

ORIGINAL RESEARCH

The ‘Forever Fallacy’: a proposed temporal distortion in cognitive behavioural therapy

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Abstract

Cognitive distortions are central to the conceptual and therapeutic framework of cognitive behavioural therapy (CBT), yet the existing taxonomy has remained largely unchanged since its development in the 1980s. This article proposes a novel addition to the distortions: the ‘Forever Fallacy’ defined as the tendency to project present discomforts, limitations or emotional states across imagined future timelines as if they were permanent and unchanging. Drawing on dual-process models of cognition, the Forever Fallacy is conceptualised as a heuristic, System A-driven distortion characterised by temporal fusion, stability projection and affective permanence. It differs structurally from established distortions like catastrophising or fortune telling through targeting the perceived duration and stability of anticipated future states rather than their content or likelihood. The article synthesises empirical research on affective forecasting, prospective cognition and temporal construal theory to ground the construct in established psychological science. Clinical illustrations demonstrate its presentation in anxiety, depression and existential overwhelm. Implications for case formulation are discussed alongside proposed adaptations to standard CBT interventions. Through articulating and operationalising the Forever Fallacy, this article contributes a theoretically coherent and clinically relevant extension to cognitive models of emotional distress, warranting future empirical validation and integration into therapeutic practice.

Key learning aims

- (1) Define and use the ‘Forever Fallacy’: recognise it as the tendency to treat a current state as if it will not change, then apply it in formulation and practice by (i) naming the patient’s duration belief (‘it will always be like this’), (ii) mapping fluctuation with time-stamped ratings (for example, 0–10 every 30–60 s for 5–10 min) and (iii) running brief, time-limited behavioural tests to demonstrate change over time.
- (2) Differentiate the Forever Fallacy from related thinking errors by focusing on time: it fuses the present with the future, assumes things will stay the same, and treats feelings as if they will last. Unlike catastrophising or fortune-telling, it concerns duration rather than how bad something is or how likely it is to happen.
- (3) Use research on affective forecasting and construal level to explain why people tend to overestimate how long and how strongly they will feel in the future and to mistake current states for fixed trajectories (Trope and Liberman, 2010; Wilson and Gilbert, 2003).
- (4) Apply targeted cognitive behavioural therapy (CBT) and third-wave methods that restore a sense of time; for example, episodic future simulation, thought records with time columns, and decentring, and test change across sessions (Holmes *et al.*, 2007; Teasdale *et al.*, 2002a; Yamada *et al.*, 2018).

- (5) Set the construct within familiar theory and brain science: Personal Construct Theory and Schema Therapy; the Looming Vulnerability model of anxiety; the negativity bias; and default mode network (DMN), amygdala interactions and neuroplasticity, to guide formulation and mechanism-focused intervention (Kelly, 1991; Young *et al.*, 2003; Riskind, 1997; Baumeister *et al.*, 2001; Phelps and LeDoux, 2005; Etkin *et al.*, 2015).

Keywords: affective forecasting; CBT; cognitive distortions; dual-process theory; metacognition; System A/System B; temporal cognition

Introduction

Cognitive behavioural therapy (CBT) remains one of the most empirically supported treatments for a wide range of psychological disorders as grounded in the identification and restructuring of distorted or maladaptive thinking patterns (Beck, 1976; Beck, 2011). Central to this model is the construct of *cognitive distortions* which are predictable, systematic errors in cognition that shape individuals' appraisals of the self, the world and the future. Early models categorised these distortions into discrete typologies most notably by Burns (1980) who expanded on Beck's original framework to offer a clinically accessible taxonomy which has been widely adopted in therapeutic practice.

Despite its clinical utility this taxonomy has remained largely unchanged for over four decades. Proposing a new distortion requires four things: (1) it is not simply a relabel of an already existing distortion, e.g. catastrophising or fortune telling; (2) it fits with evidence on affective forecasting and temporal construal; (3) its mechanism is clear (time-fusion and stability-projection); and (4) it yields testable predictions; for example, that episodic future simulation selectively reduces it (Clark and Watson, 1995; Cronbach and Meehl, 1955). Whilst it effectively captures many recurrent patterns of distorted thinking, the established taxonomy fails to address certain heuristic errors emerging from individuals' interactions with imagined future experiences. One such error as observed repeatedly in clinical settings, is the 'Forever Fallacy': the tendency to conflate a future obligation or discomfort with an imagined permanent and unchanging state resulting in a distortion of temporal perspective and an exaggerated affective response. The distortion reflects a loss of temporal differentiation whereby individuals experience the burden of imagined decades as though it were immediate and total.

This fallacy is distinct from catastrophising or over-generalisation. It is not primarily about expecting the worst, but rather about losing the capacity to project personal resource and change over time of the self, the environment, or future contingencies against an unchanging task or set of tasks.

For example, an individual may feel emotionally paralysed by the thought of a 40-year career path not due to its inherent aversiveness but because their present capacity is erroneously projected onto every future year. A newly-wed partner, after eight years of contented cohabitation, may find their spouse's previously tolerated habits such as the sound of their morning cereal slurping, suddenly becomes intolerable when imagined as repeating indefinitely 'till death do us part'. This anecdote reflects the compression of a future temporal span into the perceptual immediacy of the present. Conversely the idea of 'one day at a time' is ubiquitous across substance use disorder recovery services.

Such distortions arguably engage what cognitive psychologists identify as *System A thinking*: fast, automatic, emotionally charged, and heuristic-based processes (Kahneman, 2011; Stanovich and West, 2000) which, when maladapted, we may link to CBT's Negative Automatic Thoughts. In the case of the Forever Fallacy, System A produces a non-conscious collapse of time, fusing present discomfort with future imagination. This results in overwhelming affective responses as often incommensurate with the actual demands or uncertainties of future life events. The anticipatory anxiety thus generated arises not from logical prediction but from a heuristic conflation of 'what is' with 'what will always be'.

Crucially, CBT enables individuals to recruit *System B thinking*: the slower, effortful, reflective, and rule-governed cognition to interrogate and recalibrate these distortions. Through structured therapeutic techniques such as cognitive restructuring, behavioural experiments, and thought records, individuals can reframe such automatic projections by introducing conscious evaluation and temporal realism. For instance, a postgraduate student overwhelmed by the thought of ‘always having deadlines’ may through guided Socratic questioning recognise that academic and professional challenges will vary across time and that their personal competence will grow correspondingly. In doing so, they shift from heuristic generalisation to a temporally differentiated cognitive frame.

The Forever Fallacy also aligns with psychological findings in the field of affective forecasting. Gilbert and Wilson (2007) demonstrated that individuals systematically mis-predict their future emotional states primarily through under-estimating their capacity to adapt. People expect their current feelings to persist far longer than they actually do – a bias termed the impact bias: an old joke has a father asking his son why he hasn’t done his homework, and his son replies ‘Dad, we learned in school today that the sun will explode in 5 billion years, there is no point’; this mirrors the Forever Fallacy’s mechanism – the imagined future invalidates the functional present.

Support arises from work on temporal construal theory, which shows that individuals conceptualise distant future events in abstract, decontextualised terms, whilst near-future events are processed concretely (Trope and Liberman, 2010). When abstract fears about the distant future become emotionally salient in the present, individuals are vulnerable to the kind of temporal compression characteristic of the Forever Fallacy.

Philosophical traditions and mindfulness-based psychotherapies have also noted this collapse of time perception. There is an old Zen aphorism that even hell is tolerable if we believe we are only temporarily there to inspect the premises (Batchelor, 1997) and the Sufi reframe that ‘This too shall pass’ (Homayounpour, 2022) point to the profound role of perceived permanence in shaping subjective suffering. Modern psychological models of mindfulness suggest that suffering is intensified not solely by aversive content, but by the implicit belief in its unending duration (Kabat-Zinn, 1990).

This article proposes that the Forever Fallacy constitutes a distinct and clinically relevant distortion in need of formal recognition within the CBT model. It shall review its theoretical underpinnings in cognitive science, and clarify its differentiation from existing distortions alongside considering its role in clinical presentation. In doing so, the hope is to illustrate its value for integration into contemporary cognitive case formulation especially in the treatment of anxiety disorders, existential distress, and disorders involving future-oriented rumination.

Theoretical background

Dual-process models and cognitive distortion

The cognitive mechanisms underpinning the Forever Fallacy, and arguably cognitive distortions in general, are best understood within the framework of dual-process models of cognition, which distinguish between two types of information processing. System A refers to fast, automatic, heuristic-based processes that are emotionally charged and often unconscious. In contrast, System B refers to slow, deliberate, and analytically effortful reasoning (Evans and Stanovich, 2013; Kahneman, 2011). Cognitive distortions, notably those characterised by immediacy and emotional reactivity, are strongly associated with System A processes that prioritise speed and subjective coherence over accuracy or reflective analysis. The automatic nature of these processes can often mismatch with circumstances, leading to unhelpful mal-adaptations (Kaplan *et al.*, 2017).

In the case of the Forever Fallacy, System A generates an affectively loaded representation of the future by compressing temporal duration and projecting current emotional and cognitive limitations into imagined long-term scenarios, often occurring without conscious evaluation.

Individuals thus experience prospective burdens as imminent and totalising, bypassing any consideration of change, development, or coping mechanisms over time. At least in part, CBT functions by enabling individuals to engage System B processes to identify and correct these automatic distortions (Wenzel *et al.*, 2009). Therapeutic techniques such as cognitive restructuring, behavioural experiments and Socratic dialogue activate reflective processing and metacognitive awareness, allowing for reassessment of heuristic conclusions (Clark and Beck, 2010; Teasdale *et al.*, 2002b). System B can thus override or reframe the outputs of System A when individuals are guided to reconsider their predictions within a more temporally and contextually realistic frame (Wenzel *et al.*, 2009).

To expand on this model, Type 1 processes (or System A) are defined by their autonomy, meaning their execution is mandatory when triggered and they do not require controlled attention, making minimal demands on working memory. These processes produce default responses that are used unless a Type 2 process (System B) intervenes. The central and key feature of Type 2 processing is *cognitive decoupling*, which enables hypothetical thinking by separating representations of the real world from imaginary situations (Evans and Stanovich (2013)). This is considered a uniquely human ability. However, it is a fallacy to assume that Type 1 processes are always responsible for cognitive bias or that Type 2 processes invariably lead to correct, normative responses; in fact, Type 2 reasoning can also be biased by beliefs, although in a different manner than Type 1 processing.

Constructivist and schema-theoretic context

Personal Construct Theory holds that distress is sustained by rigid personal meanings; here the rigidity is about time. The Forever Fallacy treats what is true now as if it will stay true (Kelly, 1991). In Schema Therapy, Early Maladaptive Schemas (EMS) including Negativity/Pessimism and Vulnerability to Harm bias how the future is expected to unfold; the Forever Fallacy magnifies this by stretching those expectations across time (Young *et al.*, 2003). In practice, therapists may pair schema work with simple time-mapping, for example, a one-week ‘ups-and-downs’ log that shows urges and mood rise and fall, so patients can see, and factor in, change rather than ‘forever’.

Heuristic biases and affective forecasting

The Forever Fallacy engages a specific class of heuristic error associated with affective forecasting. This is the process via which individuals predict their future emotional states. Empirical research in this area has demonstrated consistent inaccuracies in such predictions. Notably, individuals exhibit impact bias wherein they over-estimate the intensity and duration of emotional reactions to future events (Wilson and Gilbert, 2003). This mis-forecasting is particularly relevant in clinical contexts, as it contributes to anticipatory anxiety, avoidance behaviours, and motivational deficits.

Wilson and Gilbert (2003) argue that these errors stem from a failure to account for future adaptive processes including changes in perspective, emotional regulation, and contextual variability. This failure is characteristic of System A processing: it neglects counterfactual reasoning, relies on salient affective cues, and defaults to static representations of the self across time. The Forever Fallacy may be conceptualised as an affective forecasting error rooted in a heuristic over-generalisation of the present self-state.

These mechanisms have been identified in both clinical and non-clinical populations. Research has shown that individuals with major depressive disorder are particularly prone to biased future thinking as marked by reduced episodic specificity and increased generalisation (MacLeod *et al.*, 2005). Such distortions may exacerbate feelings of helplessness and reinforce maladaptive schemas, including those related to permanence and uncontrollability core cognitive themes in depression (Beck, 2008).

The impact bias, for instance, is the tendency for people to over-estimate the intensity and duration of their future emotional reactions to events (Flynn *et al.*, 2020; Hoerger *et al.*, 2010). People might expect endless despair after a romantic break-up or enduring euphoria after winning the lottery, but in reality, their reactions are more fleeting than they anticipated. While people can generally predict the valence or direction of their emotional reactions, they show a poor ability to predict their intensity and duration. This mis-forecasting is further influenced by biases such as focalism (thinking about an event in a vacuum without considering other contextual factors) and immune neglect (a failure to anticipate one's own ability to cope with adverse conditions).

Temporal construal and psychological distance

Temporal cognition also plays a critical role in the Forever Fallacy. Construal Level Theory (CLT) posits that the psychological distance of an event whether temporal, spatial, social, or hypothetical, modulates how it is mentally represented (Trope and Liberman, 2010). Distant future events are generally construed in abstract, decontextualised terms whilst near-future events are processed with greater specificity and concreteness.

Paradoxically, when future events are affectively salient or personally threatening the abstract construal can be over-ridden, which results in a distorted fusion of distant and immediate experience. In these cases individuals respond emotionally as if the imagined future were present. This phenomenon is supported by functional neuroimaging studies showing overlap between brain networks involved in episodic future thinking and those activated during present-moment emotional processing (Schacter *et al.*, 2008).

Importantly, the default mode network (DMN), particularly regions such as the medial prefrontal cortex and posterior cingulate cortex, is implicated in both future self-projection and self-referential thought (Buckner *et al.*, 2008). Dysregulation in these areas has been associated with rumination and maladaptive prospective thinking in mood and anxiety disorders (Whitfield-Gabrieli and Ford, 2012). Such findings provide a neurocognitive basis for the Forever Fallacy, situating it within the interplay of autobiographical memory, self-construal, and affective salience.

The DMN is a network of brain regions that is more active during rest or internally focused tasks than during attention-demanding ones (Whitfield-Gabrieli and Ford, 2012). Its activity is associated with autobiographical memory retrieval, envisioning the future, and conceiving the perspectives of others. The DMN is best understood as a system of multiple interacting subsystems that converge on core hubs (Andrews-Hanna, 2012). Specifically, a medial temporal lobe subsystem provides information from past experiences, which serves as 'building blocks' for mental simulations, while a medial prefrontal subsystem facilitates the flexible use of this information to construct self-relevant simulations (Buckner *et al.*, 2008). In depression, this network is often found to be hyperactivated and hyperconnected, a state that may be related to negative rumination. This dysregulation provides a direct neurobiological correlate for the temporal distortions observed in the Forever Fallacy.

Temporal rigidity and cognitive inflexibility

The Forever Fallacy reflects a broader deficit in cognitive temporal flexibility as the ability to mentally represent future scenarios with dynamic rather than static assumptions. Individuals prone to cognitive rigidity often lack the capacity to imagine growth in their future capabilities or variability in environmental conditions. Research has demonstrated that high cognitive fusion as defined by the tendency to become entangled with one's thoughts and treat them as literal truths is associated with a range of psychopathological outcomes (Gillanders *et al.*, 2014). This includes a reduced ability to cognitively decentre from emotionally charged projections and an over-identification with current mental states. Such rigidity can be contrasted with metacognitive awareness, which facilitates the observation of thoughts as transient, conditional, and subject to

change. Techniques drawn from both traditional CBT and third-wave interventions (e.g. acceptance and commitment therapy, ACT) aim to enhance this awareness, thereby enabling the individual to challenge the perceived permanence of aversive future states (Hayes *et al.*, 2011).

Proposal of the Forever Fallacy

Definition and cognitive structure

The Forever Fallacy is defined as a cognitive distortion in which individuals project current limitations, discomforts, or psychological states across an imagined future with little to no allowance for contextual variability, adaptive change or personal development. This distortion involves a collapse of temporal perspective such that imagined future states are experienced as if they were immediate, permanent and affectively indistinguishable from the present. It arises from automatic (System A) processing and reflects a failure to engage deliberative, temporally differentiated reasoning (System B).

At its core, the Forever Fallacy involves three interlocking cognitive biases:

- (i) *Temporal fusion*: the inability to distinguish between present and future psychological experiences, resulting in the perception that anticipated burdens are already occurring.
- (ii) *Stability projection*: the assumption that current personal resources, emotional states, or environmental conditions will remain unchanged across time.
- (iii) *Affective permanence*: the belief that discomforts or responsibilities will persist indefinitely, thereby amplifying their perceived emotional weight.

These processes occur pre-reflectively, shaped by heuristic simplification and contributing to an exaggerated sense of existential overwhelm or hopelessness. Such thinking is often resistant to rational counterargument unless specifically targeted in therapy.

Clinical manifestations

The Forever Fallacy frequently presents in therapeutic settings where future-oriented anxiety, perfectionism, or existential pre-occupation dominate the client's cognitive profile. It is highly evident in disorders involving generalised anxiety, obsessive-compulsive tendencies, depressive rumination, and burn-out. Some simple clinical anonymised examples published with the kind permission of the clients follow:

Example 1 – Early career overwhelm

A 24-year-old client in the early stages of a professional career expresses exhaustion and despair at the thought of 'doing this job for the next 40 years'. Upon cognitive examination, the client is not reacting to the present workload *per se*, but to the perceived permanence of this state. The possibility of future skill development, job transitions, or changing personal interests is cognitively inaccessible. The client's System A has produced a temporal distortion: compressing decades of anticipated effort into a single, emotionally saturated mental image, without engaging reflective assessment via System B processes.

Example 2 – Relationship projection

A newly married individual reports acute irritability toward their partner's minor habit, in this case not noisy eating but his habit of clicking his neck and humming amongst other acts that were

previously tolerated during years of dating. In therapeutic discussion, the irritation is revealed to stem from the thought: '*I cannot live with this for the rest of my life*'. The client has not reassessed the behaviour itself but has projected its occurrence permanently across future decades, resulting in a disproportionate affective response. The perception of temporal permanence is central, rather than any substantive shift in behaviour or relational quality.

Example 3 – Chronic illness adjustment

A 36-year-old client recently diagnosed with a manageable autoimmune condition reports disproportionate emotional distress not in response to current symptoms, but to the belief that 'this will be my life forever'. Despite having periods of remission and an effective treatment plan, the client fixates on the imagined permanence of fatigue and dietary restrictions. During therapy, it becomes evident that the client has fused their present limitations with the next several decades, generating a cognitive frame in which improvement is not conceivable. This results in emotional numbing, behavioural withdrawal, and increased pre-occupation with existential meaning. The therapist introduces the concept of time-based reframing and uses guided imagery to help the client visualise future life phases in which health fluctuates, personal goals evolve, and coping skills expand. Through this process, the client begins to develop an alternative narrative that accommodates both uncertainty and the possibility of change.

These examples demonstrate how the distortion generates distress not from the actual conditions of the present, but from their affectively amplified and temporally fused representation in imagined futures.

Differentiation from existing cognitive distortions

Whilst the Forever Fallacy shares features and overlaps with several existing cognitive distortions, it is distinct in both its structure and clinical implications - see Table 1 for delineation of differences. Labels follow standard CBT texts (Burns, 1980). Where specific processes are noted (for example, optimism/pessimism; jumping to conclusions), peer-reviewed sources are cited. See References for Burns (1980); Scheier and Carver (1985); Baumeister *et al.* (2001) and Jolley *et al.* (2014).

Via recognising the specific cognitive fusion of time, stability and affect within the Forever Fallacy, therapists can more accurately target distortions that traditional CBT categories may overlook.

Relationship to temporal and cognitive rigidity

The distortion also aligns with constructs of temporal rigidity and cognitive fusion, as individuals engaging in the Forever Fallacy frequently struggle to mentally simulate flexibility over time. The future is represented as a static continuation of the present, echoing findings in cognitive research that individuals with anxiety and depression exhibit reduced temporal differentiation and impaired episodic future thinking (Addis *et al.*, 2007; Williams *et al.*, 1996). Furthermore, high cognitive fusion scores have been associated with greater emotional reactivity to imagined futures (Gillanders *et al.*, 2014), reinforcing the clinical salience of this distortion.

Discussion

The identification of the Forever Fallacy provides a conceptual refinement to existing cognitive-behavioural models by introducing a temporally focused distortion that is frequently under-recognised in clinical practice. As outlined this distortion manifests as a collapse of temporal differentiation and the projection of current discomforts or limitations into imagined, permanent

Table 1. Forever Fallacy and its delineation from similar cognitive distortions

Distortion (canonical label)	Core cognitive operation	Forever Fallacy – temporal signature (how it differs)	Distinct prediction/differentiator	Clinical probe/micro-intervention	Representative sources*
Catastrophising	Exaggerates worst-case consequences	Frames even minor/neutral states as intolerable because they are presumed permanent, not (only) because they are worst	Selective change with duration-reappraisal tasks rather than probability re-estimates	‘If this feeling returned for 5 minutes/day, not all day, what changes?’ Time-bounded exposure	Burns (1980)
Fortune-telling	Predicts specific negative outcomes	Concern is infinite repetition/unchanging duration, not event likelihood	Shifts when patients track fluctuation rather than outcome occurrence	Time-series diary of intensity/duration; graph intra-day variability	Burns (1980)
Over-generalisation	Infers broad rules from single instances	Projects temporal scale (unchanged across time) rather than category breadth across situations	Reduced by time-indexing evidence (episodes vary across days) more than by counter-examples of category	‘What was different yesterday vs today?’ Plot run charts	Burns (1980)
Emotional reasoning	Treats feeling as fact	Misattributes duration to current affect (‘it will feel like this forever’)	Sensitive to duration-labelling (e.g. ‘this is a 10-minute wave’) even if affect intensity stays high	Surfing scripts with explicit start/peak/offset markers	Burns (1980)
Pessimistic thinking	Global negative expectancy set/trait outlook	A structural temporal error that can attach to neutral content (e.g. ‘paperwork forever’), distinct from trait valence	Selectively reduced by temporal differentiation even when trait pessimism remains stable	‘Name one task that definitely ends today; what ends next?’	Scheier and Carver (1985); Baumeister <i>et al.</i> (2001)
Jumping to conclusions (JTC)	Hasty inference under evidence scarcity (including ‘beads task’)	Not evidential haste but temporal fusion – the present collapsed into the entire future; can co-occur but separable	JTC improves with evidence sampling; Forever Fallacy improves with duration-reality testing	‘Before deciding, sample 3 more data points’ vs ‘Track how long this state actually lasts’	Jolley <i>et al.</i> (2014)
All-or-nothing (dichotomous) thinking	Binary evaluation (perfect/failure)	Temporal absolutism about persistence rather than	Improves when partial-time success is logged (e.g.	‘What percentage of today did the problem abate?’	Burns (1980)

(Continued)

Table 1. (Continued)

Distortion (canonical label)	Core cognitive operation	Forever Fallacy – temporal signature (how it differs)	Distinct prediction/differentiator	Clinical probe/micro-intervention	Representative sources*
Mental filter	Selectively attends to negatives	category categorical absolutes Selects time-slices where the state is worst and treats them as the entire timeline	30 minutes on-task) Weakens with whole-day sampling showing natural variability	'Sample mood every hour; summarise range not single worst'	Burns (1980)
Disqualifying the positive	Discounts positive data as exceptions	Discounts temporary relief as meaningless because it is 'only temporary', preserving a forever narrative	Changes when relief episodes are linked to function/learning goals	'What did the 15-minute ease enable you to do?'	Burns (1980)
Magnification/minimisation	Upscales threat or downscales resources	Upscales duration, not just magnitude; minimises time-limited relief	Normalises when time-to-baseline is tracked and shortened	'How long until baseline returns after a spike?'	Burns (1980)
Mind reading	Infers others' thoughts without evidence	Predicts unchanging social evaluations ('they'll always see me this way')	Altered by recontact experiments across time (opinions update)	'Ask again next week; compare answers'	Burns (1980)
Should statements	Rigid rules for self/others	'Should' applied to temporal stability ('this shouldn't ever return')	Loosens when relapse-as-episode model is adopted	'If it returns briefly, what is the plan for that episode?'	Burns (1980)
Labelling	Global negative self-tags	Global label is treated as permanent identity over time	Weakens with state vs trait diaries	'When did the label not fit today?'	Burns (1980)
Personalisation/blame	Self-attribution for external events	Self-blame is extended indefinitely ('I'll always ruin things')	Reduces when bounded responsibility windows are negotiated	'What part was yours this week, not forever?'	Burns (1980)

future states. Recognition of this process holds significant implications for both assessment and treatment within CBT frameworks.

Clinical implications and formulation

In standard cognitive case formulation distorted thinking is typically categorised using established labels such as catastrophising, fortune telling or over-generalisation (Beck, 2011; Persons, 2008). These categories may, however, fail to capture the *qualitative temporal mechanism* at play

when clients experience present states as enduring or existentially fixed. Integrating the Forever Fallacy into cognitive conceptualisation allows clinicians to target a broader class of cognitive errors, those that are not necessarily negative in content but distorted in duration and perceived stability.

For example, clients experiencing burn-out may not articulate beliefs such as ‘I will fail’ or ‘I cannot cope’, but rather, ‘I will feel like this forever’ or ‘This will never change’: a chronic stuckness rather than an acute negative experience. These statements signal not only distress but a deeper impairment in temporal processing and flexibility. Such beliefs are associated with increased hopelessness, reduced behavioural activation, and a narrowed sense of possibility, all of which maintain symptomatology in depression and anxiety (Beck, 2008; Fava *et al.*, 1998).

Incorporating the Forever Fallacy into case formulation enables more precise intervention planning. Perceptual Control Theory models people as regulating key perceptions towards internal reference values; when the sensed state departs from the reference, control systems increase corrective action (Carver and Scheier, 1998; Powers, 1973). The Forever Fallacy can be read as a temporal mis-estimation of that control problem: a short-lived deviation is treated as if it will persist, inflating urgency and narrowing options. In formulation: (i) specify the controlled variable – for example, ‘urge intensity $\leq 3/10$ ’, ‘heart rate < 90 bpm during a meeting’, or ‘maintain eye contact for 2 minutes’; (ii) attach an expected time course – for example, ‘craving peaks for 3–7 minutes then halves’, ‘panic arousal typically abates within 10–20 minutes without alcohol’, or ‘rumination waves last about 15 minutes’; and (iii) run brief, time-limited tests that directly probe the ‘it will not change’ prediction – for example, a 5-minute paced-breathing trial with 60-second ratings, a 10-minute delayed-response to a substance cue while plotting urge decay, or a single 15-minute behavioural task (short walk, shower, or telephone call) to observe state shift. Temporal distancing and episodic future simulation are practical tools for these tests because they make change over time explicit (Addis and Schacter, 2013; Bruehlman-Senecal and Ayduk, 2015).

Intervention strategies

CBT offers a range of tools well-suited to addressing the cognitive processes involved in the Forever Fallacy, although minor adaptations may be required to maximise their efficacy:

- (i) *Temporal reframing within cognitive restructuring*: traditional thought records can be expanded to include a ‘temporal perspective’ column in which clients assess how likely it is that their current emotional state or burden will remain unchanged across different time frames (e.g. 1 week, 6 months, 5 years). This prompts engagement of System B thinking and encourages the generation of future-specific counter-evidence.
- (ii) *Behavioural experiments focused on change over time*: rather than targeting situational beliefs alone, behavioural experiments can be used to gather evidence for *personal development over time*. For example: a client fearing lifelong relational dissatisfaction may be encouraged to track fluctuations in their perception of their partner’s habits over weeks or months, thereby challenging the belief in affective permanence.
- (iii) *Imagery rescripting and episodic future simulation*: given the involvement of the default mode network in distorted temporal projection (Schacter *et al.*, 2008), techniques which promote deliberate construction of episodic future scenarios may be effective. By constructing detailed, sensory-rich, time-located future scenes, clients increase episodic specificity and reinstate temporal distance, which counteracts the time-collapsing ‘temporal fusion’ that sustains the Forever Fallacy (Addis and Schacter, 2013; Schacter *et al.*, 2008). Guided imagery can be used to help clients simulate futures in which their internal states and external conditions have changed in plausible, adaptive ways (Yamada *et al.*, 2018).

- (iv) *Metacognitive training and decentring techniques*: metacognitive strategies which increase awareness of thought processes, for example mindfulness-based cognitive therapy (Teasdale *et al.*, 2002b) can facilitate decentring from temporally fused cognitions. Clients can be taught to identify thoughts such as ‘This will go on and on’ as mental events, rather than truths, and to consider their historical inaccuracy or lack of empirical support.
- (v) *Temporal granularity and present-moment inquiry*: conscious perception stitches experience over short windows, so pictures of the past and future are built in the present (Herzog *et al.*, 2016; Wittmann, 2011). Ask for precise timings and first signs of change to test ‘it won’t shift’: for example, ‘Rate the urge 0–10 every 30–60 seconds for 5 minutes, when does it first drop by one point?’ and ‘What changes first, the jaw tension, breathing, or imagery?’. Framing experience in time loosens the ‘always’ claim whilst keeping close to lived phenomenology.
- (vi) *Values-based planning and commitment*: in clients prone to existential distress rooted in future projection interventions from ACT may be adapted to emphasise *committed action under conditions of uncertainty* (Hayes *et al.*, 2011). The Forever Fallacy can be reframed as a normal consequence of goal-oriented consciousness that requires contextualised values clarification and behavioural flexibility, not the resolution of future guarantees. This approach is grounded in a philosophical tradition known as ‘functional contextualism’ which emphasises the ‘act in context’. A key clinical focus of ACT, which is often missed in traditional cognitive models, is to identify the contextual variables that give rise to thoughts and influence their relationship with subsequent emotions and actions (Hayes *et al.*, 2013).
- (vii) *Imagery rescripting*, unlike traditional exposure techniques, focuses on directly transforming intrusive imagery to change the course of imagined events in a more desired direction. It may be more effective than verbal challenging of cognitions alone by promoting a mutually reinforcing link between imagery and emotions. This technique can also facilitate the expression of emotions that have been suppressed and help fulfil unmet needs, such as mastery and self-efficacy, thereby enabling a shift towards more adaptive emotions and cognitions (Brown *et al.*, 2023).

Integration with empirical literature

The mechanisms underpinning the Forever Fallacy are consistent with findings in affective neuroscience and prospective cognition. People overweight negative cues (negativity bias) (Baumeister *et al.*, 2001). Rapid tagging of potential threat by the amygdala and salience systems can make a feeling seem as if it will last (Kober *et al.*, 2008; Phelps and LeDoux, 2005) whilst prefrontal control networks help shift and dampen it (Etkin *et al.*, 2015). Practice alters these circuits (experience-dependent neuroplasticity) which helps uncouple a current feeling from a long-range prediction (Draganski *et al.*, 2004; Kleim and Jones, 2008). In session, use a one-minute paced-breathing drill with 15-second ratings to show the natural rise-and-fall the ‘forever’ inference overlooks.

Dysregulation in the DMN, particularly in the medial prefrontal cortex, has been associated with increased rumination and reduced ability to flexibly simulate future events (Whitfield-Gabrieli and Ford, 2012). In line with this, studies on future episodic thinking have shown that individuals with depression generate fewer positive and more repetitive future scenarios, which indicates a compromised ability to imagine variation or change (Addis *et al.*, 2007; MacLeod *et al.*, 2005).

Incorporating this distortion into therapeutic practice not only provides an explanatory framework for certain affectively loaded future thoughts but also aligns with broader models of psychopathology that emphasise inflexible, context-insensitive cognition (Harvey *et al.*, 2004). Relatedly, the Looming Vulnerability Model (LVM) describes threat as feeling as if it is speeding towards the person (Riskind, 1997). The Forever Fallacy is different: it is the sense that the state will

not end. They can co-occur ('it's coming fast and it will never end') but they call for different tests. For LVM, slow the apparent approach (for example, lengthen the imagined time-to-contact or increase distance) and track change in anxiety. For the Forever Fallacy, set a clear end-point ('we will watch this for 10 minutes only') and sample state every 60–120 seconds to make variability visible.

This helps in allowing clinicians to conceptualise distress not only in terms of belief content, but in terms of *belief temporalisation* – that is modelling how thoughts are extended across time and what assumptions underlie their projected stability.

Limitations and future directions

Whilst the Forever Fallacy is grounded in clinical observation and supported by converging theoretical literature, formal empirical validation remains necessary. Future research should operationalise the construct psychometrically, test its discriminant validity against existing cognitive distortions, and evaluate the efficacy of targeted interventions. Longitudinal and experimental studies could assess whether changes in temporal reasoning correlate with improvements in affective and behavioural outcomes across diagnostic categories.

Furthermore, developmental and cultural moderators should be explored. It is plausible that the Forever Fallacy is influenced by early learning histories, cultural time orientation, and socioeconomic conditions affecting perceived future stability. Cross-cultural and lifespan research may elucidate whether this distortion is more prevalent in populations with reduced control over long-term trajectories or heightened exposure to uncertainty.

Conclusion

This article has proposed the Forever Fallacy as a previously unrecognised cognitive distortion, characterised by the erroneous projection of current emotional or cognitive states across imagined future timelines. Expediently distinct from existing distortions in the CBT model, the Forever Fallacy reflects a heuristic collapse of temporal perspective whereby individuals experience anticipated responsibilities, discomforts, or limitations as immediate, permanent and affectively unchanging.

Drawing on dual-process theories of cognition, the construct and arguably the other orthodox cognitive distortions, have been situated within the broader framework of heuristic reasoning (System A) and its susceptibility to affective and temporal biases. The distortion arises from automatic, emotionally charged appraisals, which over-ride reflective System B processes that typically allow for contextualisation, temporal differentiation and future flexibility. Clinical examples and empirical literature from affective forecasting, prospective cognition and metacognitive processing support the conceptual validity of this distortion and its relevance to disorders involving anxiety, depression and existential distress.

The Forever Fallacy expands the explanatory reach of CBT by addressing a temporally structured form of cognitive error that is frequently encountered in therapy but not captured by extant labels such as catastrophising or fortune telling. Its identification enables more precise case formulation, facilitates targeted cognitive restructuring, and justifies the integration of techniques designed to enhance temporal perspective-taking and metacognitive flexibility.

Future empirical work is necessary to validate the construct psychometrically to facilitate differentiation from adjacent distortions, and to evaluate the effectiveness of interventions specifically adapted to its cognitive profile. Moreover, research into developmental, cultural and contextual moderators of the Forever Fallacy may reveal its transdiagnostic applicability and inform personalised treatment planning.

In recognising and addressing this distortion, clinicians may assist clients in restoring a functional sense of psychological time, one which acknowledges change, growth and impermanence and in doing so relieves the suffering that arises not from the future itself, but from the mistaken belief that the future is already here and always will be.

Key practice points

- (1) Screen explicitly for temporal beliefs ('How long will this last?', 'What changes over weeks/months?') to detect the Forever Fallacy when content is neutral but duration is assumed permanent.
- (2) Add time columns to thought records and run change-over-time experiments (symptom variability; skills acquisition) to falsify affective permanence *in vivo*.
- (3) Use episodic future simulation and imagery rescripting to model plausible fluctuations in self, context, and capability (Yamada *et al.*, 2018).
- (4) Where anxiety is high, consider differential mechanisms: looming (rate-of-approach) *vs* forever (duration/unchangeability), and target accordingly (Riskind, 1997).

Further reading

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