

1 Depression: The Basics

Depression is a very old problem

Depression is a puzzling phenomena – not only can it lead to extremely unpleasant states of mind, undermine our abilities to go about our everyday tasks, and fight off various infections and other illnesses, it can also induce people to want to kill themselves. So where should we begin the journey into the origins of depression? Has it been around for many millions of years or is it recent? Does depression arise in other species? We can debate how animals ‘feel and experience their worlds’ and whether their feelings are anything like ours. In fact, many species seem capable of showing signs that their behaviour and positive emotion systems can become toned down and depressed-like, especially following threats and struggles they can not resolve. Moreover, in the face of certain traumas, individuals of many species can show serious physical changes that significantly reduce their chances of survival, and at times they literally curl up, close down and die. So personally I believe that animals can and do suffer from depressed-like states.

This poses a question I was fascinated by when I started my PhD in 1975 – why, over the course of hundreds of millions of years of evolution, and in so many species, are depressed-like states possible? Is this positive selection – to the extent that animals that lacked a depressive response would be disadvantaged in some way (Keller and Nesse, 2006; Wilson, 1998)? If we could answer those questions would that give us clues to depression? Would it affect how we view depressions as diseases, deficits or adaptations? (Gilbert, 2001a, 2001b; Mcquire and Troisi 1998a; Nesse and Jackson, 2006; Nesse and Williams, 1995; Wilson, 1998). Considering these questions, I believe, would make a difference to how we think about depression – for as we will explore in the subsequent chapters, the potential for some symptoms of depression may have evolved as a basic way to cope with certain types of threat.

Does that mean that depression is adaptive then? Well much depends on how we define adaptive. If we mean ‘leaving genes’ behind, then frankly no one knows how depression affects gene replication rates. If we mean adaptive to the individual over their lifetime, then although some people do change and grow through a depression (Gut, 1989) for others depression does not seem very helpful. There is another intriguing question here. Is it possible that one evolved adaptive process (e.g. getting depressed and shutting down in the face of overwhelming stress) and another evolved set of adaptive abilities (related to being able to think, imagine, plan and have sense of self and a self-identity) can interact in such a way as to accentuate depression, making it in some ways ‘worse’ for us humans and

4 Psychotherapy and Counselling for Depression

potentially highly *maladaptive*? Or if we look at another process, is it possible that our vastly expanded primate and especially human needs (compared to other animals) for love and affection have come with the price that in socially hostile environments, our vulnerabilities to depression are greatly increased? I am going to answer 'yes' to both these propositions. Hence we can explore evolved adaptive mechanisms that underpin depression, that serve various protective functions, but also that in human minds, and human social and ecological contexts, these basic defensive protective mechanisms can come to operate highly maladaptively. This is because there are various ways dysfunctional feedback can be set up that accentuates and amplifies depressed states.

We know that depression has plagued our minds since recorded history. 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 biblical book of Job, with ideas that God was purposely punishing him, is regarded by some as the work of a depressed person. Other sufferers from history include composers (Gustave Mahler, Tchaikovsky, Sibelius), politicians (Abraham Lincoln and Winston Churchill) and numerous writers, artists and poets (Edgar Allen Poe and Thomas Mann). More recently, Lewis Wolpert, a well-known professor of biology, recently wrote of his own depression, efforts to understand it and made an excellent television documentary series about it (Wolpert, 1999). Although depression is still stigmatised, increasing numbers of celebrities are acknowledging having problems with depression, and conveying what they are doing to try to help themselves. Whatever else we may say about depression, it has been with us for a very long time, is common, and can be severely disabling and lifethreatening. Indeed, it is not even unique to humans, and various animal models of depression have been advanced and researched.

This book

This book is about helping depressed people via psychological interventions delivered in the context of a supportive and caring relationship. However, even though our focus is on the psychological interventions for depression, it is important to understand depression in terms of the interactions between biological, social and psychological processes. Our understanding of depression must be science-based and not simply constructed through the lens of one theory (of which there are many; Power, 2004). Thus the first section of this book addresses issues of how we can conceptualise mood, and its natural regulators – such as social relationships and control over personal goals. One approach we will explore here is that depression is related to old, evolved protection strategies (to cope with interpersonal defeats and losses) that tone up threat systems and tone down *two* different positive emotion systems of motivation/drive and contentment/soothing. Depressive patterns emerge from the interaction in these systems. Such patterns can be activated in our brains in unhelpful ways by various routes. Genetic or early acquired sensitivities may interact with major life events to overwhelm our

coping efforts (Caspi and Moffitt, 2006), or the newer adaptations of our minds, that enable us to have meta-cognitions, self-awareness and build self-identities, can focus and magnify feelings of defeat or loss (Beck, 1987; Gilbert, 1984, 1992).

The National Institute of Clinical Excellence (NICE) published their major review of depression and the effectiveness of various therapies in 2004. As they noted, there is increasing evidence that a range of interventions *designed* for depression and specific depressive difficulties can be helpful, especially those that help people with their avoidance behaviours, ways of thinking about themselves, their world and future, ways for processing emotions, and ways of coping with relationships and other problems. NICE also advocates careful attention to non-specific factors such as the therapeutic relationship. Thus part II will explore some of these. In addition, we will consider the importance of the therapeutic relationship, and the roles of therapist compassion and self-compassion as a way to reactivate positive affect systems. The latter chapters in the book explore ideas for working with key themes such as shame, approval-seeking, anger and envy.

The Nature of Depression?

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

- Motivation:* Apathy, loss of energy and interest. Things seem pointless and the future hopeless.
- Emotional:* The capacity for different types of positive emotion is reduced, and with moderate to severe depression a person may be anhedonic – meaning they lack the capacity to experience any pleasure. Depressed people may talk of feeling 'empty'. However, negative feelings can increase and there can be heightened experiences of anger or resentment, anxiety, shame, envy and guilt.
- Cognitive:* Cognitive functioning may deteriorate and a person may have problems maintaining attention and concentration. Memory can also be affected and sometimes to such a degree that people worry that they are dementing. Cognitive contents – the focus of thoughts and ruminations – become negative with negative ideas about the self, the world and the future.
- Behavioural:* Depressed people often stop engaging in behaviours that have been enjoyable or pleasurable in the past. They may withdraw from social activities, stop going out or meeting with friends or seeking help from others. Some depressed people, on the other hand, become more demanding and cling to others – desperate for reassurance. In severer forms of the condition people may suffer from psychomotor agitation and restlessness, or retardation.
- Biological:* Depressed people commonly experience problems in sleeping, such as waking up too early or sleeping too lightly. They may lose their appetite and interest in sex. There are many physiological changes, especially in stress hormones (e.g. cortisol) and important neurotransmitters such as serotonin and noradrenalin in depression.

6 Psychotherapy and Counselling for Depression

The core symptom of depression is *Ahedonia*. *Ahedonia* has different meanings. It can refer to *loss of interest* and motivation or refer to the fact that people might be motivated/interested to do things but can't feel any pleasure. For example, they would *like* to enjoy sex again and the taste of food but when they engage in these activities feelings of enjoyment are not there (see Gilbert, 2004). It is also very common to find a variety of other emotional problems in a depression, especially problems with anxiety or unexpressed anger. On the other hand, research suggests that both positive *and* negative emotions can be blunted in depression (Rottenberg and Gotlib, 2004). The exact textures and patterns of emotions then will vary from person to person.

Types of depression

Depression can vary in terms of the number, 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 can be the main or primary problem but it can also be associated with other major disorders, such as social anxiety, eating disorders, substance abuse and schizophrenia. Depression can be triggered by life events (e.g. depression may follow childbirth or the loss of a relationship), and life events may also be involved in recovery (e.g. 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 (e.g. lasting over two years), or short-lived (recovery coming in weeks or months). Some depressions also show cyclical patterns.

The current ICD-10 classification of depression was developed by the World Health Organisation (Paykel, 1989). 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.

Depression can be seen as a dimensional change from normal unhappiness or misery or as a distinct, categorically or qualitatively different state to severe unhappiness. Debates on this are ongoing, with questions about the underlying mechanisms involved in processes that produce shifts in brain states (Gilbert, 2004). Neurotic and unipolar depressions may be related to dimensional variations or mood, while bipolar affective disorder and psychotic symptoms are more categorical variations. This book focus primarily on the unipolar non-psychotic depressions.

There is increasing evidence for a form of depression called Seasonal Affective Disorder (SAD), with ongoing research suggesting there may be different types of

Depression: The Basics 7

SAD, and some are linked to bipolar disorder. SAD has some atypical symptoms, including a seasonal onset (usually autumn and winter) with relief in the spring and summer. Depressed mood 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 (Dalglish, Rosen and Marks, 1996; Kasper and Rosenthal, 1989).

Evolutionary and functional approaches: Medical approaches to classification remain wedded to symptom studies. However, evolutionary approaches start by trying to understand the functions of symptoms and underlying defensive mechanisms that have been activated (Nesse and Williams, 1995). Gilbert (1984, 1992) suggested that some depressions are linked to attachment disruption and may activate the protest-despair defensive strategy (Bowlby, 1969, 1980), while competitive defeats activate a defensive strategy to cope with interpersonal conflicts and hostile others. Recently, Keller and Nesse, (2005, 2006) found that symptoms of crying, sadness and seeking social support were linked to interpersonal losses, while anhedonia, fatigue, guilt, pessimism and rumination were linked with failed effort to achieve certain goals. Gilbert, Allan, Brough, Melley and Miles (2002) found that feelings of defeat were highly linked to anhedonia. We will explore these ideas, that different forms of depression are linked to different person – environment interactions in Chapters 5 and 6. A complicating fact here is that there are only a few basic emotion systems, and so it is the way that they are patterned in different states of mind that is at issue, a theme we will explore in Chapter 2.

The assessment of depression

There are many ways of assessing depression and, as we have seen, depression can be subdivided into various types (see Nezu, Nezu, McClure and Zwick, 2002 for a comprehensive overview). In addition to assessment of symptoms 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), shame, and social comparison (feelings of being less able, or less competent than others or different in some way).
- 2 What does the client think and feel about the future?
- 3 In what ways are certain styles of behaviour, such as avoidance and ruminations, contributing to the depression?
- 4 What are the client's current life circumstances? Do they feel defeated in their life goals?
- 5 How long has the client felt depressed?
- 6 Is the depression a change from his/her normal mood state or an accentuation of more chronic low mood?
- 7 Is there loss of enjoyment of previously enjoyed activities (e.g. sex, meeting friends, going out)?

8 Psychotherapy and Counselling for Depression

- 8 Does the client see their depression in psychological and/or relationship terms, or is there a belief that they are physically ill? Strong beliefs in physical illness can make some counselling difficult.
- 9 How trapped does the client feel and what thoughts do they have in that regard (e.g. assess risk of self-harm)?
- 10 How does the client view their resources to cope? What outside sources of help are there, and how might these be utilised in the counselling?

Social

- 1 Are there any major life events or upsets that might have triggered the depression, accentuation or maintaining it?
- 2 What are the client's perceptions of social relationships? Have there been major losses? Is the home environment aggressive or neglectful? Are there conflicts with family members – parents, in-laws, spouses/partners or children? Does the client have feelings of hostility to others (that maybe they feel unable to express or work through), entrapment, 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 or socially isolating social environment play a role (e.g. young mothers struggling to cope with young children and lacking adult company and sharing interests)?
- 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 or job seeking)? Practical problems can sometimes be overlooked.
- 6 Are their problems in the work domain (e.g. being out of work or bullying at work)?

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 some counselling.
- 5 Would a trial of anti-depressant drugs help to break up a depressive pattern? Most studies suggest that anti-depressants do not interfere with counselling and indicated if the depression is severe. The National Institute for Clinical Excellence (NICE, 2004) do not recommend anti-depressants for mild depression.

There are a host of physical disorders, including thyroid dysfunction and diabetes onset, that can involve fatigue and mild depression. Hence, all cases should be medically screened for such, especially if fatigue is a major symptom. Sleep disturbance is now known to be a major problem in depression, linked to both fatigue and suicidality (Cukrowicz et al., 2006).

Measures

The most commonly used, and well-researched, self-report scale for depression is the Beck Depression Inventory (BDI; Beck, Rush, Shaw, and Emery, 1979). This scale not only allows the therapist to gain an overall impression of the *patterns* of symptoms, but also can be used to monitor recovery. Some therapists spend time discussing responses on the BDI (Beck et al., 1979). The therapist may then ask which of the symptoms causes most distress, with the aim of coming back to them at the end of the session and targeting the symptoms with some specific interventions. However, be aware that this scale is copyright. Alternatives include the Depression, Anxiety and Stress Scale (e.g. Lovibond and Lovibond, 1995). Other measures use clinical rating scales and interviews of various forms. Good general overviews of measuring instruments for depression can be found in Berndt (1990), Ferguson and Tyrer (1989), Katz, Shaw, Vallis and Kaiser (1995), Nezu, Nezu, McClure, and Zwick (2002), and Peck (2004).

As noted, therapists are also interested in the other affects (or emotions) of depression. In some cases it can be anxiety. Various anxiety conditions often become worse when a client is depressed. In some of these cases helping the anxiety lifts the depression. For other cases treating the anxiety helps the depression. Other affects may include strong hostility or passive, unexpressed anger (this is often noted from the non-verbal behaviour of the client), envy, guilt and shame. There are some suggestions in the literature that men tend to be more aggressive/irritable at least in the early stages of their depression.

Risk

For any depression it is important to assess risk arising from the depression. Risk can take many forms. It may relate to the fact that people are avoiding work and are at risk of losing their jobs, or are having difficulties in their relationships which puts them at risk of losing a relationship or being neglectful or aggressive (e.g. to children). In some cases individuals may be very self-neglectful and not attend to basic self-care. A key risk is of course from self-harm. Self-harm can relate to forms of self-hurting and mutilation (where there is no intention to die), used as a form of emotion regulation (Babiker and Arnold, 1997). However, self-harm can also be very directed at desires to die (as an escape from depression (Baumeister, 1990)) and individuals who are impulsive can kill themselves as an impulsive act. There are a series of risk factors that should be kept in mind when assessing depression and its associated difficulties (Hawton, 1987; MacLeod, 2004). The factors that may increase the risk of a suicide attempt are:

- personality disorder, especially with poor impulse control
- use of alcohol to escape problems
- being young, male and unemployed
- a history of previous self-harm
- living alone and social isolation
- major life events of losses and exits
- illnesses that involve reduced capacities and/or chronic pain
- family disputes and high expressed emotion
- anniversaries of losses

10 Psychotherapy and Counselling for Depression

- sudden separations (e.g. from a keyworker)
- a suicide in the family.

These are common risk factors that should be borne in mind when assessing risk. Leahy and Holland (2000, pp. 30–4) offer a useful checklist for assessing risk. In addition, of course, there are a number of psychological risk factors which, in the context of the above risk factors, increase overall risk. Fazaa and Page (2003) found that high self-criticism elevated suicide risk, and Apter, Horesh, Gothelf and Lepkifker (2001) found that being unwilling to engage in self-disclosure distinguished suicide attempters from non-attempters and was significantly linked to the seriousness of the attempt. Sleep quality and nightmares have also been linked to suicidality (Cukrowicz et al., 2006). Although many people, even when not depressed, can have thoughts of suicide, if a patient has started to work out how they could do it and make plans this elevates risk. Risk is elevated again if the patient has the means to carry out their plans. Depressive cognitions that are associated with a chronic sense of hopelessness, poor coping skills and chronic sense of entrapment, with strong desires to get away, are psychological risk factors.

Unresolved traumas from the past, high levels of shame and low self-esteem can increase risk. Recovering from a severe depressive illness can also be a time when suicide risk increases. The general thought here is 'I can't go through that again'. This is particularly true for bipolar depressions, which have a high risk of suicide.

When working with people who are suicidal it is important to gain support and advice from other professionals and work out a clear treatment plan which can vary from admission, through to specific problem solving and support. The treatment plan may also involve an agreement that if a depressed person feels they cannot resist their suicidal feelings they should call their general practitioner, a crisis service or maybe the counsellor. In a counselling session, patients can find it helpful to work through problems with a counsellor in a step-by-step fashion, breaking problems down and developing a plan to work with them. Smaller, more manageable, steps are usually better. Counsellors can also help people look at 'reasons for living' which can easily go unnoticed when in a depressed state. It is important to de-shame the feelings of wanting to kill oneself but at the same time buying time and enabling the person to see that they haven't always been depressed and the depression can be resolved.

The Beck Depression Inventory (Beck et al., 1979) taps suicide risk and indicates a potential danger requiring further exploration. A combination of a desire to harm self and hopelessness are warning signs. For further explorations of assessing and working with suicidal clients, see Grollman (1988), Hawton (1987), Hawton and Catalan (1987), MacLeod, (2004), and Williams (1997).

How common is depression?

Much depends on the definition of depression and the precision of the diagnosis, but the short answer is it is *very* common; worldwide many millions of people are suffering depression at any one time. The World Health Organisation suggests

that depression will soon become second only to cardiovascular disorders as the most common health burden in the world today. Indeed, for women aged 15–45 years, it is far and away already the most common health burden. In general, some estimates suggest that as many as one person in four or five will have an episode of depression warranting treatment at some point in their lives, although this may be a conservative figure depending on social class and other social demographic variables (Bebbington, 2004; Bebbington, Katz, McGuffin, Tennant, and Hurry, 1989).

Taking into account definition and diagnostic concerns, Bebbington (2004, p. 14) suggests that: 'My best guess is that the annual prevalence rates of ICD depressive episode may be around 4% and that of DSM – IV depressive disorder around 5%.' It should be noted, however, that women suffer depression twice to three times that of men. Care should be exercised in noting how men and women present when distressed, that is males may have more denial and present with more anger (Cochran and Rabinowitz, 2000). Thus one should be aware of gender differences (Hankin and Abramson, 2001 McQuire and Troist, 1998b). Also rates vary greatly with social group, with poor and high unemployment areas having considerably higher rates of a range of health problems including depression (see Melzer, Fryers and Jenkins, 2004). Ostler et al. (2001) found depression differs between GP practices and that around 48.3% of this variation could be accounted for by poverty and socio-economic status. Although detection and treatment are slowly improving, at least in western countries, many depressed people go undetected in their communities and even those who are detected may not receive adequate treatment (Bebbington, 2004).

Not only is there a vast epidemic of misery, which affects individuals and their families, the resulting economic costs are estimated in many millions of pounds (NICE, 2004). Sadly, there is no sign that, with our increasing wealth, depression rates are reducing. If anything, competitive and materialistic societies tend to have increasing rates of depression (Arrindell, Steptoe and Wardle, 2003; Kasser, 2002), with serious concerns that depression may be on the increase, especially for younger cohorts (Fombonne, 1999; Klerman, 1988). There are many possible contributing reasons for this, including demographic changes, lifestyle changes, dietary changes, increased use of drugs with depressive side-effects, and social stresses of various forms (Gilbert, 1992, 2004; James, 1997). A counsellor who makes depression a special source of study will have no shortage of cases.

The course of depression

Posternak and Miller (2001) explored the course of depression in 201 patients on waiting lists: 20% had improved within the first two months and by six months 50% had improved. This remission rate is related to a variety of factors such as life events and depression severity. This remission rate should be kept in mind when looking at data from research trials. As many as 20% 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 (McCullough, 2000). Andrews (1998) has linked chronic depression in women to a history of sexual abuse.

12 Psychotherapy and Counselling for Depression

Relapse and Reoccurrence

About 50% (in some studies it is higher) of clients with diagnosed depression will relapse or have a subsequent episode. Age of onset can predict relapse vulnerability with those having onset before the age of 20 the more vulnerable group (Giles, Jarrett, Biggs, Guzick and Rush, 1989). With second and third episodes, risk of relapse climbs to 70% and 90% respectively (NICE, 2004).

The sources for relapse are many and include life events such as losing one's job, a stressful job that one feels trapped in but goes back to after recovery, ongoing financial strain, poverty, poor social supports, lack of a confidante, and criticism from a spouse (Belsher and Costello, 1988; Hooley and Teasdale, 1989); underlying psychological vulnerabilities such as a low self-esteem and self-critical styles (Murphy, Nierenberg, Monson et al., 2002); and unresolved issues of early abuse (Andrews, 1998; Hammen, Henry and Daley, 2000). Hankin and Abramson (2001) note that some depression-related events can be independent of self-actions (e.g. collapse of the stock market and financial or job loss) but others are linked to them. For example, some personality dispositions reduce the probability of developing close supportive relationships and increase the probability of relationship break-up and conflicts – which are linked to depression. Linked to both personality disposition and vulnerability to depression is cognitive style (reflecting certain attitudes and attributions). Iacoviello, Alloy, Abramson, Whitehouse and Hogan (2006) found that negative cognitive style, after controlling for baseline depression, affected the number of episodes (relapse), the severity of the episode and chronicity (see also Alloy et al., 2006). Monroe and Harkness (2005) suggest that once a person has become depressed their physiological systems are sensitised to more severe shifts in mood state in the face of stressful life events (a kindling theory). Both the cognitive-focused, and the physiologically-focused approaches see differences between first and subsequent episodes, with subsequent episodes being easier to trigger via a *spreading activation* of negative thinking and stress states – that is (and this is a concept we will return to) we need to think of various patterns or activity in multiple systems that produce depressed brain states.

Given the high relapse risks, there is now work exploring how to reduce relapse. Hollon, DeRubeis and Seligman (1992) suggest that depressed patients treated with cognitive therapy may be at less than half the risk of relapse than are patients treated with pharmacotherapy alone. Mindfulness cognitive therapy (Segal, Williams and Teasdale, 2002) was specifically designed for working with the second and third relapse-vulnerable group. Certain types of behavioural therapy may also reduce the risk of relapse (Klein et al., 2004). Studies have also sought to explore medication dose and maintenance in relapse prevention (NICE, 2004).

Treatment resistance

NICE (2004) notes that some patients are treatment resistant. This is defined as not having responded to adequate trials of two or more anti-depressants at an adequate dose for an adequate time. But there is also resistance to psychological therapies. In regard to the latter, resistance may relate to the degree of how embedded and trapped people are in unsupportive or critical environments or the length of time it takes for some patients to develop a trusting therapeutic relationship, and

feel sufficiently low-shame to begin to engage in the process of change. Some clinical studies 'advertise' in local media for depressed people for their trial. It is very unclear how these people differ from NHS depressed people who may be too shame prone or not motivated to answer 'advertisements'. I have treated a number of chronic and treatment-resistant depressions with a history abusive experiences, where the first six months can be spent in helping the person form the relationship and begin to engage. Although professionals are under increasing pressure to fit therapies into a relatively short number of specific sessions (which were designed for clinical trials), these may be far too short for some people. Moreover, even though short-term (16–20 session) focused therapies can be effective for some patients, still 40% and over show little response or only a partial response. Further study of this group of patients is needed (McCullough, 2000). There are, for example, debates over which components of a therapy (e.g. the focus on thoughts or behaviours) are the most effective and relapse preventive (Dimidjian, Hollon, Dobson et al., 2006).

Treating depression

There have been many different treatments suggested for depression, including drugs and ECT, and a plethora of psychosocial interventions. NICE does not recommend anti-depressants for mild depression, although rightly or wrongly general practitioners may continue to use them if they see them as helpful for chronic stress and/or sleep difficulties. These debates are ongoing in the medical profession as I write this. In regard to psychological therapies, there are many forms, including psychodynamic, marital and family therapy, social skills training, affect therapy, interpersonal therapy cognitive therapy, behaviour therapy and various hybrids and combinations. (For an overview of various therapies, see Beckham and Leber, 1995; Power, 2004.) This book will focus primarily on working with individuals. For a discussion of family and marital counselling, see Beach and Jones (2002); Clarkin, Haas and Glick (1988); Gotlib and Colby (1987); Prince and Jacobson (1995).

Poor prognostic indicators for basic counselling include: severe depression such that the client struggles to engage, serious difficulties for the client in forming a therapeutic contract; difficulty in articulating thoughts and feelings; high defensiveness; an entrenched belief that they are suffering from a physical illness, serious personality disorder 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. Psychological therapies for these people require specialist interventions.

At the risk of repetition, therapists should always be aware that all depressed states have biological effects, and some are related to hormonal/biological changes (e.g. thyroid, diabetes, chronic fatigue, the menopause, head injury, etc.). There is concern that some depressions have become over 'psychologicalised', missing important physical causes (Goudsmit and Gadd, 1991). In the social domain, 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

14 Psychotherapy and Counselling for Depression

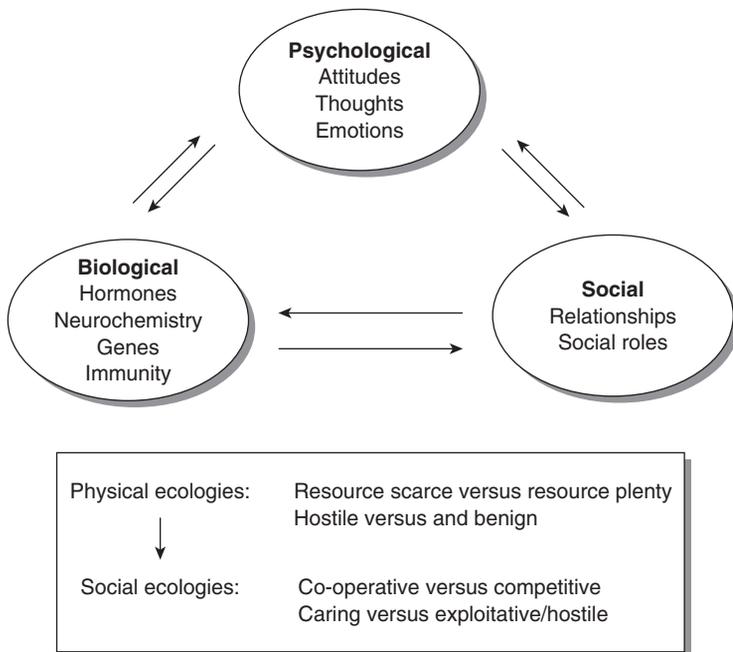


Figure 1.1 Biopsychosocial and ecological interactions From Gilbert 2004

biopsychosocial model of depression (Gilbert, 1995a; Vasile, Samson, Bemporad et al., 1987). This model is concerned with different levels of functioning rather than simple models of causality. We now turn to this.

Biopsychosocial approaches to depression

Twenty years ago Eisenberg (1986) noted that there was much in psychology and psychiatry that was either 'brainless' or 'mindless' science. This was not to perpetuate some 'dualism'. Rather the opposite. It was a call for a better science of mind and psychopathology that recognised a systems approach. This is to get away from reductionism – that depression can be reduced to a change in brain chemistry, the emergence of core beliefs or avoidance behaviour – and rather to see it as involving interacting, complex patterns of dynamic systems. Depression involves a number of complex and disabling symptoms, as noted above. It is vitally important to recognise that when people are depressed they will have disturbances at many levels of their being. Figure 1.1 outlines a simple general biopsychosocial approach.

This model suggests that there are a range of biological factors that can impact on our moods and thoughts, on the one hand, and social relationships on the other. There is good evidence that at the physiological level certain brain chemicals called 'neurotransmitters' are disturbed. Serotonin, noradrenalin and dopamine are especially implicated in depression. These affect our ability to

feel positive emotions (joy, happiness and pleasure) and take an interest in things (e.g. food and sex). They also affect negative feelings and emotions like anxiety, anger and shame.

It is also clear that depression is associated with increased activity in 'stress systems' – as if stress systems are in over-drive. For example, many depressed people have elevated cortisol – a stress hormone. Good reviews of these studies have been given by Numeroff (1998) and more technical accounts for those who want to know more can be found in Thase and Howland (1995), Thase, Jindal and Howland (2002) and Cleare (2004). The point is that the physiological changes that accompany depression will obviously affect (and are part of) moods, behaviours and abilities such as memory and concentration.

In the psychological domain people not only feel bad, but they tend to see themselves, their future and the world, negatively (Beck et al., 1979). Increasing attention has also been given to the behaviours associated with depression, such as avoidance and rumination (Dimidjian et al., 2006). As we shall see in this book, thoughts, behaviours and memories are often specific targets for therapy work. These processes clearly impact on physiological activity and social relationships.

In the social domain, depressed people may have various life difficulties and social relationship problems (Brown and Harris, 1978; Brown, Harris and Hepworth, 1995). Different types of person – environment interactions may link to different symptom profiles (Keller and Nesse, 2006). Social relationships and desired source roles can play a major role in vulnerability, onset and recovery (Champion and Power, 1995). Marital conflicts are highly associated with depression both as cause and consequence of depression (Beach and Jones, 2002). Generally, supportive and loving relationships are conducive to well-being and recovery, while critical, neglectful and hostile ones, and social isolation, are not.

The importance of emergence

At each level of our being there is self-regulation. Thus each cell of our body can self-regulate, each physiological system – the cardiac and immune system – can self-regulate. They do this of course at various levels of complexity and in ways that interact with other systems. Clearly, systems at 'lower levels' influence and pattern systems of organisation at higher levels (e.g. genes influence/build physiological systems that constitute the living bodies of animals – whether they are fish, rabbits or humans). They build the basic infrastructures for the brain that will enable people to have sensory systems, basic motivations and emotions, and be able to think in certain ways. However, higher levels of organisation can also influence lower levels of organisation. For example, if we live in a war-torn world this creates intense stress. This stress affects our physiological systems and our feelings and motivations. We now know that stress can even affect gene expression – how genes get turned on and off. The origins on that war may be from centuries earlier, as in the case of religious wars. So a conflict that began centuries ago can affect genes expression in us today!

You can see that if I ask a depressed person from a war-torn country why they are depressed, there is a whole variety of possible answers: from the history of their culture, to their own personal experiences, to how their minds and bodies

16 Psychotherapy and Counselling for Depression

react to certain events; to how their genes have built them so that they react in certain ways. To argue that one level of explanation is 'better' than another is to completely misunderstand emergence. We are all psychobiological patterns of organisation moving through time, experiencing our 'being in the world'. My job as a psychotherapist is to try to engage with a person's psychobiological pattern and explore together if there are ways that the 'pattern that gives rise to the experience of suffering' can be altered. If they experience my connection with them as sharing and caring, this may help; if we can alter behavioural patterns, this may help; if we can change the meanings, beliefs and interpretations, this may help; if we can help them with life events (e.g. get a job or resolve relationship conflicts), this can help.

Although we can isolate and study these domains, as outlined in Figure 1.1, separately, *states of mind* and *brain states* (Gilbert, 1984) are emergent phenomena from complex interactions. For some people genes are important factors in vulnerability to depression – and different types of depression have different genetic loadings. But genes do not operate in a vacuum. We now know that gene – environment interactions are complex and give rise to different phenotypes from which vulnerabilities emerge (Caspi and Moffitt, 2006), so physiological vulnerability to depression can arise from many sources. For example, early physiological maturation in the womb can affect temperament, and the way in which we engage with others, from the first days of life (Harper, 2005). Our social relationships can affect how genes are expressed. The physiological effects of interactions (e.g. if they are calming or stressful) influence which genes can get turned on and off (Harper, 2005). Our social relationships can also have a major impact on how our physiological systems mature. For example, memory systems, and emotional regulation systems in the frontal cortex, can be affected by early abusive experiences (Gerhardt, 2004; Schore, 2001). Hence, there is a very clear interaction between our experiences of the self-in-the-world and physiological maturation. Our social relationships also shape our attitudes about the world we live in, our expectations about ourselves, and our sense of self-identity (Chapter 6). These attitudes, beliefs and styles of interpreting events affect our physiological systems and our social behaviour.

Families, and the interactions between parents and their children, will be severely affected by whether the family is living in a peaceful, supportive environment or a war-torn or crime-ridden poor area. *Physical ecologies* (e.g. whether able to move outside into attractive areas, or be trapped in dark rooms or a crime-ridden block of flats) influence our states of mind and our relationships. *Social ecologies* are related to the typical beliefs and patterns of social groups. These loosely can be regarded as the cultural domain, and the cultural domain has a major impact on people's vulnerability to mental health problems and their help-seeking behaviour.

The background or early vulnerability factors interact with current life stressors. For example, a negative life event may increase the production of stress hormones. As this happens, our thoughts and emotions are affected and we focus more on negative events which further increases the production of stress hormones. A negative event may trigger underlying negative beliefs (e.g. of being worthless, useless or unlovable). As these beliefs seem 'more true', they increase stress and that releases more stress hormones and increase the symptoms of stress

(e.g. poor sleep and poor concentration). This adds to feelings of exhaustion and of being 'inadequate'. Or a belief like 'I am boring – people will get fed-up with me' may lead to reduced social behaviour and further feelings of aloneness, all of which affect the stress hormones.

In their seminal work, Brown and Harris (1978) found that in a community sample of women, depression was often associated with *vulnerability factors* (such as low self-esteem and low intimacy with a spouse) and *provoking agents* (such as various losses and threats that have long-term consequences). They suggest that events that reduce a person's sense of value and self-esteem are particularly important in depression (Brown, 1989). Social loss events that are experienced in some way as humiliating or shaming, and from which the person feels unable to escape, have been found to be more depressogenic than loss events alone (Brown et al., 1995). The linkage between life events, social relationships, self-esteem and sense of control over life's difficulties is often central in depression (Becker, 1979).

Life events and coping styles will vary in regard to gender, age and ethnic group. For example, women are more likely to be the primary child-carer, including following the breakdown of a relationship (i.e. a single parent). They are more likely to get trapped in the home with young children and suffer role strain (Brown and Harris, 1978). In some social groups women are placed in highly subordinate positions. Older age groups will be more subject to losses such as grief and changes in physical health, and for some loss of their own home requiring movement to a nursing home. Some studies suggest that depression rates are very high in these contexts (Laidlaw, 2004).

So it is useful to think of depression as sequences of *interacting processes that create complex biopsychosocial patterns that can spiral a person downwards*. All interventions, be they drugs, psychological or social support, are aimed to break into the *spiral* of depression and web of interacting processes. The point about this is to suggest that there are constant, complex multi-layered interactions occurring within us, affecting our mental state.

Different kinds of therapy will tend to target different elements of those domains. For example, biological treatments tend to target the biological domain, whereas psychosocial interventions tend to focus on the psychological and social domains. Social interventions tend to target people's interactions with their environment (e.g. helping people to find work, to sort out finances or child support, to find more conducive living places). However, each treatment should ripple through to affect other domains. Drug treatments will affect people's style of thinking and behaviour, while psychological treatments have physiological impacts (Cozolino, 2002; Linden, 2006). Thus therapists need to be aware of working with 'a person' who has a historical context to their depression, lives within a certain social context, and be mindful and respectful of their history, culture and social context.

Conceptualisation

Considering depression in this multifaceted way can be helpful when it comes to an individual formulation (Chapters 8 and 9). The kind of biopsychosocial model outlined here was first proposed by Brown and Harris (1978), and in my view

18 Psychotherapy and Counselling for Depression

remains a very useful approach. We can begin the model by identifying three key domains that can give rise to depression. These are: *early vulnerability factors*, *current vulnerability factors* and *provoking events*. These are given in Figure 1.2.

Early vulnerability factors can involve a range of things that we have already noted, such as genetic vulnerabilities, and difficult early life experiences. These individuals can be vulnerable in a variety of ways, which can be accentuated in the context of current vulnerability, such as social isolation, bullying, conflicts in the marriage or at work. As Brown and Harris (1978) suggest, these kinds of vulnerabilities typically 'load the gun'. However, in the context of a major life event, which has major long-term consequences, such as losing one's job, it can provoke a spiral down into depression. The importance of this way of thinking about depression suggests that depression is not a black and white issue, present or absent, but can exist in degrees, and depressions can wax and wane. A provoking event may be what accentuates a mood difficulty such that a person crosses a threshold and reaches a diagnosis. The diagnosis might come when a certain number of symptoms are manifest, but the vulnerability factors may exist before that and may have been eroding the person's well-being for some time.

In this type of model vulnerabilities can interact such that some individuals who have had traumatic backgrounds find it difficult to form relationships or hold down jobs, and therefore their lives tend to be plagued by a variety of life events that are linked to their interpersonal coping styles (Hankin and Abramson, 2001). Shahar, Henrich, Blatt, Ryan and Little (2003) found that in a large group of adolescents ($n = 860$), self-criticism predicted less positive life events in girls. They suggested that self-critical or self-reassuring styles impact upon what one elicits from the social and non-social environment. Thus life events are not necessarily independent of the personal style of engaging in the world.

Looking at the next level we can see that as a depression gets going, there is an accentuation of the physiological systems of stress, the psychological and especially the experiential aspects, such that people begin to experience and evaluate themselves, the world and their future in a negative light. Typically, their coping behaviours are problematic; they may quickly run out of ideas of what to do to help themselves. Or they may ruminate about why things have gone badly for them rather than focusing on coping and trying to improve their situation. Commonly running out of coping options can lead to avoidance and then feelings of being trapped and becoming overly focused on feeling defeated and on escape/avoidance. Sometimes, escaping from an abusive environment is helpful, at other times escaping from relationships doesn't lead to better times, or may make things worse and people regret it once they are no longer depressed. This level is the level of *spreading activation* of depressed brain states.

This constellation of background variables, personality, coping style and availability of social and physical resources texture the shift down in mood, making it unique in some ways to each individual person, yet also part of our mammalian and human heritage with common identifiable features, such as anhedonia, sleep disturbance and fatigue.

Because depression is such a multifaceted experience, we can see that there are a range of interventions or relieving factors that may well be helpful for the person. The psychotherapist will obviously focus primarily in the psychological domain and so this book will be focused on that, rather than on other elements of

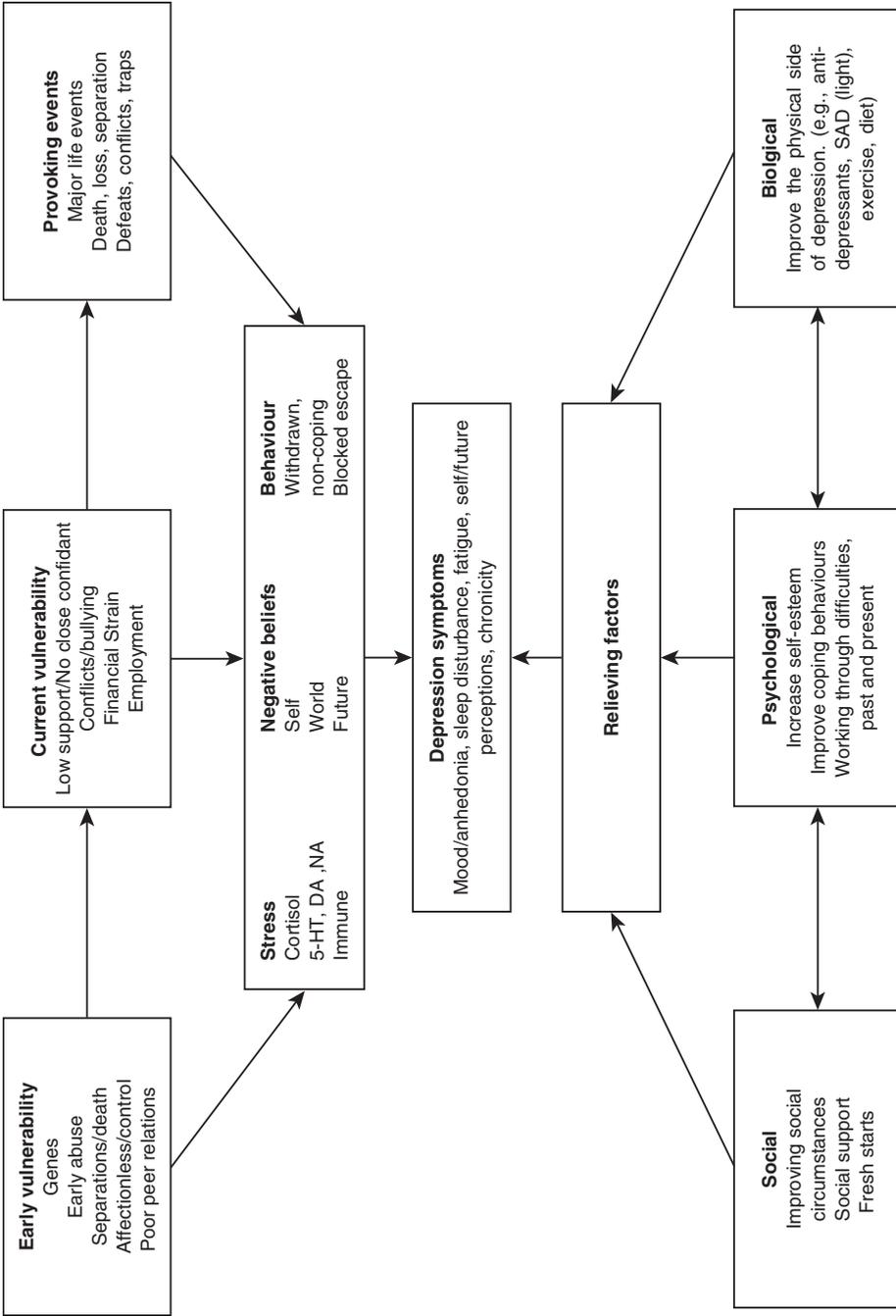


Figure 1.2 Biopsychosocial interactions in depression

From Gilbert 2004

20 Psychotherapy and Counselling for Depression

treating depression. It is important, however, to think about how a client can use therapy to produce changes in their lives (e.g. in their social relationships) which are conducive to the healing of depression. Paying attention to diet, or getting more exercise can be important too. Counsellors should be aware of these other evidence-based interventions. The key point, then, is this focus on the *whole person*, even while one is going to be working primarily in the psychological domain.

Using this book

NICE guidelines point out that people working with depression should be familiar with the *complexities* of the disorder and skilled in an evidence-based approach. In addition to being aware of NICE guidelines, two excellent handbooks of depression are by Gotlib and Hammen (2002) and Power (2004). I highly recommend these if you are going to make depression a serious study. In regard to keeping up with therapies, this is a little more tricky than it appears because approaches like Cognitive Behaviour Therapy (CBT), for which there is good evidence, are changing and evolving all the time in the light of new research on psychological processes and interventions. There are also increasing versions of CBT: some focus on more behavioural aspects, some on cognitive, and yet others on emotions or social relationships. In fact, it is becoming increasingly untenable to think about treatment in terms of 'schools' rather than process and problem-focused approaches (e.g. intervention for avoidance behaviour, rumination, self-criticism), and the problem here is that many therapies are becoming multi-modal (Lazarus, 2000). Gradually other therapies are becoming more research aware. Nonetheless, despite problems in the evidence base for a range of therapies, and major debates about the value of methods to investigate therapeutic interventions (e.g. randomised control trials and meta-analysis, use of people who answer advertisements), NICE (2004) draws attention to the evidence for *focused* therapies that have been designed for mood disorders, especially those of CBT and IPT.

This book is *not* designed as a manual-like approach to treating depression, as one might follow if doing a controlled trial. Rather, it is a process-orientated approach that tries to marry an understanding of processes that underpin depression with ideas of how to help depressed people. Clearly, your skills in basic psychotherapy and counselling and the modes of intervention, be these cognitive behavioural, interpersonal or emotion-focused, will have been learnt by you elsewhere. What this book will cover is some issues related to conceptualising mood disorders (because we have to develop our interventions by better understanding the processes underpinning depression), the formulation and focused interventions that can be helpful to people with a variety of unipolar depressions. An added aspect outlined here is a focus on compassion – and this book will build the argument for why this is important – the key elements of compassion, and how to being a compassion-focus to your therapy.

Conclusion

Depression is common. It can vary from mild to severe and from a relatively short-lived to a chronic condition. Depression sometimes ends in suicide. The depressed

Depression: The Basics 21

client can also have serious effects on their children and family. Therapists who have worked with depression for any length of time will be familiar with its misery, varied disguises and destructive potential. In working with depression one first tries to bridge into the depressed person's internal experience and needs 'to feel understood'. This can offer the first sparks of new hope and break into demoralisation. The ability to understand a depression is related to the preparedness of the therapist to see the person as a historically and socially contextualised being and not just as a set of symptoms requiring intervention. It also requires us to see depression as linked to our common humanity that we, like other animals, have the potential for depression.

In December 2004 The National Institute of Clinical Excellence published their guidelines for the treatment of depression. Their document provides a wealth of information on: the symptoms of the various forms of depression, causes of depression, rates of depression, ethnic, social and gender variations, the social costs of depression and treatment mode recommendations. It also outlined the stepped care model for developing service for depressed people. Therapists working with depressed people should be familiar with this document, and its updates. In the light of treatment recommendations there are efforts to improve access to psychological therapies. Time will tell how this will eventually work out.