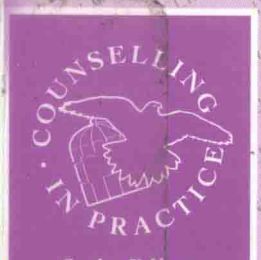
COUNSELLING IN PRACTICE

Counselling for Depression

Paul Gilbert



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Counselling for Depression

Counselling in Practice

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Counselling in Practice is a series of books developed especially for counsellors and students of counselling which provides practical, accessible guidelines for dealing with clients with specific, but very common, problems.

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Preface

Cognitive therapy began in America some thirty years ago. Since that time, it has seen enormous developments in the client groups treated and in its therapeutic approach. Two areas that have seen important changes to the early formulations are a renewed focus on the therapeutic relationship (e.g. Beck et al., 1990; Safran and Segal, 1990) and an increased focus on interpersonal cognitive processes (e.g. Bowlby, 1980; Liotti, 1988; Safran and Segal, 1990). Both these concerns are a main focus in this book. In 1988 Trower et al. published *Cognitive-behavioural Counselling in Action*. They outlined the basic techniques and issues of the cognitive approach. The present volume, for the Counselling in Practice series, is designed to build on their introduction. It explores interpersonal counselling with a particular client group – depressed people.

The aims of this book are to focus on the interpersonal themes in counselling depressed clients, including those of the therapeutic relationship. The book is divided into two sections of four chapters each. Chapter 1 addresses issues of the nature of depression and the therapeutic relationship. Here I try to capture something of the nature of the depressive experience and focus on important counsellor skills. Chapter 2 explores the central issues of interpersonal approaches, the basic domains of relationships and how these are affected in depression. Chapter 3 outlines the basic premises of the cognitive approach and why cognitive counsellors are particularly concerned with the construction of internal meaning, ways of attributing causes to things, and basic attitudes and beliefs. Chapter 4 explores the many ways of conceptualizing therapeutic intervention and challenging dysfunctional thoughts and attitudes.

The second section aims to build on these concepts, and lead the reader through a step-by-step approach to the process of counselling the depressed person. Counselling scenarios are given to illuminate specific points and highlight types of intervention. Most of these scenarios are not derived directly from taped interviews (although some are) but from notes made at the end of sessions. They are not

meant to represent exact scenes but rather to indicate and highlight issues. All client names have been changed, and minor alterations introduced in the history, to avoid identification. Chapter 5 outlines the issues that arise during the early parts of the therapy, and how to engage and agree shared understandings and goals of counselling. Chapter 6 explores the kinds of issues that arise in the middle of counselling, as the counsellor and client engage in deeper explorations and seek opportunities for change. Chapter 7 looks at some special problems that arise in depressed clients. Special attention is given to shame, guilt, envy and idealizing which often figure prominently in depressive experience. Chapter 8 explores termination issues and offers some personal reflections.

Acknowledgements

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To Jean, Hannah and James,
who love and support me,
the many clients who have guided
and taught me, and
Professor A.T. Beck who got us all
thinking cognitively and revolutionized the
psychological treatment of depression

Contents

PART I: DEPRESSION AND THE BASIC PRINCIPLES OF COGNITIVE-INTERPERSONAL COUNSELLING

1

Depression and Dysphoria and the Counselling Relationship

Depression haunts the lives of many. It exists in many forms, takes various guises and has been recognized for many centuries. Over two thousand years ago the Greek physician Hippocrates labelled it melancholia. The Greeks believed depression arose from a disturbance of the body humours, specifically black bile. Early reports of depression can be found in numerous biblical texts. King Solomon is believed to have suffered from an evil spirit and dark moods from which he eventually killed himself. The book of Job is regarded as the work of a depressive. More recent sufferers include composers (Gustave Mahler, Tchaikovsky, Sibelius), politicians (Abraham Lincoln and Winston Churchill) and numerous writers, artists and poets (Edgar Allen Poe and Thomas Mann). Whatever else we may say about depression, it seems that it has been with us for a very long time. Indeed, it is not even unique to humans, and various animal models of depression have been advanced and researched.

What is depression?

Depression affects us in many different ways and symptoms are spread over different aspects of functioning:

Motivation:	Apathy, loss of energy and interest: things seem pointless, hopeless.
Emotional:	Depressed mood, plus emptiness, anger or resentment, anxiety, shame, guilt.
Cognitive:	Poor concentration, negative ideas about the self, the world and the future.
Biological:	Sleep disturbance, loss of appetite, changes in hormones and brain chemicals.

Depression can vary in terms of the relative degree and severity of these symptoms, their duration and their frequency. Hence individuals can vary as to whether their depression is mild, moderate or severe, and they may have one episode or many episodes. Depression is often a major factor in various other conditions such as social anxiety, eating disorders, substance abuse, schizophrenia, and so forth. Depression can be triggered by life events (for example, depression may follow childbirth or the loss of a relationship) and life events may also be involved in recovery (for example, beginning a new relationship; Brown, 1989). Depression can have an acute onset (within days or weeks) or come on gradually (over months or years). Depression can be chronic (for example, lasting over two years), or short-lived (recovery coming in weeks or months). Some depressions also show cyclical patterns.

Paykel (1989) outlines the current proposed ICD-10 classification of depression which is being developed by the World Health Organisation. This system distinguishes a number of different types of depression:

1 Bipolar Affective Disorder: current episode of manic, hypomanic, depressed or mixed.
2 Depressive Episode: mild, (a) without somatic symptoms; (b) with somatic symptoms. Moderate, (a) without somatic symptoms; (b) with somatic symptoms. Severe, (a) without psychotic symptoms; (b) with psychotic symptoms. Psychotic symptoms may be further divided into mood congruent (e.g. delusions of poverty or guilt) and mood incongruent delusions (e.g. paranoid).
3 Recurrent Depressive Disorder: current episode of depressive disorder.
4 Persistent Affective Disorder: (a) cyclothymia; (b) dysthymia.
5 Other Mood (Affective) Disorders: specified/unspecified.

Paykel (1989) points out that as about 50 per cent of depressives will have subsequent episodes there is little point in separating out recurrent depression (3) as a separate type.

There is increasing evidence for a form of depression called Seasonal Affective Disorder. This condition has some atypical symptoms, including a seasonal onset (autumn and winter) with relief in the spring and summer. Mood change is associated with increased appetite, especially for carbohydrates, weight gain and increased sleep. This is an important distinction since exposure to bright light has been shown to be a promising, effective and quick treatment for this condition (Kasper and Rosenthal, 1989).

How common is depression?

To answer this question, much depends on the definition of depression and the precision of the diagnosis. If we use modern methods of classifying depression, then the figures suggest that one person per thousand will be hospitalized for a depressive disorder, and another two per thousand will be referred to psychiatrists (Paykel, 1989). However, varying numbers (3–10 per cent) may seek treatment from other sources such as general practitioners, social workers and counsellors. If we loosen the criteria, then rates of depression rise remarkably. We also know that many who are depressed do not seek treatment, and of those who do, their treatment is often inadequate.

In general, some estimates suggest that as many as one person in four or five will have an episode of serious depression warranting treatment at some point in their lives, although this may be a very conservative figure depending on social class and other social demographic variables (Bebbington et al., 1989). Worldwide, a figure of 100 million depressives has been estimated. What is most worrying is that depression may be on the increase (Klerman, 1988). There are many reasons for this, including demographic changes, life-style changes, increased use of drugs with depressive side effects, and social stresses of various forms (Gilbert, 1992). A counsellor who makes depression a special source of study will have no shortage of cases.

The course of depression

Some clients will recover very quickly and most clients will show some recovery in the first six months, but as many as 20 per cent of cases may have a chronic course; that is, the person can remain depressed at varying levels of severity for two years or more (Scott, 1988). Some clients suffer acute episodes that are superimposed on milder chronic conditions. About 50 per cent of clients with diagnosed depression will relapse (Belsher and Costello, 1988) regardless of treatment, although cognitive counselling shows some promise in being able to reduce this rate. Criticism from spouse is one of the more powerful predictors of relapse (Hooley and Teasdale, 1989).

The assessment of depression

There are many ways of assessing depression and as we have seen depression can be subdivided into various types. Generally, a counsellor rarely makes a detailed diagnosis of type, and some counsellors even wonder about the wisdom of distinguishing depression from other psychological difficulties. Assessment will

often focus on the following key areas:

Psychological

1 What does the client think and feel about him/herself? Especially important is attributional style (a tendency to self-blame) and social comparison (feelings of being less able, less competent than others or different in some way).
2 What does the client think and feel about the future?
3 What are the client's current life circumstances?
4 How long has the client felt depressed?
5 Is the depression a change from his/her normal mood state or an accentuation of more chronic low mood? Is there loss of enjoyment of previously enjoyed activities (e.g. sex, meeting friends, going out)?
6 Does the client see his/her depression in psychological and/or relationship terms, or is there a belief that he or she is physically ill? (Strong beliefs in physical illness can make short-term counselling difficult.)

Social

1 Are there any major life events or upsets that might have triggered the depression?
2 What are the client's perceptions of social relationships? Have there been major losses? Is the home environment aggressive or neglectful? Does the client have feelings of hostility to others and/or feelings of being let down?
3 What are the sources of social support, friends and family relationships? Can the client use these if available or have they gradually withdrawn from social contact?
4 Does an unstimulating social environment (e.g. boredom) play a role? Boredom is a more common problem in depression than is currently recognized.
5 Are there major practical problems that may need other sources of help? (e.g. social work for accommodation problems or advice for financial problems). Practical problems can sometimes be overlooked.

Biological

1 Is there sleep disturbance (early morning waking, waking after being asleep for a short period and/or difficulties getting to sleep)?
2 Are there major changes in appetite and weight?
3 How serious is fatigue and loss of energy?
4 Psychomotor changes, especially agitation and retardation, should be noted. If a client is very slowed up and finds it

difficult to concentrate this can hamper counselling. Severe retardation and lowered concentration may be a poor prognostic indicator for short-term counselling.

5 Would a trial of antidepressant drugs help to break up a depressive pattern? Most studies suggest that antidepressants do not interfere with counselling and are certainly indicated if the depression is severe.

The most commonly used, and well-researched, self-report scale for depression is the Beck Depression Inventory (Beck et al., 1979). This scale not only allows the counsellor to gain an overall impression of the patterns of symptoms, but also can be used to monitor recovery. A general overview of measuring instruments for depression can be found in Ferguson and Tyrer (1989), Gotlib and Cane (1989), Berndt (1990) and Sholomskas (1990).

The counsellor is also interested in the other affects (or emotions) of depression. In some cases it can be anxiety. Various anxiety conditions often get worse when a client is depressed. In some of these cases helping the anxiety lifts the depression. For other cases it is the reverse. Other affects may include strong hostility or passive, unexpressed aggression (this is often noted from the nonverbal behaviour of the client), envy, guilt or shame.

In general, a counsellor should be able to assess the main areas of functioning noted above. The other area to be familiar with is the risk of suicide in depressed clients (Hawton, 1987). The Beck Depression Inventory allows for this and indicates a potential danger requiring further exploration. Depending on their expertise, counsellors may wish to gain outside advice. A combination of a desire to harm self and hopelessness are warning signs. For treatment of suicidal clients see Hawton (1987), Hawton and Catalan (1987), Grollman (1988) and Williams and Wells (1989).

Treating depression

There have been many different treatments suggested for depression, including drugs and ECT, and a plethora of psychosocial interventions. These include psychoanalysis, family therapy, behaviour therapy and social skills training, affect therapy, interpersonal therapy and cognitive therapy. This book will take the cognitive-interpersonal approach; that is, our concern will be with the internal cognitive processes of depression, with a special focus on interpersonal cognitions, social roles and behaviour. For a discussion of family or marital counselling, see Gotlib and Colby (1987), Clarkin et al. (1988) and Beach et al. (1990).

Poor prognostic indicators for the approach outlined here

include: severe depression, making it difficult for the client to form a therapeutic contract; a clear belief that the client is suffering from a physical illness; chronicity; and clear evidence of cyclical depression. These kinds of difficulties may require alternative interventions or at least other interventions to run in tandem with the psychological approach.

The counsellor should also be aware that all depressed states have biological effects and some are related to hormonal/biological changes (e.g. thyroid, the menopause, head injury etc.). There is recent concern that some depressions have become over 'psychologicalized', missing important physical causes (Goudsmit and Gadd, 1991). On the other hand, poverty, poor social conditions, lack of social support and negative life events also increase the risk of depression, while positive life events are associated with recovery (Brown, 1989). Consequently, the approach here endorses the biopsychosocial model of depression (Vasile et al., 1987; Gilbert, 1992). This model is concerned with different levels of functioning rather than simple models of causality.

Although there are clients for whom this approach may not be suited, there are many, perhaps the majority, for whom it will be (see Hollon et al., 1991, for a recent review of the evidence on the efficacy of cognitive therapy for depression). The following chapters outline some of the central issues of working with depressed clients, discuss the various skills and qualities that are necessary for the counsellor and how these can be embedded in the cognitive-interpersonal approach. Because the focus is on internal meaning and interpersonal behaviour, this approach places greater emphasis on the therapeutic relationship than is common in cognitive counselling. For this reason, the rest of this chapter will focus on the therapeutic relationship since, without a good grasp of this, counsellors can themselves be a source of resistance to change. Some key concepts that will be helpful in working with depressed people are outlined below.

The helping relationship

There are a large number of models of helping, many of which are excellently reviewed by Corey (1991). Although counsellors differ in their focus and how they work, there are some central aspects that most share. First is the recognition that the counselling relationship is a special kind of relationship in which the client needs to be understood – not only in a superficial sense by what they say, but also in a deeper sense, that is to make contact with their internal experiences. Dryden (1989b) provides an excellent introduction