily been studied in traumatised samples (e.g., Ehlers et al., 2002; Hackmann, Ehlers, Speckens, & Clark, 2004). However, recent studies have borrowed theoretical models and experimental methodologies from the PTSD literature to delineate the characteristics (Patel et al., 2007; Williams & Moulds, 2007a) and cognitive processes (Starr & Moulds, 2006; Williams & Moulds, 2007b) associated with intrusive memories in depression. For example, Williams and Moulds (2007a) found that intrusive memories reported by a dysphoric sample contained high levels of sensory experience and were marked by a sense of 'nowness'. Sensory features predicted depression over and above intrusion frequency—in accord with findings in PTSD (Michael, Ehlers, Halligan, & Clark, 2005). Similarly, intrusive memories are more likely to be recalled from a third person, detached 'observer' perspective in high dysphoric individuals (Williams & Moulds, 2007b), a recall vantage point that is common in PTSD (Kenny & Bryant, 2007; McIsaac & Eich, 2004). In both disorders, compared with a first person 'field' perspective, an observer vantage point is associated with avoidant cognitive strategies (McIsaac & Eich, 2004; Williams & Moulds, 2007b).

Another parallel is that dysfunctional negative beliefs about both the content (e.g., 'I am to blame for what happened') and experience (e.g., 'Remembering what happened over and over must mean that I'm going mad') of intrusive memories is linked to intrusion maintenance in both conditions. Ehlers and Steil (1995) postulated that individuals with PTSD who endorse negative meanings of intrusions are more likely to be distressed by their occurrence, and as a result, be motivated to engage in avoidance strategies such as rumination, dissociation and suppression. However, these strategies promote the persistence of PTSD by preventing changes in the meaning of the trauma or the intrusions, and increasing intrusion frequency (Ehlers & Steil, 1995). This model is well supported by retrospective (e.g., Clohessy & Ehlers, 1999) and prospective (Dunmore, Clark, & Ehlers, 2001) studies. Drawing on this work of Ehlers and colleagues, two studies have found parallel associations for intrusive memories in dysphoric samples (Starr & Moulds, 2006; Williams & Moulds, in press). That is, negative beliefs about intrusive memories were significantly correlated with cognitive avoidance and depression severity, and remained so when intrusion frequency and severity of memory content were covaried. Negative beliefs were the strongest predictor of depression, explaining variance over and above intrusion frequency.

Together, these findings build an emergent picture of commonalities between intrusive memories in depression and PTSD. Furthermore, they pose a number of clinically important questions; for example, why don't negative beliefs about intrusive memories remit? A useful concept from the clinical literature that may help to answer this question is that of *safety behaviours*. Individuals with anxiety disorders engage in a range of cognitive (e.g., thought suppression) and behavioural (e.g., avoidance) strategies that, although intended to ameliorate anxiety, paradoxically maintain it. According to Salkovskis (1989, 1991), safety behaviours maintain anxiety via two key pathways: (i) preventing disconfirmation of dysfunctional cognitions and beliefs and (ii) increasing the likelihood of occurrence of the feared outcome that the safety behaviours are in fact intended to avoid. For example, in PTSD, the belief 'I'll go crazy if I think about the accident' will likely promote the safety behaviour of suppression of trauma memories. However, suppression prevents learning that one in fact *can* think about the memory and although feel distressed, not 'go crazy'. In this way, suppression contributes to PTSD persistence by both preventing disconfirmation of this faulty belief and increasing the frequency of intrusive memories. Safety behaviours are central to cognitive conceptualisations of anxiety disorders (e.g., Ehlers & Clark, 2000), an emphasis that is supported by evidence for their role in disorder maintenance (e.g., Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999; Wells et al., 1995). Harvey (2002) extended this line of investigation beyond anxiety and found that safety behaviours are common in insomnia, and are linked to the persistence of sleep difficulties.

The presence of negative beliefs about intrusive memories in depression and accruing evidence that such beliefs play an important role in the persistence of these memories raises the possibility that safety behaviours contribute to their maintenance. Initial evidence of the use of avoidance strategies such as rumination and thought suppression in dysphoric samples (Starr & Moulds, 2006; Williams & Moulds, 2007b) offers preliminary support for this proposal. However, we note that the methodology of these studies involved administration of self-report measures that indexed the specific cognitive variables of interest. Thus,