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CASE STUDY

Recurrent depression and relational trauma: a single case of memory processing

Stephen B. Barton[1,2], Peter V. Armstrong[1], Kevin Meares[3], Elizabeth H.C. Bromley[4] and David Whitton[5]

[1]Academic Department of Psychiatry, Newcastle University, Wolfson Research Centre, Newcastle upon Tyne, UK, [2]Centre for Specialist Psychological Therapies, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, Newcastle upon Tyne, UK, [3]North East and North Cumbria Staff Wellbeing Hub, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, UK, [4]Department of Physics, Durham University, Durham, UK and [5]Service user, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, UK

Corresponding author: Stephen Barton; Emails: stephen.barton@newcastle.ac.uk; stephen.barton@cntw.nhs.uk

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Abstract

Cognitive behavioural therapy (CBT) is an effective treatment for depression, but a significant minority of clients are difficult to treat, including those with histories of relational trauma. The model of Beck *et al.* (1979) proposes that adverse childhood experiences lead to negative core beliefs, and these create a susceptibility to depression. However, Beck's model does not identify trauma as a subset of adverse experiences. An alternative view is that traumatised clients internalise conflicting representations of self and it is conflict, interacting with trauma memories, that creates a vulnerability for depression. In this formulation, methods from the treatment of post-traumatic stress disorder (PTSD) could be incorporated into the treatment of depression, to emotionally process trauma memories and resolve self-identity conflicts. The aims of this study were to: (1) report the treatment of a 67-year-old man with recurrent depression and a history of prolonged relational trauma, and (2) to explore how memory processing from the treatment of PTSD can be incorporated into the treatment of recurrent depression. A single case observational design was used in the long-term treatment of a depressed traumatised client. The client received 47 individual sessions over 19 months in routine clinical practice in a tertiary CBT service. He completed repeated measures of mood, memory intrusions and sleep disruption. The client responded well to treatment with clinically significant improvements across measures of mood, memory and sleep. The effects were sustained over an 18-month follow-up. Memory processing was successfully integrated into a high-intensity treatment for recurrent depression. This is a promising approach for depressed clients with histories of relational trauma.

Key learning aims

(1) To consider how imaginal reliving can be incorporated into CBT for recurrent depression, when relational trauma is present.
(2) To consider the cognitive processing mode of depressed traumatised clients when appraising beliefs about self and others.
(3) To consider vulnerability to depression based on intrusive memories and conflicting self-representations, not only core beliefs.

Keywords: CBT; Depression; Individual CBT; Self-concept

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Background to the case study

This article reports an observational case study of cognitive behavioural therapy (CBT) for recurrent depression, in which a trauma focus was used to treat the client's depression and reduce their risk of relapse. Many adults with recurrent depression have adverse childhood experiences and early-onset depression (Chapman *et al*., 2004; Desch *et al*., 2023). These clients often benefit from CBT but they can be difficult to treat and are prone to relapse (Bockting *et al*., 2015). A possible explanation for the relapse proneness, at least for some clients, is that their childhood experiences were not just adverse, but traumatic. Cognitive therapy for depression formulates the impact of early experiences on core beliefs and assumptions (Beck *et al*., 1979); however, it is an empirical question whether this is sufficient to treat traumatic experiences. As adults, these clients often have intermittent post-traumatic stress disorder (PTSD) symptoms, but do not necessarily meet all the diagnostic criteria for PTSD. It is unknown which, if any, aspects of PTSD treatment could have a beneficial effect for this subgroup. It is not unusual for trauma-related symptoms and/or PTSD to co-occur with recurrent depression; however, within the field of CBT these disorders tend to be formulated and treated separately (Rytwinski *et al*., 2013). When relational trauma and depression are closely inter-linked, as in the current case, there is a question how to treat both problems effectively, without resorting to separate formulations or different treatment protocols (Barton *et al*., 2017; Murray and El-Leithy, 2022).

The client in this case, David, experienced a conflictual relationship with his father spanning 64 years. He suffered multiple distressing experiences which persisted until his father's death three years prior to this treatment. David received two previous courses of CBT, which formulated his experiences with his father as the source of negative core beliefs (Beck *et al*., 1979). These treatments contributed to short-term amelioration of depressive symptoms but did not reduce David's vulnerability to depression, as evidenced by multiple recurrences in the following 14 years. He requested further therapy to address the conflictual relationship with his father, and this article describes a subsequent long-term course of CBT that used a trauma focus to address this. In David's case, an individualised formulation was developed using the self-regulation model of depression (Barton and Armstrong, 2019; Barton *et al*., 2022; Barton *et al*., 2023). This sought to explain how historical trauma contributed to the triggering and maintenance of David's depressive episodes, through its impact on his self-identity.

The therapy was provided within routine clinical practice in a tertiary specialist CBT service in the North-East of England. David received 47 individual sessions over 19 months, remotely by video link, during the COVID pandemic. He completed standardised and idiosyncratic measures each month. At the end of treatment, David described the change he experienced as 'transformational', and he and his therapist agreed that learning from his case could be helpful for other clients and therapists, so the joint decision was made to disseminate the case.

After treatment, David repeated the standardised and idiosyncratic measures on eight occasions during the following 18 months. He was an active participant in the research process and contributed to the preparation, writing and editing of this article. The first author (S.B.) was the therapist; he had 17 years of experience providing CBT for mood disorders in a specialist CBT service. The second author (P.V.A.) was the clinical supervisor; he had 26 years of experience supervising tertiary CBT. The third author (K.M.) was consulted on treating aspects of David's trauma, and the fourth author (E.H.C.B.) led on data analysis. This article describes the formulation, treatment process and clinical outcomes including changes in standardised and idiosyncratic measures. It explores how a trauma focus was incorporated into the treatment of depression when standard CBT had been insufficient to provoke deeper psychological change and prevent depressive recurrences.

Demographics and mental health history

David first presented to mental health services 14 years previously, aged 53, with a major depressive episode, generalised anxiety and panic attacks. Within a month of taking sick leave, he

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was having intense and terrifying nightmares, feeling broken and had an altered sense of self. For approximately one year he disengaged from all social life and work, subsequently taking early retirement. The immediate context was burn-out from a high-pressure job, doing additional work for a charity he had set up, plus severe family stress, with three of his four adult children developing significant health problems. David received multiple treatments in the subsequent 14 years, including numerous combinations of anti-depressant medication, two courses of CBT, compassion-focused therapy (CFT) and two extended courses of family therapy. The focus of the CBT was depression and anxiety, not relational trauma.

The background context was a conflictual relationship with his father who had always been highly ambitious for David, but simultaneously felt threatened by his successes. By early teenage years, David felt in such inner turmoil that he stopped all communication with his father in an attempt at self-preservation. Throughout his adult life, David lived in a conflict of wanting to live life to the full but being hampered by a terror of living, and this schism continued to the point of his breakdown. David recovered from the extreme impact of the initial depressive episode but he was highly susceptible to recurrences, suffering six further depressive episodes in the following 8 years. Nine years after the initial episode, he experienced a further recurrence after his father informed him that he had removed him as a beneficiary of his will, leaving the entire estate to another family member. This was their final conversation. It reactivated David's sense of worthlessness, but this was tempered by the family member's promise to divide the estate equally, irrespective of the revised will. David's father died 2 years later, but the family member subsequently reneged on their promise, and David's felt-sense of invalidity was reactivated. This precipitated further post-traumatic symptoms with distressing childhood memories, traumatic dreams, rumination, social isolation, anger, bitterness, increased alcohol intake and a relapse into severe depression. Soon after, David suffered a heart attack. When he recovered, he requested further therapy to address the conflictual relationship with his father and explore its causal role in his mental health problems.

Assessment for therapy

In the 3 years since his father died, David had suffered fluctuating symptoms with periods of relative stability interspersed with depression, suicidal thoughts, increased anxiety, nightmares and a sense of personal inadequacy. His mood was highly reactive depending on his family situation and/or intrusive memories about his father. His pre-treatment depression symptoms were mild (PHQ-9 = 10), and he had sleep disruption most nights with intermittent nightmares and intrusive memories. There were three levels of sleep disruption: (i) terror-filled nightmares with a felt-sense of an evil presence; (ii) frantic dreams that would lead to punching and kicking in the bed; (iii) anxious dreams that would reflect current worries or concerns (e.g. family health). The nightmares and intrusive memories were a combination of re-experiencing and remembering, both provoking emotional pain and distress.

The Impact of Events Scale (IES-R; Weiss and Marmar, 1996) confirmed clinically significant intrusions (intrusion subscale 28/32), moderate hyper-arousal (hyper-arousal subscale 11/24) but minimal avoidance (avoidance subscale 1/32). David reported that he had overcome a lot of cognitive and behavioural avoidance, encouraged by previous courses of CBT, including abstaining from alcohol. The International Trauma Questionnaire (Cloitre *et al*., 2018; Cloitre *et al*., 2021; Karatzias *et al*., 2017) suggested historical disturbances of self-organisation consistent with complex PTSD (CPTSD); however, David did not meet full diagnostic criteria for major depression or PTSD prior to treatment. Rather, he had a fluctuating pattern of post-traumatic symptoms and was highly susceptible to recurrent depression.

The agreed treatment goals were for David to be at peace with self and God; to move beyond the limits and harms caused by the paternal relationship; to improve sleep quality and reduce the risk

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of further depression. The following standardised measures were agreed, to be repeated monthly across treatment:

(a) Patient Health Questionnaire: to measure changes in depression symptoms (PHQ-9; Kroenke *et al.*, 2001).
(b) Positive and Negative Affect Schedule (client-selected items): to measure changes in positive and negative affect (PANAS; Watson *et al.*, 1988). David selected the five positive and five negative items that were most personally relevant to him (positive items: *attentive*, *inspired*, *at ease*, *enthusiastic*, *confident*; negative items: *sluggish*, *irritable*, *downhearted*, *distressed*, *frightened*). These were rated on a 7-point scale, indicating the intensity they had been experienced in the preceding week.

The following idiosyncratic measures were also agreed, targeting David's particular difficulties: intrusive memories and sleep disruption. In each case there was a problem statement and a goal statement, and these were rated for strength of agreement on a 7-point scale.

(a) Memories (*unpleasant memories have been intruding; I've enjoyed remembering good times*).
(b) Sleep (*I've had nightmares, violent sleep and/or frantic dreams; I've had full nights of peaceful, restful sleep*).

Process of therapy

The top panel in Fig. 1 is a plot depicting the treatment components that were delivered across 47 sessions of therapy.

A coloured dot indicates that the relevant component was delivered in that session. The components were derived from the self-regulation model of depression (Barton *et al.*, 2023), delivered in the amount and sequence indicated by the emerging case formulation, not a pre-set protocol. More than one component could be delivered in any particular session. Overall, there were four interlinked treatment phases: preparation, memory integration, self-organization, and staying well; however, these were not discrete stages. They developed progressively into each other with components integrated across the treatment process.

Preparation (sessions 1–11; 0–3 months)

The preparation phase built a strong working alliance, and developed a case formulation and an explicit rationale for change. Eleven sessions may appear a lot for these tasks, but the context was a third course of CBT following two that had only provided temporary symptom relief. Careful preparation was indicated, to formulate the case thoroughly and potentially offer a novel therapeutic approach.

Previous CBT had developed a formulation of the impact of the paternal relationship as an adverse childhood experience. As a child, David experienced his father as emotionally cold, lacking in compassion, warmth and empathy; critical of him such that whatever he did was not good enough. David was a high achiever at school, university and in his subsequent career; he was ambitious and hard-working with some perfectionist traits. Previous therapists had formulated this as insecure striving, seeking to compensate for negative core beliefs (i.e. 'invalid', 'worthless'). Throughout his life, David would push himself hard, in spite of huge self-doubts, and this was a recurrent source of internal pressure and intense fear. His breakdown, aged 53, resulted from living beyond his limits, with crippling self-doubt, multiple family stresses, intense work demands and the unresolved paternal relationship. However, David experienced striving and ambition as a

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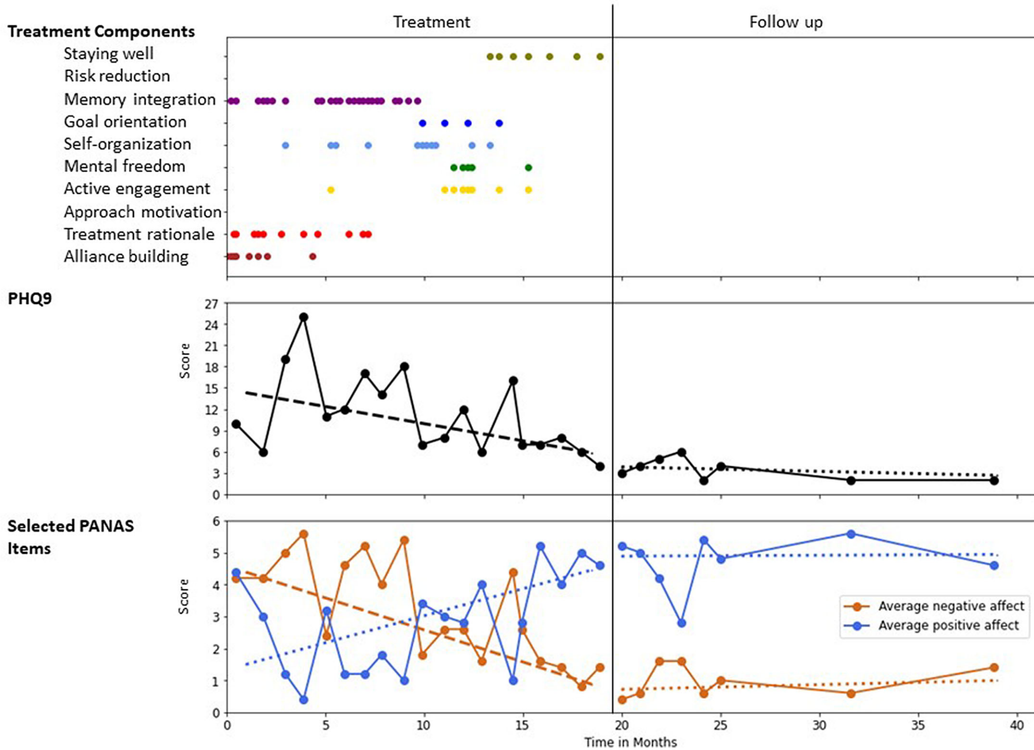

Figure 1. Treatment components and standardised measures.

secure and natural aspect of his personality. He was not convinced that he was compensating for negative beliefs, rather he described an internal conflict between different self-states. His personality was naturally striving and ambitious, wanting to live life to the full, but this was encumbered by intermittent states of terror and worthlessness. The core conflict for David was wanting to live life to the full but feeling weighed down and hampered by a lack of confidence and self-worth.

David also had conflicting views of his father. For most of his adult life he believed that his father was interpersonally limited but benign in his intentions; they had a personality clash that was frustrating for both parties. The events surrounding his father's will five years before had raised a more disturbing possibility, that his intentions had not always been benign; over an extended period he had disliked David and sought to disadvantage him while trying to maintain a positive superficial appearance. David was deeply unsettled by the possibility his father had been intentionally harmful towards him. Understandably, David's conflicting views of himself, and his father, had provoked a lot of self-analysis over the preceding years. The conflict was perpetuated by an intellectual struggle to make sense of intrusive memories, which would take David into abstract conceptual thinking and lead to rumination and/or a cognitive impasse (Watkins and Teasdale, 2004). This is depicted in Fig. 2.

The possibility of caregiver malevolence, combined with David's PTSD symptoms, suggested he may have been traumatised by the paternal relationship and not just depressed by it. Trauma is traditionally associated with life-threatening physical events, such as war combat or road traffic accidents, as defined in ICD10: '*The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone*'. A caregiver relationship characterised by prolonged intentional harm has the potential to threaten personal security and wellbeing in a

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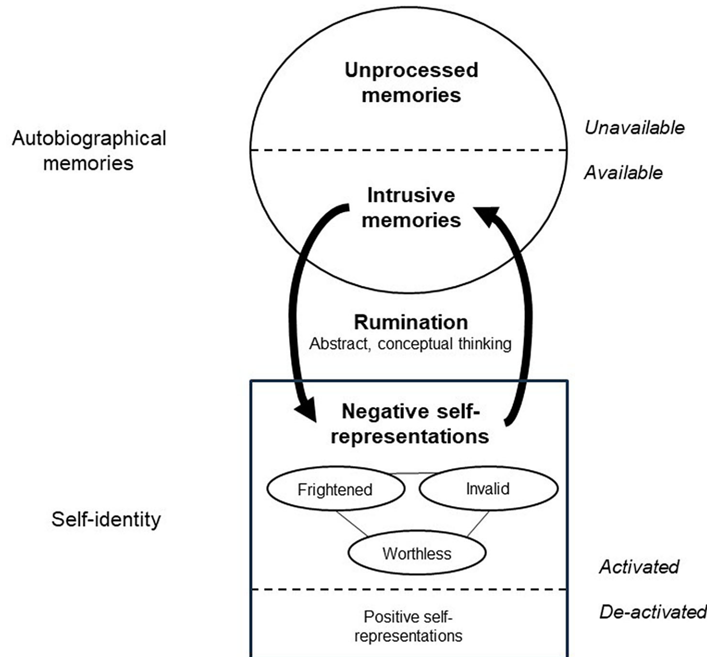

Figure 2. Formulation of post-traumatic depression.

different but equally impactful way. This hypothesis led to a new treatment rationale. Rather than reviewing the evidence for beliefs about himself and his father, which is the usual approach in cognitive therapy for depression, it may be more beneficial for David to emotionally process memories of experiences with his father through imaginal reliving. The plan was twofold:

(a) Encourage David to switch from abstract to experiential cognitive processing (Watkins and Teasdale, 2004). Rather than intellectual inquiry about himself and his father, he was encouraged to recall specific autobiographical memories of occasions spent interacting with him.
(b) He was encouraged to relive those concrete emotional experiences in imagination, in the same manner as cognitive therapy for PTSD (Ehlers and Clark, 2000).

It was hoped that this would facilitate emotional processing, and also elaborate the contextual information available to make sense of the relational conflict. In this way, the memory processing aspect of cognitive therapy for PTSD (Ehlers and Clark, 2000) would support the 'collecting evidence' aspect of cognitive therapy for depression (Beck *et al*., 1979), allowing the competing beliefs about self and other to be reality-tested.

However, this was not a rational or verbally led process. In post-traumatic cases, the key information is unlikely to be verbally accessible at the outset of treatment, so an emotion-focused process is essential for new and relevant information to come to light (Brewin *et al*., 1996). Weighing up the evidence for different beliefs at the start of treatment could be counter-productive, or even harmful, if the most important information is not yet accessible. David expected it to be upsetting, emotionally turbulent and depressing in the short term, to recollect and relive experiences with his father in this way, but he accepted the rationale that the emotional focus would counteract his tendency for intellectual analysis. He also recognised that working

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through a six-decade timeline was likely to bring new discoveries and a deeper understanding of the paternal relationship.

Memory integration (sessions 12–31; months 4–9)

Concrete emotional experiences were prioritised in this phase, with understanding and intellect playing a supporting role. Working with a timeline of over 60 years, each decade was approached in turn, starting with early memories of David being with his father. A timeline was established for each decade and memories were accessed through the filter of how David *felt* in his father's presence, with a strong emotional focus. David was encouraged to recollect details of what occurred, allowing himself to feel the emotions and re-live the experience when hot-spots occurred.

David had strongly affirmative and positive memories of his mother, but no positive memories of his father. As predicted, negative self-representations were activated and David became, temporarily, more depressed (see PHQ-9 scores; Fig. 1). The emotions that David re-experienced were sufficiently intense to be on the limit of what he could tolerate: absence of connection, resentment, upset, fear, frustration, distress, anger, sadness, pain and hurt. Similar emotions were evident across each decade, with David reliving specific experiences in detail. This included hot-spots that were difficult to process, for example, particular conversations. He remotely visited some of the sites using Google Earth.

The memory integration process had both emotional and cognitive effects. Although it was very distressing for David, he was able to allow painful emotions to come into awareness and experience feelings rather than avoid them or push them away. Continuation of the treatment required ongoing consideration of whether the emotional pain was bearable, whether David had the coping skills in place to manage the process, and the introduction of pauses for reflection. Cognitively, these pauses allowed new discoveries to be made explicit and consolidated. David remembered several experiences that he had forgotten, and this deepened his understanding of his father and their relationship.

A significant part of the process was elaborating his knowledge of his father, expanding the context of his early and adult life, to understand his personality and interpersonal functioning in greater depth, including relationships with others, not just David. This process is not a routine part of CBT for either PTSD or depression, but it emerged out of the need for more detailed contextual information. It was akin to a third-party psychological formulation, with multiple sources of evidence, and an aim to generate as many hypotheses as possible about who his father was and what went wrong in their relationship. This included David having conversations with family members. A lot of distressing information came to light, including that his father had coerced family members not to share their portion of his estate with David, and not to disclose that those conversations had taken place. On multiple occasions, his father had tried to maintain a positive impression while acting differently in secret, including thwarting some of David's projects. As more information came to light, David became less conflicted about whether his father was benign or malevolent: it became apparent to him how much his father had disliked him and tried to sabotage him, in all likelihood from a very young age. Not surprisingly, this was a deeply painful realisation.

David was committed to staying compassionate towards his father and not fall into blame or resentment. His father suffered emotional neglect and material deprivation as a young person and was misinformed for several years about the identity of his own father. Most likely, he was also traumatised by his experiences as a prisoner in the Second World War. Tragically, this appeared to provoke bitterness and resentment that was mostly hidden behind a pretence of confidence and self-importance. He was quick to blame, denigrate and dismiss others who did not admire him or allow him to dominate situations. The outcome appears to have been a strain of compensatory narcissism in his personality that was expressed particularly harmfully, to the point of

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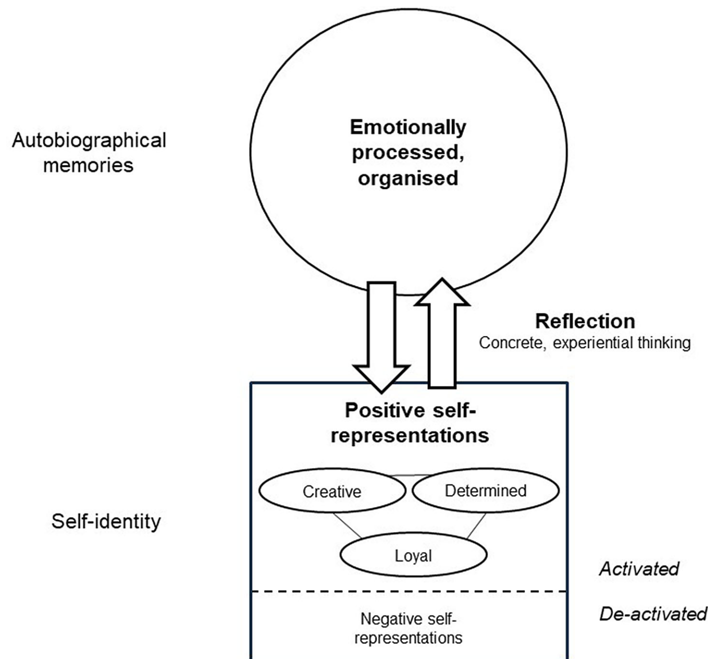

Figure 3. Post-Treatment self-regulation.

malevolence, towards David. As the therapy developed, the hypothesis of 'malignant narcissism' was generated and, for David, this provided a convincing description of his father's personality and a good explanation of his relationships.

At this point in the therapy, at month 9, there was a significant psychological change in David, akin to finding the final piece in a jigsaw: it helped everything else fall into place. David began to experience resolution and peace; his mood and sleep improved and his attention switched to the present and future, no longer feeling encumbered by the past. The nightmares and intrusive memories reduced significantly. Through the memory processing, over time David built an increasingly elaborated and accurate representation of his father, which enabled episodic memories to be integrated and accommodated in a new way.

Self-organisation (sessions 32–42, months 10–14)

The recognition of malignant narcissism also produced a change in David's self-identity, depicted in Fig. 3. Negative self-representations dissipated (e.g. worthless, invalid, frightened) and positive self-representations strengthened markedly (e.g. creative, determined, loyal). As negative self-representations weakened, mental and emotional space was freed up for David to appreciate his personal qualities in a clearer and deeper way. He also had a new prism to update his understanding of his personal history. There was an internal re-organisation of his past that now aligned more closely with the truth, as best as he could understand it. Prior to therapy, David had hoped treatment would have a 'surgical' effect, as if removing a malignant cyst, and then returning to a previous experience of self. Instead, he experienced post-traumatic growth, developing a deeper appreciation of what had gone wrong with his father, and accommodated those truths with much more detailed understanding.

This intrapsychic change was also reflected in contextual changes. In the 14 years since first experiencing breakdown, David had remained partially withdrawn from a range of social situations. He started to re-engage in these situations, for example, joining a new church where he

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experienced a warm welcome and strong sense of belonging. Initially, this positivity was overwhelming, and he needed time to adjust to it. Therapy encouraged gradual engagement, affirming David's needs and desires, and supporting him to take manageable steps to become more socially connected and integrated.

Staying well (sessions 43–47; months 15–19)

As David's renewed sense of self and life consolidated, his reliance on therapy reduced and sessions reduced to approximately monthly, with the aim of staying well and minimising the risk of relapse (Jarrett *et al*., 2001). He was transitioning gradually away from therapy towards more naturalistic support, especially his church. Staying well involved explicit reviews of what he had learned and the changes that had occurred, as a way of consolidating the affective and cognitive changes. It also included preparing for the occasional reactivation of trauma memories.

Treatment outcomes

David's written reflection after therapy provided a synthesis of the change he experienced, as follows:

> '*I'm at peace with myself and God. I was stuck and trapped in this for years; now I'm liberated. With hindsight my prior understanding of the relationship with my father was incomplete. Therapy helped me to accept the sheer awfulness of the situation. It encouraged me to explore my history through feelings, not just facts. This accessed a lot more memories, some of which needed a long time to work through and process. Facing the whole truth revealed the horror of the situation, in particular, the intensity of hate my father felt and the harm he intended towards me. I then had to deal with those awful truths. I was more distressed by the significance of what had happened than re-experiencing the memories. In time, I came to realise the problem was his, not mine. I knew this before intellectually, but what occurred was a much deeper, non-verbal change that is difficult to put into words. I now feel unencumbered; I've handed the badness back to him. I'm liberated from it; it is his, not mine. It has changed my sense of who I am. What is left is my true self: it was there all along, but struggling under the weight of the trauma.*'

David's self-report is reflected in changes in the standardised and idiosyncratic measures across and after treatment, represented in Figs 1 and 4, respectively.

The standardised measures, shown in Fig. 1, were tested for the effect size of trends within the treatment and follow-up phases using the Kendall Tau-b statistic calculated by ranked comparison of measure data against a dummy coded time variable [1, 2, 3, 4 ...] (Parker *et al*., 2011; Parker and Vannest, 2014). The median trend line for each measure in each phase, was found using Theil-Sen regression and plotted with dashed lines for significant trends and dotted otherwise. The median gain for each measure during the treatment phase was also estimated and given with all Tau-b and p-values in Table 1 (grey text indicates $p >= 0.05$, black text indicates $p < 0.05$). The Kendall Tau-b statistic (non-overlap using a dummy phase variable [0, 0, 0, ... 1, 1, 1 ...]) was also used to assess the significance of difference in average scores between the treatment and follow-up phases for all measures (Tarlow, 2017). A comparable analysis was conducted on the idiosyncratic measures shown in Fig. 4, also reported in Table 1.

All measures showed significant ($p < 0.05$) trends during the treatment phase in line with the therapy goals, except for PANAS positive affect which was marginally non-significant. All treatment *vs* follow-up contrasts were significant in the predicted direction. Importantly, given the recurrent nature of depression in this case, there were no significant trends found within the follow-up period (with the exception of a continuing reduction in problem sleep), with no relapse

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Table 1. Statistical tests Within and Between phases

	Within-phase trends					Between-phase contrast	
	Treatment			Follow-up		Treatment *vs* follow-up	
Measures	Tau-b	*p*-value	Median Gain	Tau-b	*p*-value	Tau-b	*p*-value
Standardised							
PHQ-9	−0.38	**0.027**	−8.9	−0.31	0.30	−0.63	**0.00014**
PANAS (NA)	−0.54	**0.0014**	−3.7	0.23	0.44	−0.58	**0.00053**
PANAS (PA)	0.32	0.058	3.1	0.00	1.00	0.48	**0.0037**
Idiosyncratic							
Problem memories	−0.68	**0.00014**	−5.7	−0.05	0.88	−0.47	**0.0082**
Problem sleep	−0.35	**0.047**	−2.2	−0.70	**0.02**	−0.48	**0.0061**
Good memories	0.50	**0.0056**	3.7	−0.04	0.89	0.60	**0.00059**
Good sleep	0.38	**0.033**	2.0	−0.21	0.51	0.68	**0.00013**

Values in grey text indicate $p >= 0.05$; black text indicates $p < 0.05$.

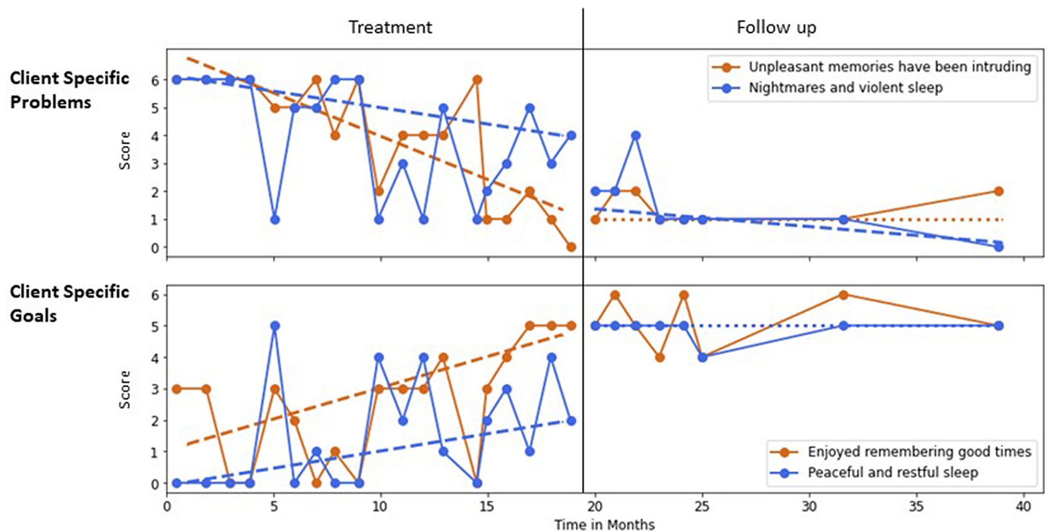

Figure 4. Idiosyncratic measures.

or recurrence, most measures staying close to their ceiling or floor values and the PHQ–9 score remaining equal to or below 6 throughout follow-up. This provides evidence that the gains achieved during the treatment phase were consolidated and sustained.

Discussion

There are two main limitations in this case study; firstly, it was an observational rather than experimental case with no pre-treatment baseline measures. The significant trends in measures across treatment, and the gains maintained during follow-up, provide robust evidence of sustained change, but it would be stronger still if comparisons had been possible with pre-treatment levels on the key measures. Secondly, it is a single case in need of replication to increase confidence in the treatment effects. The authors are not proposing that this method will be appropriate for all clients with recurrent depression; nor are we claiming that all clients with adverse experiences are suffering from trauma. Rather, we suggest that a subset of clients with recurrent depression and

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adverse experiences will be traumatised, and they may benefit from memory processing prior to weighing up beliefs about self and others.

Cognitive therapies for depression and PTSD have some overlaps, for example negative appraisals that can perpetuate avoidance and unhelpful coping, but the convention has been for depression and PTSD to be formulated and treated as distinct disorders. This makes sense for clients who have one or other disorder, but it creates something of a 'no man's land' for clients with depression and relational trauma, especially if they do not consistently meet all the diagnostic criteria for PTSD. In David's case, he presented primarily with recurrent depression and although previous therapists were aware of the conflictual history with his father, the absence of a consistent PTSD diagnosis resulted in post-traumatic processes being overlooked. For clients like David, a richer formulation is needed of the functional links between trauma and depression, not limited by the homogeneity of simpler cases.

Like many clients with recurrent depression, David knew intellectually that he was not a worthless and invalid person, but this did not limit the emotional force of those self-representations when they were activated (Stott, 2007). This head/heart difference had a particular significance in David's therapy: his default processing mode was abstract/conceptual and prone to intellectual rumination, and this contributed to the impasse he had reached (Watkins and Teasdale, 2004). Trauma memories have strong affective and sensory properties and are not always stored in a verbally accessible way, so abstract reasoning was mismatched to the processing mode that was needed for David to resolve his internal conflict. When he switched to concrete, emotional processing, there were three related effects: (1) emotions had an opportunity to be felt and experienced, rather than suppressed or avoided; (2) a lot of new information came to light, because the past was being accessed in a different way; (3) representations of self and others were updated to accommodate new information. From a trauma perspective, this enabled distressing memories to be processed and integrated. From a depression perspective, it generated a lot of new information to 'reality-test' beliefs about self and others.

In the relational traumas experienced by depressed clients, the client has often been neglected or abused by caregivers, a spouse or partner, and it is common for them to have an internalised sense of guilt, shame or humiliation, even though they are the victim and not the perpetrator. It was a distinctive feature of David's therapy that a lot of attention was paid to elaborating his understanding of his father, mitigating the risk of therapy being overly self-focused and/or ruminative. By the end of treatment, David's beliefs about his father had changed a great deal, particularly regarding his malevolence and malignant narcissism. The change in David's self-identity was qualitatively different, as if negative self-representations had dissipated through an affective and non-verbal process. In terms of the head/heart difference, this suggests the importance of therapeutic work on self-identity being sufficiently experiential and affective in focus, even if this is distressing in the short term. It also suggests that elaborated representations of significant others could be of benefit when treating relational traumas of this type.

The self-regulation model of depression views self-identity as a network of self-representations that are activated or deactivated at different points in time. Core beliefs are not fixed in the manner suggested by Beck *et al.* (1979), rather they are an *output* of currently active self-representations. This generates an alternative way of formulating the impact of traumatic experiences: negative self-representations are internalised and these compete within a network of other representations, sometimes feeling true (activated) and sometimes not (deactivated). In difficult-to-treat cases, such as David, internal conflict can be formulated as a competition between different felt-senses with the rationale for change to activate positive self-representations and deactivate negative ones (Brewin, 2006). For David, this was a more compelling and motivating hypothesis than the core belief formulation he had received in previous CBT (O'Connor *et al.*, 2022).

The high intensity nature of the treatment, with 47 sessions provided over 19 months, raises a question about the feasibility of providing this therapy in primary and secondary care settings. Standard courses of CBT are usually in the 12–20 session range which is sufficient for many

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clients, but relapse rates are in the region of 30% in the following 12 months (Vittengl *et al.*, 2007), and standard doses may be insufficient for clients with chronic or difficult-to-treat mood disorders (Cuijpers *et al.*, 2010; Hollon *et al.*, 2014). Clients with recurrent depression sometimes receive multiple standard courses of therapy spaced over a number of decades, and it is an empirical question whether a very high-intensity treatment, such as that received by David, would provide a better opportunity for therapeutic gains and be more cost effective in the long term. David was an older adult, aged 67; it is possible that younger clients with less prolonged trauma could benefit from this approach in fewer sessions and a shorter time frame.

Key practice points

(1) When clients present with recurrent depression, assess whether they were traumatised by their childhood experiences and not only adversely affected by them.
(2) When depressed clients have suffered trauma, intrusive memories may need to be emotionally processed first, to support the re-appraisal of beliefs about self and others.
(3) Depressed clients who try to conceptualise relational traumas may need to adopt a concrete emotional processing mode, to reduce the risk of abstract analysis and rumination.

Further reading

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Data availability statement. Copies of the single case dataset are available from the first author on request.

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