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Patients' Explanations for Depression: A Factor Analytic Study

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Objectives: Previous questionnaire studies have attempted to explore the factor structure of lay beliefs about the causes of depression. These studies have tended to either fail to sample the full range of possible causal explanations or extract too many factors, thereby producing complex solutions. The main objective of the present study was to obtain a more complete and robust factor structure of lay theories of depression while more adequately sampling from the full range of hypothesized causes of depression. A second objective of the study was to explore the relationship between respondents' explanations for depression and their perceptions of the helpfulness of different treatments received. Method and design: A 77-item questionnaire comprising possible reasons for 'why a person might get depressed' was mailed out to members of a large self-help organization. Also included was a short questionnaire inviting respondents to note treatments received and their perceptions of the helpfulness of these treatments. Data from the 77-item questionnaire were subjected to a principal components analysis. Results: The reasons rated as most important causes of depression related to recent bereavement, imbalance in brain chemistry and having suffered sexual assault/abuse. The data were best described by a two-factor solution, with the first factor clearly representing stress and the second factor depressogenic beliefs, the latter corresponding to a cognitive–behavioural formulation of depression aetiology. The two scales thus derived did not, however, correspond substantially with rated helpfulness for different treatments received. Conclusions: The factor structure obtained was in contrast to more complex models from previous studies, comprising two factors. It is likely to be more robust and meaningful. It accords with previous research on lay theories of depression, which highlight 'stress' as a key cause for depression. Possible limitations in the study are discussed, and it is suggested that using the questionnaire with more recently depressed people might yield clearer findings in relation to perceptions of treatment helpfulness.

INTRODUCTION

Social representations of illness have long been a central interest of psychologists. However, as Hamilton and Dobson (2002) note, there has been surprisingly little attention within the clinical psychology literature to the '. . . role of patients' models of depression . . . as a potential mod-

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erator of patients' acceptance of, participation in, and benefit from, different therapies' (p. 887). In this regard Jorm et al. (1997a) reported that an Australian general population sample rated day-to-day problems, traumatic events, recent bereavement and childhood adversity as the most likely causes of depression, with more biological factors being considered to be less important. They further found a large difference between lay people's views about the most appropriate treatments for depression and those of mental health professionals, with the latter group of respondents being much more positive about medical treatments (e.g. medication, ECT, etc.) than were lay people (Jorm et al., 1997b).

Similar views on the aetiology of depression were reported by Rogers, May, and Oliver (2001), who interviewed British patients in primary care settings. These authors found that depressed patients often attributed the onset of their depression to being unable to cope with their everyday circumstances in the face of some additional stressor, such as poverty, occupational insecurity, social exclusion or interpersonal problems. Their attendance at the GP surgery did not indicate their acceptance of a 'medical' model of depression: while they realistically anticipated that they would be offered antidepressant medication, they generally valued the opportunity to have some form of counselling more than medication. Dowrick (2004) similarly reported that depressed primary care patients made little distinction between what was happening in their lives (e.g. redundancy, family conflict etc.) and how they were feeling, noting that 'patients may in effect be operating within an alternative taxonomic system from that employed by doctors' (p. 69), with them generally seeing interpersonal and social problems as being inextricably bound up with becoming depressed.

Furnham and Kuyken (1991) developed a 32-item questionnaire from a pilot in which 20 subjects were asked to complete the sentence 'People get depressed because they . . .'. Their non-clinical sample (n = 201) tended to rate all 32 causes as being fairly important, with the lowest endorsement being for '. . . are bored' and the highest for '. . . lose their spouse through death'. Factor analysis produced six factors, which were labelled social structure deprivations, interpersonal difficulties, traumatic experiences, affective deprivations, negative self-image and interpersonal loss.

In a subsequent extension of this work, Kuyken, Brewin, Power, and Furnham (1992) compared causal beliefs about depression in three distinct groups, i.e. depressed psychiatric patients, clinical psychologists and lay people. In an interview, subjects were first asked to describe why *people in general* might become depressed. In the second part of the investigation the participants were asked to rate the explanatory power of different theories of depression (biological, diathesis-stress, cognitive and psychodynamic), and then to rate the likely helpfulness of various treatments for depression (medication, cognitive therapy, ECT, social intervention and psychoanalysis). In summarizing a complex set of results, the authors suggest that 'depressed patients tend to endorse a short précis of biological theory more than do clinical psychologists and more readily mention biological explanations as a cause for depression than do non-depressed controls' (p. 264), while '. . . clinical psychologists appear to endorse psychodynamic beliefs about the aetiology of depression more than depressed or lay persons' (p. 265).

One group of researchers (Addis & Carpenter, 1999; Addis & Jacobson, 1996)has attempted to explore the relationship between clients' models of depression and the acceptability and effectiveness of different psychological interventions. To this end they have reported the development and validation of the Reasons for Depression (RFD) questionnaire (Addis, Truax, & Jacobson, 1995). The RFD assesses the reasons respondents give for *their own* depression, using the following subscales: achievement; intimacy and existential; physical; characterological; childhood; interpersonal conflict; and relationship (following the initial development of the RFD a further subscale, Biological, has been added to the RFD—see Thwaites, Dagnan, Huey, & Addis, 2004).

Using the RFD, Addis and Jacobson (1996) explored the relationship between clients' conceptualizations of the causes of their depression and their response to different types of therapy. While they did not find any simple relationship between the RFD and treatment outcomes, they did report two interesting findings. First, clients who tended to provide *many* reasons for their depression (regardless of the exact reasons given) had a poorer response to what they term behavioural activation (BA; i.e. an intervention that emphasized activity scheduling). Second, clients who endorsed more of the 'existential' reasons for their depression had better outcomes in an intervention that included 'cognitive' elements in addition to the behavioural elements (CT), and had worse outcomes in the BA treatment.

A second study by this group (Addis & Carpenter, 1999) used an analogue population's responses to different treatment rationales. Again

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a similar pattern of results emerged. Those participants who gave many reasons for depression reacted less positively to a description of the BA treatment, and more positively to a description of an insight-orientated (IO) treatment, which emphasized developing links between past and present events. However, it should be noted that this second study is not directly analogous with the first study. The BA treatment protocol that was used in the second study was more similar to the CT treatment protocol that was used in the first study, with the IO treatment protocol being markedly different from the CT treatment protocol that was used in the first study. However, the authors nonetheless conclude that the findings from these *two* studies suggest that those people who offer more reasons for their depression are more likely to resist an activation-orientated treatment rationale than are people who offer fewer reasons for their depression.

The present research aimed to build upon the previous questionnaire studies that have attempted to explore the factor structure of lay beliefs about the causes of depression. The intention was to obtain a complete and robust factor structure of the lay theories of depression, by sampling from the full range of hypothesized causes of depression. To this end, the present study aimed to develop a questionnaire that assessed the full range of factors that academic theories have hypothesized to be causes of depression. A second aim of the study was to explore the relationship between respondents' preferred explanations for depression and their perceptions of the helpfulness of different treatments.

METHOD

Participants

Participants were recruited from a self-help organization that operates throughout Wales, Depression Alliance Cymru. Questionnaires were sent out to all 504 members of this organization, as part of a regular mail shot. Questionnaires were returned by 194 members, 21 of which were unusable as they had not been adequately completed. This gives a return rate for analysable questionnaires of 34%. There were 56 men and 108 women in the sample, with nine participants failing to specify their gender. The mean age was 45 (standard deviation [SD] = 13.7) years. Participants were asked to estimate how long they had been suffering with depression, with the mean figure being 17 (SD = 11.9) years.

Measures

The questionnaire comprised 77 possible reasons for why a person might get depressed. Participants were invited to indicate 'how important you believe each of these reasons to be in causing people to become depressed'. Participants responded to each reason on a Likert scale, scored 7–1 and anchored 'very important' to 'very unimportant'.

The 77 possible reasons were derived from two sources. First, the authors of the present study reviewed the previously cited research, including the questionnaires that had been used in each of the above studies, and identified those items that weighted significantly on each of the factors that the study authors had extracted. Where similar items were identified across different studies a consensus wording was sought, so as to produce one (broadly comparable) item. Second, the authors reviewed the cognitive therapy (Gilbert, 2000) and interpersonal psychotherapy (IPT) (Weissman, Markowitz, & Klerman, 2000) literature, in order to identify causes of depression proposed by these models. These were then operationalized as belief statements for inclusion in the questionnaire. This resulted in a 72-item pilot questionnaire. A panel of four experienced clinicians was then invited to comment on the item pool. Items that were considered unclear were reworded. Those items that were deemed redundant were removed from the questionnaire, and a further 10 items that the clinicians believed to be important causes of depression were added. This resulted in a 77-item questionnaire assessing the following broad pos-sible causal domains of depression: social stressors; depressogenic beliefs; interpersonal problems (as defined in IPT); biological causes; trauma (adult); and childhood trauma/adversity.

Participants were asked to indicate on a separate sheet whether they were currently receiving, or had ever received, any of the following treatments: antidepressant medication; counselling; ECT; cognitive behaviour therapy (CBT); psychodynamic therapy; and community psychiatric nurse (CPN) support. Participants were also asked to indicate, on a Likert scale, scored 7–1, how helpful they had found those interventions that they had received or were currently receiving. This scale was anchored 'very helpful' to 'not at all helpful'.

RESULTS

Respondents' Experiences of Treatment

The number of respondents who reported currently receiving, or having received in the past, the

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Table 1. Number of respondents (percentages in parentheses) who were currently receiving, or had in the past received, each of the listed interventions, associated mean helpfulness ratings[a] and confidence intervals (95%)

	Antidepressant medication	Counselling	ECT	CBT	Psychodynamic therapy	CPN support
Currently receiving	93 (56%)	40 (24%)	0	9 (5%)	3 (2%)	17 (10%)
Received in past	67 (40%)	107 (67%)	22 (13%)	69 (41%)	9 (5%)	40 (24%)
Helpfulness	3.9 ± 0.32	3.9 ± 0.32	2.2 ± 1.07	4.2 ± 0.41	2.8 ± 1.1	4.1 ± 0.55

[a]Scores re-scaled, so that 0 = 'not at all helpful' and 6 = 'very helpful'.
ECT = electroconvulsive therapy. CBT = cognitive-behavioural therapy. CPN = community psychiatric nurse.

therapeutic interventions being studied is listed in Table 1, along with the mean reported helpfulness of these intervention and the associated confidence (95%) intervals. While it is impossible to be sure that all the participants in the present study either currently, or in the past, met strict diagnostic criteria for a major depressive episode, it is clear from the above that nearly all had at some time received antidepressant medication and/or some form of psychological therapy. Taken in conjunction with the percentage of those who had received ECT and CPN support, this suggests that most of the respondents had received fairly extensive treatment for depression.

Table 1 further indicates that antidepressant medication, CBT, counselling and CPN support are broadly equivalent to each other in terms of their perceived helpfulness, with the confidence intervals for their respective means overlapping. ECT and psychodynamic therapy are, however, reported as being much less helpful than the other interventions, with the confidence intervals for the former interventions not overlapping with the confidence interval for ECT, indicating that ECT is perceived as being significantly less helpful than the other interventions. The perceived helpfulness of CPN support was correlated with the perceived helpfulness of medication ($r = 0.42$, $p < 0.01$) and counselling ($r = 0.54$, $p < 0.001$), and the perceived helpfulness of CBT was correlated with the perceived helpfulness of counselling ($r = 0.39$, $p < 0.01$).

Beliefs about the Causes of Depression

The reasons that were rated as being the most important causes of depression (means in parentheses) were: have recently lost a child (5.3); have recently lost their spouse/partner through death (5.2); have developed an imbalance in brain chemistry (5.2); have suffered sexual abuse in childhood (5.1); and have been raped or sexually assaulted (5.1). The least important causes of depression were: have a food intolerance or food allergy (2.6); have recently retired (3.0); have recently moved to a new area to live (3.1); have children who have recently left home (3.2); and have problems with the criminal justice system (3.3). The belief that depression is caused by an imbalance in brain biochemistry had a small but statistically significant correlation with the rated helpfulness of medication ($r = 0.20$, $p < 0.01$). While the correlation between this belief and the reported helpfulness of psychodynamic therapy was quite substantial ($r = -0.46$), this correlation did not reach statistical significance due to the small sample size ($n = 12$).

Factor Analysis

The factor structure of the questionnaire was determined using the exploratory factor analysis procedure proposed by Cattell (1978). The number of factors that were to be retained was determined using the Scree test, which indicated that the data were best described by a two-factor solution. The Scree plot is presented in Figure 1, with the first two factors having eigenvalues of 9.60 and 4.66, respectively, and accounting for 23.8% of the variance of the factor solution. Two factors were then extracted from the data using principal axis factoring, with the factors being rotated to simple structures via direct oblimin rotation. Oblique factors were chosen as it was initially assumed that different models of depression might be correlated with each other (e.g. social stresses with interpersonal problems etc.). However, as the canonical correlation between the factors approached zero, the rotation was repeated with orthogonal factor (normalized varimax rotation). The factor weights for each item are reported in Table 2.

Inspection of Table 2 indicates a clear factor structure, with only 14 of the 77 items weighting across factors. The first factor clearly represents stress, in the broadest sense, as a cause of depression. It

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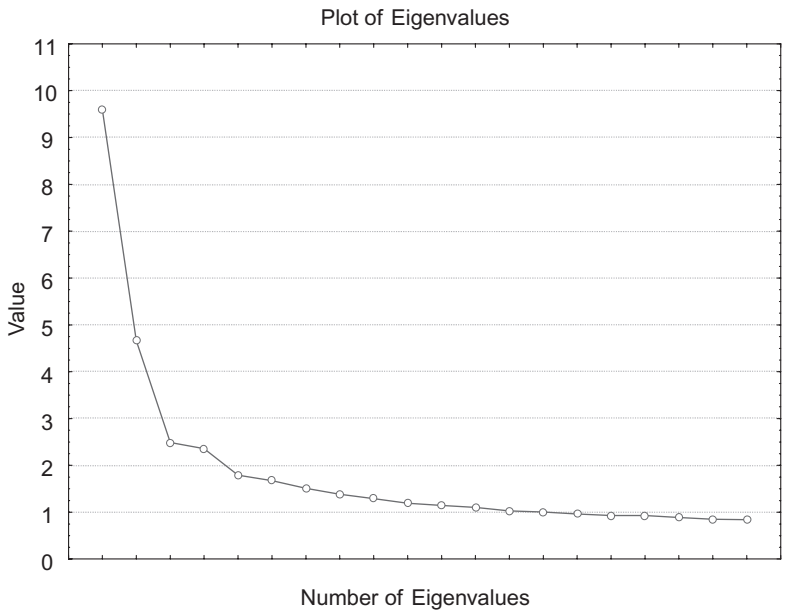

Figure 1. Plot of eigenvalues

Table 2. Factor loadings for each item

Item number	Question	Factor 1	Factor 2
61	Have become physically disabled	0.81	
43	Have recently lost their job	0.77	
62	Have recently discovered that they have a terminal illness	0.76	
36	Live in a run down area and cannot move out	0.75	
66	Have recently discovered that a loved one has a terminal illness	0.75	
26	Are in an abusive relationship	0.73	
59	Have a partner or spouse who is depressed	0.73	
54	Are having difficulties conceiving a child	0.72	
15	Suffered physical abuse in childhood	0.71	
48	Have recently become a carer for a family member or a loved one who has a serious illness or disability	0.71	
10	Have suffered a serious physical assault	0.70	
18	Have serious conflicts with their spouse or partner	0.69	
58	Have recently suffered a serious injury	0.69	
65	Have recently divorced	0.69	
21	Live in unsatisfactory accommodation	0.68	
30	Suffered emotional abuse in childhood	0.68	
40	Suffered extreme deprivation in childhood	0.68	
55	Have a long term physical health problem	0.68	
63	Live in a high crime area	0.67	
20	Suffered sexual abuse in childhood	0.66	
67	Are being victimized as a result of being a member of a minority group	0.65	
28	Have serious problems with their children	0.64	
1	Are homeless	0.63	
3	Have recently lost their spouse/partner through death	0.63	
5	Have been raped or sexually assaulted	0.63	
13	Have recently lost a child	0.62	
35	Were bullied at school	0.62	
39	Are experiencing the ill-effects of dugs or alcohol	0.62	
41	Have serious financial difficulties	0.60	

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Table 2. (*Continued*)

Item number	Question	Factor 1	Factor 2
16	Cannot find employment	0.59	
38	Are in conflict with friends or family	0.59	0.35
11	Have problems with the criminal justice system	0.58	
51	Have to work very long hours	0.57	0.32
45	Suffered the loss of a parent during childhood	0.56	
8	Have recently lost a close friend or relative through death	0.55	
31	Have to work in a very stressful environment	0.55	
75	Have children who have recently left home	0.55	0.31
76	Have recently moved to a new area to live	0.55	0.35
23	Are being victimized or bullied at work	0.53	0.40
44	Have a food intolerance or food allergy	0.52	0.32
33	Have serious problems with neighbours	0.52	
72	Have recently had a child	0.51	
50	Had a poor relationship with their parents during childhood	0.50	
69	Have recently retired	0.46	
53	Are experiencing problems associated with getting older	0.44	0.40
14	Have a poor diet	0.41	
25	Had parents who were depressed	0.38	
6	Lack close friends	0.33	0.32
42	Make lots of negative comparisons between themselves and others		0.84
22	Are very self-critical		0.79
47	Define their own self-worth only in terms of their achievements		0.78
52	Think negatively about themselves		0.78
64	Worry about what other people think of them		0.78
17	Blame themselves for setbacks		0.78
71	Are negative in the way they think about themselves		0.77
37	Set themselves unrealistically high standards		0.76
74	See things in all-or-nothing ways		0.74
60	Believe that other people do not like them		0.73
73	Dwell on past failures and setbacks		0.73
68	Are pessimistic in their outlook on life		0.72
7	Jump to negative conclusions rather than look for alternatives		0.71
32	Believe they are responsible for other people's happiness		0.71
27	Believe they are responsible for solving other people's problems		0.65
12	Place unrealistic demands on themselves		0.64
70	Have failed to fulfil important goals		0.59
57	Have lost status in work	0.43	0.50
19	Do not take enough exercise	0.37	0.49
2	Ignore positive things about themselves and focus on the negatives		0.47
29	Have become 'run down' and physically exhausted		0.46
56	Are overly concerned with their physical appearance	0.37	0.46
46	Have a monotonous, mundane life	0.34	0.41
34	Are not getting enough sleep	0.39	0.41
49	Have a 'nervous disposition'		0.38
77	Have lost touch with friends	0.34	0.38
4	Have developed an imbalance in brain chemistry		
9	Have inherited the problem from their parents		
24	Have a hormonal imbalance		

Note. For ease of interpretation, only factor weights greater than 0.3 have been reported.

contains items assessing adult and childhood trauma, social/economic problems and interpersonal difficulties. The second factor clearly represents depressogenic beliefs as a cause of depression.

Scale Construction

Those items that weighted significantly (factor weight >0.4) on one factor, and did not (factor weight <0.3) on the second factor were combined

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to form two scales.Two items that met these criteria were subsequently excluded from the Depressogenic Cognitions scale (items 29 and 70), as their item content was deemed not to be consistent with the definitions of this scale. This resulted in one 39- and one 17- item scale assessing the above constructs. These scales had alpha coefficients of 0.97 and 0.95, respectively, and were correlated with each other 0.31 ($p < 0.001$).

Associations between Scales and Treatment Received

The two scales, Stress and Depressogenic Beliefs, were correlated with the rated helpfulness of the interventions the respondents reported having received. All of these correlations were small ($r < 0.2$, NS), with the exception of the correlations between the rated helpfulness of psychodynamic therapy and the perceived importance of stress as a cause of depression ($r = 0.45$, NS) and the perceived importance of depressogenic beliefs as a cause of depression ($r = –0.32$, NS). When the mean score on the Depressogenic Beliefs scale of respondents who were currently, or had in the past, received CBT (mean = 81.3) was compared with the mean score for those respondents who had never received CBT (mean 75.9), the former group was found to have rated depressogenic beliefs as being a significantly ($t = 2.0$, $p < 0.05$) more important cause of depression than had the latter group. Conversely, those respondents who had received ECT rated depressogenic beliefs (mean = 70.3) as being a significantly ($t = 2.18$, $p < 0.05$) less important cause of depression than did those who had never received ECT (mean = 79.4). There were no other significant mean differences on these subscales between treatment groups.

DISCUSSION

The present study produced a clear two-factor solution, from a large pool of items ($n = 77$) assessing a broad range of possible causes of depression. The simplicity of the present structure contrasts with the eight- and six-factor solutions obtained (respectively) by Addis et al. (1995) and Furnham and Kuyken (1991). The parsimony of the current factor structure is particularly striking given that care was taken to ensure that the items fully sampled the full range of aetiological factors that have been postulated by academic theories of depression. In this regard it is particularly noteworthy that the previous studies (Addis et al., 1995; Furnham & Kuyken, 1991) failed to include items assessing biological causes of depression. Moreover, Furnham and Kuyken (1991) relied upon a small sample of lay respondents to generate items, producing items that principally assessed life events and social stresses as causes of depression, and they only included one item that assessed depressogenic beliefs as a cause of depression, 'think negatively'. We would therefore argue that while the present factor structure is less complex than that identified by previous authors, it is nonetheless likely to be more robust and meaningful.

Various authors (e.g. Rogers et al., 2001) have highlighted salient interpersonal and environmental stressors which most patients identify as causes of depression. These appear clearly in the present results, with stress (both interpersonal and social) emerging as the first factor. This was also true for depressogenic beliefs, which emerged as a clear second factor. This is particularly noteworthy given that the items that weighted on this factor had been derived from a review of CBT theory. It is interesting to note, however, that no separate factor emerged which corresponded to the main foci of IPT (i.e. life transitions, bereavement and interpersonal conflicts). The items that were specifically constructed to assess interpersonal stressors/problems were all subsumed in the more general Stress scale, together with items assessing childhood and adult trauma as well as social stressors and deprivation as causes of depression.

Although items relating to biological causes of depression were well represented in the item pool, no factor assessing biological causes emerged. This is particularly noteworthy given that there was a small, but nonetheless significant, positive correlation between the reported helpfulness of medication and the belief that depression is caused 'by an imbalance in brain biochemistry'. In summary, these findings suggest that the Stress and Depressogenic Beliefs scales are the two principal dimensions in terms of which most sufferers construe the causes of depression.

The present study produced little in the way of significant correlation between overall scores on the two scales assessing sufferers' beliefs about the causes of depression and their ratings of treatment helpfulness. One reason for this may relate to the limitations of the present study. This is that sufferers were asked to reflect upon treatment that many of them would have received quite some time ago. Moreover, there is no guarantee of the fidelity of the treatment sufferers reported having received,

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with it being possible that those who reported having received 'CBT' may not have received a pure form of this intervention clearly differentiated from generic counselling, thereby attenuating correlations between beliefs about the causes of depression and the perceived helpfulness of different interventions.

Moreover, in the present study most sufferers appeared to have been depressed for many years—as, indeed, might be expected in a population which had decided to join a self-help organization. It is possible that, as a result, the present sample contains a large number of respondents with treatment resistant depression, for whom few interventions have any clear efficacy. This is partially supported by the ratings of treatment efficacy, which indicate no clear superiority for any one intervention over any other, with the exception of the lack of helpfulness of ECT. Thus, the failure to find any strong links between respondents' beliefs about the causes of depression and the perceived helpfulness/acceptability of different interventions may possibly reflect sample characteristics. It seems at least plausible to hypothesize that a study in which recently depressed patients were allocated to, say, CBT and either problem-focused counselling or IPT, might reveal a clearer pattern of results, with those sufferers who most highly endorse casual beliefs involving stress being likely to benefit most from IPT or problem-solving, and those who most highly endorse depressogenic beliefs being more likely to benefit most from CBT.

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APPENDIX: ATTRIBUTIONS FOR CAUSES OF DEPRESSION QUESTIONNAIRE

Listed below are some reasons why people might become depressed.

Please indicate **how important** a reason you believe each of these is in **causing people** to **become depressed**. Do this by marking the point on the scale that follows each statement which best describes how important a reason you consider this to be.

		Very important						Very unimportant
1.	Are homeless	1	2	3	4	5	6	7
2.	Ignore positive things about themselves, and focus on the negatives	1	2	3	4	5	6	7
3.	Have recently lost their spouse/partner through death	1	2	3	4	5	6	7
4.	Have developed an imbalance in brain chemistry	1	2	3	4	5	6	7
5.	Have been raped or sexually assaulted	1	2	3	4	5	6	7
6.	Lack close friends	1	2	3	4	5	6	7
7.	Jump to negative conclusions, rather than look for alternatives	1	2	3	4	5	6	7
8.	Have recently lost a close friend or relative through death	1	2	3	4	5	6	7
9.	Have inherited the problem from their parents	1	2	3	4	5	6	7
10.	Have suffered a serious physical assault	1	2	3	4	5	6	7
11.	Have problems with the criminal justice system	1	2	3	4	5	6	7
12.	Place unrealistic demands on themselves	1	2	3	4	5	6	7
13.	Have recently lost a child	1	2	3	4	5	6	7
14.	Have a poor diet	1	2	3	4	5	6	7
15.	Suffered physical abuse in childhood	1	2	3	4	5	6	7
16.	Cannot find employment	1	2	3	4	5	6	7
17.	Blame themselves for setbacks	1	2	3	4	5	6	7
18.	Have serious conflicts with their spouse or partner	1	2	3	4	5	6	7
19.	Do not take enough exercise	1	2	3	4	5	6	7
20.	Suffered sexual abuse in childhood	1	2	3	4	5	6	7
21.	Live in unsatisfactory accommodation	1	2	3	4	5	6	7
22.	Are very self-critical	1	2	3	4	5	6	7
23.	Are being victimized or bullied at work	1	2	3	4	5	6	7
24.	Have a hormonal imbalance	1	2	3	4	5	6	7
25.	Had parents who were depressed	1	2	3	4	5	6	7
26.	Are in an abusive relationship	1	2	3	4	5	6	7
27.	Believe they are responsible for solving other people's problems	1	2	3	4	5	6	7
28.	Have serious problems with their children	1	2	3	4	5	6	7
29.	Have become 'run down' and physically exhausted	1	2	3	4	5	6	7
30.	Suffered emotional abuse in childhood	1	2	3	4	5	6	7
31.	Have to work in a very stressful environment	1	2	3	4	5	6	7
32.	Believe they are responsible for other people's happiness	1	2	3	4	5	6	7
33.	Have serious problems with neighbours	1	2	3	4	5	6	7
34.	Are not getting enough sleep	1	2	3	4	5	6	7
35.	Were bullied at school	1	2	3	4	5	6	7
36.	Live in a run-down area and cannot move out	1	2	3	4	5	6	7
37.	Set themselves unrealistically high standards	1	2	3	4	5	6	7
38.	Are in conflict with friends or family	1	2	3	4	5	6	7
39.	Are experiencing the ill effects of drugs or alcohol	1	2	3	4	5	6	7
40.	Suffered extreme deprivation in childhood	1	2	3	4	5	6	7
41.	Have serious financial difficulties	1	2	3	4	5	6	7
42.	Make lots of negative comparisons between themselves and others	1	2	3	4	5	6	7
43.	Have recently lost their job	1	2	3	4	5	6	7
44.	Have a food intolerance or food allergy	1	2	3	4	5	6	7
45.	Suffered the loss of a parent during childhood	1	2	3	4	5	6	7
46.	Have a monotonous, mundane life	1	2	3	4	5	6	7

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		Very important						Very unimportant
47.	Define their own self-worth only in terms of their achievements	1	2	3	4	5	6	7
48.	Have recently become a career for a family member or a loved one who has a serious illness or disability	1	2	3	4	5	6	7
49.	Have a 'nervous disposition'	1	2	3	4	5	6	7
50.	Had a poor relationship with their parents during childhood	1	2	3	4	5	6	7
51.	Have to work very long hours	1	2	3	4	5	6	7
52.	Think negatively about themselves	1	2	3	4	5	6	7
53.	Are experiencing problems associated with getting older	1	2	3	4	5	6	7
54.	Are having difficulties conceiving a child	1	2	3	4	5	6	7
55.	Have a long-term physical health problem	1	2	3	4	5	6	7
56.	Are overly concerned with their physical appearance	1	2	3	4	5	6	7
57.	Have lost status in work	1	2	3	4	5	6	7
58.	Have recently suffered a serious injury	1	2	3	4	5	6	7
59.	Have a partner or spouse who is depressed	1	2	3	4	5	6	7
60.	Believe that other people do not like them	1	2	3	4	5	6	7
61.	Have become physically disabled	1	2	3	4	5	6	7
62.	Have recently discovered that they have a terminal illness	1	2	3	4	5	6	7
63.	Live in a high crime area	1	2	3	4	5	6	7
64.	Worry about what other people think of them	1	2	3	4	5	6	7
65.	Have recently divorced	1	2	3	4	5	6	7
66.	Have recently discovered that a loved one has a terminal illness	1	2	3	4	5	6	7
67.	Are being victimized as a result of being a member of a minority group	1	2	3	4	5	6	7
68.	Are pessimistic in their outlook on life	1	2	3	4	5	6	7
69.	Have recently retired							
70.	Have failed to fulfil important life goals	1	2	3	4	5	6	7
71.	Are negative in the way they think about themselves	1	2	3	4	5	6	7
72.	Have recently had a child	1	2	3	4	5	6	7
73.	Dwell on past failures and setbacks	1	2	3	4	5	6	7
74.	See things in an all-or-nothing way	1	2	3	4	5	6	7
75.	Have children who have recently left home	1	2	3	4	5	6	7
76.	Have recently moved to a new area to live	1	2	3	4	5	6	7
77.	Have lost touch with friends	1	2	3	4	5	6	7

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