Having outlined the main concepts of the cognitive± interpersonal approach to depression, we can now look at how these can be incorporated and crafted into a counselling rela- tionship, starting with an overview of certain aims of counselling:

Basic aims

1 Developing rapport.
2 Exploring possible fears, concerns and expectations of coming for counselling.
3 Shared understanding and meaning.
4 Exploring the story and eliciting key themes and cognitive emotive styles:
(a) taking a historical perspective; (b) working in the here and now.
5 Sharing therapeutic goals.
6 Explaining the counselling rationale.
7 Increasing awareness of the relationship among thoughts, feelings and social behaviour.
8 Challenging and moving to alternative conceptualizations.
9 Monitoring internal feelings and cognitions, and role enact- ments.
10 Homework and alternative role enactments.

Making this kind of list is helpful for clari®cation but should not be taken too literally as marking any set stages. For example,

building a therapeutic alliance goes on throughout counselling. It commences when the person enters the room and is still import- ant when it comes to saying goodbye. Secondly, all therapies have a certain course, e.g. beginnings, middles and endings/termina- tion. Beginnings are taken up with getting to know the client and the nature of the current dif®culties, but also the client needs to get to know you. Different clients move through these stages at different paces and they often overlap. Some clients will move through the early stages very quickly, others less so. In this chapter our main concern is to explore the early part of coun- selling ± beginnings and engagement.

Your interpersonal style will help to put the person at their ease and create a place of safety. Your style needs to be responsive to the client. Over formality with very af®liative clients, or over friendliness with more reserved personalities, may not be com- fortable for them. Different types of counselling will proceed in different ways. The client needs to know the kind of role rela- tionship they will share with the counsellor. For example, some therapies are relatively free- oating and discursive, whereas others are directive and structured (Dryden, 1990). Cognitive approaches attempt to include the best of both free and directive approaches. Space is given to clients to explore and gain their own insights and generate their own solutions. This is conducted within the basic structure of the cognitive approach.

Developing rapport

The process of developing rapport and eliciting a depressed client's interest in the possibility of change can be one of the most dif®cult. However, the techniques of change cannot be used with- out a good collaborative alliance. Indeed, many have cautioned against the tyranny of technique. Some cases of counselling fail because rapport and a good working relationship are not estab- lished. Resistance can be sometimes traced back to this early stage. Clients may not have felt understood, there may be various, unaddressed shame issues, and/or the client feels that the coun- sellor is pressuring them to change. Even a mild degree of relief early in counselling can help to build the therapeutic alliance. The important aspect here is that the client gains a sense of someone who is going to work with them, and take their views and feelings seriously.

Also, it is the counsellor's role to do what he/she can to put the client at ease and acknowledge the asymmetrical nature of the role relationship. Depressed clients often have an acute sense of

powerlessness and inferiority. Although one might not feel one- self to be personally threatening, this does not mean that the depressed client will experience you as non-threatening. Interper- sonal skills, such as smiling, taking an open posture and maybe offering a coffee may be reassuring. We should also

pay attention to context. Try to create a relaxed atmosphere by attending to the setting. Comfortable chairs without an intervening desk are essential. Dress reasonably conventionally so that one's presentation is neutral without being overly formal or too `way out'.

Fears and concerns in coming to counselling

When many of us seek help for the ®rst time there are various hopes and fears of the ®rst attendance. One can create an oppor- tunity to discuss various thoughts and feelings the client may have about coming to counselling: what are their explanations and expectations? After initial introductions, the counsellor may discuss the nature of the referral or the way the person came to take up counselling. Early in the ®rst interview they might then ask various questions. For example, one might ask `Before we start to discuss things in more detail, I wonder if we could look at what has been going through your mind about coming here today.' Here are some typical negative thoughts and feelings that might arise:

1 I was told to come (by general practitioner, spouse, friends).
2 I thought I had to do something.
3 I do not want to have to take drugs.
4 Iwantyoutotellmewhattodo.
5 It's pointless, there is nothing to help me.
6 I doubt that you will understand me.
7 I expect you'll tell me it is my fault and to pull myself together.
8 You might discover I am a weak or bad person or a hopeless case.
9 I want to come but my spouse does not. (Hence, there may be various efforts to sabotage the counselling process at home. The counsellor may suggest bringing spouse or family members to counselling.)

Whatever the fears and doubts about engaging in counselling the counsellor tries to clarify them and bring them into the open, but does not engage in detailed discussion because, at this point, the client will have no evidence to judge how they are going to get on with you, how the counselling will be structured, or how

useful it will be. So it is put to one side but not forgotten. If the depressed client has strong fears or doubts about coming for counselling, the counsellor may say something like `I see your concerns. At this point, since it is early days, perhaps we could see how this session goes and review the situation as we go.'

Many of the basic fears of the depressed person relate to shame (Gilbert, 1998c). So, early in counselling fears of being seen as inadequate, weak or bad can be addressed. We will be looking at shame in Chapter 8 but in many cases it is not far from the surface and the counsellor should be mindful of this. Nonverbal and verbal communication are often aimed at reassurance and offering unconditional positive regard, but this is something the client has to experience during counselling before they may feel safe enough to explore shame issues. Shame is one of the biggest blocks to developing a therapeutic relationship and therapeutic alliance. There is no quick solution to it and it is the basic attitude of the counsellor that determines if the content of shame can gradually emerge. For example, a client may know what the central issues are (e.g. previous sexual abuse; feeling that they are a fraud; or that underneath they feel deeply resentful and vengeful). However, they are too frightened (shame prone) to discuss them for fear of what the counsellor will think. In these cases the depressed client and counsellor can get into a kind of shadow dance of skirting around central issues. One should not assume that clients are prepared to reveal their central problems simply because they have presented themselves for help. For example, a client mid-way through counselling, when a central issue of aggressive, envious fantasies had been discussed, said:

You know, when I ®rst came here I knew in my heart what I needed to talk about but just felt too ashamed to say. As we went through our ®rst session I knew it was pointless because I couldn't tell you about it. That's what made me feel hopeless about this counselling. During each session we got close and I backed away and afterwards got so angry with myself and you for avoiding the issue.

The client had expected that the counsellor would condemn these feelings, as had occurred in childhood. The counsellor accepted the client's anger for not being able to deal with it earlier and said simply that these feelings had been very painful for her to carry alone. So feelings of hopelessness can arise

because the client has a secret agenda but is too fearful to reveal it. This is why the approach should be gentle and why trust is something that grows. The problem here is that early on the client has no experience of the counselling on which to make judgements and so it is

not helpful to try to reassure the client with platitudes. Most clients prefer looking at the evidence approach rather than efforts to reassure them when they know perfectly well that they have not told the whole story, and therefore the counsellor cannot possibly know what is actually on their mind.
The counsellor should also beware of telling clients that `You will need to trust me' or `I can't help you unless you trust me.' No one is going to develop trust by instruction! Second, having a client reveal something shameful or something they have not told anyone else can feel like a positive validation of the counsellor and put them in a privileged position. However, beware of an eagerness to `get the client to talk'. This can be experienced as intrusive and is not helpful. Beware the counsellor who boasts of how their clients reveal to them. Some patients may not return to therapy if they reveal things too early because they are ashamed to face the counsellor again (Gilbert, 1998c). If very shameful material has been discussed it can be useful to mention to the client that having revealed this they may feel anxious about returning. This would be quite natural but that you have worked with such material before and hope that the person will return. Moreover, the key process is healing wounds not just dragging up the past. Despite our best efforts though we can still lose clients this way.
Other behaviours that help to develop rapport with the client and to overcome the fears of coming for counselling are those core skills outlined in Chapter 1.

Key issues 6.1 Beginning the process

1 Be aware of the power issues of counselling and try to create a safe place, e.g. friendly and open.
2 Give an opportunity to discuss fears of coming to or under- taking counselling.
3 Avoid providing false reassurances or making control state- ments, e.g. you must trust me.
4 Be aware that trust builds from experience.
5 Be aware that a client might have secret things they wish to talk about but are too ashamed.

Shared meaning

Sometimes we can look too hard for the important information and miss the obvious that presents with little effort. Even in very brief discussions early in counselling key themes and concepts can

be present. For example, the key theme that the counsellor will ®nd out something bad about them may be a central issue in counselling (e.g. the fear that others will reject them if they get too close). So it is not always the case that key themes are `deeply hidden.'
After the initial discussion of the thoughts and fears of coun- selling, the counsellor may begin to start to explore the current situation and what has brought the client into counselling. Coun- sellors differ on this. In my approach I might spend some time exploring basic symptoms and perhaps go through a Beck Depression Inventory (Beck et al., 1979). Part of feeling under- stood is that the client has been given an opportunity to tell how bad things are, such as sleep disturbance or loss of energy. The counsellor 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 speci®c interven- tions. The counsellor must make contact with the reality of the client's experience. If sleep disturbance (say) is the most troubling symptom to the client, and the counsellor does not address this, then the client may feel that the counselling is not in tune with their experience.
By the end of this stage the counsellor and client will have shared the reasons for the referral, the feelings about attendance and the basic symptomatology and experiences of being depressed. It is now possible to move to the next phase of exploring the story.

Exploring the story

At the start of obtaining the story the counsellor may need to be directive and use closed questions to begin the process. Below we will use the case of a client we will call Peter.
Counsellor: We have spoken a little about your feelings of coming to counselling and the symptoms you are experiencing. Perhaps we could start to look at what's been happening to you recently.
Peter: Yeah. Things seem to have been piling on top of me. I feel washed up, like there is no point any

more.
Counsellor: How long has that feeling been with you?
Peter: Oh, I don't know, maybe a year. Maybe longer.
Counsellor: What about before that? Looking back two years, how were
you feeling then?
Peter: Well, not like this. Things seemed to be going okay then. Counsellor: So you have been feeling low for about a year, but before
that things seemed okay. Peter: Yes.

Counsellor: Has there been anything that has happened over this year that seems to be related to this feeling low?
Peter: Well, there isn't one thing. It's a number of things.
Counsellor: A number of things? Could you tell me about them? Peter: We were hoping to move to a new house about a year ago and
then we ran into ®nancial dif®culties. Then there was a problem at work. I didn't get the promotion I was due and all our plans started to slip away. My wife and I started to argue and I got pretty irritable. It seemed nothing was going right for me.
[The client then explained various life events and how they had happened].
Counsellor: So you have had a pretty rotten time recently. There seems
to have been a number of major disappointments for you. Peter: Yes, you could say that.
Once the counsellor has a general idea of life events (which in reality can take a lot longer than outlined here), he/she may wish to focus the discussion and share the dif®cult problems. A common cognitive concern is to go with the worst case or worst fear.
Counsellor: Looking at each of the disappointments, which one seems to have affected you most?
Peter: Well, right now it is my relationship with my wife. We were quite close early on like, but now we seem to be drifting apart. In a way I know it's me. I think I've messed it up if I'm honest.
Counsellor: So it's your relationship with your wife?
Peter: Yes, we argue a lot. She doesn't understand how I feel about
things. She tells me we'll be okay and that I am making mountains out of molehills. I try to explain but she doesn't want to listen.
This is a rather common theme in depression and tells the story about feeling misunderstood and not receiving empathy from loved ones. Here we see the client oscillating between `I've messed it up' and `She doesn't want to listen.' The counsellor should also be alerted to the possibility that the client may fear that the counsellor will turn out to have a similar attitude (i.e. he/ she won't listen). This theme needs empathic handling. If one rushes in too fast with techniques, the client can get the idea that `Just like others, the counsellor thinks I am being irrational.'
Sometimes clients can present with a more angry style. For example, `I keep trying to explain how I feel to others, my GP and so on, but they don't seem to listen.' One response might be `So you feel that people who you are looking to for help, don't listen to you.' In other words, some kind of re ection of feelings of frustration can be useful. Unhelpful responses are ‘Well you haven’t told me’ or ‘I can’t help you until you tell me your dif®- culties.' These are defensive responses by the counsellor.

Let us return to Peter who has con icts with his wife. The underlying theme is feeling that others do not appreciate his internal struggle and dif®culty. Now at this point the counsellor has a choice. The counselling may become focused on historical data, or counselling may proceed to explore the meaning of the wife's behaviour for the client. Let us look at both options.
Historical data gathering
Counsellor: If I understand you, some of your depression now revolves around the thought that your wife doesn't want to know about your worries and fears. We might call that a key issue for you right now. I wonder if we could just look at that in more detail for a moment. Have you had these kinds of ideas before?
Peter: Well, thinking about it, it has often seemed that way. As a child my parents had a lot of ®nancial problems and were always rowing and there was never much time for us kids. I mean they tried and all

that, but if we had problems they didn't really want to know.
Counsellor: Hm, this early feeling of others not having time for you, and it being tied up with money dif®culties, may be important. Could we stay here a little and see how things were for you as you grew up?
The counsellor can then explore systematically the following key relationships:
1 Relationship with mother.
2 Relationship with father.
3 The relationship between mother and father.
4 Relationships with siblings.
5 Peer and school relationships.
6 Early dating relationships.
7 Marital relationships.
8 Relationships with children.
9 Other signi®cant relationships, e.g. with grandparents, uncles, aunts or teachers.
As one moves through the life history, the counsellor is constantly checking on two things. First, repetitive patterns (e.g. of rejection, neglect, abuse or over-protection or needing to look after signi®cant others). Second, the counsellor is interested in the attitudes and beliefs that may have developed in these relationships by asking questions such as: What did you make of that?; What did that mean to you?; What sense did you derive from that?; What did you conclude from that? For example:

Counsellor: What was your relationship with your mother like?
Peter: Well, I felt sorry for Mum. She had too many problems. Dad wasn't that interested really. He was more in the background. He worked hard and then spent a lot of time with his mates down the pub. He'd whack us if we were naughty but not show much interest.
The client then went on to reveal various ideas that others were generally unavailable to him, that his fears and concerns were not taken seriously and, importantly, that nobody could see things from his point of view. We were able to crystallize this basic theme as lack of recognition and that he had been very concerned through his life to gain recognition. So it began to make sense how the problems at work (failing to get the promotion), and those with his wife, were related to the underlying theme of lack of recognition and the associated disappointment.
The interpersonal school of cognitive counselling (Guidano and Liotti, 1983; Liotti, 1988; Liotti, in press; Safran 1998; Safran and Segal, 1990) views early attachment relationships as important to the subsequent experience of self and others and the source of key attitudes (see Chapter 2). Sometimes clients may feel parents had high expectations of them that they were unable to reach, but they would only be loved and acceptable if they did reach them. Clients can also have highly idealized attitudes to parental ®gures. Here the basic theme can be of attempting to win parental approval but of feeling they have failed to do so and are not good enough. Evidence suggests that there is a tendency for depressed clients to have experienced their parenting as low on warmth and high on control. Some depressed people have experienced very authoritarian parenting. This shapes their basic experiences of others, especially those in authority. In such cases, shame- proneness can be particularly pronounced and fears of being `not good enough', inferior, inadequate or a failure and courting criticisms or rejection, and/or being controlled, become apparent in the counselling relationship. As a consequence, the depressed client may have learned various tactics to cope with parental style: (a) to be submissive and avoid trouble; (b) to try to achieve in an effort to impress others and win approval; (c) to put the needs of others ®rst at the expense of themselves (perhaps more common in women); (d) to be aggressive and ensure that they control others (perhaps more common in men).
Other key issues can involve sibling rivalry and competitive- ness (Fennell, 1989). Obtaining an outline of basic experiences and attitudes to signi®cant others will be important and it helps a client begin to comprehend how their depression may be the result of basic attitudes and experiences that existed before the

depression (Gut, 1989; Safran, 1998; Safran and Segal, 1990). Sharing these experiences can aid rapport and heighten the experience of being understood, of having shared something of one's life with the counsellor.

Sometimes acknowledgement of the basic themes in a life history can arouse strong emotions. For example, consider Susan discussing her relationship with her mother:

Susan: My mother was cold. If we hurt ourselves she would say not to be a sissy and to get a grip. I can't really remember her ever hugging us that much or showing that she cared. If I see things on the TV where a mother and child get together and love each other or something, it really ®lls me up.

Counsellor: [pausing and watching to see if this idea is starting to activate signi®cant feelings for the client. The counsellor gets the feeling of something she is struggling with.] Maybe that feeling of ®lling up taps into something you would like, a kind of recognition of some deep hurt?

Susan: [eyes beginning to water] Oh yeah, [pause] yeah.

Counsellor: [pause and gently] Could you tell me what is going through your mind right now?

Susan: Your words of deep hurt. Like it is real deep, maybe too deep. Counsellor: Too deep?

Susan: Yeah, too deep.

Counsellor: Like it's beyond reach?

Susan: Yeah, I guess so.

Counsellor: That's sounds like a hopeless, empty feeling.

Susan: [cries and nods].

In this situation the counsellor has used empathy and been able to tap into a theme of emptiness and loss that is very charged with affect. However, the hopelessness aspect is related to ideas of it being too deep and beyond reach. Later Susan changed this to `beyond repair'.

This example demonstrates that even in the ®rst session, if one explores historical data, one may tap highly charged affect related to basic beliefs and memories. As in Susan's case, these can often be associated with a certain kind of hopelessness of things being too late or beyond reach and repair. The counsellor may have a real sense of the need and emptiness of the client. At these times the experience of being understood and sharing that affect is important. The empathic response is one of being with the client rather than trying to do something to the client. Strong affect can stir up various feelings (e.g. to rescue) in the counsellor, but one should be cautious of defending against this affect with plati- tudes, or switching immediately to cognitive reconstruing.

It is possible that a client might reveal a horri®c story (say, of abuse) with little or no affect. Here the counsellor notes the absence of affect and may draw attention to this later. However, working with what has been called `split off' emotions and feelings is more complex than we can outline here (see Greenberg and Safran, 1987; Greenberg et al., 1993).

In exploring these issues the client can begin to build a picture of how previous experiences have led to various basic themes and self-schemata. Recall that during the historical exploration the counsellor asks `What did this mean to you?' Here one is inter- ested in how the self-structure has developed. Let us stay with the case of Susan:

Counsellor: You were saying that you felt your mother rarely hugged you, and this has given you the feeling that maybe things are beyond repair. Could I ask you to focus on that feeling for a moment and tell me what you have concluded about yourself.

Susan: Now or then?

Counsellor: Well, both really. Let's think about then, like when it was happening to you.

Susan: I'm not sure. I saw that other parents seemed to hug their kids and wondered why it was different at home. I guess in the back of my head I began to think maybe there was something wrong with me. Counsellor: Something wrong with you?

Susan: Like she didn't love me because I was unlovable.

Counsellor: Did you have any ideas about what it was that might be unlovable about you.

Susan: [pauses and looks down] I've never mentioned this to anyone

before, but you know I was the second girl and I sometimes thought that maybe they wanted a boy rather than another girl.

At this point in our counselling we note that Susan has intro- duced two new ideas of (a) lovability and (b) gender. The coun- sellor could check on the evidence ± e.g. because her mother didn't hug her, why did that mean she didn't love her? Or, look to see if she thought her sister had been treated differently. But at this stage, that might cut across the ow of meaning and sharing that is emerging. So the counsellor notes this connection, continues to explore self-ideas and feelings, and later offers a crystallization.

Counsellor: So you had the impression that because your mother didn't hug you that much, and you saw it was different for other kids, that maybe this was because she didn't love you. And you also had the idea that maybe this was because she had wanted a boy rather than another girl.

Susan: Yeah, that sounds close to it. Yeah.

During the counselling it was then possible to look at evidence and (in this case) discover that her mother was equally distant

from her sister. There was little evidence that her mother wanted a boy. However, her sister had coped with the mother's distance differently, leading Susan to feel more inadequate in comparison with her sister.

At this stage we have engaged historical data to explore basic key themes in self±other relationships. This is part of developing rapport and also exploring the basic life themes of the person's story. It helps clients feel understood. Clients are not a set of disconnected problems to which one can apply techniques ad hoc. Rather, one needs to have a sense of the whole person, since people live with their history and make sense of the present by virtue of what has happened in the past (Liotti, 1988, in press; Safran, 1998; Safran and Segal, 1990). In other words, we learn to experience ourselves via the interactions we share with others (Gilbert, 1992). Nevertheless, it is not always appropriate to go into detail over life history. Also different schools of cognitive counselling have different views on the value of historical work (Mahoney, 1990; Mahoney and Gabriel, 1987). Thus one might prefer to work in the present, though historical working is nearly always important because (a) it helps to develop a sharing and closer relationship; (b) it often makes clear certain underlying patterns and beliefs that might be dif®cult to formulate or be aware of when working in the present (e.g. Susan's view that for her mother she had been born the wrong sex); and (c) it gives people a sense of perspective and continuity with their lives.

Working in the present

Above, we noted how the counsellor had worked with Peter's present problems with his wife. However, this is only part of the current information. In cognitive counselling a very important concern is to gain information on how the client evaluates the self, since it is often negative self-evaluation that is particularly linked to depression. To elicit the central ideas of the self it is often helpful to focus on a speci®c example and create an inference chain:

Counsellor: Peter, this theme of recognition is obviously important to you. However, I wonder what goes through your mind about yourself when others don't seem to recognize your feelings in the way you might wish.

Peter: I'm not sure I understand what you mean.

Counsellor: Right. Well, let's think about a particular example. Let's imagine that tonight you try to talk to your wife and she doesn't take much interest. What will go through your mind?

Peter: Hm, I think I feel something like, she doesn't really care that much. I am being a nuisance to her and shouldn't feel this way.

Counsellor: You shouldn't feel this way?

Peter: Yes.

Counsellor: What do you say about you? What are your feelings about you as a person?

Peter: I feel maybe I am making mountains out of molehills. Then I think, God, I must be weak and stupid for getting into such a state about things. If I'm honest part of me starts to dislike myself and I feel pretty worthless, inadequate, but like I'm trapped.

Counsellor: So then you have two sets of ideas and evaluations, one about others and one about you. First is the idea that your wife doesn't recognize you and that feels disappointing. You interpret this as evidence that she doesn't care. But also because you feel unrecognized you feel weak, stupid and worthless. Is that how it is?
Peter: Yeah. I feel pretty much a failure really.
What has happened here is that the counsellor has taken a speci®c example of the problem, set it up for detailed exploration and elicited the typical constructions that Peter makes. If one has access to historical data then one might see this as a repeating theme. Note how the counsellor spells out the different self±other evaluations (by saying `You have two sets of evaluations, one about you and one about others'). Having arrived at this point in the process it is now possible to consider tactics for change.

Key issues 6.2 Sharing and basic themes

1 Explore the current events that have led up to the depression and which may be continuing.
2 Look at the most dif®cult situation, or go with the worst.
3 If working with historical data, explore past signi®cant relationships of the client and how these took on certain meanings.
4 Attempt to identify basic interpersonal styles and beliefs.
5 Note critical events (past or present) that stir up strong emotions and try to illuminate key self±other beliefs, clarifying these with the client.
6 Note possible areas where there is an absence of affect and a detached attitude.
7 When working in the present, create inference chains and separate and clarify key self±other beliefs.

Sharing therapeutic goals and developing the therapeutic contact

Sharing therapeutic goals and developing the therapeutic contact means establishing with the client an agreed focus for work, agreeing the potential for change:

Counsellor: So far, Peter, we have talked of some of the things that are bothering you right now and [if appropriate] we have looked a little at your early life. Do you think working on some of those issues would be helpful?
Peter: What do you mean?
Counsellor: Well, you mentioned that you get disappointed and angry when your wife does not recognize your feelings and that you then begin to get angry at yourself. Suppose you could learn another way of dealing with this situation that didn't lead you to feel bad about you or think of yourself as weak, would that be helpful?
Peter: Oh, yes, of course. If I could cope better I would be happier. Counsellor: So that might be a useful start. Perhaps one goal of our work together might be to see if we can help you cope in a different way at home?

Thus, beginning to share therapeutic goals involves hypothesiz- ing what would be helpful. Asking questions like `Do you think it would help you if . . .' or `What do you think would be most helpful to you right now . . .?' allows the client to begin the process of working towards change. It is little use the counsellor heading off in a direction that has not been agreed with the client (e.g. well I suggest we do this, or you do that). Although depressed clients often appear compliant, compliance is not the same as collabora- tive work. It is the skill of the counsellor to guide the client towards goals that are workable and seen as helpful, and to recognize the difference between compliance and collaboration. Sometimes this takes considerable therapeutic effort.

As mentioned earlier, in self-psychology (Kohut, 1977; Wolf, 1988), cognitive counselling (Beck et al., 1979) and also rational emotive counselling (Ellis, 1977b) the counsellor pays particular attention to the self-experience and cognitions. In cognitive coun- selling this is called self-downing or self-attacking. In a case like Peter's we would be cautious about moving too quickly to dispute the fact that his wife does not care, without ®rst attending to self- attacking and self-experience. There is no hard evidence that this is necessary, but it is my clinical impression that it is. For example, imagine that you feel others have not treated you well. You would want to ®nd someone who, although they may not agree or disagree, shows empathic understanding and does not rush into trying to convince you that you are being oversensitive.

Later, when you feel better about yourself, it will be easier for you to recognize this, if it's true. Nevertheless, the evidence that Peter uses to believe his wife does not care for him will need to be addressed.
So, at the end of this part of the session, the counsellor has agreed with Peter that work will proceed by looking at his own self-downing and self-critical attitude.

Explaining the therapeutic rationale

As one moves through the ®rst few sessions, and normally around the time of sharing therapeutic goals, the counsellor will introduce and educate the client into the rationale of the cognitive approach. Cognitive counsellors see this as important because it enables the client to understand and take an active part in counselling and to make the therapeutic goals clearer. We do not believe that a simple statement such as `We are here to talk about your feelings' is enough. There can be problems if the counsellor gives the impression that they know what is going on, what to expect and the stages counselling will take, but the client is left largely in the dark. Also, clients are helped if they learn that there are things that they can do to help themselves and that the counsellor will offer guidance on this. Whatever model is used in counselling it is important that clients should be educated into the kind of process it will follow. Introducing the model can go something like this:
Counsellor: We agreed just now that if you could ®nd ways of helping you tackle this problem without `attacking yourself' this might be helpful to you. Can I show you how we might approach this? [At this point the counsellor explores the client's interest.] We call this a cognitive approach. We will focus on the meaning you give to events. A simple way to show this is for me to write an example with you and then look again at your current situation.
Following this, one takes a pad and pencil and, if necessary, moves one's chair to be at the side of the client. The counsellor may offer various examples of how thoughts can affect feelings (remember the lemon example on page 52). The counsellor may then draw out two or three columns (see Appendix 4) and run through some simple example (e.g. the one given on page 54 of the lover who does not phone). Following this, check that the client understands the approach. Does it make sense? Often, the simple act of sitting next to the client and engaging in a shared task helps the sense of collaboration. However, if a person is very depressed this may be inappropriate, or if the client gives off various nonverbal signals of lack of interest, then one has to slow it down. So, while you are sharing the model, attend to the client's verbal and nonverbal behaviour and check on any thoughts they might be having (e.g. it is too logical, it won't help my feelings). However, assuming that the client agrees, one then moves to use the client's example.
Counsellor: Okay, Peter, you have mentioned that problems with your wife seem to be central right now. One way we can explore this is to

begin to make sense of how you think about these interactions. So we can write down together the typical sequence of events, thoughts and feelings.
For Peter it went like this:

Triggering Events	Beliefs and Key Thoughts	Feelings
Telling my wife about my money worries but she tells me not to worry.	She doesn't understand. If she cared for me she would try to listen to me. You have to take responsibility for worrying. You should be able to cope with this. You must be a weak sort of person for not being able to cope. You are not worth caring for. You are worthless.	Angry, depressed, withdrawn.

Notice that sometimes a client will talk to themselves as if talking to another (e.g. you should, you must, you are etc.). Now this is quite common in depression and suggests a basic split in the experience of the self (Greenberg, 1979; Greenberg et al., 1990, 1993; Gilbert, 1992, in press b). One should notice this for it points to potential ways of intervening later (e.g. the two chairs approach on page 85; Greenberg, 1979; Greenberg et al., 1993).
In helping clients write thoughts down in this way a number of things are happening. First, it helps to

crystallize those half- formed ideas in the mind and to clarify meaning. Second, it helps in the process of shared understanding, and offers a focus. Third, and rarely mentioned in the literature, there is a behavioural exposure aspect to this approach in that the thoughts and their feelings are subjected to repeated exposure, challenge and desen- sitization.

Increasing awareness

Once the client has understood the approach, the counsellor has many choices of how to increase awareness and challenge dysfunctional thoughts. These were outlined in Chapter 4. The counsellor can begin to challenge the thoughts one by one; for example, by looking at the evidence for the thought, and/or exploring alternatives. Alternatively, the counsellor might use the friend technique to challenge the whole inference chain. In later sessions, the two chairs might be used. Also counsellor and client can work down or up the chain. My preference is to work up the

I am worthless
I should be able to cope
Wife doesn't listen
She doesn't care about me
Feeling low/ worrying

Figure 6.1
The inference chain and emotions in Peter's case

chain, to tackle the worst thing ®rst, which is self-attacking and poor self-experience.

One also wishes to put across the idea that internal meanings (thoughts and personal constructions) are fuelling the dysphoric emotions. This is an educational aspect. Hence one may stop at this point and draw out the inference chain and emotions in a circle. The circle for Peter is shown in Figure 6.1.

Counsellor: Do you see how this sequence of events and ideas drive this circle around, such that you end up feeling worse until eventually you withdraw and go to bed. We could probably draw another circle that puts in the fact that when you withdraw, your wife also with- draws more, and so again things get worse for you.

Peter: Now that you draw it out like that it seems so clear. That's exactly what happens. But I still can't see how it's going to change.

In this case writing down and drawing has helped the client clarify the issues. At these times one can check on the level of agreement and the possibilities of `yes but' thinking.

Counsellor: Okay, Peter, this is an important part of our work together, to gain more understanding of what goes through your mind, why, and how what goes through your mind makes things feel even worse.

At this time one begins to encourage the client to start to monitor his/her own thoughts and behaviour inside and outside counselling. One might give them thought recording forms that

have two or more columns (see Chapter 4), or one might write the key thoughts and attitudes on a card and ask the client to monitor how often he/she has these thoughts between sessions. In the early days try to keep it simple. More complex ones can be built as you go (see Blackburn and Twaddle, 1996).

Let us now review our thoughts regarding the key issues in sharing therapeutic goals, explaining the rationale and increasing awareness.

Key issues 6.3 Sharing and explaining the therapeutic process

1 Once a key set of dysphoric attitudes has been identi®ed, use questions to explore what might be helpful, e.g. `What would be helpful to change?'; `Would it help if you could . . .?', etc.
2 Gain the client's cooperation in targeting certain cognitions or behaviours, i.e. agree therapeutic goals.
3 In depressed clients, look for the self-attacking and self- undermining cognitions.
4 Be clear about how you are to work together. Write things down, offer examples.
5 Use various procedures, e.g. writing down an inference chain and drawing circles of interacting thoughts and behaviours.
6 Prepare the client to begin to do this kind of monitoring for
him/herself.

Challenging and moving to alternative conceptualizations

To help develop alternatives we can work off the circle or go back to the chain. As I have noted many

times, self-attacking is often triggered by disappointment. It is important to help clients recog- nize this and reconsider and recognize their genuine emotions.
Counsellor: What we can do now is to see if there are other ways that you might cope with this situation. Let's start with the idea that you are worthless. How does your wife not listening to you make you, a human being, worthless?
Peter: Well, it doesn't I guess, it just feels that it does. [Here the client has shifted the idea of worthlessness into a feeling so the counsellor can use this.]
Counsellor: Looking at it now does that feeling seem reliable?
Peter: Well, logically no not really, but then that's how I feel. Counsellor: Well, right; you do feel bad but suppose it was something
else other than worthlessness. What else might this bad feeling be? Peter: [thinks for awhile] Lonely, disappointed. [pause] Empty, I guess. Counsellor: Can you be in touch with those feelings for a moment?

The counsellor then stays here and explores images, feelings or memories enabling the client to gain deeper insight into how disappointment and emptiness launches the self-attack. Some- times memories of being put down come to mind.
Counsellor: Can you see how, when you feel unrecognized and disap- pointed and lonely, this triggers a self-attack and makes you think that you're worthless?
Peter: Hm.
Counsellor: Okay, so suppose we were to change that idea of worth-
lessness and stay with lonely and disappointed. How would that
feel?
Peter: [pauses, thinking] I would still feel upset but maybe not so angry
with myself.
Later the counsellor might add:
Counsellor: Well, it is possible that you learned to self-attack when you felt unrecognized as a child. Perhaps we can make some changes in this and help you develop a more accepting, caring attitude to yourself. It seems to me that the one time you need to care for you, you put the boot in, a kind of kicking you when you're down.
Peter: [client smiles] Oh, yeah, I've always been good at that.
Here the counsellor has attempted to shift the self-experience to a feeling of disappointment from a self-attack. Remember in Chapter 2 we said that our relationships with ourselves can either be one of hostility or nurturing. Here we try to turn the attacking self into a caring self (Gilbert, in press b). This is likely to need repetition many times since for Peter there is a long history of the experience of lack of recognition triggering the self-attack. Also note that sometimes we need to help clients experience speci®c feelings more deeply. In these cases anger at self becomes a secondary emotion to disappointment and loss, especially in depression, and this linkage will need further work (see Wolf, 1988). The counsellor's empathy for the disappointment will be important in the healing process. From a cognitive point of view, a clear insight into the linkage of the feelings of disappointment and anger at the self is helpful. Thus before moving to challenging, one can provide further opportunities for re ecting the client's experience of disappointment and loneliness.
Counsellor: The feelings of disappointment are painful and you are not sure what to do with them.
This may lead to further discussion about how to cope with disappointment or historical events. It may also lead to attitudes like 'I have to be loved and recognized, otherwise it is terrible and

unbearable.' Thus the experience of disappointment itself may be heightened by the client telling him/herself that they cannot possibly bear it. Following this the counsellor can move to more cognitive work.
Counsellor: Let's think more about this idea of worthlessness. Now sometimes we might call this 'black and white' thinking, or 'either/or' thinking. Like if my wife recognizes me I am okay, if not I'm worth- less. Suppose you had a friend and one day he comes to you with a rather similar story, what would you say to him?
Peter: I'd understand his feelings I think.

Counsellor: So you wouldn’t say well, ‘I’m sorry my friend, your wife doesn’t share your fears therefore she doesn’t care for you. You should be able to cope, therefore you are worthless.’ Peter: [smiles] Oh, no, I wouldn’t say that. Counsellor: Would you think it?

Sometimes people would think harshly of others, although they would not say so and this needs to be recognized. The counsellor’s response here can be, ‘Well, you are certainly consistent. But if you did say it, how would your friend feel?’, again getting across the idea that the attack leads to feeling worse.

At this point one again has a choice. We can continue to work the theme of worthlessness in various ways. We might talk about different parts of self (see Chapter 5), pointing out that we are made up of multiple bits, feelings, competencies, abilities and so forth and that the client is globally rating themselves negatively due to one situation or theme. We may talk about putting all one’s eggs in one basket, or use the straight line. One could encourage the client to draw up a list of things that they can do which does not depend on the spouse/partner’s recognition. Other possibilities involve distinguishing self from performance judgements (IT± ME), breaking up black and white thinking, the friend technique and advantages±disadvantages of maintaining these beliefs. In role reversal one might say `How might you convince a friend who has a similar experience, that because his wife does not listen to his money worries this does not mean that she does not care for him or that he is worthless.' Re-attribution training can also be used; for example, can Peter generate alternative explanations for why his wife does not wish to listen to his worries? When Peter was asked this he said it was his wife's attitude to things. Her approach was, `If you can't change it, worrying only makes it worse.' Thus we had an alternative explanation for his wife not wishing to focus on his money worries. This technique therefore involved Peter challen- ging his thoughts with `What is the evidence that I am worthless because my wife doesn't listen to me? Maybe she just sees things

differently' and `Maybe she is worried too, but deals with it in a different way.'

To help clients learn how to challenge their thoughts, the counsellor may wish to offer handouts that have been speci®cally prepared for depressed people (e.g. Fennell, 1989). One can also suggest reading material (for example, an appropriate chapter in David Burns' book, Feeling Good, 1980, or Gilbert's Overcoming Depression, 2000). These can then become subject for discussion, although it is not a substitute for the actual counselling. One can also engage in more philosophical discussions and sometimes arrive at particular phrases that seem to appeal to clients. For example, with those who are socially dependent one can discuss the advantages and disadvantages of having others decide one's self-worth. And a challenge of counselling is `to become the keeper of one's own self-worth.' One client came up with `To want approval is natural, to rely on it is a pain.' The exact interventions depend on the case, but the basic intervention is to help break up the global self-attack and sense of worthlessness.

By the end of this intervention the client will have an agreed set of alternative ideas to call on in situations of disappointment. (You will have noted by now that I see disappointment as often central to depression). Sometimes one can write these out on a ash card, on one side of which are the typical depressing thoughts, and on the other the agreed alternatives. Clients often like this because it links them back to the counselling situation when they are on their own and triggers memory of the session.

Often, because the counsellor has come in on the side of the self and has attempted to rescue it from internal attack and self- attacking, while at the same time helping the client to acknowl- edge affects like disappointment, emptiness and so on, this can put the counselling relationship on a sound footing. From here, the client may be able to consider the way his wife is actually caring and to focus on what she does do rather than on what she does not.

Key issues 6.4 Challenging and moving to alternative conceptualizations

1 Look for and clarify the negative self-beliefs and self-attacking in the depressed client’s cognitive style.

2 Help the client to recognize the situations and feelings that often precede self-attacking, e.g. disappointment.

3 Be empathic to these feelings of disappointment in depression, which often centre on evaluations of how others treat the client or goals that are not being met.

4 Note ideas like ‘I must be or have to be recognized, otherwise it is unbearable and I am a worthless

person.'
5 Use a variety of approaches to interrupt the disappointment ± self-attack, self as worthless sequence; e.g. looking at the evi- dence, focus on black and white thinking, or use the friend technique.

Monitoring internal feelings and cognitions, and role enactments

A major aspect of all therapies is to increase awareness outside the counselling situation. There are a number of ways of doing this. One is to teach clients how to use dysfunctional thought records (Blackburn and Davidson, 1995; see Appendix 4). Some clients take to this very easily and ®nd it helpful, others do not. Some- times it is helpful to write out ash cards that they take out whenever they feel themselves slipping; this acts as a prompt. Sometimes making audio tapes of sessions helps. It is helpful to advise them to note any discon®rming ideas they might have. For example, a client would see the value of the ash card during counselling but when alone would discount it's validity, 'It's too rational; I can't change my ideas that simply.' The intervention here might be, 'Well, perhaps that is true but let's try for a while and see how it goes. What have you got to lose?'

Cognitive counsellors often talk about developing the observing self (Beck et al., 1985). It has been found that if depressed clients can distance themselves from their thoughts and look in on themselves, this is helpful. Hence the counsellor can suggest that: 'One part of the self that we are trying to develop is your observ- ing self and your self-awareness. If we can help you identify ideas and images as they pass through your mind then we might have a better handle on helping to change them.' This process of increas- ing self-awareness via self-monitoring (thought catching) can be very helpful with some clients (Beck et al., 1985; Safran and Segal, 1990). Teaching self-awareness and increasing the activity of the observing self helps put a buffer between the thoughts and the affect associated with them.

Another aspect is to say, 'One aspect of yourself we are trying to develop is your nurturing or caring self. When you challenge some of your negative ideas what does it sound and feel like inside?' Check that the client is not being critical for being irra- tional! Some clients feel an overly rational approach is a cold and distant approach so we need to introduce the idea of compassionate rationality (Gilbert, 2000). Have them practice a warm voice or

even use warm and helpful images (Gilbert, in press b). The key idea is that the inner change for negative thoughts should not be cold or hostile.

Homework and alternative role enactments

Cognitive counsellors believe that helping clients make changes in their actual social behaviour is more important than waiting for it to happen. This is the value of homework, which can be set up in a number of ways, but again it is engaging the client's collaboration that is important not their compliance. With compliance they may go through the motions of the homework but not really engage it. At the end of the session one gives a summary of what has taken place. This might be written down for the depressed client to take away and re ect on. Let's think about Peter.

Counsellor: We are coming to the end of the session now and I would like to go through what we have shared together. You started by telling me that things seem to have been worse for you over the past year, and that this is associated with a number of disappointments and ®nancial worries. We looked a little at your early life and found that you have often had the idea that others didn't really have time for you. We then looked at a speci®c area that is causing you distress right now and this was to do with your relationship with your wife. Here we noted two key themes. The idea that your wife does not care for you because she tells you that you are making mountains out of molehills, and the idea that because of this you are weak and worthless. We also explored how these ideas go around in your mind making your distress even greater. [pause] Is that a fair summary?

Peter: Yes, I think so.

Counsellor: Okay, Peter, given what we have discussed can you think of anything you might like to try out between now and the next time we meet?

This involves helping clients to plan their own homework. This again is aimed at encouraging the client to collaborate actively in the process of change.

Peter: I guess I have to practice not putting myself down when my wife doesn't want to hear about my problems.

Counsellor: How could you do that?

Peter: By being more aware, as you say, of my disappointment and not

attacking myself when I feel disappointed.
Counsellor: Yes, that's right. Otherwise you have two problems. One is the disappointment and the other is the attack on you. [Counsellor points to the circle [page 138] and watches to see if Peter is thinking about it.] So over the next week, can you keep a note of the

situations that arise when this circle seems to be activated? Note down your thoughts and how you tried to cope with them. We can explore that in more detail next week.
However, the counsellor is also aware that helping Peter make changes in his social behaviour would be important both for him and the quality of his marriage. Thus, the counsellor explores the possibility of Peter taking on new roles within the relationship. In the case of role enactments it is helpful to enable the client to predict the social consequences of their behaviour.
Counsellor: You were also saying earlier that you and your wife get into arguments about things, especially your view on money, and you both withdraw from each other. Would it be worth trying not to engage this subject right now as it is such a bone of contention?
Peter: Oh yes, if I could stop doing that it would be much calmer at home. It really winds her up.
Counsellor: Well, shall we try for a week and see how it goes? You can bring your worries about money here and we will look at them together.
Here the counsellor has attempted to bring some relief to the marital situation by making the counselling the focus for his fears and worries. This is aimed at setting a new style in the relationship. At some point the partner might be invited to the counselling but at the moment it is helpful to see if the client can make changes himself. There may also be various resentments that will have to be worked with but these will come later.
The other area one might focus on is how they could share more positive relations. Could Peter take his wife out, e.g. to a ®lm or on a walk? What were the things they enjoyed doing in the past? Thus increasing the level of mutually rewarding activities can be helpful. The counsellor can discuss how the depression can cause problems in marriage against one's true desires. Thus, looking at how a client might instigate a more positive role relationship can be important. But, of course, this depends on the case, and the client has to have a basic desire to continue the relationship. In cases where there is much resentment, and a desire to terminate (escape) the relationship, then working on shared activities may be counterproductive. There may be too much anger with the spouse to make this an attractive idea, at least early in counselling.
In these situations the couple may need to be brought together for marital counselling. In Peter's case the loss of the previously good relationship was another source of disappointment. Helping him focus on how he could improve it again was helpful to him and made him feel more in control.

Key issues 6.5 Homework and alternative role enactments
1 Help the client recognize that self-monitoring is part of home- work and also a useful life skill.
2 Teach the client to monitor and test out cognitions between sessions and review this with him/her at the beginning of each session.
3 Help clients plan their own homework and behavioural experi- ments.
4 With depressed clients, these behavioural experiments often involve developing more rewarding social behaviour, e.g. seeing friends, or relating in a different way to a spouse or partner.