Second Edition

COUNSELLING IN PRACTICE

Counselling for Depression

Paul Gilbert

Series editor: Windy Dryden
Associate editor: E. Thomas Dowd

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Paul Gilbert

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Preface to the first edition

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

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

The second section aims to build on these concepts, and lead the reader through a step-by-step approach to the process of counselling the depressed person. Counselling scenarios are given to illuminate specific points and highlight types of intervention. Most of these scenarios are not derived directly from taped interviews

(although some are) but from notes made at the end of sessions. They are not meant to represent exact scenes but rather to indicate and highlight issues. All client names have been changed, and minor alterations introduced in the history, to avoid identification. Chapter 5 outlines the issues that arise during the early parts of the therapy, and how to engage and agree shared understandings and goals of counselling. Chapter 6 explores the kinds of issues that arise in the middle of counselling, as the counsellor and client engage in deeper explorations and seek opportunities for change. Chapter 7 looks at some special problems that arise in depressed clients. Special attention is given to shame, guilt, envy and idealizing which often figure prominently in depressive experience. Chapter 8 explores termination issues and offers some personal reflections.

Preface to the second edition

In the time since I wrote the first edition of *Counselling for Depression* things have changed, including gaining more experience in working with depressed people, who are the greatest teachers. Also our own research efforts on submission, escape and defeat behaviour have been illuminating in a number of ways (e.g. Allan and Gilbert, 1997; Gilbert and Allan, 1998). For example, we have found that many (but by no means all) depressed people feel unable to escape from the things that cause them pain. These may either be their relationships, dashed hopes and aspirations, relationships or physical illness. Depressed people can suffer a constant bombardment of negative thoughts, feelings or conflicts, from which escape seems impossible. So they often feel defeated and overwhelmed by their negatives. Therapy can help reduce that bombardment and help the person develop more internally supportive relationships, more helpful coping behaviours, and elicit more support in the external world.

The outline of the book is similar to the first edition but some chapters have been extensively re-written and updated and there is an extra chapter devoted to interventions. Chapter 1 discusses the nature of depression and the importance of various aspects of the therapeutic relationship. Chapter 2 has been re-written to accommodate new understandings and findings in research on depression. The typical backgrounds, themes of depressive thinking and various coping behaviours that often can be ineffective for depressed people are covered. Chapter 3 outlines some of the basic premises of the cognitive approach to depressive disorders and notes how depressed people tend to 'dwell' on various negative thoughts, feelings and negative scenarios of the future. Chapter 4 explores the different processes for cognitive behavioural interventions for challenging the various negative thoughts and behaviours. Chapter 5 offers insight into challenging negative cognitions in specific ways and in particular internal shaming cognitions. I also cover in more detail the importance of developing inner warmth.

Part 2 begins with Chapter 6 which outlines some of the ways to begin the counselling process for the depressed person. Chapters 7 and 8 then focus on special issues that are likely to arise in counselling depressed people. Because this book is focused on interpersonal themes, these two chapters give examples of working with specific problems. Chapter 9 gives an overview of the types of interventions discussed, explores termination issues and basic therapeutic relational issues that can arise in counselling. In particular we will finish by exploring some of the beliefs and thoughts of counsellors when they try to help depressed people.

This edition also contains new appendices to help guide you in identifying negative thoughts, questions to challenge them, and how to work with thought forms.

As for the first edition, this book is not designed for people with no training or experience in counselling. We anticipate that people using these techniques will have undergone proper training in counselling and that the approaches outlined here can be weaved into their practice. Ideally this should be done with supervision from trained cognitive therapists. This book also gives a particular approach to counselling a depressed person. There are many excellent cognitive therapy books currently on the market and no one book can cover all of the basic principles and ways of working.

This book is focused primarily on the interpersonal dynamics and interpersonal thinking styles of depressed people. This book is designed to take you through a form of counselling process step by step. It also offers some thoughts about how to deal with specific problems. It has not gone into detail about counselling couples or families, even though the book is concerned with interpersonal cognition. Again, this would be too much for one book and is better dealt with by those who are skilled in working and writing on depression in that way. You will note that the text has been updated with new references, which I hope will be useful for you to explore deeper into the depression literature. Working with depressed patients is always a challenge. Each person is unique, although depressed people will have many themes and issues in common. A book such as this can only be a guide that I hope will be useful to various therapists and their clients.

Acknowledgements

First edition

Special thanks go to the series editor, Professor W. Dryden, for asking me to attempt this endeavour, and his encouragement during the writing. His advice was, as always, invaluable. He worked hard on the manuscript, and tried to steer me away from obscurity and lapsing into evolutionary theory. Appreciation goes to Dr C. Gillespie for his support and advice, and his comments on various chapters. Many thanks also go to Susan Worsey and Sue Ashton, who both worked hard on the text. I am indebted to the many clients who, over the years, have shared their depressive experience with me and enabled me to learn from them. They have been the best teachers. Gratitude also goes to Nell Hadlow who helped to correct the manuscript and get it into readable form. Thanks also to Joyce Chantrill and Pat Gibbins.

Second edition

The Southern Derbyshire Mental Health Trust and University of Derby have been supportive in setting up the Mental Health Research Unit which has aided our research into depression. Many thanks to them, especially Dawn Forman (Dean of Health & Community Studies) and Dorothy Lane, Director of Nursing and Human Resources (SDMHT). I am also grateful to Diane Woollands for her expert, efficient and supportive secretarial skills. And as always love and gratitude to my family and the many patients who continue to teach me.

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

PART 1

DEPRESSION AND THE BASIC PRINCIPLES OF COGNITIVE INTERPERSONAL COUNSELLING

1

Depression and Dysphoria and the Counselling Relationship

Depression haunts the lives of many. It exists in many forms, takes various guises and has been recognized for many centuries. Over two thousand years ago the Greek physician Hippocrates labelled it *melancholia*. The Greeks believed depression arose from a disturbance of the body humours, specifically black bile. Early reports of depression can be found in numerous biblical texts. King Solomon is believed to have suffered from an evil spirit and dark moods from which he eventually killed himself. The biblical book of Job, with ideas that God was purposely punishing him, is regarded as the work of a depressed person. More recent sufferers include composers (Gustave Mahler, Tchaikovsky, Sibelius), politicians (Abraham Lincoln and Winston Churchill) and numerous writers, artists and poets (Edgar Allen Poe and Thomas Mann). Lewis Wolpert, a well-known professor of biology, recently wrote of his own terrible depression, efforts to understand it and made a TV documentary about it (Wolpert, 1999). 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 life threatening. Indeed, it is not even unique to humans, and various animal models of depression have been advanced and researched.

What is depression?

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

Motivation: Apathy, loss of energy and interest. Things seem pointless and the future hopeless.

Emotional: The capacity for positive emotions 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.

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 and important neurotransmitters such as serotonin and noradrenalin.

Types of depression

Depression can vary in terms of the relative degree and severity of these symptoms, their duration and their frequency. Hence individuals can vary as to whether their depression is mild, moderate or severe, and they may have one episode or many episodes. Depression is often associated with other major disorders such as social anxiety, eating disorders, substance abuse and schizophrenia. Depression can be triggered by life events (for example, depression may follow childbirth or the loss of a relationship) and life events may also be involved in recovery (for example, beginning a new relationship; Brown, 1989). Depression can have an acute onset (within days or weeks) or come on gradually (over

months or years). Depression can be chronic (for example, lasting over two years), or short-lived (recovery coming in weeks or months). Some depressions also show cyclical patterns.

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.

There is increasing evidence for a form of depression called Seasonal Affective Disorder (SAD). This condition has some atypical symptoms, including a seasonal onset (autumn and winter) with relief in the spring and summer. Mood change is associated with increased appetite, especially for carbohydrates, weight gain and increased sleep. This is an important distinction since exposure to bright light has been shown to be a promising, effective and quick treatment for this condition (Dalgleish et al., 1996; Kasper and Rosenthal, 1989).

Biopsychosocial approaches to depression

Depression involves a number of complex and disabling symptoms as noted above. It is vitally important to recognize that when people are depressed they will have disturbances at many levels of their being. There is good evidence that at the physiological level certain brain chemicals called 'neurotransmitters' are disturbed. Serotonin, noradrenalin and dopamine are especially implemented in depression. These affect our ability to feel positive emotions (joy, happiness, interest, pleasure) and take an interest in things (e.g. food and sex). They also affect negative feelings and emotions like anxiety, anger and shame. Depressed

people not only experience loss of positive feelings but also an increase in negative ones.

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 Nemeroff (1998) and more technical accounts for those who want to know more can be found in Thase and Howland (1995). The point is that the physiological changes that accompany depression will effect 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). As we shall see in this book these are often targets for work when counselling a client. In the social domain depressed people may have various life difficulties and social relationship problems (Brown and Harris, 1978; Brown et al., 1995). A good overview of the complexities of depression, including discussion of genetic dispositions, can be found in Beckham and Leber's (1995) important and very useful handbook on depression.

Interactions

If we think of depression as involving changes in many different domains of functioning then we can see how there can be interactions between them. This is the essence of the biopsychosocial approach (Gilbert, 1995). What this means is that we need to consider depression as a complex web of interactions. For example, a negative life event may increase the production of stress hormones. As this happens our cognitions 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 increases the symptoms of stress (e.g. poor sleep and poor concentration). This adds to feelings of exhaustion and of being 'useless'. Or a cognitive 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 fact, it is useful to think of depression as sequences of interacting processes that spiral a person downwards. All interventions, be they drugs, psychological or social support, are aimed to break into the spiral of depression.

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. 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 et al., 1989). Many will not receive treatment. Worldwide, a figure of 300 million or more has been estimated making depression one of the most common health hazards in the world today. Not only is there a vast epidemic of misery, which affects individuals and their families, the resulting economic costs are estimated at billions of pounds! What is most worrying is that depression may be on the increase (Fombonne, 1999; Klerman, 1988). There are many reasons for this, including demographic changes, life-style changes, increased use of drugs with depressive side effects, and social stresses of various forms (Gilbert, 1992; James, 1997). A counsellor who makes depression a special source of study will have no shortage of cases.

The course of depression

Some clients will recover relatively quickly and most clients will show some recovery in the first six months, but as many as 20 per cent of cases may have a chronic course; that is, the person can remain depressed at varying levels of severity for two years or more (Scott, 1988). Some clients suffer acute episodes that are superimposed on milder chronic conditions (McCullough, 2000). About 50 per cent of clients with diagnosed depression will relapse (Belsher and Costello, 1988) regardless of treatment, although cognitive counselling is able to reduce this rate. Hollon et al. (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 (see also Sacco and Beck, 1995). Criticism from a spouse is one of the more powerful predictors of relapse (Hooley and Teasdale, 1989).

The assessment of depression

There are many ways of assessing depression and as we have seen depression can be subdivided into various types. It has also been

noted that depression affects various domains of functioning. Assessment will often focus on the following key areas:

Psychological

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

Social

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

Biological

1 Is there sleep disturbance (early morning waking, waking after being asleep for a short period and/or difficulties getting to sleep)?
2 Are there major changes in appetite and weight?
3 How serious is fatigue and loss of energy?

4 Psychomotor changes, especially agitation and retardation, should be noted. If a client is very slowed up and finds it difficult to concentrate this can hamper counselling. Severe retardation and lowered concentration may be a poor prognostic indicator for short-term counselling.
5 Would a trial of antidepressant drugs help to break up a depressive pattern? Most studies suggest that antidepressants do not interfere with counselling and are certainly indicated if the depression is severe.

The most commonly used, and well-researched, self-report scale for depression is the Beck Depression Inventory (Beck et al., 1979). This scale not only allows the counsellor to gain an overall impression of the patterns of symptoms, but also can be used to monitor recovery. A general overview of measuring instruments for depression can be found in Berndt (1990), Ferguson and Tyrer (1989), Gotlib and Cane (1989) and Sholomskas (1990). Katz et al. (1995) is especially recommended.

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

In general, a counsellor should be able to assess the main areas of functioning noted above. The other area to be familiar with is the risk of suicide in depressed clients (Hawton, 1987). The Beck Depression Inventory (Beck et al., 1979) allows for this and indicates a potential danger requiring further exploration. Depending on their expertise, counsellors may wish to gain outside advice. A combination of a desire to harm self and hopelessness are warning signs. Also, if a client has plans for killing her/himself, then this is a serious risk (Williams, 1997 gives an excellent overview of the issues). For treatment of suicidal clients, see Grollman (1988), Hawton (1987), Hawton and Catalan (1987) and Williams and Wells (1989).

Treating depression

There have been many different treatments suggested for depression, including drugs and ECT, and a plethora of psychosocial

interventions. These include psychoanalysis, family therapy, behaviour therapy and social skills training, affect therapy, interpersonal therapy and cognitive therapy. (For an excellent overview of various therapies, see Beckham and Leber, 1995). This book will take the cognitive–interpersonal approach; that is, our concern will be with the internal cognitive processes of depression, with a special focus on interpersonal cognitions, social roles and behaviour. For a discussion of family or marital counselling, see Beach et al. (1990); Clarkin et al. (1988); Gotlib and Colby (1987); Prince and Jacobson (1995).

Poor prognostic indicators for the approach outlined here include: severe depression, serious difficulties for the client in forming a therapeutic contract; 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.

The counsellor should also be aware that all depressed states have biological effects and some are related to hormonal/biological changes (e.g. thyroid, the menopause, head injury, etc.). There is recent concern that some depressions have become over 'psychologicalized', missing important physical causes (Goudsmit and Gadd, 1991). 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 biopsychosocial model of depression (Gilbert, 1995; Vasile et al., 1987). This model is concerned with different levels of functioning rather than simple models of causality.

Although there are clients for whom this approach may not be suited, there are many, perhaps the majority, for whom it will be (see Hollon et al., 1991, and Sacco and Beck, 1995 for recent reviews of the evidence on the efficacy of cognitive therapy for depression). The following chapters outline some of the central issues of working with depressed clients, discuss the various skills and qualities that are necessary for the counsellor and how these can be embedded in the cognitive–interpersonal approach. Because the focus is on internal meaning and interpersonal behaviour, this approach places greater emphasis on the therapeutic relationship than is common in cognitive counselling. For this reason, the rest of this chapter will focus on the therapeutic relationship since, without a good grasp of this, counsellors can themselves be a source of resistance to change. Some key concepts

that will be helpful in working with depressed people are outlined below.

The helping relationship

There are a large number of models of helping, many of which are excellently reviewed by Corey (1991). Although counsellors differ in their focus and how they work, there are some central aspects that most share. First is the recognition that the counselling relationship is a special kind of relationship in which the client needs to be understood – not only in a superficial sense by what they say, but also in a deeper sense, that is to make contact with their internal experiences (Gilbert et al., 1989). Dryden (1989a, b) provides an excellent introduction to these issues which include: understanding the basic structures of counselling, the process and stages of counselling, issues of transference and counter-transference, dealing with reluctant and resistant clients and termination issues (see also Egan, 1998).

Here we focus on selective aspects of the therapeutic relationship that are of special interest to those working with depressed clients. Two counsellors can be noted – Carl Rogers and Heinz Kohut. There are, in fact, many overlaps between them, as recorded by Kahn (1985, 1989), and they were at the same university (Chicago) for ten years, although they do not seem to have acknowledged each other.

Carl Rogers (1902–87)

Rogers (1957) was one of the first counsellors to emphasize the relationship between counsellor and client as a source of healing. He argued that the therapeutic relationship should have three basic elements: (a) accurate empathy; (b) congruence, genuineness and 'counsellor realness'; and (c) unconditional positive regard.

Much has been written on the nature of accurate empathy and what this entails (Goldstein and Michaels, 1985) and we shall return to this below. 'Counsellor realness' means that the counsellor should act in a genuine way and not mask feelings or pretend. However, others think that there are limits to the non-masking of feelings in counselling and doubt the value of expressing negative feelings to clients (Kahn, 1985), especially with depressed clients. In general, there should not be 'a counselling persona' that one puts on when one sees the client. Nor should the counsellor slip into a detached and technique-orientated mode of relating. The client's awareness that the 'person' of the counsellor is 'with them' in the session provides an important interpersonal

experience. This is particularly important for depressed people because they often feel separate and cut off from others and think that others cannot be bothered with them or understand them.

The therapeutic atmosphere should be one of warmth and engagement, rather than one of technique-focused detachment. The counsellor should provide an atmosphere of genuine care and concern rather than a 'job-orientated role'. These experiences in Rogers' view were both necessary and sufficient to enable the client to find within themselves the solutions to their own problems.

Heinz Kohut (1913–81)

Kohut (1977) went further than Rogers, and argued that there were certain kinds of internal experience that needed to be understood and recognized in the client. These were (a) the need to feel valued and approved of (*mirroring*); (b) the need to have others whom he/she can turn to and feel comforted by (*idealizing*); and (c) the need to feel like others (*belonging*).

Mirroring: The need to be valued and approved of arises from a child's early exhibitionist behaviours (the 'look at me, daddy, watch me do this' behaviour). When a parent mirrors pride to the child ('well done, that's very good'), the child internalizes a good and vigorous sense of self. For example, if a child shows off and the parent praises the child, then the child experiences him/herself as able and good. Note that not only will the child experience the parents as approving but will also experience him/herself as approved of and attractive. In terms of love the child not only experiences him/herself as loved but also *lovable* (Gilbert, 1992). And, of course, the internal experience to 'showing off' cues a positive affect. If, however, the parent repeatedly puts the child down ('don't do that, you look stupid'), or shows no interest, then the child experiences him/herself as bad, shameful or ineffective to influence the attentions of others. Thus Kohut argued that social interactions give rise to 'self objects'. A self object is an internal experience of the self (not just a memory of how others have responded). Our self object relationships (internal experiences) are usually elicited in social roles (see Gilbert, 1992). For example, in social situations I might experience myself as incompetent and feel shame/embarrassment. This shame/embarrassment reflects a self object experience of 'me as ashamed'.

Morrison (1984) notes Kohut's distinction of 'defensive self-structures' which mobilize efforts to conceal deficits in self, and 'compensatory self-structures' which mobilize efforts to make up for a weakness in self, literally to compensate. Morrison offers a

complex but interesting idea that depression often results from the inability to maintain compensatory structures. The individual simply cannot achieve the ideals which are necessary (be it via a relationship or personal effort) to lift self-esteem (to feel competent and lovable) and restore a sense of self-cohesion and vigour. He notes similarities with Bibring's (1953) concepts, but unlike Bibring he places shame as a central affect. Understanding shame helps us to understand narcissistic rage, especially in depression (Gilbert and Andrews, 1998; Mollon and Parry, 1984). We will return to the issue of shame in Chapter 8. But it is useful to keep in mind that a client's need to feel (and be seen as) good, able and talented is often paramount in working with clients.

Idealizing: This relates to the fact that the child needs to rely on others. When those to whom the child looks up to respond with helping and caring responses, the child feels soothed, secure and loved and develops basic trust. When this is not the case, the child feels that there is no one there for them and is unable to feel soothed in the presence of strong negative emotions (sadness, anxiety and anger). Subsequently, as an adult, the person might resort to various defensive measures (e.g. drinking) to try to sooth themselves when under stress rather than cope adaptively. They may be distrustful of the counsellor, expecting to be let down in some way.

In counselling, the counsellor can empathize with the needs of the client in his/her wish to have some 'strong other' come to the rescue and make things better. Thus the counsellor can recognize a client's yearning for rescue, his/her fear of abandonment and aloneness and being beyond rescue, beyond help. Hence, if a client says 'Can you help me? I feel so desperate', the counsellor should not say 'Well, it's up to you', or throw it back. Rather, the counsellor should focus on a collaborative journey, recognizing the client's need for rescue. Possible responses are, 'I recognize your need for help. Let's look at your problems together and see what you find helpful. Now, what's been going through your mind?'

Belonging: This relates to a child's need to feel at one with others, part of a group or relationship rather than an outsider and cut off. There is much evidence now that this is an important and powerful motivation for humans (Baumesiter and Leary, 1995). Again, a counsellor can empathize and recognize the yearning to belong to some group and feel part of some social situation.

DEPRESSION Kohut's theory of depression is very well summed up by Deitz (1988). Basically, depression results when a client has

lost the external inputs (e.g. relationships) or the internal positive dimensions of self-experience that maintain positive feelings about the self. The goal of counselling is to facilitate and develop contact with internal positive self objects (or in cognitive terms positive self-schemata and attitudes) that bring back or develop representations of self as having worth and being able, rather than those of being worthless and unable. Basically, it is very difficult for a person to feel better if they keep putting themselves down and self-criticizing. Deitz (1988) notes that these ideas are similar to cognitive counsellors' notions of self-schemata.

In a way, Kohut's view of depression is that it is nearly always secondary to a 'painful sense of disappointment'; disappointment that life has turned out the way it has; that others are not as loving or reliable as was hoped; that plans have not come to fruition and so on. Somehow one has not made it; a position portrayed so brilliantly in Arthur Miller's play, *Death of a Salesman* (for a further discussion of this, see Baker and Baker, 1988). It is important to help the person articulate their sense of disappointment and to reflect on the sources of this disappointment, often of unrealistic aspirations, misinterpretations or unmet needs. In this theory, anger is secondary to feeling one is blocked and thwarted.

THE INTERNAL EXPERIENCE The counsellor attempts to make genuine contact with the depressed client's internal experiences. These can be of various forms; for example, a sense of weakness, badness, shame, envy, fear, hopelessness, emptiness, and so forth. The idea that some of these experiences relate to unmet needs or punitive early experiences is helpful and Kohut's concepts allow us to be more focused in our empathy. It is through our empathic understanding and responses that a client is able to feel understood and recognized. No matter what technique one uses, if these are not provided then counselling may run into difficulties.

Some key issues of the therapeutic relationship are as follows:

Key issues 1.1 The therapeutic relationship

1 The counsellor recognizes the basic ingredients of a therapeutic relationship and how it differs from other forms of relationship.
2 The counsellor offers time and space for exploring and the 'invitation' to talk.
3 The counsellor shows openness, genuineness and positive regard – and is nonjudgemental.
4 The counsellor attempts to become aware of the basic interpersonal needs of the depressed client in terms of mirroring,

recognition, valuing and idealizing experiences to be worked with and understood rather than ignored.

5 The counsellor recognizes the common experience of disappointment as part of the depression. The counsellor attempts to create a 'safe place' for counselling to take place.

Empathy

It is recognized that the counsellor should attempt to form an empathic relationship with the client, enabling the client to feel understood and accepted, and to explore painful feelings. However, there remains confusion over the nature of the empathic relationship as it can be mimicked in an automatic way and in this sense be non-genuine. Also, there are common misunderstandings about empathy. Common ones are confusions in the distinctions between genuineness, unconditional positive regard and empathy. Consider two examples from Book (1988: 422):

Example 1

A first-year resident, when verbally assaulted by a paranoid client, responded, 'I'm glad to see you can get your anger out.' The client hesitated, looked perplexed, and then angrily roared, 'You bastard! To be so happy that I am this upset!' When asked about his comment, the resident stated, 'I was just trying to be empathic.'

In this example the counsellor had confused a genuine desire to help the patient feel safe to express his anger with empathy.

Example 2

A Holocaust survivor raged against the rudeness to which he felt subjected at work. His Jewish counsellor responded, 'It really makes me angry when I hear that. What the hell's the matter with them?' The client responded, 'That's what I'm telling you. They're all a bunch of butchers.'

In the second example the counsellor was responding from his own frame of reference. Book (1988) gives many other examples of confusions between genuineness, unconditional positive regard and empathy, including hearing but not really believing that a client can mean what they say, or making subtle alterations in the client's statement that actually changes the meaning.

In empathy, one listens and attends to both what is actually said and expressed, and what is not. One notes possible hidden shame and resentment, the fear of loss or the disappointment that lies behind a self-attack (Gilbert, 2000). As Kohut (1977) points out, a client's rage can often hide a deep sense of loss, being devalued and marginalized. An empathic response helps the client make contact with those feelings and their internal self-judgements. Another misunderstanding of empathy is filling in the blanks or finishing a client's sentence for him/her. This can be experienced as an intrusion. Instead, the counsellor can respond so as to help the client fill in his/her own blanks. Thus, as Book (1988) says, empathy may be understanding what the client is going to say, but being empathic is not saying it. A good measure of empathy is whether or not it enables clients to deepen their understanding and continue with their narrative.

A genuine empathic response from the counsellor is not necessarily perceived as such by the client, and therefore Miller (1989) refers to the 'therapeutic empathic communication process'. This is a five-stage model involving a counsellor's recognition of the client's internal experience (via the client's verbal and non-verbal cues), the sending of signals of recognition, and the client's ability to recognize and internalize such signals (i.e. I understand, I show you I understand, and you understand that I have understood). Empathy is a way of being with, or an 'in-tuneness to', the client, not simply a skill to be 'brought to bear'. As Margulies (1984) pointed out, empathy requires a 'sense of wonder' and caring interest (Gilbert, 1989). Interest alone can appear detached. Caring alone can involve more sympathy and too vigorous an effort to 'get the client better'.

SYMPATHY AND EMPATHY There is no clear evidence that sympathy at times is not helpful, but empathy is regarded as the more helpful. Thus it is beneficial to be clear about the differences. Table 1.1 taken from Gilbert (1989) outlines some of these differences.

Consider a client who is crying and giving strong signals of emptiness and loneliness. Our empathic feelings are close to how the client actually feels: empty, alone. Our sympathetic feelings are those that elicit the desire to touch the person, help alleviate the pain, to reassure them that it's going to be okay. In very emotional situations it can be quite difficult to recognize these differences. At times, sympathy is not necessarily anti-therapeutic and can be helpful, especially when blended with empathy in the form of compassion (Gilbert, 1989). However, the counsellor must be clear about the distinctions and not be carried away by feelings

Table 1.1 *Distinctions between sympathy and empathy*

Sympathy	Empathy
Involves a heightened awareness of the suffering or need of the other. Something to be alleviated. The focus is on the other person's well being.	Involves a heightened awareness of the experiences of the other (not necessarily suffering) as something to be understood.
Behaviour is on relating, acting for, alleviating (or mediating responses).	Behaviour is on knowing, conceptualizing, understanding.
Sympathy is relatively automatic and effortless.	Empathy is effortful and depends on imaginal capabilities.
In sympathy the self is moved by the other.	The self reaches out to the other.
The other is the vehicle for understanding and some loss of identity may occur.	The self is the vehicle for understanding and never loses its identity.

of the desire to rescue, which can break into the client's self-healing process and not match the client's needs. Key issues in empathy are as follows:

Key issues 1.2 Empathy

1 Empathy involves attentiveness to the verbal and nonverbal affective messages emanating from the client.
2 It is nonjudgemental.
3 It encourages exploration, especially of core areas and life themes and is sensitive to blocks and/or fears.
4 It is focused on knowing, understanding and sharing rather than helping, and alleviating (as in sympathy).
5 Empathy is reflective and thoughtful and involves effort, unlike sympathy which can be immediate, automatic and is relatively effortless.
6 It is flexible and avoids the client feeling 'pinned down or exposed'.

IS EMPATHY ENOUGH? Cognitive counsellors doubt that the qualities of accurate empathy, positive regard and genuineness are, by themselves, sufficient to produce change. Education into the way an individual thinks about events and labels or puts him/herself down is crucial for change. But cognitive counsellors do believe that these qualities are necessary ingredients of a helping

relationship. Although texts on cognitive counselling do not always stress the role of the therapeutic relationship (but see Dryden, 1989b), it is assumed that the counsellor is already proficient in these skills (Beck et al., 1979). Unfortunately, not enough attention has been given to these aspects in some texts.

Frank (1982) suggests that many states of depression and other conditions are the result of demoralization. A variety of approaches can reduce demoralization if they include such things as understanding, sharing, respect, interest, support, encouragement, acceptance, validation, forgiveness, education and even inspiration. Thus, a helping relationship may go far beyond the ingredients first noted by Rogers. Gilbert (1989, 1993) has pointed out that there are two fundamental systems in the brain – defence and safety. When individuals perceive threats, their actions and cognitions are self-defensive to avoid harm. Such actions tend to be automatic and rapid and reduce the chances of exploration. Safety involves such aspects as trust and confidence that the environment will not deliver threats. Safety increases exploration of, and integration of, material. Many depressed clients are highly attuned to threats (e.g. of losses, put-downs, rejections). The counsellor therefore tries to engage the safety system to allow exploration of painful material and enable the client to begin to take the risks necessary for change. To a large degree psychopathology arises when the defence system is highly activated.

Validation

Many clients may wonder if their feelings are valid – maybe they should pull themselves together or should not feel what they do feel. This can be the case for past events as well as the present. In these situations it is important that the counsellor attempt to validate the person's inner experiences. It can be useful to be clear with the client that they feel what they feel for good reason. In my own work I tend to look at possible adaptive significance (or advantages) of negative feelings. For example, a client may say 'I shouldn't get so depressed or anxious over these events. I am blowing them out of all proportion'. To this I might say 'Well you might prefer not to be so depressed or anxious but sometimes our feelings are there because we evolved to act on them quickly (offer some examples, see Gilbert, 2000)'. The key point is that given the way the client sees and evaluates situations, their feelings are understandable and not evidence of personal weakness or stupidity. Indeed, this can be the first step towards helping people understand the cognitive approach as well as developing a collaborative relationship.

Validation can also be important in session. Many clients will have experienced others as not being straight with them or covering up. For example, half way through a session a client said:

Client: You know you look tired and not really here today.

Now, one could be defensive and say 'what makes you say that?' Or 'well I am trying my best'. Or not respond to it all with 'what is going through your mind'. But first it is important to validate the client's experience if it is true.

Counsellor: You know you're right, I am feeling tired today.

You might then follow up with more exploration of the feelings and meanings of this. In this particular case, noting my tiredness had triggered beliefs in the client that she should not 'burden me further'. This led to an important discussion of being sensitive to others and fears of being a burden.

Counsellor skills

There are various core skills that help the construction of a therapeutic relationship, especially the development of accurate empathy. These help convey a sense of being understood and cared for. They act as encouragements to the client to continue to explore and discover.

NONVERBAL BEHAVIOUR We are only just beginning to research and explore the impact of nonverbal behaviour in counselling, but it is probably profound. Facial expressions and body posture help to convey a sense of being with the client. Nonverbal behaviour helps to set the emotional climate of counselling and the conditions of warmth. One's style should be relaxed and welcoming but not too laid back or detached.

MINIMAL ENCOURAGERS Often clients only require prompts. These can be nonverbal, such as nods or other head and eye movements, or verbal prompts such as 'Hmm', 'Ah-ha', etc. Subtle prompts may call forth different types of information from more direct questions which can be controlling or directive. Sometimes it is useful to encourage exploration with simple words like, 'Because?', 'And?' or 'So?' This is short for 'this happened because . . .?', 'You see that as important because . . . ?' (Nonverbal behaviour and voice intonation are important here: a 'so' can sound hostile rather than a position of interest.) These help the

person to link ideas and allows the discussion to flow more naturally. At other times the counsellor can encourage exploration with more open questions 'Can we look at this more closely?', 'Can you say more about that?' Also, if the counsellor does not understand what the person is saying or meaning then it is helpful to say so, for example, 'I'm not sure I understand that, could you help me by explaining further', or 'Can we go into that a little more?' etc.

OPEN AND CLOSED QUESTIONS Open questions leave the person to respond in their own way. For example, the classic cognitive question of 'What was going through your mind?' is an open question. Other examples are 'What did you make of that?' or 'How did that affect you?' Closed questions are aimed to elicit more specific information. 'Can you tell me how you are sleeping?', 'What is your sex life like?' Closed questions do not allow the client to articulate their own meanings and should be used sparingly. Many novice counsellors are good at closed and directive questions but less skilled with open questions, the real bedrock of counselling.

REFLECTING FEELINGS Sometimes feelings are implicit in a message and the counsellor can draw attention to them. This requires attentiveness to the way a message is conveyed, for example:

Client: When Sally invited me in for a coffee after the dance I just had to turn her down. At that point I wanted to get home as quickly as possible.
Counsellor: Sounds as if her offer made you pretty anxious.
Client: Absolutely. I found my stomach turn over in case she wanted me to stay the night and all.

However, the same statement given in a different way and in a different context may prompt a different reflection of feelings:

Client: When Sally invited me in for a coffee after the dance I just had to turn her down. At that point I wanted to get home as quickly as possible.
Counsellor: Sounds as if her offer made you irritated.
Client: Absolutely. She knew I had a busy day the next day and that I was really tired and there she was making more demands on me.

Reflecting feelings enables the counsellor to convey his/her understanding and awareness of the client's internal view and experience. However, the cognitive counsellor might follow this up with a statement like 'So you thought that Sally was making demands on you'. The counsellor would be cautious not to

reinforce the idea that it was Sally's request that produced the affect. Rather, the counsellor would direct attention to the client's interpretation of Sally's behaviour and that maybe this interpretation is open to an alternative view. Thus, although cognitive counsellors reflect feelings, they also attempt to make clear that it is the interpretation that is important in influencing the type of feelings a client may have.

PARAPHRASING Paraphrasing also enables the counsellor to convey understanding, but here the focus is on content. This is not to be confused with simply repeating what the client has just said in parrot fashion (sometimes mistaken as an empathic response). Rather it is designed to show 'being with' the client and understanding the meaning in the message.

Client: After the relationship broke up my car went wrong so I was stuck at home and just had time to brood. The bills were piling up and I've just put them to one side. Now they are threatening to cut off my electricity. I just can't get things sorted out.
Counsellor: So your time to brood on the lost relationship has made it difficult for you to keep on top of things.

SUMMARIZING Summarizing is similar to paraphrasing in its basic skill but takes larger chunks of meaning, follows long(er) periods of exploration, and focuses on core theme(s), for example:

Counsellor: Given what you have been saying about your family and recent events, you perceive that no one has shown much interest in your difficulties and this has led you to think that you are rather unimportant and uncared for.

Summarizing is used in many different ways. It is often helpful in taking a history and can be a form of crystallization, to help a client and counsellor focus on *recurrent patterns/themes of behaviour, events and styles of explanation for events*. It can also be used when the counsellor explores an inference chain (see Chapter 3). It is useful to summarize frequently, to clarify with the client a shared understanding. Many novice counsellors do not summarize enough.

When we look in more detail at the cognitive model for depression it is important to keep in mind that cognitive counselling requires the counsellor, at the outset, to be proficient in these basic counselling skills of empathy, reflection of feelings, paraphrasing and summarizing. Practice and supervision are helpful to 'craft' these aspects and to understand and gain empathy for their use

and timing in the sessions. However, it is the basic empathic concern that will help here rather than attempts to apply them mechanically (e.g. I must get in at least four minimal encouragers, a couple of paraphrases, and four or five summaries etc.).

Getting it wrong

No one is perfect and we can often get it wrong. We make an intervention that seems to change or interrupt the flow of the dialogue and the client becomes silent or looks away. Such nonverbal signals are important to note. Sometimes a simple acknowledgement or even apology is helpful.

> *Counsellor*: I note that when I said [. . .] that you were silent and looked away. Maybe I misunderstood you. Did anything go through your mind just now?

or

> *Counsellor*: When I said we need to look at your thoughts about this event you looked hurt – like maybe I am being insensitive or not really understanding. What went through your mind?
> *Client*: Well you think my problems are all because my thinking is wrong – it's all my fault.
> *Counsellor*: I am really sorry to have given that impression. I was just interested in the meaning you had about this event [pause]. But I wonder if you often have that thought that I see it as all your fault for thinking wrongly?

And what happens if you are exploring a sequence of thoughts that seem to be leading nowhere or are getting confused.

> *Counsellor*: I wonder if we can pause here for a moment. I am not sure about what is going though your mind but I am thinking we are getting a bit lost here. Can we back track a bit and try to pick up the key threads again?

If you get into a hole, stop digging. Misunderstandings, confusions and/or therapeutic ruptures are *common* and counsellors should be quite prepared to focus non-defensively on them. When you do this you are modelling a capacity to be open, able to make mistakes and deal with them. This is partly what collaborative means – working together, 'battling and struggling together', openly sorting out confusions and misunderstandings. Although some clients with certain types of difficulties will find your imperfections a source of anger, others will benefit greatly from your openness and non-defensive style. Of course I am not suggesting that you become overly submissive, only that you are open.

We can now summarize the core skills in counselling:

Key issues 1.3 Core skills

1 Attentiveness to verbal and nonverbal behaviours in both counsellor and client.
2 Attendant behaviour of listening and observing.
3 Minimal encouragers.
4 Reflecting feelings.
5 Paraphrasing.
6 Open and closed questions.
7 Summarizing.
8 Awareness of therapeutic ruptures and the (nondefensive) reparation process.

A model of helping

It often helps to have some key principles that will act as our road map of process. Here is an outline that may be useful:

1 Making contact with the client and enabling the client to express him/herself and tell his/her story. This also involves creating a place of safety.
2 Making an effort to form an 'empathic connection' with the client and see through his/her eyes, how it is for him/her now.
3 Enabling the client to comprehend 'being recognized and heard', and that the counsellor is attempting to make an empathic connection; the counsellor is trying to understand 'it' from the client's point of view, how it feels inside, the depth of despair, the hopelessness, the fear and the sense of failure/shame, the feelings of unmet needs (i.e. counselling is not technique-focused irrespective of the client's actual feelings).
4 Offering a coherent, understandable approach to working with internal experiences and social behaviours. This involves enabling the client to understand and be a collaborative partner in the process of counselling. In this respect cognitive counsellors differ radically from the non-educational approaches. Their basic belief is that the more clients understand the nature of their distress and can learn what they can do to change and cope, the sooner they will recover and the less likely they are to relapse.
5 Developing a working therapeutic alliance that enables the client to become open to new experiences (e.g. in counselling) and to become more explorative.
6 Engaging the client to move, take risks, rework past losses and form new insights and new conceptualization for experience. Forming shared goals.

7 Working with blocks to change and facilitating 'the hard work' for change.
8 Developing resistance to future depression by (for example) learning to be less self-critical or self-attacking but to respect the self as a fallible human being.

Concluding comments

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 client can also have serious effects on his/her children and family. Counsellors who have worked with depression for any length of time will be familiar with its varied disguises and destructive potential. In working with depression one should first try to bridge into the depressed client's internal experience and needs 'to be understood'. This can offer the first sparks of new hope and break into demoralization. From here the cognitive–interpersonal approach will enable counsellors to be in tune with basic concepts of interpersonal relationships and self evaluations and also to be aware of techniques for challenging negative beliefs about these. In the next chapters we explore some of the typical themes, interpersonal styles and problems you are likely to meet when you work with depressed people.

2

Interpersonal and Evolutionary Dimensions of Depression

When people become depressed they usually have a mixture of external and internal problems. External problems can be focused on relationship conflicts (e.g. unsupportive, neglectful, abusive or demanding), work or finances, or concerns about health. It is therefore useful to draw up a problem list with the depressed person with one of the aims of counselling being to explore new ways of coping with these external problems. However, one of the reasons people struggle with external problems is to do with the way they think about their life difficulties and the implications they draw about themselves (e.g. as a failure or inadequate and the future as hopeless).

In regard to the key themes of depressed thinking Beck (1967; Beck et al., 1979) noted that the conscious focus of many depressing thoughts are negative views of the self, the future and the world. Within that framework, interpersonal (Safran, 1998) and evolutionary approaches (Gilbert, 1992; McGuire and Troisi, 1998a) further suggest that such negative views are often focused on social relationships. Depressed people can feel thwarted in their efforts to feel loved, lovable, supported, accepted or socially competent; can feel thwarted in their ambitions, and/or can feel overly controlled (restrained or criticized) by others (Beck, 1983). Social relationships and the meanings placed on them often play an important role in the onset, maintenance and recovery from many depressions (Brown et al., 1995; Gilbert, 1992; Horowitz and Vitkus, 1986). This chapter will explore some of these interpersonal themes and how counsellors can be mindful of them in their assessments and therapeutic efforts.

In a 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 (see also Chapter 7 of this volume, and Brown, 1989). Recently, 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, self-esteem and sense of control over life's difficulties is often central in depression (Becker, 1979). Working with beliefs about 'self' as a social agent who is loved or lovable, has social value and control over relationships, will be a central focus of this book.

In view of the importance of social events to depression, Klerman et al. (1984) developed the interpersonal approach to treating depression. They emphasized the role of (social) life events, the nature of significant relationships (mostly in the present, but also with some consideration of early relationships), the interpersonal behaviours a person uses to gain and maintain relationships and resolve conflicts (see also Markowitz and Weissman, 1995). This model proposes various specific triggers for depression: grief and loss, interpersonal role transitions, role conflicts and social skills deficits. The model outlines various therapeutic interventions for dealing with each source of difficulty. Cognitive counsellors also believe that it is our attitudes and beliefs concerning important relationships that are often the focus of therapeutic intervention (Beck, 1983; Beck et al., 1979).

History of relationships

It is sometimes said that cognitive therapy is not concerned with the past. This is false. It is true that for many problems detailed work with past memories is neither necessary nor sufficient for change and that working to change people's current beliefs is central. But what has gone before affects what comes after and in some cases attention to the past may be vital, especially since some depressed people can suffer from intrusive aversive memories (Reynolds and Brewin, 1999). Indeed, at times opportunities to re-evaluate the meaning of these events and grieve past losses may be crucial for change to occur. Also helping people recognize the origins of their negative beliefs can be very useful in moving to change them.

Many therapists, including cognitive therapists (Beck, 1967) have long suggested that negative styles of thinking (e.g. I am unlovable; I am a failure) arise from early experiences with

parents, peers and others. Early acquired negative beliefs may not be observable when a person is well. They may be latent but can be activated by life events. Over recent years there has been development of these ideas and an effort to gain a clearer understanding of how our early relationships shape adult styles of relating and the beliefs that go with them (Safran, 1998). Thus, cognitive–interpersonal counselling explores some of the origins of these early beliefs, how they are activated in the present, become amplified in depression, and how a client can begin to change them. Cognitive counsellors have begun to utilize concepts from attachment theory to help formulate client problems.

There is a large body of evidence that early relationships with parental figures, siblings and friends result in the development of *internal working models* of relationships (Bowlby, 1973, 1980; Guidano and Liotti, 1983; McCann et al., 1988) or *relational schemata* (Beck, 1983; Safran, 1998; Safran and Segal, 1990). An internal working model or relational schemata are sets of basic ideas, beliefs, memories and expectations about the self and about others, and typical styles of interaction. For example, I may have a working model that people in authority will always try to force me to do what they want and that I have to comply. Or I might have an internal working model that I need other people to love and approve of me but others are unreliable and rejecting (see Chapter 3).

There is, of course, much written on how early life histories can carry risk for later depression and I am able to offer a very brief sketch here (see McCullough, 2000). Counsellors should certainly be mindful of the possibilities of severe early neglect and abuse, both physical and sexual, in those presenting with depresion. An excellent review of the research in this area can be found in Bifulco and Moran's readable and disturbing book, *Wednesday's Child* (1998). Their data make clear that abuse undermines people's ability to cope with stress and increases vulnerability to depression. These early traumas also affect the maturation of the stress system. Andrews (1998) also offers a good review of this work and how abuse increases proneness to various forms of shame and chronic depression. It is very important that those counsellors not familiar with working with abuse cases should seek advice, supervision and possibly pass the client to someone experienced in this area of work. The therapeutic skills needed will often exceed those outlined here.

As discussed in Chapter 1, early life is a time we learn about our lovability. Some children grow up in highly competitive families where parents, in an effort to push their children onwards and

upwards, are very critical. They may be unable to reward or approve of good behaviour if it does not meet a certain standard. For example, when Jane came second in an exam her parents wondered what stopped her from coming first. Those growing up in such environments can carry beliefs about themselves as 'never being quite good enough' and live with a constant background sense of disappointment and failure in self and others.

Based on a large body of research and clinical observation, we can pick out some common early life themes that reoccur many times in working with depressed people.

Parental unavailability: These individual's will have experienced parental separation and abandonment. Sometimes this is through parental illness, death or divorce. This theme can also be a major issue in those who were adopted, fostered or were in care as children (Verrier, 1997). In such people the search for (and conflicts about searching for) the biological parent(s) can be intense and it can be useful to link them up with various adoption agencies and support groups who can help them in their search.

Parental inaccessibility: Parents may have been physically present but not able to act as a care provider or give emotional support. Some depressed people describe such parents as cold, distant, disinterested or neglectful. Despite having made repeated efforts to form emotional links with the parent they have not been able to (Bowlby, 1980).

Parental abuse: Some depressed people experienced their parents as abusive. Both physical and sexual abuse can be highly damaging to their psychobiological maturation, development of basic trust and capacity to form intimate relationships.

Parental criticism and control: Parents who are excessively controlling and/or excessively use shaming or guilt induction in their efforts to force their children to comply, often produce people who are extremely sensitive to shame and guilt. Such children often learn to self-blame when problems arise in relationships and can easily feel others can control them.

Parental competitiveness: Some depressed people experience their parents as demanding excessively high standards of them and shaming them or withdrawing from them if they don't achieve these standards. Another aspect of competitive families can be where parents compete with the children. Parental criticism can sometimes be an effort on the parent's part to show they are superior (e.g. as mother) to their child. Such children often grow up feeling inferior to their parents.

Parental favouritism: Some children feel they were less favoured or loved than a sibling(s); they can have an acute sense of

inferiority. This may be seen to be because they had a certain personality, were of a different gender or lacked the talents of the favoured sibling(s). Recent evidence suggests that recall of parental favouritism, and of being a less favoured child is associated with depression (Gilbert and Gelsma, 1999). Such children can become adults who feel that they have to constantly compete for affection, but that they are not good enough to succeed (unless one can do something special) and they may experience problems of envy and shame.

Turbulent parents: Some children grow up in turbulent households of constant conflicts and where one or both parents often threaten to leave. Such children can feel not only at risk of being dragged into the parents' conflicts or forced to take sides, but live under constant threat of abandonment and become very sensitive to other people's moods. Sometimes these children become appeasers having taken on the role of trying to calm others down. At other times they may try to avoid dependence on, or closeness to, others because it is too risky.

Unpredictable parents: Some depressed people experienced their parents as highly unpredictable. This pattern can be especially noted where parental mental illness has been a problem. Again, such people can become highly sensitive to the moods of others, and find it difficult to rely on or trust others.

Needy parents: Some people have children in order that there is someone around who will love them. They use their children to boost their inner sense of lovability or to give a purpose in life. They can put great pressure on the child to act in this way for them. Also, a dependant parent may try to turn their child into a carer, using guilt along the way.

Anxious parents: Some parents are extremely anxious of their own safety and those of their children. Rather than being a source for soothing and calming down for the child they are more likely to alarm the child. Some of these children can go on to become easily alarmed themselves, especially by minor difficulties such as physical illness, where they are prone to ruminate on possible dangers to the self.

As you can imagine these early life themes are not mutually exclusive and in fact combinations are more the rule than the exception. Moreover, some coping efforts may lead the child to behave in exactly the opposite way. For example, a child with a very fussy and anxious mother may become very cavalier about risks. A child with a very demanding parent with high expectations may give up, 'drop out', and be an underachiever. So these are only examples and guides. Each individual is unique in how

they make sense of their early life. By the time a person comes to therapy they will exhibit influences from the past, both family and peers, plus their own coping efforts.

Styles of relating

As a result of our early experiences, research suggests that there are four or so basic interpersonal styles that emerge in childhood and are carried through into later, adult life. Some of these result in major difficulties in adjusting to loss, role conflicts, and role transitions later in life. These styles have been summarized by Collins and Read (1990).

Secure attachment: These individuals are able to get close to others or cope with distance. They are comfortable with depending on others and with others depending on them and rarely worry, in the normal course of events, about abandonment or getting too close and intimate. They have a basic trust in themselves and in others. In counselling they develop trust fairly easily, are open, but also recognize boundaries.

Anxious attachment: These individuals feel that they cannot get close enough to others and are very sensitive to cues of rejection or abandonment. They often worry that their partners and friends may leave them or ignore them. Their need for constant reassurance of their lovability and acceptance sometimes drives others away and can show up as clinginess, possessiveness, jealousy and other anxious forms of attachment and relating. They are more likely to be emotionally expressive.

Avoidant attachment: These individuals prefer distance and are uncomfortable if others get too close. They do not like to be dependent on others nor for others to be dependent on them. They often find that their partners wish for them to be closer but this call to intimacy is frightening to them. They are often distrustful of others' motives and are sensitive to being hurt and/or controlled in relationships. They are the least emotionally expressive and may be subject to strong shame.

Ambivalent attachment: These individuals show mixtures and oscillations of anxious and avoidant. If others get too close they are worried about being controlled and 'swamped' and show avoidant patterns. If others are too distant they are worried about abandonment and aloneness and show anxious patterns. In borderline clients this oscillation can be marked (see Liotti, in press).

These basic self–other beliefs and relational styles influence the experience of connectedness and relatedness with others and may be acted out in the counselling situation, i.e. some depressed

patients appear anxious and needy, others are withdrawn, distant or hostile, yet others oscillate between these two styles. Recently, Liotti (in press), Sloman (in press) and Safran (1998) have written on how these attachment styles affect the therapeutic relationship and interventions. It is useful that you have some shared view of past relationships and how these may impinge on their current relating style, including that of therapy.

Key issues 2.1 Relationship history

1 Early attachment relationships play a central role in forming internal working models about self and about others.
2 When a client becomes depressed, different types of attachment relations may become prominent or exaggerated and these can be enacted in the counselling relationship and outside it.
3 At present there appear to be four basic patterns of attachment relationships: secure, anxious, avoidant and ambivalent.
4 The counsellor should be aware that different depressed clients will have different interpersonal styles. Some will want to be very close and cared for, while others will stay distant and aloof, yet others will oscillate between closeness and distance.
5 Counsellors should be mindful of the complexities of early attachment relationships and the possibility of there being serious disturbances in such relationships, such as abuse. In these cases counsellors unfamiliar with these issues are advised to seek close supervision or pass clients to more experienced therapists.

Other relationships

Attachment theory tends to focus on close relationships. However, there are various forms of relationship that we can have with others, such as work relationships and friendly relationships. These roles may become central to our plans, hopes and expectations for the future. If the enactment of these roles is frustrated or blocked we may become depressed because we lose an important source of self-value and self-esteem (Brown and Harris, 1978). This is the central idea in the work of Oatley and Boulton (1985) and Champion and Power (1995).

Another approach to social roles has been from evolution theory (Gilbert, 1989, 1992, 1995; Gilbert and Bailey, in press). This approach explored *care-eliciting* behaviour (how we elicit care, support and love); *care-giving* behaviour (how we care for others and the self); *cooperative* behaviour (how we join in with and share with others, develop friendships and participate in group

activities and have a sense of belonging); *competitive* behaviour (how we maintain or raise our status, how we feel in comparison to others and how we assert ourselves); and *sexual* behaviour (how we gain, maintain and relate to sexual partners). Different people are sensitive to 'failures' in these various roles. For example, one person may feel they are not able to elicit enough love and care; another person might feel burdened with guilt for not caring enough for others; another person may feel too frightened to assert themselves in relationships (Gilbert, 1989, 1992). From this approach depression is seen to arise from the experience of powerlessness – feeling defeated in one's 'struggle' and attempts to achieve desired social goals (e.g. love, respect, control) and trapped in environments when defeats (role failures) keep coming (Gilbert, in press a). McGuire and Troisi (1998b) have looked at the different roles men and women seek to pursue and suggest that one of the reasons depression is higher for women is that current environments are more thwarting of women's goals than men's.

Whether or not one takes an evolutionary view to the inner origins of our basic social motivations (e.g. to form attachments, belong to groups and gain status, develop sexual relationships – love, status and sex; Gilbert, 1989, 1995) all humans are typically motivated to pursue these things. On the whole we feel happier when we feel loved, have status and sense of belonging, but more likely to feel low when we lose love, are given unwanted low status (seen as inferior) and are rejected. Indeed, many of the typical self–other beliefs that are common in depression tend to focus on these domains (e.g. lovability, status and belonging).

The point is that there are many themes that can become the focus for depression and self-evaluations. These in turn can become a focus in counselling. Indeed, many researchers and therapists (e.g. Young et al., 1993) have outlined various basic interpersonal schemata (or basic self–other interpersonal beliefs) in depression. These include for example: abandonment, mistrust, personal defectiveness, and self-sacrifice. My own view is to focus on themes rather than specific schema (Gilbert, 1992). This is because, as in stories, *themes* can have great variety and fluidity, mix together, change over time and so forth. Novel themes may arise in specific cases.

Depressive themes: the inner *self* relationship

Above we looked at history of relationships and current relationship styles. We now move on to focus on internal self-

evaluations and self-schema. Clients bring with them, into counselling, a history of how they have come to understand themselves in relation to others in the domains outlined above. Sometimes negative views of self (e.g. being unlovable, being incompetent or inferior) may be latent but become activated by life events (Beck, 1967). For example, Carol became depressed when a relationship broke up and she had feelings of being inferior – undesirable. This was partly associated with reactivation of memories and (body) schemata of episodes of teasing as an adolescent where she was labelled as fat and unattractive. Understanding how depressed people think and feel about themselves is obviously important in counselling. Below we will note a number of key issues and themes to self-experiences and relationships.

Approval

A need for approval (being valued) is a very human need and not a pathology. Most humans want to be seen as attractive to others: to be chosen as a friend or lover, to be selected for a job, and to be welcomed into a group (Gilbert, 1997). And social support (receiving signals from others around us that we are loved, valued and approved of) can have powerful physiological effects (Gilbert and McGuire, 1998). So, as with many of the themes we will discuss here, it is often a matter of balancing our capacity (and skills) to gain approval and support from others, while at the same time being able to cope with conflicts and criticism and maintain some sense of our autonomy. Nonetheless, the type and amount of approval one needs from others, and one's feelings about one's 'approval rating' are common themes in how depressed people think about themselves. That is, some people are highly prone to depression if the supplies of approval dry up or turn to rejection and criticism (Beck, 1983; Beck et al., 1983; Burns, 1980). Arieti and Bemporad (1980a,b) offer a clear exposition of people with strong approval needs:

> They do not experience satisfaction directly from effort but only through an intermediary, who gives or withholds rewards. They have formed an imagined agreement with the important other that may be called a bargain relationship . . . in which the individual foregoes the independent derivation of gratification in return for the continuance of nurturance and support of the esteemed other. This pattern of relating was initiated by the parent during the childhood of the predepressive individual but in later life the individual will reinstate similar relationships in a transferential manner. Other characteristics of this type of depressive personality are clingingness, passivity, manipulativeness and avoidance of anger. These character traits may be seen as the means by which the

> individual attempts to extract support from the needed other as well as to ensure continuation of the relationship. (Arieti and Bemporad, 1980a: 1360–1)

Beck (1983; Beck et al., 1983) calls these types *sociotropic*. The psychoanalytic writers, Blatt et al. (1982), refer to them as *anaclitic*, while existential theorists (e.g. Yalom, 1980) call these styles *the pursuit of the ultimate rescuer*. In attachment theory these would be *anxious attachment* styles. Arieti and Bemporad (1980a,b) emphasize the failure to individuate and develop autonomy. Depression and a sense of powerlessness arise when people feel they cannot secure this highly valued goal.

Key beliefs of self include: 'I need stronger others on whom I can rely; I am nothing or empty without love; life is meaningless without a close relationship(s); I can't stand it if people don't approve or like me; I must be what others want so that they will like (and not abandon or reject) me'. In other words the 'sense of self' and emotions are closely linked with approval and support gained and obtained.

Achievement

Some depressed people seem over-focused on achievement. Achievement focused people may attempt to ward off beliefs of personal inadequacy and depression by obtaining lofty goals. Some may have a more chronic form of personality difficulty characterized by many taboos (e.g. on pleasure). Arieti and Bemporad (1980a) outline the characteristics of these individuals as follows:

> These individuals invest their self-esteem in the achievement of some lofty goal and shun any other activities as possibly diverting them from this quest. Originally, achievement was rewarded by the parents, and so high marks for some outstanding performance was sought as a way to ensure support and acceptance. In time, the individual selects some fantastic goal for himself which he then pursues frantically, apparently for its own sake. However, closer scrutiny reveals that the achievement of this goal is burdened with surplus meaning. The individual believes that the goal will transform his life and, possibly, himself. Attaining his desired objective will mean that others will treat him in a special way or that he will finally be valued by others. Just as the dominant other type of depressive individual uses fantasies of the relationship to derive a feeling of worth, the dominant goal type of depressive individual obtains meaning and esteem from fantasies about obtaining his objective. Both types also use these fantasies to eschew ratification or meaning from other activities in everyday life. In contrast to the 'dominant other' type, this form of depressive personality is usually seclusive, arrogant and often obsessive. In addition, this form of personality organization is commonly found in men. . . . (Arieti and Bemporad, 1980a: 1361)

In other theories these would be seen as *narcissistic* vulnerabilities. Beck (1983) outlined a similar vulnerability but called it *autonomy*. Such people follow a strategy of gaining approval and respect via achievement (Gilbert, 1992). Although some people may deny they wish to be dominant, their fantasies show that this is often the issue. In one case a person felt that, as the second child, his parents would rather he had been a girl and he felt a less favoured and loved child. His older brother did well at school and in a subsequent career, whereas he felt he was a disappointment to his parents. Much of his striving had been to try to do things that were special or outstanding which his family and others would recognize, and on which they would bestow high respect, admiration and status.

Key beliefs are: 'I must succeed and be recognized as having done so; life is meaningless without a clear goal; achievement is the way people are measured; without success, I am a failure; without success; no-one will be interested in me; who remembers who came second'.

Self-worth

Approval types and achievement types both have the same ultimate desire – to be valued, but they have very different strategies for securing it. In therapy it often comes down to an issue of what offers a sense of being valued and having self-worth. We derive a sense of self-worth in childhood from a combination of the approval, attention, reinforcement and praise bestowed on us by parents, teachers and others, and a sense of mastery that comes from achievement. Thus self-worth is often related to ideas of being worthy of, and therefore deserving of something, e.g. praise, attention, love and so forth. This is a complex point related to our biological predispositions and our need to appear attractive, able and talented to others and elicit their investment, support and sense of being valued (see Gilbert, 1997, Gilbert and McGuire, 1998). A typical depressive self-worth belief is, 'I have nothing of value to contribute to a relationship, group or even society at large'. While approval types tend to focus on intimate relationships, achievement types tend to focus on a larger social domain, e.g. being successful and respected in one's career.

Shame

Depression is especially likely if life events elicit a sense of shame (Andrews 1998; Gilbert, 1992; 1998a) or humiliation (Brown et al., 1995). In a way shame is the opposite side of the coin to self worth

– a kind of negative self-worth; it is an experience of the undesired self. Although shame is commonly seen as an emotion (Tangney and Fischer, 1995), the theme of shame – related to beliefs of being damaged, flawed, inferior or bad in some way – is common in depression (Andrews, 1998). For some depressions these themes and issues have been around a long time and the person has never really had a robust sense of themselves as attractive, acceptable and able. They carry an inner sense of shame (Gilbert, 1998a, Tantum, 1998). We shall be meeting shame again in Chapter 8. Severe problems with shame can affect the therapeutic relationship and treatment.

Are you as good as others: the role of social comparison

Our inner sense and experience of self can be strongly influenced by how we compare ourselves with others. In fact, social comparison is one of the oldest forms of social cognition and even animals engage in it. For example, an animal has to work out if it is stronger or weaker than a potential opponent before it decides whether to fight or flee (Gilbert et al., 1995). The theme of social comparison (in how people derive their self-worth and make judgements about it) is common in depression. Indeed, many of our emotions and behaviours and even life goals are affected by how we compare ourselves with others – and, in general, depressed people compare themselves very unfavourably (Swallow and Kuiper, 1988). For a good general overview of social comparison in relation to health see Buunk and Gibbons (1997).

Parental favouritism can make people acutely aware of social comparison issues as can some of the competitive dynamics of school and peer groups. Kate was depressed about her appearance. She said that since schooldays she had been aware of there being a 'hierarchy of attractiveness' – where the prettiest girls got more attention and seemed to be happier. She had spent many years feeling bad (shame) because of her negative social comparisons with others and images presented in the media. She had a strong belief that only if she could move up the hierarchy of attractiveness could she feel confident and be happy. There is evidence now that 'attractiveness' is of great benefit in securing many social outcomes (Etcoff, 1999).

There are two types of social comparison, *superior–inferior* (related to some hierarchy) and *same–different* (related to belongingness or connectedness; Gilbert, 1992). Depressed people often make negative social comparisons in both domains; that is they feel both different from others and inferior (Brewin and Furnham, 1986; Swallow and Kuiper, 1988).

Key beliefs might be: 'Others are more able, better, nicer more attractive than me. In any competition for love, respect or prestige, I will lose out to others. Only if I raise my relative status will I be accepted, approved of or "chosen"'.

Self-criticism

Partly because people feel they are not reaching the standards they want or think they should, and/or because they feel they are not up to the standards of others (unfavourable social comparison), and/or because in the past they have been heavily criticized by significant others, depressed people can feel immensely disappointed in themselves (Gilbert, 2000). When this happens they are often self-critical. Now self-criticism may serve many functions (Driscoll, 1989) but negative self-beliefs and actual hostility to the self can be extremely important to assess in depression. Indeed self-criticism (Blatt et al., 1982), self-dislike through to self-hatred can be a serious complication in depression – the latter being more commonly associated with personality disorders. Self-nurturing versus self-attacking dispositions need to be clearly identified as a key area for work and various (agreed) strategies engaged to challenge such negative self views and attacks (Gilbert, 2000; in press a).

Greenberg and his colleagues have indicated that there appear to be two aspects of this internal self-relationship that often come together to produce depression:

> Based on our clinical observation, it appears that depression is much more likely if a person's weak/bad, hopeless, self-organisation is triggered, than if the critical self and negative cognitions alone are activated. It is much more the person's response to the negative cognitions and their inability to cope with the self-criticisms, than the cognitions and criticisms alone, that lead to depression. People are unable to counter or combat the negative cognitions when the weak/bad helpless state has been evoked. This is when depressed affect emerges. (Greenberg et al., 1990: 170)

Clearly then, the counsellor will need to ascertain the strength of any internal attacks (and where they come from and what is their function) and how the person is able to counteract them. A central focus in cognitive–interpersonal counselling, especially for depression, is concerned with how people rate and judge themselves as social agents; their sense of attractiveness and competency. The idea that we can have attitudes to ourselves that are either hostile and down-putting (e.g. self-downing, or inwardly shaming), or nurturing and facilitating is important. In many forms of depression one finds that the internal attitudes to self,

that is the relationship we have with ourselves, is hostile, down-putting and shaming (see Gilbert, in press b). Part of the role of the counsellor is to help the client (a) to recognize the degree and extent of internal self-downing and negative self-talk (e.g. 'I'm a failure, I'm boring, I'm useless'); and (b) to change this negative self-talk to a more nurturing and accepting self-talk and self-relationship. This is achieved by teaching a client to recognize and avoid self-labelling, and extreme and global self-evaluations (see Chapter 4). It is not only via the cognitive behavioural challenges that this is achieved but also via basic therapeutic skills and the relationship established between client and counsellor.

Efficacy and control

Efficacy beliefs and themes are often prominent in depression. Seligman (1975, 1989) showed how a perception of helplessness can trigger depression. Here the basic beliefs are, 'I am ineffective and have little control. Nothing I do can work'. These basic beliefs not only affect self-esteem but give a negative view of the future, leading to hopelessness (Abramson et al., 1989). They will also affect persistence and even our preparedness to try different or new things (Peterson et al., 1993). Few of us are likely to put much effort into something if we think we are bound to fail no matter how hard we try. Lack of control has also been linked to anxiety disorders (Chorpita and Barlow, 1998).

Defeat

In my view, loss of control becomes depressing when it ignites feelings of being defeated. Many depressed clients feel defeated by life's difficulties – often compounded by their own self-criticisms and attacks. They often feel they have lost important 'battles or struggles', or are simply 'beaten down' by life events. Gilbert and Allan (1998) explored experiences of defeat and found they were highly correlated with depression. Indeed, even after controlling for hopelessness, defeat remained highly correlated with depression. Experiences of defeat are more likely to ignite depression when they are associated with inner experiences of being a loser or a failure. So it is probable that your depressed clients will feel defeated and that they cannot 'win' whatever goal or struggle they are, or have been, engage(d) in (e.g. for affectionate relationships, status, or achievement goals). Sometimes clients will need to learn how to fight or try harder, sometimes to change tactics (e.g. become assertive rather than aggressive), and sometimes how to bow out gracefully without feeling a personal

failure. Some of these strategies are outlined for clients elsewhere (Gilbert, 2000 and in later chapters).

Affect

Depressed clients may have many kinds of negative emotions that can be the source of confusion. A person's own internal feelings can be a source of negative self-judgements. Strong feelings of rage, envy and shame (which are socially focused) can activate negative self-schema. Typical depressive beliefs are 'My feelings are beyond my control' or 'My negative feelings are unacceptable and evidence of a bad, weak, inferior or unlovable self. Therefore to feel good about myself I must repress, control or conceal these feelings.' Negative affects can act like internal stimuli that cue negative self-experience (Gilbert, 1992, 2000). In effect people can feel ashamed of what they feel and think. This may influence how ready they are to discuss them in counselling. Of course, it is not only negative affects that can be a source of negative self-judgements and shame. For example, a client felt strong sexual attraction to a man at work and thought that this was sinful.

Sometimes, emotions and memories can be poorly integrated into consciously available schemata. Thus the counsellor may need to help the client with emotional repression by focusing on the meaning and experiences of affect, especially as it occurs during counselling (Greenberg and Safran, 1987). For those interested in emotional processing and meaning creation in therapy, Greenberg and Pascual (1997) and Greenberg et al. (1993) are recommended texts.

Shamed by depression and fatigue

People can have negative beliefs about moods and fatigue. It is very common to find people are ashamed of being depressed and depressed about being depressed. They may believe that depression is evidence of being weak and that others will look down on them or dismiss them as not up to it – a neurotic. Also, because depression can involve loss of the ability to engage in pleasurable activities and constant fatigue, depressed people can feel very unattractive to others. They may feel they are boring or a 'drag' to be with – unattractive. For some people the loss of energy can be a source of further depression and anger with the self. And people can feel defeated by their loss of energy, e.g. 'I can't feel better about myself until my energy returns.' The experience of fatigue can activate many negative powerful beliefs about personal unattractiveness to others and not being able to secure valued goals.

Grief

It is not uncommon to find a depression is triggered by a grief or that as someone becomes depressed they find themselves experiencing grief feelings that might have been blocked – sometimes for years. As people engage with grief this might be a time when various fears about feelings surface. For example, a person may fear being overwhelmed and 'knocked out of action' by the power of grief feelings. Or (as noted above) a person may be ashamed of the feelings (e.g. spontaneous crying) of grief. Or a person may start to feel guilty for not having done more in the past for the person who has died or left. Grief can therefore be an important complication in treating depressed people. For this reason counsellors working with depressed people should have some knowledge of grief work (e.g. see Nolen-Hoeksema and Larson, 1999).

Nurturing the self?

The above outlines core themes about how the self judges and feels about 'self', e.g. as worthless, inferior, unloved/unlovable, defeated, a failure, etc. These themes will mix and blend together in different ways for different people. As a result of such harsh, cold or fragile internal self-relationships many of our therapies suggest that an important aspect to treatment is to ensure that the self is supported. It is very difficult to help people change if they remain highly critical of themselves, internally shaming and see defeats as 'finishing them off'.

Counselling therefore often needs to help people become more self-accepting, nurturing and forgiving. This involves creating a safe environment that facilitates exploration of both internal experiences and de-shames inner feelings and thoughts. It may not be helpful going too quickly into negative feelings of rage or envy if these add to a sense of badness, inferiority and/or shame, before a good therapeutic relationship is established (a safe environment), or if the counsellor has not ascertained that the client can cope with these internal experiences without launching a savage attack on the self. For example, a man had great difficulties in coming to terms with grief over the loss of his mother but had a highly idealized view of her (although in reality she sounded rather emotional, needy and neglectful). However, until he had reduced his self-critical attitudes and changed his self-attacking style, he was unable to deal with the strong emotions aroused. He was too busy telling himself 'I shouldn't feel like this', or 'These feelings are bad, I must get rid of them.' Grief itself was seen as evidence of personal weakness. Hence, there was little

point in trying to work through the grief until he could come to accept his own feelings without putting himself down.

Key issues 2.2 Depressive themes

1 Some of the key self-focused themes involved in depression are: approval, achievement, self-worth, social comparison, self-criticism, efficacy, defeat, and affect management.
2 For each theme there are three issues: how people judge themselves, how they judge others and how they think others will judge them.
3 Basic self–other beliefs help to organize social behaviour and relationship style. For example, believing one is inferior to others may lead to inhibited and cautious or anxious social behaviour.
4 Many dilemmas and negative feelings are difficult to work through if clients are intensely self-attacking. So attention to self-critical thoughts or styles is often necessary.

Depressive coping and defences as key themes

Having looked at some basic self-experiences and relational themes in depression we can move the analysis to consider coping behaviours. There is a large literature on coping in depression which I can only mention briefly here (see Lazarus, 1994, 1999). Basically, when confronted with stressors we have two coping tasks. First, to try to deal with the problem(s) (problem focused coping) and second to cope with the emotions (anxiety, anger and depression) elicited by the meaning of the stressful event (see Carver et al., 1989 for an outline and measure of typical coping behaviours). To cut a rather long and complex story short, as people become depressed they tend to become relatively poor at problem focused coping and focus on trying to control painful emotions. Moreover, the ways they try to cope with emotions such as using alcohol, avoidance, or excessive help seeking can often make things worse. For this reason problem solving therapies or therapies that use problem solving techniques, such as breaking problems down, going a step at a time, engaging rather than avoiding the problem, or learning new skills to deal with problems, are often helpful for depressed people.

There is, however, an evolutionary angle on the way we can conceptualize coping difficulties in depression and link maladaptive coping to increased activation of stress and other neurobiological systems. This is related to a consideration of how we

naturally tend to defend ourselves when confronted by threats and losses. In fact all humans and other animals have a basic, innate menu of defensive behaviours for dealing with threats. These include flight and escape; e.g. running away from a danger; avoidance; fighting back; submitting and backing down or giving up if the odds are overwhelming; and seeking out help and protection from others (Gilbert, 1993). Most of these were designed by evolution to be for short-term use. But like physical defences of diarrhoea and vomiting, what is helpful and adaptive for the short term may become mal-adaptive in the long(er) term. If the behavioural defences of (say) escaping, avoidance, fighting back, or submitting are used over a short term and are effective, they may deactivate our stress systems. But in depression we often see that these defensive behaviours are either ineffective or they are highly aroused but not expressed. For example, a person wants to escape from (say) a painful marriage (high escape motivation) but is unable to.

In the last few years our research and that of others (Dixon, 1998) has suggested that depression can often involve heightened desires to engage in such defensive behaviours, but not being able to. In essence depressed people can suffer from *arrested and ineffective defences*. I have found that exploring these with clients can be illuminating of the processes and conflicts that depressed people face. Let's look at each in turn.

Blocked escape and entrapment

Related to perceptions of self-efficacy and defeat are the opportunities to change situations, or *escape from aversive, non-supporting/rewarding or over-demanding ones*. Sometimes a key theme in depression is a perceived lack of opportunity to 'get away', which can be experienced as *entrapment* (Gilbert, 1992). Entrapment may arise in a relationship, whether intimate (e.g. a marriage, family) or social-public (e.g. work), that one cannot get out of – but would very much like to. For example, a person would like to leave their neglectful or abusive spouse but for economic reasons, guilt, fear of the spouse's reaction or fear of aloneness they are unable to leave. Thus they feel they have little control over their future and feel trapped. A sense of being stuck in an undesirable situation and not being able to move from it is more common in depression than is sometimes recognized. Brown et al. (1995) have shown that entrapment is a more powerful predictor of depression than loss alone.

Gilbert and Allan (1998) explored feelings of entrapment that were both externally focused (feeling trapped and wanting to escape from relationships or situations) and internally focused

(wanting to escape from inner pain, feelings and thoughts). In regard to inner states depressed people often feel trapped by their depression and loss of energy. The data suggest that many depressed clients feel very trapped and are highly motivated to escape but feel unable to (technically called arrested flight). As noted above, they may be stopped from escaping for many reasons: it may be too costly to move on (e.g. leave a job or marriage); they may feel too guilty or frightened to do so.

It can be very useful to explore with a client feelings of desire for (and strength of) escape. They may, however, be ashamed to tell you. For example, a depressed young mother may feel too guilty and ashamed to admit that part of her feels overwhelmed by the demands of motherhood and would like to leave it all behind. Or a person may have very ambivalent feelings about leaving a marriage. In my experience giving space to explore feelings of wanting to escape can have many benefits. First, it helps clients recognize they can discuss these feelings in a non-shaming way. Moreover, sometimes the very real dilemmas of whether to give-up on, leave or stay in a relationship may be central to recovery. For example, in emotionally and physically abusive relationships a woman may feel that it is her fault that the problems exist (Andrews and Brewin, 1990), but as she gives up self-blaming may recognize the need to leave.

Sometimes depression remains while people remain stuck in these dilemmas and the counsellor can offer support through this difficult and painful life transition – especially if escape or ending (getting out of) a relationship is the preferred option. At other times, if people learn to be more assertive and control the demands on them then desires to escape subside. And, of course, at times the strength of the desire to escape can be related to the depression itself and falls away as the depression recedes. It is important though that counsellors aid the client to explore the dilemma and not put any pressure on them to go one way or another.

Escape and avoidance behaviour shows itself in other ways too. If one asks clients why (for example) they go to bed or don't get up, they may reveal that it is not only because they feel tired but also because they are avoiding and escaping from the demands of the day. Often depressed people will openly admit that this is hiding behaviour motivated by strong desires to escape. Such desires may well be 'driven' by various negative beliefs, but whatever the source, the key issue is that escape motivation is highly aroused but does not bring relief. Indeed, such behaviour can often leave a person feeling worse. In this sense the defensive behaviour is ineffective.

In regard to internal entrapment, the depressed person may be unable to distract themselves from painful feelings and worries. Sometimes they feel they would like to escape from their feelings and thoughts – to be internally at peace. It is also not uncommon to find some depressions beginning with a physical health problem from which the person feels they cannot escape or recover. A sense of being trapped in (and wanting to escape from) a diseased or crippled body can be powerfully depressogenic.

One should be aware that high flight motivation is associated with suicide – especially if it is painful physical (e.g. illness related), major life crises (e.g. debts) or emotions and feelings that a person is trying to escape from (Baumeister, 1990; Williams, 1997). So this is another reason to explore it. Also, the more flight motivated a person, the less they may be able to see positives in their current environment. So trying to focus on 'positives' before escape motivation is assessed and explored can be problematic.

Key questions to ask clients are: Do you have strong feelings of wanting to escape from or hide . . .? Do you ever think that you would just like to run away? How trapped do you feel in your current situation? Have you ever thought of ways to escape? What stops you?

Need for space

A common theme in depression is a need for space. Sometimes people can feel overwhelmed by the demands and responsibilities on them and they need some temporary respite. Desires to escape can sometimes be linked to lifestyles where a person has no personal space. This is particularly common in women who have various degrees of 'role strain' – trying to cope with children, work and marriage. Carers of dementing relatives may have needs to get away and have space. Again, however, there may be much guilt around such desires ('I am a bad person to want to put my mother in a home'). Helping a person create time for 'personal space' can be very helpful especially if they can learn to do it without feeling guilty.

When general practitioners or counsellors advise mildly depressed people to take a holiday there is an intuition that 'getting away' from stressful situations can be helpful. It can allow the stress system to settle down and help bring perspective. If people do feel better when they do this it is important that recognition is given to how their current situation is increasing their stress. At other times this kind of intervention does not work. For example, if the problems are in the family relationships then

taking a holiday with the family can make things worse. Some people can't 'switch off' and worry about what is happening back home or at work. And, of course, some people may not have the resources for holidays. So counsellors have to be sensitive to the issue of space from whom or what.

When people become excessively fatigued and depressed about being 'tired all the time', it is not uncommon they are exhausted and are poor at taking time out or having respite. There may be very practical reasons for this (e.g. demands of family and work), but also these folk can be highly driven and work themselves to a frazzle. They may have unrealistic expectations of what they should be capable of, compare themselves negatively with those who seem to achieve a lot and drive themselves hard. Helping people see they may be exhausted and may need quite a long time to recuperate and sometimes need medications can be a tough lesson for them. Such people are especially vulnerable to feeling defeated and (more) depressed by their loss of energy. The linkage here is: high demands or personal drive → get exhausted → feel defeated and can't reach goals → feel defeated and more depressed.

Key questions to ask are: Do you feel that you would like to take time out and get away, at least temporarily, from your current situation? Do you feel you have enough personal space in your life? What stops you from making more space for yourself?

Arrested fight and anger

There is a good deal of evidence that many depressed people experience increases in their anger (Gilbert, in press a; Riley et al., 1989), but again this anger is either arrested (not expressed) or if it is expressed it is ineffective and makes things worse. Sometimes anger is expressed in rages or irritability for which the person may then feel guilty, but at other times anger is blocked. People may inhibit their anger because they are ashamed of it, feel it is unjustified or fear losing or damaging a relationship. However, it can be useful to explore with clients the degree of their anger and what they do about it. Some depressed people just feel more generally irritable and on 'a short fuse'. Others are 'embittered' and have a strong sense of being treated unfairly or unjustly. Such folk may ruminate on their anger and desires for revenge. Constantly ruminating on a sense of injustice but not being able to do anything about it not only increases a sense of powerlessness but also probably keeps the stress system in a high state of arousal. For such people working with their anger may be important (Gilbert, 2000).

Key questions to ask are: Do you feel very irritable inside? Do you find you are quick to anger? Do you feel a sense of injustice – like life has treated you unfairly and you'd like revenge somehow? How do you express anger? What stops you?

Submissive behaviour

Submissive behaviour is a basic form of defensive behaviour that is many millions of years old (Gilbert, 1992, in press a). Many animals can exhibit submissive behaviour especially when they are under challenge from more powerful others. In humans, beliefs in personal inferiority and being subject to criticisms and attacks can trigger submissive behaviour. There is now good evidence that many depressed people either have history of taking submissive positions in relationships or become submissive as their mood goes down (Allan and Gilbert, 1997). A sense of being in a one-down position and under the control of others can arise from abusive or neglectful relationships. The key point is that a sense of inferiority and weakness can activate internal inhibition, social anxiety, reduce explorative behaviour and inhibit assertiveness (Gilbert, 1992, in press a).

Submissiveness can often be associated with a type of approval seeking by being excessively accommodating to others. The basic belief here is 'In order to be loved and avoid abandonment I must accommodate myself to others – be for them what they want me to be' (Young et al., 1993). Clearly this limits the degree to which a person can feel free to express his/her own needs, preferences and desires in relationships. This submissive inhibition of self can lead to further feelings of inferiority, a loss of power and limits assertive behaviour (Gilbert, 2000).

Not uncommonly depressed people can feel resentful at their own submissive behaviour (angry submission). They may back down and may put the needs of others first but resent it. So they either lack the skills to act assertively or are to frightened to act assertively.

Key questions to ask are: Do you tend to back down if you are in disagreement with others? Are you frightened to stand up for yourself? Do you feel resentful if you have to back down or go along with others when you don't want to? What stops you from being more assertive?

Arrested help seeking

Help seeking is another common defensive behaviour, and in children it is the most typical way to cope with threats and things that are overwhelming. Knowing that there are people who can

help, support and understand a person when in a crises can be very soothing. However, some depressed people do not help seek or if they do it is rejected. For example, some people become depressed because they simply don't have access to support (Brown and Harris, 1978). Others avoid help seeking because they are ashamed to admit they can't cope or are depressed – depression can be seen as very unattractive to others. Yet others avoid help seeking because they think that it won't help them. And yet for others gaining help makes them feel obligated to the help provider and in a one-down position.

Key questions to ask are: Do you have people around who you feel can help, understand or support you? Are you able to acknowledge a need for help? How would you like to use help? What stops you from seeking help?

Key issue 2.3 Depressive coping and defences

1 When under threat it is natural to experience increased arousal of defensive feelings (e.g. anger and anxiety) and behaviours (e.g. desires to escape, fight, back down or seek help).
2 It can be useful to explore these and in particular the strength of such motivations and what stops the person from acting on them (e.g. dilemmas).
3 Counsellor and client may then decide that these aspects of their functioning require attention because if defensive motives remain highly aroused but do not bring relief then 'stress' (with all its physiological effects) is likely to be maintained.

Activating the social environment: social relationships and the self

Research has shown that from infancy onwards we are not passive responders to an active environment, but actually help to shape it. Thus, various basic beliefs about the self and others may result in us engaging the environment in a certain way which will confirm our beliefs. For example, a jealous person is so demanding of evidence of loyalty that eventually the partner tires and leaves, thereby confirming the person's basic belief of the untrustworthiness of lovers. A man believes that he has to control others and trust is dangerous. He is rather aggressive at work. When he gets into difficulty he finds that few are interested in helping him. This strengthens his belief that others are untrustworthy and uncaring. Thus life is a process of forming models and schema of the world, acting as if these are true and eliciting certain kinds of

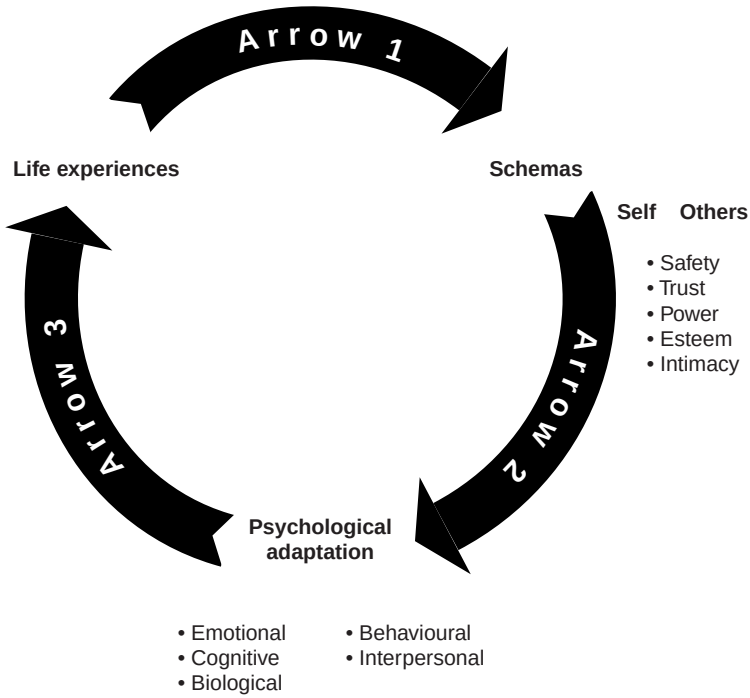


Figure 2.1 *The relation among life experiences, schemas and psychological adaptation (from McCann et al., 1988: 559, with permission)*

feedback from the environment that (often) confirm our schema. This is outlined in Figure 2.1.

The cognitive–interpersonal counsellor may focus on the interpersonal behaviours that a client is enacting. The client–counsellor relationship often allows this sequence to be observed (that is, schema activation – interpersonal (role) behaviour – social/environmental responses – schema maintenance or amplification). Thus, the client behaves in certain ways which invite certain responses from the counsellor or others and these in turn may be such to confirm the client's schema. Many of these enactments affect the relationship via transference and counter-transference experiences. Watkins (1989a,b) offers an excellent overview of these issues.

To clarify these points we can explore some examples. Stephen had strong moral views that one should not impose ideas or personal needs on others. He was also anxious about rejection.

Thus, he had difficulty in making requests of others and tended to try to give hints to them hoping they would pick up on his needs. This was a particular problem when it came to dating women because he held back on giving signals of his attraction to potential lovers. He was not able to present himself as 'keen and interested'. Thus various possibilities went unexplored and by his own account he tended to be a 'background person'. The outcome was that in reality he presented himself as overly shy, rather boring, and was often ignored in social situations. In other words, Stephen appeared unenthusiastic, rarely sent signals of positive reinforcement to others and was 'hard work' in social situations. Thus he relied on the initiations of others. Eventually his loneliness and anger at feeling left behind lead to a serious suicide attempt. His internal models of self and others had the effect of eliciting certain kinds of response from his social world which reinforced his negative schemata of himself. He also felt envious of others and disliked people who were 'more pushy'.

Dora wanted to have a close relationship with a man. Unfortunately, confident men made her feel anxious and inferior and she avoided them. She thus tended to make relationships with unconfident men of low self-esteem. These relationships rarely lasted as the men frequently had problems in emotionally relating to her.

Marj had been placed in a caring role early in life due to parental illness. In her relationship with her husband she saw herself as the strong one and the one who always stayed calm. When talking about her husband's angry outbursts she would (with pride) tell how she would stay calm and tell him that he was making mountains out of molehills and to leave things to her. If he got irritated with her she would simply walk away and tell him to 'stop being childish'. She failed to understand how this irritated him even more. In the day hospital she presented as a very competent person interested in others, full of advice but not really dealing with her own emotional pain and loneliness, which most often she denied. In reality, she was far from empathic of others. People found her intensely irritating. Unfortunately, she lacked insight into how her 'caring' behaviour was often controlling, and she remained aloof when it came to talking about her own feelings of emptiness. Thus although she wanted to be close and to feel that she was of value to others, in fact she elicited hostility and rejection.

Coyne (1976a,b) presented a model of depression which suggested that depressed behaviour is unattractive to others and therefore tends to elicit aversive responses. Although it seems a cruel twist, that depressed people should alienate people at

exactly the time they may need their support, there is much evidence for this view (Segrin and Abramson, 1994), and it offers one way of understanding why some depressions linger on. Depressed people initiate fewer positive interactions (e.g. going to a film, out to see friends, or sex), in part because they see it as too much effort, or predict they won't enjoy it. Not surprisingly, then, many marriages involving a depressed person are marked by a good deal of hostility (Beach et al., 1990; Gotlib and Colby, 1987). For both partners marriage can be seen as a trap as much as a source of support (see Prince and Jacobson, 1995).

Thus, via our role relationships, we can 'activate' the environment into presenting certain types of responses. In cognitive–interpersonal counselling this is often a focus – to enable clients to understand how, at times, they are eliciting the very reactions from others that they complain of.

Nevertheless, many individuals can be on the receiving end of a good deal of hostility or neglect which they do not elicit, and in these cases the problem can be more one of entrapment. So counsellors have to be aware that this is a complex area, and the comments here should not be taken to mean that depressed patients cause their own problems.

Key issues 2.4 Interpersonal working

1 Many depressions revolve around interpersonal issues.
2 The counsellor can become aware of how the client's interpersonal styles are often brought into the counselling setting (e.g. anxious, attachment or avoidant).
3 The counsellor can pay particular attention to the basic themes in depression (e.g. approval, achievement, self-worth, efficacy, defeat, entrapment, affects and social comparison).
4 The counsellor can note how typical defensive behaviour of flight (escape, hiding) and/or aggression inhibition are in themselves stressful and often make matters worse. Attention is given both to the behaviours themselves and the beliefs that may lay behind them.
5 The counsellor can explore with the client how his/her behaviour may activate the environment to respond in ways that are undesirable.

Concluding comments

We have seen that depression often involves negative views of the self (e.g. as inferior, worthless, bad, incompetent, defeated), and

the use of arrested or ineffective defences (e.g. of escape, avoidance, fight/submission or support seeking). These combine to produce increasing spirals of depression. The more you work with depressed people the more you will learn to spot these themes. Moreover, becoming skilled in asking questions which get to the core of a client's experience (e.g. shame, desires to attack/retaliate or get away), in a non-shaming way, can build the therapeutic relationship and help people feel understood.

Cognitive–interpersonal counselling utilizes all the basic propositions of the cognitive approach. There is a focus on the construction of meaning via attributions, attitudes, beliefs and so forth. The interpersonal dimension focuses on the early origin of self-other beliefs and increasingly is making links with attachment theory (Safran, 1998), social psychology and evolutionary psychology (Gilbert, 1992; Gilbert and Bailey, in press; McGuire and Troisi, 1998a). There is concern with how various beliefs result in social behaviour and activate defensive behaviour, which in turn can act to confirm negative beliefs. Moreover, there are increasing efforts to illuminate how these feedback mechanisms are also highly physiologically potent processes (see Gilbert and McGuire, 1998 for a review). We are a long way from fully understanding these interacting processes, or the role of genes on vulnerability and form of depression, but we do know that for mild to moderately depressed people counselling can offer opportunities to learn how to cope with depression, and develop more nurturing relationships with self and others. The next chapter will explore the specifically cognitive aspects of depression and further foundations for interventions.

3

Cognitive Models of Helping and Change for Depressed Clients

Successful counselling relationships are often rooted in three key issues. These are: (a) *the bond* formed between the counsellor and client; (b) *the goals* and objectives of the counselling process; and (c) *the tasks* and activities carried out by the counsellor and the client to reach desired goals (Bordin, 1979; Dryden, 1989b). Problems in counselling are sometimes due to difficulties in one or more of these. For example, if a client fears you or does not trust you, you will not get far. If the client and you cannot agree on how counselling should progress; the tasks and work of the therapy (e.g. monitor thoughts in cognitive therapy, or free associate in psychoanalytic, or work with the family in family therapy) then again one can get stuck. Finally, there has to be an agreed formulation and set of goals. Establishing these can take time but it is usually time well spent. Sharing an understanding of the goals and tasks of counselling and gaining agreement to move forward in a particular way is called the *therapeutic contract*. If counselling is not going well it is often useful to revisit issues of the therapeutic relationship and contract. It may be that problems here are stopping client and counsellor *working together*.

As part of this process, counselling relationships pass through certain stages. Egan (1998) has outlined a general model for counselling which is also applicable to a cognitive approach. These stages include:

The present scenario: this is the first stage in the counselling process. Here the counsellor focuses on the basic tasks of inviting the client to tell his/her story, gaining insight into current difficulties and developing an appropriate relationship.

The preferred scenario: this marks the second stage. Here the counsellor negotiates and clarifies the goals, aims and objectives of counselling with the client. This is often helped by a clear and agreed formulation.

Getting there: this is the third stage in the counselling process. Here the counsellor and client focus on the tasks of achieving the goals and objectives that have been agreed, and moving towards termination.

Each of these stages may be further subdivided, taking into account such things as resistances and blocks to change. The cognitive model moves through these stages with a particular focus on the interpretations, evaluations and beliefs of clients. The cognitive model argues that it is the *personal meanings* of events which are the key focus in counselling. For example, separation or divorce may be seen as a relief to one person, yet as a serious blow to self-esteem and future plans to another.

The cognitive domain

Cognitive based counselling focuses on our thoughts and styles of interpretation of the environment and social events, and also the implications we derive about ourselves (Sacco and Beck, 1995; Tarrier et al., 1998). For example, Mary does not want to go out with me any more (event). This is because she does not like me any more (interpretation). This means I am unlovable (self-judgement) and can never be happy (future self-judgement).

There are three basic concepts in cognitive counselling comprising:

1 Automatic thoughts: these are the immediate ideas and interpretations that spring to mind. In depression they are often self-evaluative and carry implications for the future.
2 Rules for living and basic attitudes: these are the ideas and beliefs that guide our lives and set us in particular styles of living (e.g. I must be successful; I must be approved of). Basic attitudes are not always easily accessible and the client may hardly be aware of them.
3 Self-other schemata: these represent internal organizing systems that form the basis of our self-judgements and experiences on the one hand, and our judgements and experiences of other people on the other. Cognitive therapists sometimes use the terms 'beliefs' and 'schemata' interchangeably.

Automatic thoughts

Automatic thoughts, as the name implies, are those interpretations/ideas/thoughts that seem to come automatically to mind;

they are our pop-up thoughts. They are the immediate, consciously available thoughts, require little or no effort and seem plausible. They are not arrived at through reflective reasoning. In depression they are often self-evaluative and future directed. Automatic thoughts are not necessarily in clear/syntactic language and can be poorly formulated, using fragments of grammar. Also, it is common for them to occur in images or inner scenes, daydreams or fantasies (Gilbert, 1992; Hackman, 1997). Just think of how powerful inner images can be. For example, try this (after you have read the next few sentences). Close your eyes and think of a lemon in a bowl of fruit. Now image reaching for it. Take a knife and cut into it. Pick up one half. Squeeze it gently and see in your mind the falling of tiny droplets of the juice. Now put it to your mouth and suck. Okay, chances are you might have had some twinge in your mouth just from the image? If you fantasize on sexual images you may become sexually aroused. And if while lying relaxing in the bath you remember you had to be at an important meeting, you may become anxious or annoyed with yourself for forgetting. Thoughts, images and sudden memories, then, are powerful and can activate feelings and bodily processes.

Let's look at a different example – one related to trying to imagine why a certain event has occurred. For example, what goes through a person's mind when their lover promises to phone at a specific time but does not phone as promised? For a moment just close your eyes and image such an event; you have a lover who you are expecting to phone you tonight. You are looking forward to the phone call. As the time goes by and the phone does not ring what goes through your mind?

In real life this type of event may lead us to fantasize about the possibility that the lover has lost interest, or does not care enough to remember, or is out with someone else. We may construct scenarios of seeing the lover in some particular place (e.g. a pub) and imagine him/her having a good time, laughing, drinking, etc. We may enter into internal elaborations and amplifications of our thoughts and fantasies as if we are making 'videos in the mind'. For example, having decided that our lover has forgotten because she/he decided to go somewhere else (e.g. down the pub) and is out having a good time, we may start to rehearse in our minds an argument or what we intend to say the next time they do phone. We may even rehearse something that we know in reality we would not carry out due to fear of being rejected/disliked, or because of moral concerns. However, if we had an image that something bad had happened (e.g. a road accident) then our whole set of feelings and thoughts would be different.

Thought catching: Sometimes we may not be fully aware of our automatic thoughts but experience only emotions. For example, when the telephone does not ring we may find ourselves becoming anxious, sad or irritated, but our awareness of our *thinking* may be hazy or poorly recognized. Hence, the depressed person may need to train themselves to *attend* to their automatic thoughts so as to sharpen their focus and make them subject to more detailed analysis, communication and challenge. The client can be taught to say to themselves: 'Okay I am feeling sad or angry about this so how am I actually seeing it; what am I saying to myself?' This is called *thought catching*. So clients are taught how to attend to changes in moods or feelings – to become attentive to these changes. They can also try to identify events around these changes. To help people become skilled at thought catching they can be taught how to *write things down* – to take time out to explore their thinking in relationship to their feelings. Thought catching and focusing is a key aspect of the cognitive approach because the typical way people interpret situations will be a focus for therapy. As we move through this book many examples of this process will be given.

Linking thought and feelings

A person can be shown the cognitive model by using examples like the one given above and by highlighting the relationships between events, thought and emotions. The counsellor may write down three columns A, B, C. A stands for an *Activating event*, B stands for *Beliefs* and C stands for *Consequences*. This is called the triple column technique.

A	**B**	**C**
Activating event	Beliefs/appraisals Interpretations	Emotions Behaviour Biology

The counsellor may then use the example of a lover or friend who does not phone or some other example. First, a counsellor may say:

> One way we can work together is to understand that the way we see certain things affects what we feel about them. It's about the meaning of things to us. I would like to show you an example of how this works. Image that a friend or lover was going to phone you tonight but then they didn't. I will write that down in the A column. Now it is possible that we might have various different feelings about that. We could be angry or irritated, anxious or sad, or stay calm. I will write those down in

the C column. Now let's think about the kind of meanings and thoughts that would go with each feeling and I will write these down in the B column.

If possible the client is encouraged to do this with you and generate thoughts/images. Ask: What is likely to be in your mind if you felt angry? What is likely to be in your mind if you felt sad and so forth? So the result might look like:

A (Activating event)	B (Beliefs and meanings)	C (Emotions)
Lover has not phoned as he/she promised.	They don't love me enough to remember and care.	Sadness
	They are so thoughtless. I bet they went off down the pub. How dare they.	Anger
	They are usually reliable. Something must have happened to them.	Anxiety
	I guess they were busy or could not get to a phone.	Calm

The counsellor may use this type of example to indicate how the interpretation of an event is associated with emotional, behavioural and biological changes. To show how the thought also affects *behaviours* the counsellor would then say 'what might you *do* if you felt sad; what might you do if you felt angry,' and so forth. These can be written down under the emotions.

Three other areas should be discussed: *images*, *context* and *history*. In the case of feeling angry about such an event the person may have various images of their lover out having a good time in the pub. In anxiety, the person may have images of some accident to the lover. In regard to context, if the lover is on an oil rig where phones keep breaking down compared to being at home or having a mobile phone, then these contexts will affect the probable interpretations. As for history, if it is very uncommon for the lover not to phone this will have a different impact than if it is common. Further, if a person has suffered (say) frequent abandonments in the past then an evaluation that 'the lover is about to abandon me' will make a lot of sense even if (in this case) it is inaccurate.

Explanation of the cognitive model should be conducted in a friendly way and the use of gentle humour during the example sometimes helps to relax a client. It is important to check with the

person that they see the validity of this approach. When this has been agreed the counsellor can then say, 'Okay, now let's use the same kind of approach to the kinds of problems you seem to be having. Can you give me an example of an event that has upset you in the past week? Right now, we are mainly interested to understand what this event meant for you.' This is then written down under A. The emotions/feelings and behaviours elicited are written in column C. Then the counsellor says, 'Now let's look at what was going through your mind at B, to see if we can understand what meanings are associated with those feelings and behaviours at C' (Beck et al., 1979; Gilbert, 2000; Trower et al., 1988).

Thoughts are meaningful

The most salient aspect of automatic thoughts is their *core of meaning*. An important procedure of cognitive counselling is therefore to explore the immediate thoughts, teach how to recognize these thoughts as they occur and how to challenge them (e.g. Beck et al., 1979; Blackburn and Davidson, 1995; Fennell, 1989; Sacco and Beck, 1995; Trower et al., 1988). There are now texts that allow both client and therapist to understand and work on this together (Greenberg and Padesky, 1995; Padesky and Greenberg, 1995). My own self-help book can also be given to clients to help understand this approach (Gilbert, 2000). Because cognitive therapy involves a psycho-educational approach it is useful to be aware of, and have to hand, various reading materials that clients can take away and use. By having a variety of materials clients can choose which seems best for them. Some depressed people, however, may need some relief from depression before they can concentrate on reading materials. It is also useful to be fairly guided (at least in the early stages) in reading and work with (say) a chapter at a time so that it is manageable and clients don't feel overloaded.

Key issues 3.1 Automatic thoughts

1 They are triggered by events which may be external (e.g. criticism from another person) or internal (e.g. an emotional feeling or spontaneous memory).
2 They are immediately available and just jump or pop into the mind. Thus they require little or no effort and appear to be spontaneous.
3 They occur in shorthand, often as images, and are poorly formulated in language.

4 They follow no clear sequence as in logical reasoning or problem-solving.
5 They can be difficult to turn off, especially in the presence of emotional arousal.
6 They often seem plausible and reasonable to the client, although they may be far fetched (e.g. catastrophic).
7 They can arise in spite of evidence to the contrary.
8 People often need to train themselves to be attentive to (thought catching) and monitor their automatic thoughts.

Inference chains

Once clients understand the linkage between thoughts (interpretations) and feelings it is then possible to begin to deepen the exploration by searching for some underlying, deeper meaning or more global or extreme evaluations and beliefs. One of the most common forms of this type of work is called *inference chaining or laddering*. This technique is one of *guided discovery* – not interpretation.

Inference chains are the ways our thoughts and interpretations are linked together. An inference chain follows an 'if A then B' form of reasoning. In other words, the client associates one idea or outcome with another. Usually a subsequent inference is more global, extreme and emotionally laden. For example: 'If my friend ignores me then it means he/she does not like me. This is because I am a boring person. If I am a boring person then I am unlovable. If I am unlovable I will never find a loving relationship and will be alone and depressed forever.' Let's look at the lover example again. A sequence or pattern of thoughts might be:

A	**B**	**C**
Lover has not phoned as he/she has promised.	1 They don't love me enough to remember and care. 2 They are losing interest in me. 3 This is because I am not attractive or desirable enough. 4 Most people get bored with me when they get to know me. 5 I will never find someone who loves me.	Sadness.

1	I bet they went off down the pub.	Anger
2	They are thoughtless and unkind.	
3	This is typical of men/women. They are completely unreliable.	
4	I am not going to be treated like this. Just wait till he/she does phone!	

Some clients can be ashamed to admit what they are thinking and counsellors should be very sensitive to this for two reasons. First, because the client may tell you what they think you want to hear or not reveal too much of what they are actually thinking (because they feel ashamed or silly to admit it). Sitting in a counsellor's room in the cold light of day may make the thoughts seem irrational and silly. I suspect we all have thoughts that we would not necessarily find it easy to admit to someone else! Understanding they are irrational however may itself not change them. Second, because in the early stages one cannot be sure that what the client offers as their negative thoughts are actually the ones causing most distress, one needs to keep an open mind ready to change track as more information becomes available and trust develops.

Types of question

Eliciting an inference chain is a kind of directed (as opposed to free) association. The cognitive counsellor is active and directive in the use of questions, and does not go beyond what has been said. To explore an inference chain requires a preparedness to suspend efforts to modify thoughts as the exploration unfolds. Some counsellors tend to jump in too quickly with their own interpretations or ideas, e.g. 'Do you think you are thinking this because . . .?' or 'Isn't this because . . .?' or the counsellor engages in guessing. In cognitive exploration the counsellor tries not to suggest ideas but to let the person discover them for themselves. Cognitive counsellors believe that self-discovery works better than interpretation. Hence, the importance of the Socratic 'what' or open question. By Socratic we mean a type of discussion which invites further exploration. We look at the meaning of Socratic further in the next chapter.

The most basic questions are 'What went through your mind?' or 'What is going through your mind?' These are both examples of

open questions which enable the client to focus more clearly and avoid vague descriptions of 'it', 'always', 'something'.

Other common questions are:

What would happen if . . . ? What would happen then/next? What does that lead you to think/believe? What conclusions do you draw from that? What do you think this means?

To get at more specific self–other schema you might ask:

What do you think other people thought? What do you think was going through their minds? What do you conclude about yourself? What were you thinking about yourself? What do you think they were thinking about you? What were you thinking about you?

To work with historical data you might ask:

When was the first time you thought/felt this way and what was happening? (elicit images and memories). Do you often have that view? How often have you felt/thought this way?

The counsellor can ask the client how *strongly* they believe something by giving it a percentage rating; e.g. Out of 100 how strongly do you believe this? One can also ask about *frequency*; e.g. How commonly do you tend to think like this?

As a rule of thumb 'what' questions encourage the person to explore the *implications* of their thoughts/interpretations. That is the Socratic part. The implications the counsellor is particularly interested in are those related to the pursuit of long-term goals and rules for living, idealizations, hopes and fears, and schema or self-views and ideas about significant others. In other words, what does this thought or idea imply? One can also note the underlying themes, issues of shame and blocks to exploration.

Another form of questioning seeks to explore a more causal form of thinking. In this case the questions follow a 'why' set of questions, or less often a 'how' set of questions.

Why do you think that? Why do you think that happened? How do/did you reach that conclusion? How do you think other people would see you because of that? How do you think other people will react to you?

Although cognitive counsellors sometimes use 'why' questions, Egan (1998) argues that 'why' questions can be experienced as

threatening. Thus they should be used cautiously or when you have established a good working relationship with the client.

Yet another set of questions seeks to enable clients to make predictions:

What are you likely to feel when you think this way? What happens when you behave this way? How do others respond to you when you behave this way? What are the advantages and disadvantages of thinking/behaving this way? What would be the advantages and disadvantages of making this change?

Helping clients predict the consequences of their ways of thinking, and predicting what would happen if they changed, is important in cognitive counselling as we shall see later. Again, it should be emphasized that the purpose of these kinds of questions is *guided discovery* – to give form and clarity to vagueness. Hence, the counsellor should be aware that sometimes clients may not actually answer the question but remain vague or answer a different question. Thus, the counsellor wants to enable the client actually to focus on the question put. These questions are designed to help the client gain a clearer idea of what is going through his/her mind, the core essence of the meaning. They are not just to satisfy the curiosity of the counsellor.

When exploring an inference chain with such questions it should be conducted in the manner of a *collaborative friendly venture*; it is not an interrogation. The style of the interaction should be one of caring interest (Gilbert, 1989). The counsellor should avoid just 'firing off' questions, one after another, and intersperse questions with reflections and paraphrases. One tries to foster in the person a desire to explore and discover (guided discovery), yet also convey a sense of safety. Counsellors need to be sensitive to the current state of the client. For example, if a client has a desire to share painful feelings and be understood, has serious shame problems or is very inhibited, then there is little point doing highly focused work. The counsellor must be sensitive to these issues.

Cognitive therapists use these Socratic type questions in two basic ways (Sacco and Beck, 1995).

1 To *probe* the ways people are reasoning – to explore their basic constructs – to illuminate the links in the chains of their reasoning.
2 And later to stimulate people to *challenge* and *reflect* on this reasoning and see if it holds good. Here one may help the

client gain evidence for or against their judgements, to do various homeworks and experiments to test out their theories and ideas. This is called *collaborative empiricism*. Counsellor and client explore *together* the validity of various beliefs. This is the focus on the next chapter.

In general, Socratic questioning involves:

1 Seeking information that a person can (is able to, or prepared to) give.
2 Helps to redirect attention and refocus the nature of the problem.
3 Moves from the specific to the more general so that the person:
   a) Gains increasing insight into their general/basic beliefs.
   b) Develops the skills to challenge and change key conclusions and beliefs.

Let's look at an example: Jane was a depressed single parent who was trying to start a new relationship with Dave. However, she was cautious and doubtful of his feelings for her and very attentive to cues of rejection.

Counsellor: Jane, you were saying that this weekend has been particularly bad for you. Can you remember any particular event that seemed to start it off?
Jane: I guess it was Friday night. Dave had said he would come over but then he phoned to say that he would not be able to make it as he had to go down to London to pick up some work.
Counsellor: How did you feel about that?
Jane: I was real disappointed and went to bed. I just switched off. Everything seemed pointless.
Counsellor: What went through your mind?
Jane: Hm . . . something like, here we go again. I am obviously not that important to him. He has better things to do. Maybe he would prefer not to be coming over.
Counsellor: So you thought he'd prefer not to come over. Did you have any thoughts about why that might be the case?
Jane: Yes. I got to thinking that maybe I am not really that much fun to be with. He probably thinks I am a rather boring person and does not want to get too involved with a single parent with kids. I began to think that sooner or later he would pull out of the relationship and I'd end up alone again.
Counsellor: I see, so when Dave didn't come over you began to think that there were things about you that he was rejecting, like being a single parent and that you felt you were boring.
Jane: Yes.

Counsellor: Suppose for the moment that Dave does pull out of the relationship. What would go through your mind then?
Jane: I'd think that everything is empty and there is no point. Life is very hard on one's own.
Counsellor: What would you feel about you?
Jane: Oh, that this is typical. I am a loser and better just accept that. It's pointless to try to make meaningful relationships. I get this sense of being unlovable somehow, you know like deep down there is something wrong with me. So I am going to be on my own. That really makes me depressed. Everything seems so empty.

In this case we see that the disappointment is linked with a number of more catastrophic thoughts about self as boring, being unlovable and destined to be alone. The counsellor listens for *key words* that may *act as markers* for underlying beliefs, e.g. boring, empty, pointless.

Sometimes one might say: 'Let's explore the worst. Let us for the moment suppose that X has happened. Now what is going through your mind?' Very often in depressed clients the worst is about being abandoned, rejected, worthless, pointless and powerless.

Sometimes if clients find it difficult to put thoughts into words a counsellor might ask a client to imagine a situation and talk about the inner picture in their minds. One person who was having difficulty expressing his thoughts about his depression in language was asked to describe a picture. After some thought he said: 'it's like I can see this party going on and I'm standing in the garden or somewhere. It's very cold, maybe snowing and very dark. I know that no matter what I do I will not be allowed in, but must stay outside just looking in and being on my own.'

Complex chains

Dryden (1989c) has articulated the importance of complex chains; that is, how one set of ideas and conclusions sets off another set of ideas and conclusions, or how one theme triggers another. This is a common problem in depressed clients. They may say things like 'My head is full of so many thoughts' or 'Everything is just zooming about inside'. For example, a person became angry because she thought that someone was deliberately doing something to hurt her. However, the experience of anger led to fear, with the thought, 'If I get angry I may get out of control. If I get out of control I will look silly and be humiliated.' So she believed she would not say anything, but then was resentful with the thought, 'Why do I never stand up for myself and let others push me around. I am a weakling.' Hence thoughts about being hurt and pushed around,

thoughts about looking silly, and thoughts about herself as a weakling were all tied up together. In such cases the counsellor attempts to help the person stay with one theme at a time.

Dryden (1989c) points out that if a person gets highly emotionally aroused it may be very difficult to get out of this cycle with cognitive restructuring. Typical is the depressed person who says, 'I understand the ideas but when I get really low I can't get out of it.' Sometimes distracting physical activity, like running or digging the garden, and at other times working on graded tasks, can be helpful. Relaxation can be unhelpful especially if this increases focus on self and rumination on negative thoughts. Hence distraction which involves some motor activity can be more effective. Also in these situations the counsellor identifies complex chains (or interacting themes) and teaches early identification. Here it is preventive measures that must be taken. The client learns that if they spiral down then it is difficult to get out, so they 'get in early' with coping responses.

Specificity

Cognitive counselling for depression follows behavioural analysis in that there is concern to be very specific about the events (antecedents) and eliciting situations. Depressed clients are often vague about things that trigger mood changes and need to work to become more focused. When this happens it is sometimes possible to arrive at a list of specific situations that trigger negative affects, thoughts and beliefs. Specificity helps to target interventions and also to focus the client on the fact that things can become manageable and controllable.

Writing thoughts down

Clients can be taught how to use various thought recording forms. Examples of these are given in the Appendices (pages 210–13). I tend to use the more simple forms – although other cognitive therapists have developed more complex ones (Beck et al., 1979; Greenberg and Padesky, 1995; Sacco and Beck, 1995). I tend to work on a few thought forms collaboratively in session first and then invite the client to try for themselves – this becomes part of homework. Some clients take to this readily, others do not. So it is important to have a clear understanding of this in the therapeutic contract.

Dwelling and ruminating

Elsewhere (Gilbert, 2000) I have made the distinction between those thoughts that are truly automatic and those a person dwells

on and turns over and over in their minds. Dwelling and ruminating on negative thoughts is what typically drives people further into depression and they can spend a long time focused and repeatedly indoctrinating themselves with their negative thoughts. It is almost as if they have addictive qualities. I have found it is useful to help people recognize the difference between automatic thoughts and repetitive ruminations. You can ask: How much time do you spend thinking this way? Once the rumination cycle starts up, how do you break into it? What do you think happens to your feelings when you dwell? It is then possible to show how those thoughts and feelings can spiral down together but drawing out circles (see next chapter).

Types of feeling in relation to negative thoughts

We have seen that negative thoughts are often associated with negative feelings; that there is a linkage between B and C. However, recall the thoughts of Jane who, when Dave did not come over for the weekend, said 'Oh, this is typical. I am a loser and better just accept that. It's pointless to try to make meaningful relationships . . .'. Now, such thoughts made her more depressed. But what might be the emotions of the thoughts themselves? What is the emotional tone associated with the delivery or generation of the thoughts?

Counsellor: When you think like that Jane what is the emotional tone of the thoughts? I mean, how do you actually say them in your mind?
Jane: How do you mean?
Counsellor: Well, you could say them to yourself in a matter-of-fact way, or in an anxious way or an angry way. What way do you say them?
Jane: [pauses] Oh pretty angry I guess. Like if only I could be different then the relationships might work out.
Counsellor: So when you 'kind of' hear these thoughts in your mind they are angry?
Jane: Oh yes – I feel very angry and frustrated with myself.

Now self-attacking and self-criticizing in depression is rarely neutral, but as the term 'self-attacking' implies is often fired with disappointment and anger. In recent years I have become very interested in *the emotional tone of the delivery of self-evaluative thoughts* – and anger is common. In the next chapter we will see how it can be useful to focus on the tone of thoughts and help people to become more caring and supportive (Gilbert, 2000, in press b). Indeed it is important that when people *challenge* their automatic thoughts they *do not* do so with another form of self-attacking, e.g. Come on, stop being so irrational. Get your head

together. Now what's the bloody evidence – stupid! We will look at this again in the next chapter.

Key issues 3.1 Exploring automatic thoughts

1 Help clients recognize the link between feelings and thoughts.
2 Introduce them to the basics of thought catching and thought monitoring.
3 Choose which kinds of thought form you are going to work with and do some worked examples with them.
4 The use of certain types of questions, such as when, what, why and how, help the client to clarify what is going through his/her mind.
5 These questions are aimed at facilitating guided discovery.
6 Sometimes the counsellor can use mental images and/or pictures rather than rely on spoken words. At other times the counsellor can explore using the client's fantasies, such as 'Let's imagine that . . .'.
7 Depressed clients often have various sets of thoughts that become complex chains with interacting themes. At these times the counsellor tries to be specific by following one theme or idea at a time.
8 Clarity is helped by writing down thoughts, e.g. with the triple column technique.

Cognitive distortions

The strength of the emotion or mood dip can often be associated with the global evaluations at the end of the chain and the nature of these evaluations (i.e. this would be terrible and unbearable). As clients link ideas together there can be various distortions in their thinking. This may be because they focus on certain negative details and exclude positive alternatives. Or it may be because people 'jump to conclusions'. For example, 'this relationship has failed so *all* will fail' or 'I failed at this examination so I will *fail everything*.' Or 'I will *never* be a success.' As the mood worsens, thinking becomes more black and white and extreme. Beck et al. (1979) suggest that there are particular types of distortions in the reasoning and automatic thoughts of depressed clients:

1 Arbitrary inference – drawing a negative conclusion in the absence of supporting data.
2 Selective abstraction – focusing on a detail out of context, often at the expense of more salient information.

3 Overgeneralization – drawing conclusions over a wide variety of things on the basis of single events.
4 Magnification and minimization – making errors in evaluating the importance and implications of events.
5 Personalization – relating external (often negative) events to the self when there is little reason for doing so.
6 Absolutistic, dichotomous thinking – thinking in polar opposites (black and white). Something is all good, or totally bad and a disaster.

Others have added egocentric thinking, 'People must think the same way I do', and the telepathy error, 'People should know how I feel without me having to tell them'. Some of these 'errors' are not original to cognitive theory. For example, black and white thinking is called 'splitting' by object relations theorists. Also, it has become apparent that human reasoning in general often involves these styles of reasoning (Hollon and Kriss, 1984) and that depressed clients are not untypical in this. Content is more important. There is also an evolutionary aspect such that under stress it is common for us to start to 'imagine the worst', become highly attentive to threats, and distorted in our thinking (Gilbert, 1998b) – such styles of thinking actually may have had adaptive functions. However, it can also become highly maladaptive.

Since Beck first introduced these basic distortions there have been various changes in the language used to describe them (e.g. Burns, 1980). In the Appendix 1 are some of the more typical types of 'depressive styles of thinking', as I prefer to call distortions. It can be useful to go over these together as part of the psycho-educational approach so that clients can see the typical ways a depression leads us to think. Thus they are written from the point of view of a client. It is in fact useful to explain to clients that this is the *depression* style of thinking. (And there is a style of thinking associated with anger and a different style associated with being happy, and yet a different one associated with anxiety, etc.) Most people tend to think in a certain way as they become depressed, just as most of us tend to get increased temperature as we get sick, or shiver when we get cold. However, there are things we can do to bring our temperature down or to get warm again – and challenge our negative thinking.

The use of the term 'cognitive errors', sometimes used to describe these cognitive styles, is unfortunate and led to debate about whether or not clients are erroneous in their thinking; that is, the client is wrong and the counsellor is right. However, in some cases depressed people may actually be more accurate than

non-depressed people (Taylor and Brown, 1988). There are many reasons a client may fall into certain negative styles of evaluation: life events, as a result of previous history and also because it is part of the natural way the brain processes information when under stress (Gilbert, 1998b). Under stress we can naturally tend to assume the worse. It is vitally important that, as clients come to identify and recognize their distorted thinking, they *do not* see this as evidence of being stupid in some way. The more the counsellor can help the client recognize that cognitive distortions are understandable, e.g. because of past history, stress and human natural tendencies to think in certain (often irrational) ways, the more the client can be orientated to the hard work of challenging their thinking.

To suggest 'error' is to suggest 'a correct' way of thinking. These debates cloud the key issue of understanding meaning. Others have tried to overcome this problem with terms like dysfunctional versus functional/adaptive or 'goal securing' thinking. Thus, whether a thought is rational or not depends on whether it moves us closer to a desired goal. There are many philosophical problems with this view, however, thus it is preferable to talk in terms of depressing thoughts or anxious thoughts, etc.

Social comparison

Some depressed people derive a sense of self-worth by social comparison. Social comparison is a very normal way of thinking about ourselves. However, while we can look downwards and compare ourselves with less able others, and count our blessings, those vulnerable to depression tend to look upwards and compare themselves with others who are superior to them in some way. For example, young women may compare themselves unfavourably with images of beauty in the media or people they see on the streets. Because they don't feel as good as those they compare themselves with they can often feel like failures. Negative social comparisons can often be a trigger for feelings of disappointment in the self and self-criticisms. So it is useful to check out how the client compares him/herself with others, the targets they choose to compare themselves with, and emotional consequences of such comparisons.

Rules, assumptions and attitudes

Life rules can be regarded as the instructions or beliefs that relate to happiness and avoidance of pain and unpleasantness (e.g. 'To be happy I must be loved' or 'I must be successful', and so forth).

Certain rules and attitudes have been developed into the dysfunctional attitude scale (DAS) (see Blackburn and Davidson, 1995: 211–14, for a copy of this scale). Here are some typical dysfunctional attitudes, from the DAS:

4) If I do not do well all the time, people will not respect me.
11) If I can't do something well there is no point in trying.
16) I am nothing if a person I love doesn't love me.
23) I should be upset if I make a mistake.
25) To be a good, moral, worthwhile person I must always put the needs of others first.

Dysfunctional attitudes relate to various domains and social themes, such as perfectionism and approval (e.g. 'People will probably think less of me if I make a mistake'; 'If a person asks for help it is a sign of weakness'). Much work has now been conducted with the DAS in depression (Sacco and Beck, 1995). It has been found that depressed clients score significantly higher on the DAS than nondepressed people. However, so do many client groups and dysfunctional attitudes are not specific to depression. DAS scores correlate with neuroticism (Teasdale and Dent, 1987). It has also been found that the DAS is mood sensitive and subject to changes in mood state.

Nonetheless in so far as rules for living represent people's basic philosophies of life these can be very important to focus on. They are not automatic in the sense that they just pop into the head but they may well show up when one is exploring automatic thoughts.

For example, Anna was feeling guilty about turning down a friend's request for baby sitting because she felt too tired. We had looked at an inference chain that went 'I should have put myself out. It was selfish of me to put my needs first. Carol will think I am selfish and won't like me so much. Maybe I am selfish.'

Counsellor: Sounds like this is a basic belief or rule for living you have. You must put others first. If not you are selfish and others won't like you?
Anna: Oh Yeah. I think that. Always have.

Traps, dilemmas and snags

Ryle (1990) has explored various cognitive concepts and expressed them in a helpful framework. He has suggested repetitive themes (called traps, dilemmas and snags) in various forms of psychopathology, which are especially relevant to depression. These set

up various (approach–avoidance) conflicts, increase arousal and lead to confusion.

TRAPS These are negative assumptions leading to various forms of behaviour, the consequences of which reinforce the assumptions. For example, 'I am boring to others, therefore they won't be interested in what I have to say, therefore I won't say anything. The result is I behave in a boring way and people lose interest in me' (see Chapter 2 and page 87).

DILEMMAS In dilemmas a person acts as though available solutions or possible roles are limited to polarized alternatives (false dichotomies). Often they are unaware that this is the case. For example, 'Either I express my feelings (but then get rejected), or I conceal them (but then feel resentful). If I love someone then I must give in to all their wishes.' In cognitive counselling this is called black and white thinking and uses the 'if then' style of thinking. When feeling trapped, dilemmas can revolve around these black and white dilemmas. 'Either I leave this relationship and am miserably alone or I stay and have to put up with it.' Such thinking can lead to feelings of there being 'no way out'.

SNAGS Appropriate goals or roles are abandoned (a) on the (true or false) assumption that others would oppose them, or (b) independently of the views of others as if they were forbidden or dangerous. The depressed individual may be more or less aware that he/she acts in this way and may relate this to feelings such as guilt. In cognitive counselling we use the advantages–disadvantages approach to explore this aspect (see Chapters 4 and 6). For example, 'If I get better I might be more assertive but then I might not like myself or become more like my (disliked) mother.' Snags manifest themselves in the 'yes but' styles of thinking. Many counsellors have pointed out that depressed clients often engage in 'yes but' responses. Never underestimate the possible snags some clients may feel about recovery!

Key issues 3.2 Dysfunctional attitudes

1 Dysfunctional attitudes are often generalized 'rules for living'.
2 They can be over-rigid and generalized and can involve concepts like always, never, must, should, have to. Dysfunctional attitudes lack flexibility.
3 They are dysfunctional because they keep us from our goals or lead to poor role enactments (e.g. the more I have to be close to

someone the more this may drive them away; or, I believe that I must never fail so I withdraw and don't try at all).
4 They can lead to various traps, snags and dilemmas.
5 In depression they tend to be focused on the themes we outlined in Chapter 2.
6 In depression they are often related to various roles (I must be caring, I must be loved, I must gain respect).
7 Dysfunctional attitudes are linked to basic self-experience (I feel bad if a rule is broken, but good if successful). The occasional positive reinforcement of them may maintain them.
8 They are linked to basic hopes in the future (e.g. If I am loved then I will be happy; if I am successful then I will be good – a somebody rather than a nobody).
9 They are often culturally reinforced (e.g. we should be individualistic and achieve, or women should be always loving and caring).

Self-other schema

The work on schema is one of the most important developments in cognitive counselling in recent years. As cognitive counselling has become interested in the more long-term and complex forms of depression, the role of schema or schemata has become paramount. Schema relate to central and basic organizing systems for knowledge about the self and others. These are built up through life as the result of interpersonal experiences (Figure 3.1).

However, there are other domains such as, 'How I think others see me' (e.g. as able, kind, etc.), and 'How I want others to see me'. Cognitive counsellors also make a distinction between conditional and unconditional self–other schemata. A conditional view is 'I am good if . . .', whereas an unconditional view is 'I am bad regardless, i.e. there is nothing I can do to make me into a good person' (Beck et al., 1990).

In uncomplicated depression episodes it is believed that there is a switch from previous (usually) positive schemata of self and others to the activation of negative schemata (e.g. I used to feel okay about myself but now I feel a failure). This is important for counselling because it is believed that stored in long-term memory is a set of positive schemata, and working at the level of automatic thoughts and attitudes, gaining and testing hypotheses, will help to reactivate these positive schemata which do exist, but have become latent in the depression (Beck et al., 1979; Blackburn and Davidson, 1995; Fennell, 1989).

In depressions associated with personality disorder, however, positive schemata of self and others may not exist or at least may

History
Parents
Siblings
Peers
Teachers

	Self	**Other**
Positive	Able, good, attractive, wanted, competent, worthy, caring, friendly, etc.	Able, good, attractive, wanted, competent, worthy, caring, friendly, etc.
Negative	Unable, bad, unattractive, unwanted, incompetent, unworthy, uncaring, hostile	Unable, bad, unattractive, unwanted, incompetent, unworthy, uncaring, hostile

Note: Self–Other schema can often be put into single words that describe personal attributes: I am . . .; The other is . . . . They can be highly emotionally charged and represent core aspects of identity – the basic sense of ourselves and others. Their emotional 'power' can be elicited in interpersonal relationships.

Figure 3.1 *Self–other schemata*

be very fragile even at the best of times (e.g. I have rarely felt okay about myself and always felt a failure). Hence, techniques to reactivate and tap into a person's premorbid level of functioning are ineffective because there is rather little (in long-term memory) to tap into. The counselling with personality disorders then becomes much more one of developing something 'anew'. This takes much longer, and requires a different focus of counselling, especially on the importance of the therapeutic relationship (Beck et al., 1990). Hence it is important to gain some idea of the person's premorbid level of functioning. However, it is not always helpful to think in terms of personality disorder versus non-personality disorder. In reality these are dimensional issues and all of us have areas where our basic self–other schemata could do with a little development. Also most personality disorders show major overlaps and many clients show various aspects of them. Nevertheless, novice counsellors often attempt to use techniques designed for non-personality disordered folk with clients with personality disorders, to the disappointment and frustration of all concerned. The main issue here is one of, 'how much in the way of growth and new schema does the person need to develop?' A number of counsellors take the view that in some cases we grow

out of our psychopathologies, and the issue of maturation and new learning (rather than reactivating positive schemata) is a key issue in counselling (Gilbert, 1995; Safran, 1998). These developments greatly enrich the cognitive model and offer up new ways of working therapeutically. A helpful text in this regard has been edited by Kuehlwein and Rosen (1993). See also McCullough, 2000.

Key issues 3.4 Self–other schemata

1 There are basic core self–other belief structures (e.g. I am. You are).
2 The counsellor needs to explore whether there has been a major shift from previous positive self–other schemata to negative schemata, or an accentuation of negative self–other schemata.
3 Once activated, these schemata tend to be self-perpetuating and defended against change; that is, the person distorts information to maintain them (e.g. by personalization and focusing on the negative).
4 In some clients, although their schemata are negative they are also comforted by being familiar – what is known and predictable.
5 When a schema is activated, it tends to generate high (usually) defensive arousal and trigger defensive responses (fight/flight/avoidance, etc.).
6 Our basic self–other schemata often come from early life.
7 Thus they may be difficult to articulate in language but are 'experienced' as feeling states.
8 Sometimes a client feels and behaves 'as if' negative schemata are operative even though they may not be able verbally to label the schemata.
9 Typical triggers of schemata are lack of recognition or control, and actual or potential losses of valued relationships.
10 They can activate complex interacting chains of thoughts and feelings, giving the experience of 'many things rushing through one's mind' and a sense of fragmenting and falling apart.

Conceptualization of a case

Let us now try to put these various aspects together. We can conceptualize a case of depression as representing an interaction of previous life history, the development of self–other schemata and basic attitudes to life, roles and basic interpersonal styles, critical incidents that lead to negative self-evaluations, and automatic thoughts (see Fennell, 1989). Appendix 2 offers a formulation and case conceptualization sheet. Here is an example:

EARLY EXPERIENCES

Parents only seemed to pay me any attention if I was successful and achieved things.
Failures led to punishment or neglect or being ignored and feeling a disappointment to them.
I learned to feel disappointed in myself if I failed.

Self as	*Others as*
Not good enough, a failure, a disappointment, lacking.	Fickle, rejecting, powerful, critical, demanding.

SCHEMATIC BELIEFS

I can only value myself and feel in a positive relationship to others if I am succeeding.
Others will only value/like me if they see I am successful and worthy.

BASIC ATTITUDES AND RULES FOR LIVING

I have to show others that I am competent and try hard.
I have to achieve things to maintain my sense of self-worth.
Without success I will be ignored and not respected or attended to.
To feel good about myself I have to have others' admiring attentions.
Without success, if people got too close to me they would discover I am empty.

ROLES AND SOCIAL BEHAVIOUR

I constantly try to demonstrate competence.
I rarely praise others but expect others to praise me.
If others get in my way then I withdraw or compete with them.
If others want things from me (like time in intimate relationships or having fun) that could distract me from my life goal then I must distance myself.

CRITICAL INCIDENTS AND SITUATIONS TRIGGERING DEPRESSION

Lack of recognition, admiring attention.
Failures of various kinds at college, work, etc.
Entrapments (e.g. my need to earn money means I cannot pursue qualifications).
Being marginalized.

NEGATIVE AUTOMATIC THOUGHTS
It's my fault I am not successful.
I am not good enough. I am useless.
I will never make it. It is all too difficult.
There is no point in trying.
Others will not like or respect me.
I have no control over my life.

Depressed symptoms	*Social behaviours*
Loss of energy.	Withdrawal from others.
Increased performance anxiety.	Angry/irritable with others.
Strong wish to escape, hide.	Reduced positive social interactions.

This scenario is not untypical in achievers. By conceptualizing a case in these terms it is possible to have an overview which acts as a kind of map. You can use these headings to gradually build up a shared formulation with your client. It must be an agreed one though. If you were to do such a 'case' review or conceptualization on yourself would you focus on the positives or negatives? This is important because it is useful to discuss with the clients the way in which the review/case conceptualization itself may be *negatively biased* and exclude the positives. Both you and the client can then keep a copy – but be free to change it in the future if needs be – nothing is written in stone. This helps clarity in understanding and also negotiating interventions.

You will note that I have included a subheading for roles and social behaviour. Cognitive therapists often miss this aspect in their formulation (e.g. Fennell, 1989) but in interpersonal counselling it is important for people to understand how their behaviours can often accentuate their difficulties and vulnerabilities (see Chapter 2 and page 87).

Case review

So to review: the case formulation process may at first focus on current life problems (critical incidents) and typical automatic thoughts. One may then move to gaining the history, exploring key early relationships (see Chapters 2 and 6) with the family of origin, peer/school relationships, and sexual and marital ones. From these one might start to notice key themes, e.g. of not feeling loved or lovable, being a failure, teasing or school bullying, not being able to assert oneself in conflict situations or always having to be in control. One might note themes from early life coming

through into current life conflicts and relationships. Then collaboratively one might start to consider a person's key rules for life and how these might have arisen from early life. These in turn can be linked to typical social behaviours and ways of relating.

Once a case formulation has been agreed the counsellor can introduce the cognitive–interpersonal model and way of working. Helping clients understand how their typical ways of thinking may be accentuating their depressions is important for it will build the basis for later work.

Complications

Sometimes a critical event can bring to life a number of underlying vulnerabilities. For example Derek fell and broke his leg badly. This put him in a dependent position and he always liked to be in control. He worried about how others would see him having to take so much time off work. He became very sensitive to feelings in his leg and worried that it would never get back to how it was. This would stop him from doing all the things he had done previously. Even when the plaster was off he would wake at night sure that he could 'feel the bone moving' and that it had not healed properly. He felt he could not talk to his doctor about this as he would look stupid and would be seen as a 'neurotic nuisance'. As he became more stressed he worried that he would always feel anxious. Also as he got depressed he started to have grief feelings for his mother who had died five years earlier. At the time of her death he 'had been too busy at work to grieve much' and had tried to keep 'those sort of feelings under control.' However, when his wife found him crying one day he felt very ashamed and very out of control. Not used to a man who had such feelings his wife became alarmed and called the doctor. So this case focused on issues of fear of non-recovery, normalizing such fears (and challenging these ideas with alternative evidence); loss of control over feelings – especially one's of dependency; shame of feelings (not being strong); and complex unresolved grief.

It is very common for depressed people to have multiple problems and themes and sometimes a problem list could be obtained. This allows clients to be aware that although one tends to work with a specific theme at one time, other issues will be addressed. Moreover, the counsellor may become aware of problems and issues that the clients either do not, or would rather not focus on. Again in a collaborative way the counsellor can direct attention to these issues. Problem lists cannot anticipate things that will emerge in counselling sessions over time – and so, as

with all such lists and structures, they can become more of a straight-jacket than a help – so you should stay flexible.

We have suggested the sequence of (a) obtaining the story, (b) exploring preferred scenarios, and (c) moving to these preferred scenarios (Egan, 1998). It is however important to recognize that if the dysfunctional attitudes, role enactments and self–other schemata (or in Kohut's, 1977, terms self object relations) are not addressed then, although the client might gain some temporary relief by reactivating his/her abilities to be successful, he/she will still remain vulnerable to future episodes. Thus, although the client's preferred scenario might be 'to be successful and gain recognition from others', the counsellor should also help the client recognize the potential dangers in these solutions. Here the counsellor might address the underlying sense of emptiness in the self, the conditional self-beliefs that drive needs to be successful.

Concluding comments

Counselling depends on the enactment of a certain kind of interpersonal relationship (Egan, 1998; Dryden, 1989b). It is not a friendship (although it is conducted in a friendly way), but a collaborative endeavour with the focus on the client's internal experience, life difficulties and his/her social behaviour (including the social behaviour expressed in the counselling, e.g. control, avoidance, etc.). The qualities and skills of the counsellor, in terms of his/her ability to make contact with the client's internal experience, is central to counselling work. Clients who feel they are misunderstood and their internal experience unrecognized are unlikely to cooperate in counselling or reveal and work through painful experiences.

However, it is helpful for the counsellor to have some kind of understanding of the process of depression and a map for exploring and intervening. Cognitive counselling does this by helping the counsellor think about particular aspects of the client's style of interpreting, make meaning of his/her life experiences, develop achievable life goals, and more satisfactory relational styles. These techniques and approaches have now applied to a wide range of difficulties (see Tarrier et al., 1998).

4

Changing and Intervening I: Basic Principles and Behavioural Techniques

So far, we have explored some basic concepts of the cognitive interpersonal model. In this chapter we will focus on the techniques for bringing about change. It is wise to remember that, while techniques are important, much research shows the crucial role of the counselling relationship as an agent of change (Beckham, 1990). So try not to become mesmerized by these techniques and watch out for your own automatic thoughts (see Chapter 9).

I work with the biopsychosocial approach (see Chapter 1 and Gilbert, 1995) and often discuss with depressed people the nature of depression – that is when we are depressed there is a physiological aspect to our depression (e.g. our stress systems may be overactive, and we may be physically exhausted), a psychological aspect related to how we see ourselves now and in the future (including health worries), and a social aspect related to current social relationships and external life problems. The counsellor may outline how these domains interact, for example, by noting that dwelling on negative thoughts is physiologically powerful and stress inducing. One might (say) explore how ruminating on anger/unfairness is likely to stimulate the stress system rather than soothe it (see Gilbert, 2000). The key point is to help clients recognize that depression affects us at many different levels, that these levels interact, and the holistic nature of counselling work.

If a person is very physiologically disturbed with high arousal, sleep disturbance and poor concentration, medication may be necessary. One might need to discuss the advantages and disadvantages of medication for depression. Burns (1980) gives a good overview of how to discuss medication issues with a client – especially when there are strong beliefs like 'taking medication is shameful or a sign of weakness'. Some find that when they feel less exhausted by taking an anti-depressant or more 'shielded' by

the anti-depressant, they are more able to focus on what they need to do to change and fully recover. There are times though when people can feel better when they come off their anti-depressants and start to work on their key life problems and negative styles of thinking.

Another general principle that I adhere to for depression is to *increase the positives* and *reduce the negatives*. You can find a basic schema for this in the overview given in Chapter 9. As we saw in the previous chapter depressed people are often subject to negative external signals (such as criticism for others or thwarted goals) and internal negative signals such as self-criticism and defeatist thinking. This chapter and the one following will offer ways to challenge these. It is also the case that the depressed person may have few positives in their lives and so increasing the frequency of social rewarding behaviours and increasing self-accepting and valuing cognitions can be helpful. Given these basic principles we can now explore aspects of the therapy process. We begin with the basics of the cognitive approach.

Basic philosophy for change

We have already noted that cognitive counselling is based on a philosophical approach which originated with the Stoic philosophers. These philosophers were concerned with the nature of subjective meaning – what is beauty? what is honour? what is justice? None of these questions can be answered by recourse to objective science, but rather arise from the application of various (often personal) criteria. Consequently, the Stoics were interested in the qualities that make up subjective meaning and they developed a method of enquiry to do this, called the Socratic Method of Dialogue. This dialogue was designed to reveal the underlying criteria for meaning and to consider alternatives. So the types of questioning we looked at in Chapter 3 are designed to explore the process of reasoning by which an individual comes to a certain view and to stimulate a person to consider alternatives for their view.

Although cognitive counselling is based on the Socratic Method of Dialogue it is not to be confused with debating, arguing and trying to prove that the client is wrong. Nor should it be used to invalidate a person's *experience and feelings*. Indeed, validating feelings can be important (see Chapter 1). Rather, the counsellor attempts to find examples that help to look at a wider frame of *evidence for beliefs* and *consider alternatives* which helps the depressed client *re-evaluate his/her own interpretations and beliefs*,

and develop new ones (see Chapter 5); that is, the dialogue is designed to help the client do psychological work. If one simply tries to show clients they are wrong in their beliefs one is likely to run into resistance (Egan, 1998), or one may end up with compliance and not collaboration.

Cognitive counselling is not about positive thinking, looking on the bright side, ignoring negative or social realities or painful dilemmas. Rather, it involves exploring personal meaning and attempting to change states of mind by a gentle revelation that labels like 'I am inferior and useless' or 'I will never get better' are subjective judgements not facts. This involves enabling a person to explore and recognize that the way he/she is reasoning about him/herself, others and relationships add to, rather than help cope with, difficult life situations. There is, in the Buddhist tradition, a distinction between purposeful and purposeless suffering, and many, but not all (Gut, 1989), depressions have much about them that is purposeless and are just endless spirals of despair that block exploration and growth. Thus, counselling is also a journey of exploration, growth and change (Katakis, 1989).

The process of change

Collaborative empiricism

Collaboration is a two way process. Not only should clients collaborate in their own therapy process but you should collaborate with your clients – being sensitive to their issues, fears and abilities. Cognitive counselling for depression is centred on collaborative empiricism (Beck et al., 1979). This means two things: first, continually checking with the person that you have a mutual understanding and engaging the person to become involved in the process of change. This may involve helping the person plan his/her own homework, and become actively engaged in the explorative process rather than being reliant on the skills of the counsellor. Second, it is an 'evidence' and 'personal theory testing' based approach; that is, there is a focus on the evidence and the nature of interpretation of that evidence (see Tarrier et al., 1998).

Collaborative approaches require the counsellor to be sensitive to the interpersonal style of the client (see Chapter 2). The techniques for change need to be embedded in basic counselling qualities and skills (Chapter 1). While techniques are relatively easy to describe *their simplicity is often deceptive*. For example, once a technique has been used, such as testing the evidence for a belief, this may need to be used *many* times before the client takes it on board. In fact, even the most obvious of beliefs (e.g. 'I am a

failure') can take many hours of work before the person gradually gets the hang of the idea that performance and personhood (performance evaluation and self-evaluation) need not be equated. One needs to be patient and persistent and often use the same techniques over and over again. When one reads in the books about various alternative thoughts that clients might generate, what is sometimes not said is that these can be the product of hours of careful work, emotional exploration, looking at it in this way and then that, and much practice in challenging negative thoughts. Part of the problem here is that some counsellors come to cognitive counselling with some cultural notion of the Freudian view that once insight and catharsis are achieved change is at hand. Far from it. This is often only the first step and much work remains to be done in terms of repeating interventions, exposure, trial-and-error learning, developing new skills and gaining confidence in those skills, learning, working through disappointments, finding hidden blocks, and so forth.

Psychic valium?

Many of us hope that counselling or therapy will act quickly to relieve our pain. If we are honest we'd like psychic valium. So it is easy to see that some will become disappointed if the things they try do not bring immediate relief or as much relief as they hoped for. Helping clients understand that therapy (changing the way we think) is hard work and that learning new skills is time consuming and effortful can be an important (if painful) first step. Counsellors themselves must also come to terms with this and not abandon efforts if they are not at first successful. Many analogues can be used here such as building up muscles one has not used for a while or getting physically fit. At first the exercises may hurt more than they give benefit but if one stays with them they can be successful. This of course does not mean that one does not try to instil hope early on (Beck et al., 1979) or one is overly focused on the 'struggle' of therapy to the point the client thinks it is bound to be too hard and they couldn't do it. But it is to help clients cope with changing their thoughts when this takes time. It is step by step (Gilbert, 2000).

Procedures

Helpful procedures for challenging depressive thinking are listed below, but these must be set within the context of a therapeutic relationship. None of these is in any sense a magical change process – rather they represent ways of working to be conducted in

the atmosphere of 'caring interest' and an empathic relationship. Evidence suggests eight main counselling issues which tend to be associated with good outcome:

1 Role structuring and creating a therapeutic alliance.
2 Developing the therapeutic contract and commitment for change.
3 Conducting behavioural analysis (what happens when, how, etc).
4 Negotiating treatment objectives (what are we trying to achieve, is there agreement on this?)
5 Executing treatment tasks and maintaining motivation.
6 Monitoring and evaluating progress.
7 Programming for generalization beyond the counselling situation (e.g. teaching antidepressant behaviour).
8 Preparing the client for the termination of counselling.

Given these preliminary comments, we are now able to explore specific kinds of intervention. In general, these fall into the main areas of: monitoring and recording; awareness training; behavioural change and role enactments; and in the next chapter, working on specific thoughts and beliefs and developing positive schemata. There is much data now on how these techniques can aid mood regulation and the reader interested in this evidence could consult Parkinson et al. (1996).

Monitoring and recording

UNDERSTANDING THE MODEL It is important that the depressed client understands the model and its aims. You can use examples to demonstrate the links between thinking and feeling (e.g. the lover who did not phone example in Chapter 3). Clients need to understand what is going on, rather than thinking, 'Well, I guess the counsellor must know what (he/she) is doing.' The client's engagement in understanding helps to bring him/her into the counselling process.

UNDERSTANDING THE ISSUE OF MEANING It is useful to explain that meaning may be implicit rather than explicit. Meanings need to be articulated, but may be difficult to articulate. Clients do not walk around with well-articulated attitudes and schemata in their minds. Meaning is often not coded in language so it may need to be worked with in different ways, e.g. pictures, images or re-enactments. Metaphor is another good way to help convey meaning. Hence,

although one will try to put things into spoken and written language, this does not mean that the thoughts that are associated with distress occur in the best spoken English.

SELF-MONITORING This is achieved by encouraging the depressed client to become aware of, and then monitor, his/her thoughts, feelings/emotions and behaviours. This alone can have therapeutic value. Various thought records can be used for this (see Appendix 4 and for alternatives, Greenberg and Padesky, 1995). However, some depressed clients find this difficult and may tend to produce some automatic thoughts just before coming to counselling to please the counsellor. Also clients may not be very skilled, at least to begin with, in identifying their thoughts or even their feelings (Parkinson et al., 1996). Sometimes diary keeping is a useful procedure. The client makes a record of events, thoughts, feelings and actions at the end of the day. The person is asked to note changes in moods or feelings during the day and note how these are associated with changes in thoughts/beliefs and personal meanings. For example, Jane noted that she tended to feel more depressed in the evenings and by noting her thoughts recognized a connection between feeling low and thoughts that her boyfriend may not phone and if he didn't this meant he didn't really care about her. Diaries can then be the source for joint exploration. It is useful to try to encourage clients to be aware of their thoughts as they actually happen (Safran and Segal, 1990) and especially those that arise in the counselling session.

THE JOURNAL This is similar to diary keeping but here the counsellor encourages the client to write a diary of their thoughts each day or as they are going through counselling. With some clients it is helpful to suggest they write about why they think they have become depressed; to write a mini autobiography and to note repetitive themes. This does not suit all clients but some find the act of writing about themselves gives them a new insight and awareness. The client can write anything he/she likes here from past memories to current reflections on counselling.

AGENDA SETTING Cognitive counselling tries to be clear about agendas. Hence at the beginning of each session it is often helpful to form an agenda for the session. This involves monitoring thoughts and feelings about the previous session, checking mood, checking on homework, and deciding the crucial areas to be covered in the session to come. However, the counsellor needs

to be careful since some clients can hold back issues until well into a session. So at all times the counsellor remains flexible. For example, a client's mother had died between sessions but the counsellor had focused on a homework that had gone badly and spent most of the session exploring this. Also, if one is too rigid the client may rely on the counsellor and not bring his/her own material.

Awareness training

The next set of techniques involves helping the depressed client gain increased awareness of the role of their beliefs and personal meanings in their depression. As part of this it is useful to help clients gain insight into just how hostile or self-handicapping their thoughts can be (see Chapter 2). I have already noted thought catching in Chapter 3 (page 53) which is a key aspect of cognitive work so you might want to review that section. Following are some further ideas for helping people gain insight to their thinking.

FANTASIES A lot of what goes through our minds are plans and expectations of things that take the form of inner fantasies. Humans have natural tendencies to internally rehearse, plan for good and bad events and fantasize. These serve various functions. Fantasy can also be our inspiration, a way of escaping reality, or our projections into the future. For example, a depressed client with a difficult life situation would often fantasize that someone would come and rescue her, rather than her changing her situation (which she felt powerless to do). Under stress she would always have in the back of her mind, 'Never mind one day someone will come.' As the years passed and things got worse, this fantasy could no longer sustain her. In another case, whenever a client had an argument she would simply switch off and fantasize being alone. In this way she never engaged in conflict but nevertheless was depressed by the idea, 'It's no good I shall have to live alone, relationships are just too difficult.' She would then spend many hours planning how to cope alone rather than confront the relationship's difficulties. Sometimes fantasies can even be of death. Depressive fantasies often contain an 'if only' element.

It is not always the case that clients will tell you of their repetitive fantasies (sometimes due to shame and sometimes due to the feeling that these are part of the deepest, inner self), and therefore one has to ask for them (e.g. 'What are your main fantasies or day dreams? When you find yourself wandering off into your

inner thoughts, what kind of thoughts and images do you have or dwell on?').

Some clients may have fantasies about the counsellor and this can also be explored. A client may feel that the counsellor might have sexual desires for them, or they may have sexual desires for the counsellor, or that the counsellor is secretly thinking they are a hopeless case. These *transference* ideas and fantasies can be very disruptive to the collaborative relationship if not addressed (Watkins, 1989a), but the counsellor needs to work sensitively so as not to act in a rejecting way while maintaining clear boundaries.

VIDEO PLAY Our natural abilities to create fantasies can be used in what can be called the video technique. In this technique you ask the person to make a kind of inner video of situations. For example a person is frightened to act assertively. So you could say: 'Let's take a particular situation in which you would like to be more assertive and make an inner video. Start with being in a situation – what is happening?' Client describes a situation. 'Now run the video on to where you start to act assertively. What is happening?' As the person runs through the scenario from start to finish the counsellor obtains information about what is going through the person's mind. Let's look at the assertiveness example. Anne had difficulties in addressing her upset over her partner's behaviour of going to the pub and leaving her behind. So we did a video play. She closed her eyes and 'played the video' of events in her mind.

Anne: I can see myself starting to tell Fred how cross I am at his going out. I feel anxious.
Counsellor: Okay run the video on. What is happening?
Anne: He is looking angry – like I am a pain.
Counsellor: What are you thinking at this point?
Anne: Oh no, he is not going to listen to me. He is just going to storm out.
Counsellor: Okay, you see indictors that he will storm out. What are you feeling and thinking?
Anne: I am becoming anxious and more angry. I wish he would listen.
Counsellor: Okay, what happens next?
Anne: I can see myself get tongue tied, or just getting more angry. It all goes wrong. He storms out.
Counsellor: What happens now – when he is gone?
Anne: I feel lots of things, angry I guess and sad – let down but also that I shouldn't provoke him like this. Maybe I am a real pain to live with. I feel more depressed.
Counsellor: Because you have these scenes in your mind, is this why you rarely challenge Fred?
Anne: Yes, I guess so. It is only when I can't take it any more that I go at him.

This technique allows you to gather a lot of information quickly. We learn that Anne gets angry before confronting Fred. She 'lets things' build up partly because she predicts her boyfriend will simply cut off from her if she challenges him. Then when he is gone she feels *defeated* and starts to self-blame. You are possibly already starting to formulate ideas for intervention. Could Anne learn to express her feelings in a more assertive and less angry way? Could she give up self-blame and seeing herself as a pain if Fred does walk out? Might there be other reasons that Fred storms out, e.g. that part of him feels guilty or ashamed and he cuts himself off from this. 'Video play' can be used in many situations to obtain information on imagined or actual sequences or scenes, e.g. various anxieties, fears of abandonment and so forth.

ROLE PLAY Actual role play is another powerful technique for eliciting various forms of meaning and is a useful way of eliciting affect and demonstrating the power of cognitions in the counselling situation. There are a number of ways this can be done. For example, take Anne who is frightened of behaving assertively in many situations. She could be asked to role play an assertive sequence of behaviour. The counsellor then explores the beliefs about this (e.g. I am being unkind; Fred will think I am being selfish/unreasonable and I must maintain his approval; or, I will be embarrassed and go blank). Over time the counsellor may also introduce her to various assertive skills. Other forms of role play can involve the re-enactment of previous painful events, e.g. arguments. Again, the counsellor can check the personal meanings about these episodes. Subsequently, they can practice alternative behaviours and cognitive responses. Clients are encouraged to try out their new skills and cognitions in real-life situations.

As a rule of thumb, role play works best when the client and counsellor have developed a good working alliance. Without this the client may feel too self-conscious, not really get into the role play but just mimic it, and not really be in touch with the powerful emotions that need to be understood and worked with.

THE TWO CHAIRS A useful technique for increasing awareness of the 'power of the internal (often negative-hostile) self-dialogue' and its emotive effects is the two chairs technique (Greenberg, 1979; Greenberg et al., 1993; Greenberg and Safran, 1987). In this situation the counsellor elicits the negative dialogue in the form of an inference chain. For example, Jane bought a dress that when she tried on again at home she felt did not fit. Her thoughts were 'I bought the wrong size dress. I bulge all over the place. I am fat

and stupid.' This was written on a card and placed in one chair. She was then invited to sit in this chair and read the card to the chair opposite saying out loud, 'You bought the wrong size dress. It bulges all over the place. You are fat and stupid.' We can call this the attacking or critical chair. When a certain level of affect had been put in to this, she changed back and sat in the chair at which the attack is directed. She was then asked to explore her feelings about this attack being levelled against her. In the attacking chair she felt angry and annoyed with herself but in the other chair her feelings were of passive acceptance of the attack, sadness and helplessness.

In the next chapter we will outline how these self-attacking messages can be challenged by both rational and compassionate challenges and even by fighting back – refusing to accept the accusations of the self-critical part of oneself, e.g. 'Just because the dress does not fit as I would like does not make me fat or stupid, because (gives the reasons); you keep running me down and your attacks are part of the source of my problems and low moods; how about a bit of support right now?' One client failed to get the job he wanted, blamed himself and labelled himself as a bum. In the two chairs he was able to give himself the message: 'many people fail to get the jobs they want. Maybe they were looking for someone with different skills. Failing to get a job is evidence of problems in the job market, not of being a bum.' He was able to empathize with the disappointment and sadness of not getting the job and reduce the self-attacking.

For now, however, note that the client gains deeper and more emotional insight into the power of their internal thoughts about themselves and current situation. One can also ask things like, 'Did that type of attack remind you of anyone?' Sometimes this may turn out to be a parental figure. This can have the effect of eliciting important feelings and the counsellor needs to be sensitive to allow this to emerge and work gently with it rather than rush in with cognitive restructuring. The two chairs allows for repeated interactions with the self-critical part. You might also dialogue with it asking what it wants to achieve, when it did begin and how it might reduce its attacks (see Gilbert, in press b; Greenberg, et al., 1993).

If a parental figure has been identified as the source of the negative self-dialogue, then from the feeling chair they may wish to say things like 'Why were you always running me down? Why didn't you help and support me?' Again, these exchanges can get quite emotional and powerful so it is important to gain *experience and training before trying out this approach*. I include it here to show

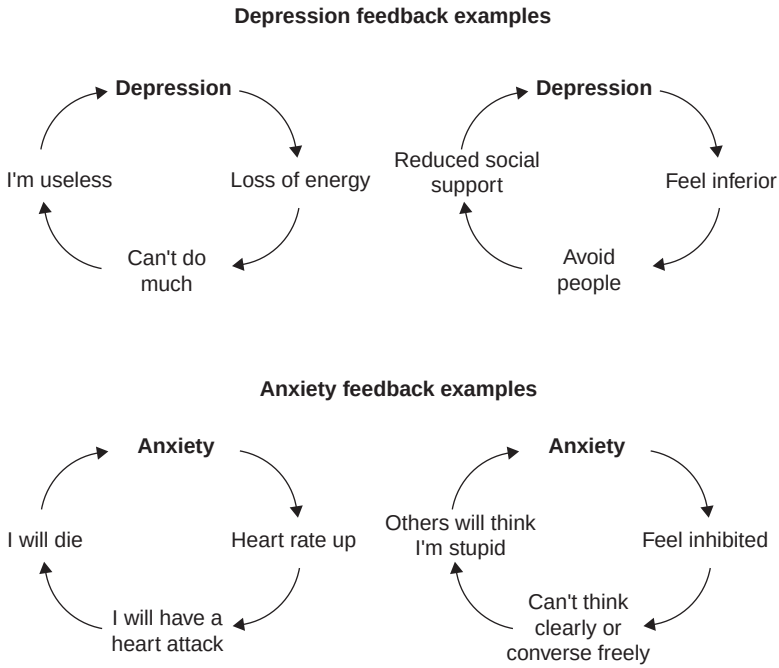
how it can be used to increase awareness, make contact with affect, and help the client to dispute internal self-downing. However these techniques are not advised to be used by novice counsellors.

Other challenges to self-criticism can involve warm and compassionate ones (see Chapter 5) where the person tries to be sensitive to their hurts and fears. So, for example, in a warm voice they might say: 'I know I didn't get the job and that is very disappointing. I guess it is only natural to be upset about this. But I have got jobs in the past and if I keep trying I have a fair chance in the future. Not getting the job is evidence of how hard it is to get jobs nowadays, not evidence of bum-hood.'

DRAWING OUT RECURSIVE FEEDBACK In developing the therapeutic contract and commitment for change it can be helpful for clients to gain insight into how their thoughts and behaviours increase rather than reduce their difficulties. Making diagrams of summaries with a client gives a visual overview (for more complex formulations and diagrams see Blackburn and Twaddle, 1996). Diagramming is especially helpful to show positive recursive feedback, which can be drawn as circles (Figure 4.1). For example, 'I feel depressed → when depressed I can't do anything → when I can't do anything I feel useless → when I feel useless I get more depressed → when I get more depressed I do less', etc.

The positive feedback nature or the spirals of these patterns can be demonstrated for cognitions and behaviours (Figure 4.1). Discussion can centre on where best to intervene and help make predictions. For example, 'If you could stop putting yourself down when you feel unable to do things would this be helpful? What would be the advantages and disadvantages of giving up putting yourself down?' Also, one can write out the sequence as if conceptualizing a case (as shown in Chapter 3, pages 72–3). This enables depressed clients to gain an overview of the issues and helps the role of cognitions in depression to become more understandable and manageable.

NONVERBAL BEHAVIOUR To increase awareness it is often useful to be attentive to the depressed client's nonverbal behaviour (Safran and Segal, 1990), the clenched hand or jaw or the averted eyes. The counsellor can draw attention to this, e.g. 'I noted, while you were talking about your girlfriend, that your jaw seemed clenched and tight. Could you focus on your jaw and explore what was going through your mind?' or 'What is your jaw saying?' Sometimes clients are not aware of these nonverbal changes. Directing their attention to them can be helpful and illuminating.



Note: Help clients identify their own typical feedback loops and how to break into the circle.

Figure 4.1 *Drawing out mood/emotion and thought interactions*

Key issues 4.1 Awareness training and self-monitoring

1 As part of change the client needs to become more aware of his/her internal meaning-making, thoughts, beliefs and schemata.
2 Awareness training is focused on the links between internal meaning and affective state.
3 Awareness training can take various forms such as monitoring feelings and thoughts, reenactments, a focus on images, fantasies, nonverbal behaviour and two chairs.
4 Once these meanings and cognitive styles are identified, they are subjected to progressive clarification and exposure.
5 Clients can learn how to monitor more closely their internal life and in this way, with increased awareness, make it subject to change.

Behavioural approaches

The next chapter will focus on more specific interventions for thoughts and beliefs. Before this we focus on behavioural interventions which are often salient ones, especially early on in therapy and if people struggle with the cognitive elements. Some behavioural therapists believe that changing behaviours and increasing rewarding and rewardable behaviours are key to mood change.

Helping people change their behaviours sometimes means giving up unhelpful and ineffective defences (Chapter 2). For example, avoidance, where someone stays in bed a lot, may be a key target for change. Gradually learning to plan activities in a step by step way can be helpful (Greenberg and Padesky, 1995). Or it may be the person has to build more personal space into their lives.

SCHEDULING ACTIVITIES – INCLUDING POSITIVE ONES Some clients find it very difficult to carry out certain tasks because their ability to plan ahead has been affected by the depression. 'Scheduling activities' can be taught in the counselling session and worked out in a collaborative way. One client suffered from loneliness and therefore we scheduled that he should visit friends on as many evenings as possible. Clients can learn to schedule in activities on an hourly basis through each day (e.g. 9 a.m. get up and have breakfast; 10 a.m. go to the shops and buy groceries for the week; 11 a.m. phone a friend and visit, etc.). People can rate the degree of mastery and pleasure of these activities on say a 1–5 scale of low-high. Some people find this kind of activity working, planning and rating very useful.

It is important to focus on the doable and build from there. Activity planning can be helpful but, again, while some clients take to this easily and find it helpful, others do not. So work with the individual and do not 'force' techniques on clients because the books recommend them as options.

Activities should also include things that the person may find rewarding. If the person schedules too many boring activities (e.g. doing housework because they feel they ought to), then although they may have a sense of achievement this may not be enough to keep them going. Doing difficult or boring things can be matched by trying to schedule in more positive things. So one aspect is to try to increase the number of rewarding activities in the day – even if at first these are only minimally rewarding.

HOMEWORK Teaching the value of homework is an important part of the cognitive approach, although clients vary as to the ease in which they engage in it. Homework is an essential part of cognitive counselling, not only for gathering evidence but also for beginning to develop new repertoires, skills and expectancies. It is useful to encourage the client to suggest their own homework, e.g. 'How do you think you could practice overcoming this problem?', and/or 'Given what we have been speaking about, what do you think you need (to do) to get over/help (with) this problem?'

In planning homework with depressed clients there are some tips:

1 *Challenging but not overwhelming*: In the same way you learn to drive, you would not go onto a motorway the first time out (i.e. homework needs to be realistic and approached as graded tasks, see also Dryden, 1985).
2 *Getting better rather than feeling better* (Beck et al., 1985): Here you can make the point that engaging fears or doubts and challenging negative cognitions may result, at first, in feeling worse. However, one can learn how to cope better and identify what the cognitions, and problems are that contribute to feeling worse. Try to engage the person in their own training and encourage them to generate homework ideas. Progress should be in steps. Ask questions like 'How could you test this idea?'
3 *Fear of getting better*: This is a common fear, or at least fear of what needs to be achieved to get well. If this dominates the picture then homework can be sabotaged. It may be useful to use the advantages–disadvantages technique to get at this (see Chapter 5). In some cases of depression this issue can take much work.
4 *Disqualifying achievements*: Typical here are the ideas that 'Anyone could do that. Compared to what I used to do it is so simple.' Help clients to imagine that if they have fallen in to a deep hole it helps to have a ladder that they walk up rung by rung as it is not possible to jump to the top. Thus the image is on 'moving forward' rather than unrealistic expectations. The key issue is a step by step approach (Gilbert, 2000).
5 *Homework to please the counsellor*: Sometimes clients will engage in therapy homeworks to please the counsellor, and not because they really understand why they are doing it. Their thoughts form as well written and neat but on exploration they lack emotional engagement. The client is writing down what they think is expected of them, not what actually helps them.

If clients say that the homework or behavioural work makes them feel worse the counsellor is able to use this to advantage, e.g. 'Well, this is helpful because we can look more closely at what is going on', or 'Well, this is helpful since it shows that you are really engaging in the problem.' The counsellor should be cautious of falling into the trap of expecting the client to feel better with homework and becoming disheartened when the client says they feel worse. The more the counsellor allows the client to feel worse from homework and to use this experience constructively the easier it is for the client not to fear bringing negative information to the counselling. We want to avoid the client thinking outside counselling, 'Well, I didn't like to tell my counsellor this because he is trying so hard and it would upset him/her.' Or 'I don't want to tell my counsellor this does not work because it upsets him/her and they may lose interest in helping me.' Also the counsellor should avoid setting him/herself up in the position of trying to get the client better. This usually leads to exhausted counsellors and problems in counselling. The process is collaboration, with agreement on the purpose of the therapeutic endeavour.

HOMEWORK SHAME Homework is a time when clients can feel they have to perform – accurately catch their thoughts, competently generate alternatives and schedule activities. Many clients feel they will fail at these and therefore have a sense of shame. Counsellors should be very sensitive to the issue of shame in homework and clarify (often many times) that homework is not like being at school where one will get marks for 'good' work or might court the counsellor's disapproval or contempt for doing things poorly. Sometimes clients can get angry and frustrated because try as they might they can't make the 'therapy work' for them. The sensitive counsellor will explore these things. For example, Sally had trouble writing down her thoughts. While in the therapy she could understand it but at home alone it was more difficult. This left her feeling frustrated and useless and that the therapy might not work for her. She was also fearful to reveal her frustration at the therapy. However she revealed enough for us to work on these themes and especially her fear (and shame) of failure (see Gilbert, 1998c for further discussion).

LONG- AND SHORT-TERM GOALS FOR CHANGE You may recall that in Chapter 2 we noted that some depressed people have problems tackling their difficulties. This can in part be due to feeling overwhelmed by the size or number of difficulties. So here the counsellor helps the client to select short-term, obtainable changes or

tasks rather than be over optimistic and likely to fail. It is a step by step approach (Gilbert, 2000). Clients are often poor at generating *steps to change* and may disqualify small steps (e.g. disqualifying the positive). It is also quite useful to check out the fantasies of getting/being better. Sometimes these can be quite unrealistic and over-idealized. The client may have held a belief that one day he/she would be magically better and never be unhappy or frustrated again. The slow progress of getting better, and dealing with the frustration of two steps forward and one back, all need to be worked through (see pages 181–4).

IMAGE SUBSTITUTION In cases where anxiety is high it is useful to have clear insight into the images and fantasies. Then you can develop alternative images and fantasies with clients that they can practice in the feared situation. You can practice generating new internal video-like scenes (see above). For example, one depressed client who was afraid of the dark had an image of being attacked but imagined herself as helpless. This had come from her early life when her mother was very physically aggressive and where passivity was the only way to reduce the attacks. Hence we taught her to practice imagining fighting back. She had never thought of this possibility but it proved a very helpful intervention in her case, especially when she had seen the connection between her passivity images and problems in her childhood. It is actually quite difficult not to think of something, hence advising clients not to think about their automatic thoughts does not work. It is better to find alternative thoughts or images (see Hackman, 1997).

SOCIAL SKILLS TRAINING Some depressed clients have difficulties in certain interpersonal skills, e.g. assertiveness (Argyle, 1984; Arrindell et al., 1988). In these cases instruction and behavioural practice may be helpful. One can give reading material (e.g. Dickson, 1982) or arrange to attend assertiveness training classes. Same-sex groups can be especially helpful. This can often be better than trying to do it all in individual counselling. In a group the client will have an opportunity to practise with others, share experiences and so forth. Here the counsellor is trying to enlarge the client's opportunities for new learning. However, skills sometimes do not generalize outside of the counselling situation. Various negative thoughts may inhibit this. Hence some clients are skilled but inhibited.

NEW ROLE ENACTMENTS Related to social skills is the identification of how a person would like to behave socially. This can be to act

assertively or in a more caring way. In these situations one may talk about the role, the skills that are necessary and the blocks to their enactment. For example, a depressed man wanted to show more affection to his children but felt embarrassed to do so. He was worried about being seen as sissy and his actions being misunderstood as sexual. Simple discussion of this issue and some normalization, sharing of the fears and information on the role of physical touch, was helpful. In another case, a depressed woman wanted to show more affection to her children but often felt she did this out of guilt rather than genuine concern. Also, after an argument she found it difficult to reconcile with them, without feeling she was giving in. However, she wanted to repair the relationships between them. So we talked about the guilt, based on her thoughts that she 'was not good enough', and about the value of reconciling behaviours. I used examples from chimpanzees to show the importance of reconciliation. She thought that if she instigated reconciliation she was saying she was in the wrong and was admitting defeat. Via cognitive restructuring and behavioural training she was able to make changes.

USE OF SELF-HELP READING Some depressed clients find reading material very helpful in bringing out core dilemmas, finding ways to overcome negative thinking styles and reading about others with similar problems. The counsellor should be aware of a range of reading material that they can recommend to their clients as appropriate. In fact the publishers Robinsons now have an excellent series of self help books covering areas of anxiety, social anxiety and self-esteem. I recommend these to both counsellors and clients (see Gilbert, 2000).

ANXIETY REDUCTION If anxiety is prominent in depression (which clinical experience and research shows it often is) then many of the behavioural techniques for anxiety control can be helpful (e.g. relaxation and desensitization, breathing control, see Clark, 1999). However, some depressed clients do not find relaxation exercises helpful. This is because, in depression, the client can be highly focused on internal negative ruminations and thoughts. It is often more helpful to use various forms of distraction activity that require their attention to be outwardly directed. In other words, work with what is helpful to the individual. It is also helpful to be familiar with ways of helping people with social anxiety as this can be a common complication in depression (e.g. see Bates and Clark, 1998; Beidel and Turner, 1998).

ALONE, COUPLES, FAMILIES OR GROUPS? Last but by no means least I should highlight that there can be a tendency in cognitive counselling to focus purely on the person who has the difficulties. Certainly this book is focused on this. However, the complete counsellor would also have skills in recognizing the need for working with couples, families, and in groups. One simple question to ask is: 'Would you like to work on this problem with your partner/family?' Then work out the advantages and disadvantages. Sometimes new interpersonal understandings and skills are more easily achieved in helping people work out their problems with others. So although there is not the space to outline in any useful detail how to work with couples, families or groups, the counsellor should at all times consider the need and value for this (Beach et al., 1990; Gotlib and Colby, 1987), and when to refer to others to do this. (For further discussion of these issues and others related to the social domains of depression see Milne, 1999).

Some of the main features of behavioural interventions are:

Key issues 4.2 Behavioural interventions

1 Cognitive changes need to be translated into changes in behaviour.
2 Key changes are to increase the rate of positively rewarding behaviours and to reduce the rate of negative behaviours such as avoidance, engaging in unrewarding or aversive behaviours.
3 Behavioural change and experimentation produce opportunities to gain further information and to observe blocks to change.
4 Behavioural interventions are also designed to gain new insights and practice new skills.
5 Behavioural interventions must be realistic and agreed.
6 Often the behaviour at issue is social. Thus change involves new interpersonal enactments and roles.
7 Some aspects of counselling can be understood as a process of exposure to feared internal and external experiences and situations, involving not only insight but desensitization to what is feared (e.g. assertiveness).
8 Recognize the possible need and values of involving others in the counselling process.
9 Be prepared to refer on for more specialist interventions (e.g. family therapy) if necessary.

Concluding comments

Helping people become more aware of the relationship between the way they think about events and feelings is a key issue in

cognitive counselling. Clearly if people believe that there is no relationship between thinking and feeling or that their thoughts are simply the outcome of feeling depressed then they are not likely to engage in the hard work for change. Thus, understanding the model and helping a client gain insight into 'thought catching' and take responsibility for his/her cognitions and behaviours is important for collaborative working. As we will see in the next chapter there are specific techniques for helping people challenge those thoughts that are likely to increase their depression rather than reduce it.

It is also useful to realize that people change their behaviour as they become depressed and these changes can increase and maintain depression. So behaviour change is sometimes one of the early tasks for the counsellor. The role of behavioural practice, homework and also social skills training, in the forms of developing new social and interpersonal behaviours or becoming more assertive, can do much to offer people a sense of regaining control.

Blending these ways of working into skilful counselling takes time and practice. Many of these basic interventions are not achieved in five minutes but can take hours of work and repetition. They offer powerful means by which we can engage a depressed person's self-experience and help him/her shift out of these states of mind. However, clients are not socially decontextualized and the environment can be a powerful recruiter of negative self-beliefs. There is not the space in this book to focus on how a counsellor might think about more social interventions but see Milne (1999).

5

Changing and Intervening II: Challenging Negative Thinking and Developing Inner Warmth

When we are depressed it is all too easy to look on the black side and give more weight to the difficulties, problems, threats and harms that confront us; we lose perspective and this can increase our stress. As our stress system becomes more activated our thinking moves further towards focusing on the harms, losses and threats. So one aspect is to help depressed people regain a more balanced perspective on themselves and their difficulties and explore ways of coping.

Target specific thoughts and beliefs

LOOKING AT THE EVIDENCE Evidence gaining and testing is a key element of cognitive counselling, but what constitutes evidence? What the counsellor thinks is evidence the client may not, or the client may have unarticulated ways of disqualifying it – this needs checking. Generally, it is useful to help clients consider evidence *for and against* a belief. There are various thought forms that can be used for this (Greenberg and Padesky, 1995). Appendix 4 offers a number of different worked examples, and discussion of their value. Many of the interventions in this section are about gaining checking and testing evidence.

IS THERE ENOUGH INFORMATION? When seeking evidence for and against a belief it is useful to ensure that there is enough information to make judgements. Sometimes depressed clients focus on very small aspects of the situation and it is useful to encourage a wider exploration. For example, when Tim's girlfriend came over to see him she seemed down and distant. His thoughts were, 'Jenny seemed off me last night. I am sure that she is losing

interest in me.' The counsellor can then explore how Jenny behaved when she met the client last night. Did Jenny give any information about why she was quiet? Did Tim ask her? Exploring the situation may reveal information like, 'Well, actually Jenny is worried about losing her job.' This can then lead to looking at alternatives, e.g. 'Jenny was off me because she felt down and worried and she tends to withdraw when she is worried.' When we are depressed it is not uncommon to personalize an undesired outcome to the self. When we do this we forget that other people have issues and worries themselves that might better explain their behaviour.

LOOKING AT, OR FOR, ALTERNATIVES Looking for alternatives is an important aspect of considering evidence. Sometimes depressed clients are convinced that there is only one way to view things. Here one teaches the client to consider *thoughts as theories* or *hypotheses*, and the more theories and hypotheses one has the better. This is similar to Kelly's (1955) view of teaching people how to treat themselves as scientists. So one explores the generation of alternative ideas/views. There are many types of question that can be used for this (see Appendix 3). For example, Harry, a student, gave a party in his room but some of his 'friends' did not attend. He concluded this was because they did not like him enough to come.

Counsellor: Harry, you gave the party and some of the people you wanted to come did not show up. One idea is that this is to do with you; that they don't like you enough. However, let's look at the evidence for this idea. Do you have any other evidence that they do not like you. For example, how do they treat you on a day to day basis?

Harry: Oh, day to day they seem friendly enough. I guess they help me with my work if I ask them.

Counsellor: Okay what other reasons might there have been for them not attending? If you were a neutral outsider and were looking in – what other reasons may there have been for them not attending?

Harry: (thinks) Well Tom, who I wanted to come, can be unreliable. He's got a new girlfriend and maybe was out with her trying to get her into bed.

Counsellor: Anyone else?

Harry: Sally was planning to come but she was unsure if she was going to go home this weekend.

Counsellor: Could you ask these people and see if these other ideas fit? It is disappointing that they did not come to the party but not necessarily evidence of your like-ability – they may have had other things they wanted to do?

These are fairly simple examples for the purpose of making clear the techniques. Of course, often, the issues are more complex and distressing but the principles are the same; to try to gain a balance in thinking. And if Harry were very narcissistic he might think others should give up their goals (with the girlfriend or going home for the weekend) to come to his party as proof they liked him.

WRITING DOWN Clients often find it helpful to write things down. This helps to slow thinking down, stop it from turning into depressing spirals of thinking and breaks up rumination. See Appendix 4 for further discussion on this. In the early stages the counsellor and client may do this together. Later clients do it for themselves. One simple method is with the use of two columns. In one column the depressing thoughts are written, and in the other various alternative and challenging thoughts. This is called the double column technique. For example, suppose Harry had the thought, 'I will never get better'.

Depressing thoughts	*Alternative/coping thoughts*
I will never get better.	1 This idea makes me feel worse and I may be underselling myself. 2 I can work on small steps towards understanding my depression and overcoming it. 3 I haven't always been depressed so I have shown myself I am capable of coping. 4 Because things are difficult right now doesn't mean they will always be difficult.
Degree of belief: 75%	Degree of belief: 50%

As we work on the depression, both the degree of belief in 'I will never get better' and its frequency slowly reduces. Here is another example of Jane who bought a dress in a hurry and when she got home found it did not fit as she would have liked (see pages 84–5).

Depressing thoughts	*Alternative/coping thoughts*
I bought the wrong dress size. It bulges. I am fat and stupid.	1 It seemed to fit in the shop, but I was in a rush. 2 I can probably take it back.

3 Having a dress that is slightly too tight doesn't make me 'fat'.
4 Even if I am heavier than I would like to be many millions of women feel similarly – thanks to the media!
5 There is no link between body size and abilities.
6 Being a rushed mother who tries hard for her family and occasionally buys things that don't fit means only that I am a rushed mother who occasionally buys things that don't fit – nothing more.

Degree of belief: 70% Degree of belief: 60%

In fact the alternative thoughts can be written in a fourth column we saw in Chapter 3 and Appendix 4. The fourth column is where the challenges to negative thoughts are written down.

Writing down is for the clarification it brings, and acts as a focus for discussion. In the alternatives column it is important that clients *genuinely* recognize the thoughts and ideas as alternatives and not as another form of instruction (this time coming from the counsellor, i.e. I believe(d) that, but really I ought to believe this). The moment the client shifts into a submissive position and feels they need to submit to the counsellor rather than it being a collaboration against the common problem of depression, one runs into resistance.

DEGREE OF BELIEF It is helpful to explore with the depressed client the degree or extent to which they believe something is true. This can be given a percentage rating as noted in the last two examples. Beliefs are not always 'all or nothing' and in counselling depressed people one will see changes in the degree of a belief rather than its absolute removal. Sometimes even a 10% change is a major change.

PROMPTS Depressed clients can forget what has happened in the counselling session. Therefore it is helpful for them to have prompts. This can be done by clients taking home thought records, summaries and diagrams worked through in the session. They might then make new ones or make comments on the things that have been written out to bring back to the next session. Another form of prompt can be to make a tape of the session so that the person can listen to it and make notes on it. Again, these can be

brought back to the next session and discussed. Some clients like to have tapes of the session others do not.

FLASH CARDS Another form of prompt is to make flash cards. A flash card is a blank card about the size of a postcard. On one side of the card the client works out, with the counsellor, his/her thoughts, e.g. 'I am never able to do as good a job as I'd like. I always seem to fail. I am a really useless person. What's the point of trying?' Rather than writing out these thoughts for themselves they can put a tick on the card as a thought happens. On the back, the counsellor and client work out some challenges that the client feels are helpful (Gilbert, 2000). For example, 'Actually I don't fail at all things – just sometimes – and that is natural; failure is a black and white word and in fact it's more about disappointment than abject failure; these are pretty unkind things to be saying to myself when I'm feeling down; I would not speak to a friend like this; I don't have to do everything perfectly; just because my mother called me these things doesn't make it true; I can take it in stages and learn to focus on what I can do; I can define a half-full glass as half-empty or half-full.'

Different clients find different forms of challenge helpful. For one client an appeal to reason is helpful, for another the appeal to self-nurturing. Sometimes clients say 'When I looked on the back of my card I heard your voice and that was helpful.' This helps the internalization of positive self-statements and cues memory. Gradually clients learn to challenge for themselves automatically.

DWELLING, RUMINATION AND FREQUENCY As noted in Chapter 3 it is also useful to explore the frequency and extent to which a person dwells on a negative set of thoughts or ideas. As people improve they find they think less and less about them. One can also use this information to say 'Given that such negative thoughts are stressful and distressing can you see that if we *could* reduce their frequency this may be helpful by giving your stress system time to recover? Dwelling on negative thoughts can be like picking at a scab so that healing (of your stress system) can't take place.'

TIME FRAMES This focuses on how the person would think about this event or situation in (say) six month's time. This is appropriate for small day to day set backs, but may not be for major dilemmas of (say) how to end a relationship. Projecting forward into the future where the client is unlikely even to remember a particular hassle or set back that has upset them is helpful for keeping perspective. Also looking back and noting how they

might have seen this (say) six months earlier, before they became depressed, can again help people recognize that some of their negative views are due to being in 'a state of depression.'

ROLE REVERSAL Helping the client think about how others might interpret events can be useful. Thus one can ask 'How do you think others might respond to this? What accounts for the difference?' But watch out for beliefs like 'I know others would see it differently but this just goes to show how silly I am.' The idea is that helping the client see things from the other person's perspective helps to move the cognitive focus away from the self. Another form of role reversal helps the client to challenge their beliefs, through being encouraged to help someone else who has the same beliefs as themselves. For example, suppose a client says 'I will never be able to succeed. I will never find the kind of relationship I need. My life is pointless and worthless.' The counsellor might say 'How might you help someone else who seemed trapped in this way of seeing things?' If the client attempts to do this, and is able to come up with alternative ways of thinking and looking at the problem, the counsellor may play devil's advocate and say 'But suppose this person said, "I have tried all those things and they don't work", how would you respond to them?' In this way the counsellor avoids pitting him/herself against the client and through role reversal has encouraged the client to explore alternatives to their own negative thinking by helping someone else. The counsellor might continue this with questions like 'What do you think would stop this other person from acting on your ideas?' This enables a dialogue that helps the person to change their perspective.

ADVANTAGES AND DISADVANTAGES This is an approach that has many uses and is used in many different therapies. It helps to show up dilemmas and it also gives clients a clear insight into what may be blocking them from change. Write out two columns headed Advantages and Disadvantages (or Gains and Losses), then list the ideas in each. Let's look at an example of self-blaming:

Reducing self-blaming

Advantages	*Disadvantages*
Would feel better.	Might become more angry.
Would take more risks.	Might become aggressive like mother (the not nice me).
Would not feel so inferior.	Might never see my faults.
Would stop hurting myself.	Others might not like me.

It is not uncommon that one of the disadvantages of changing is that the person sees themselves as becoming more like a disliked (undesirable) other. For example, in this case, the client's mother rarely blamed herself but mostly blamed the children. The client worried that by not blaming herself she might become like her (disliked) mother. Thus work focused on the type of blame (e.g. self, trait or behavioural) and helping her distinguish between blaming and responsibility (see Chapter 7). For the moment let us explore another example. A person realizes his perfectionistic attitudes are problematic but has trouble changing them:

Reducing perfectionism

Advantages	*Disadvantages*
Could relax.	Might become slapdash.
Feel less pressured.	Might make mistakes.
Could spend more time with my family.	Might miss opportunities to get on.
	Might become no better than others.
	Would lose self-respect.

In the above case the client was sure that in becoming less of a perfectionist he would lose his self-respect. In a way he was proud to be perfectionistic and would be shamed by reducing it. Thus, although he was quite happy (supposedly) to work on his perfectionism, in fact he was not able to until it had become clear to him the potential costs, as he saw them, and worked with them.

There are many 'costs to change' and the fear of change can be an important focus for counselling, e.g. 'I might be abandoned. I might not like myself. God might not like me. I might become like others whom I dislike. Although things are bad now they may be worse if I change.' While clients can agree goals in the counselling session, it is always worth running through the potential gains and losses to highlight possible losses. No client will change if somehow they sense that changing will make them worse (see pages 149–56).

Other typical losses are: 'If I give up my anger it is condoning what others have done to me, or it is saying it does matter, or I will feel powerless. If I give up putting others first and become more focused on my needs then I will become selfish and unlovable. If I give up black and white thinking then I can never be certain, and that's dangerous', and so forth. A common disadvantage in revealing a secret, like a history of abuse, an abortion, sexual or other behaviour, is 'If I tell you then you will dislike me and won't want to help me.' The approach can become more complex by exploring long- and short-term advantages and disadvantages.

By writing these down the client is able to be clear about the dilemmas and hold them in one frame, as it were, and then there can be a new agreement to work on not just the goal but the fears of reaching the goal. Sometimes whole sessions can be given over to this one form of intervention (see Chapter 7).

OTHER PEOPLE'S GAINS? In some cases of depression it is useful to consider the possibility of what others might gain from the client's depression. In various forms of family counselling it has been noticed that as a family member's depression reduces, other problems surface. A colleague, Elspeth MacAdam, gave the example of an adolescent girl whose mother could not decide about making a long-term commitment to a new male friend. While the daughter was depressed the mother was able to avoid the problem. In the counselling the adolescent was offered the idea that her depression protected her mother from having to make a difficult decision. It had a remarkable effect by refraining the problem as protection of mother (see also Sloman, in press).

Hence one can speculate on issues such as 'I wonder what your spouse/family gains by your being depressed and clinging onto them.' At first a client may be perplexed by such a question, but it can 'get them thinking'. This kind of question is in part aimed to illuminate the power issues that may be involved in depression, but also to help a client see a depression in a new light; that is, paradoxically, a depressed position can actually be protective of the self or of someone else. For example, if the client were not depressed they might leave a relationship. There is now growing evidence that depression acts to inhibit assertive behaviour and this can have the effect of maintaining the power of others (see Gilbert, 1992). Thus one can look at the advantages–disadvantages of depression to self *and others*.

MOURNING THE LOST CHANCE OR IDEAL When helping people change it is useful to recognize that there may be a secret fantasy about what their dysfunctional attitudes or behaviours may achieve if they stick with them (e.g. 'If I *could* get my performance perfect then I would be successful. Only if I am successful will I be loved and respected. If I *could* be nice all the time then I would be loved.') As argued elsewhere, sometimes clients find it difficult to come to terms with ordinary human failings because they wish to be superior to others (Gilbert, 1989, 2000 and Chapter 2 this volume). By achieving lofty goals or being superior they think they will fulfil basic human needs for love, respect, admiration, etc. Hence it often happens that overcoming resistance to changing such

dysfunctional attitudes may involve the opportunity to mourn these lost ideal possibilities (see Chapter 7). The advantages–disadvantages (see above) can be a useful technique to help explore these aspects. The client will be less likely to shift on these if the underlying ideals are not addressed (see Chapter 7).

WORKING WITH THE PAST It can be useful for clients to recognize that certain ways of coping may have been adaptive at one time, and are not evidence of inferiority or stupidity. Here we can use three columns.

Current belief	*Contributing past experiences*	*Alternatives*
I have no control over my life.	1 My parents said I must always do as I was told.	1 I am an adult now and can choose.
	2 I had to change schools often due to my father's job.	2 I can stay where I am now if I wish.
	3 My parents often disliked my friends.	3 My choice of friends depends on my feelings and preferences.
Degree of belief: 80%	Degree of belief: 100%	Degree of belief: 45%

In the above example, it is not just a case of writing things down but using the columns to clarify meanings and experiences, such that (in this case) the person gains insight as to why it seems 'as if' they have no control (and this may have been true at one time) but they can now make changes. This involves giving up trying to please parents or fit in with others and gaining more confidence in one's own decisions and preferences. In the above case, as counselling progressed, we saw changes in the degree of belief, with column 1 reducing and column 3 increasing. This indicates again that counselling is *a process* and rarely produces sudden change.

ADDITIONAL AREAS AND CHALLENGES The above are the most common forms of challenge but here are some additional areas that you may wish to discuss with clients (see also Appendix 3 and Tarrier et al., 1998):

1 Are they misunderstanding the nature of causes? Most events are multi-causal.

2 Are they confusing a thought or idea with fact?
3 Are they assuming that every situation is/will be the same?
4 How would they look at this if they were not depressed?
5 Are they confusing a high probability with a low probability?
6 Are they being honest with themselves?
7 Are they asking questions that have no answers?
8 How would they feel about this (event) in a month or a year?

The above offers an overview of the kinds of intervention that are possible with depressed clients. The key issues in targeting specific cognitions are as follows:

Key issues 5.1 Targeting specific cognitions

1 The main focus is on the client's internal cognitions, interpretations and beliefs.
2 The counsellor aims to increase the client's awareness of these and their contribution to depression. Various techniques can be used to do this.
3 The counsellor and client try to identify typical forms of cognitive style or distortion (e.g. personalization, disqualifying the positive, black and white thinking).
4 Insight is important but it is not the main goal of the approach. Cognitions are treated as hypotheses and theories, not facts.
5 The counsellor and client work together to decide what is evidence; is an alternative reasonable rather than just pulled out of the hat?
6 The counsellor and client recognize both the advantages and the fears/disadvantages of change.

Challenging the negative self, cognitions and feelings

As Beck (1967) and many others have made clear, depression often involves negative thinking about the self. Freud used the term *superego* to describe self-attacking. Gestalt therapists suggest there is a part of ourselves that plays top dog and attacks and criticizes and a part that plays underdog and feels the effects of being attacked. In the last chapter we looked at how the two chairs technique could be used to illustrate this to clients. In this section we will look at various techniques for challenging self-attacking and negative thinking about the self.

PART-SELVES It can be useful to explain how we are made up of different parts. For some people this helps in understanding that

inner conflict is common because we often seek different goals at the same time; e.g. part of me would like to go fishing but part of me knows I need to go to work or I'll get the sack; part of me would like to get my own back on the bullying boss but part of me is anxious about losing the conflict and being fired. From here it is possible to discuss inner conflicts and aid the person to explore fully the conflict rather than try to suppress one side of it with thoughts like 'I shouldn't feel this way' or 'I shouldn't want to do this.' (See Greenberg et al., 1993).

THE INNER CRITIC OR BULLY Once the person has insight into the nature of different part-selves and inner conflict (Rowan, 1990; Gilbert, in press b) it is then possible to suggest that when things don't work out, or we fail in our efforts or are not as we would like to be we can feel a sense of disappointment and frustration. Out of this disappointment and frustration there can be a self-attack (see page 182). Remember Jane above, who called herself fat and stupid for buying the wrong size dress. That's an example of self-attack. Once the person is able to verbalize the typical self-attacking thoughts which are usually internally shaming thoughts (e.g. I am a failure, I will never make good, I am worthless, nobody could love me) it is then possible to label this part of the self as the self-attacking part, or the inner shamer, the inner critic or inner bully (Gilbert, 2000). Many depressed people can feel their inner shamer or critic as powerful and they usually agree with its judgements. In effect they feel they have to submit to their own self-attacks and rarely feel able to 'fight back' or challenge them.

EXTERNALIZING SELF-ATTACKING It can be useful to ask depressed people to focus on the emotional tone of the critical thoughts, e.g. 'if you run those thoughts through in your mind what emotions do you have when they put you down?' These turn out to be mostly angry, aggressive or contemptuous. One can then ask: 'If your critic were a person who you could see, what would he/she look like?', i.e. use visualizations. Commonly, depressed people find this easy to do and use descriptions such as: big, powerful, dark, looming, with an angry face, or sadistic smile (Gilbert, in press b). One might then say, 'Given these qualities it is easy to see how you would struggle to challenge it.' You might also decide to name it so that these aspects of self can be externalized. I tend to go with simple names like 'bully' or 'shamer' because I point out that self-attacks in depression usually seek submission and cause more depression and anxiety just like any other real bully does.

Once a person understands this then the counsellor and client *need to agree to collaborate on reducing the power of the bully or inner shame*. To begin with one might use the advantages and disadvantages technique to explore what a person may lose if they reduce the power of the bully and become less self-critical. This may illuminate fears such as 'If I don't bully myself I won't achieve anything'. Or, 'I deserve to be bullied if I fail.' Or even 'It is such a big part of me or has been with me for so long I would feel empty without it.' It is important then to not assume that challenging the bully will be plain sailing as some people will have various beliefs about why they should retain it.

At each step of the way one seeks to clarify how delivering negative internal signals can increase one's stress, negative feelings, low mood and may be physiologically harmful. Having externalized, visualized and named the inner self-attacking part of the self it is then possible to begin the process of challenging it, undermining its logic and developing a more compassionate attitude to self (see below). One might ask 'If you saw a bully criticizing and attacking another person who you cared about what would you like to say or do?'

Some people find that counter-attacking the bully or inner critic/shamer in role play or the two chairs helpful (e.g. 'You are unfair and very simple minded.' 'You never say helpful or supportive things.' 'Any dude can attack and find fault, that's easy to do.' 'It's disgraceful the way you treat me and I am not going to focus on you any more'). For some learning how they have been pushed around by their inner self-attacking and how to stand up to it can be very helpful. For others it is a mixture of slowing working with negative thoughts and developing a more compassionate attitude to self (see below). It is important to separate out the genuine feelings of disappointment, frustration or sorrow (which can at times be intense) over a set back or loss from the negative self-labelling and attacking that can flow in their wake. No life can be pain free but we can help people treat themselves better when things go wrong.

The key to this kind of working is to gain the collaboration of the client to challenge their own bullying and self-attacking thoughts. In what follows are various ways to do this. The techniques below can be used whether or not you work with the inner attacking thoughts in the way just described or just focus on negative thinking about the self.

THINKING IN BLENDS, SHADES OR DIMENSIONALLY A very common difficulty in depression (and self-criticism) is dichotomous thinking or

thinking in black and white. In analytic theory this is called 'splitting'. There are two aspects here. Basic black and white thinking and coping with ambivalence (Gilbert, 2000).

For basic black and white thinking there are various challenges. One is to draw a straight line with a bipolar construct. For example, suppose a client says, 'My performance was a complete failure.' The counsellor may draw a line like this:

Failure	———————————————	Success
Bad		Good
Terrible		Wonderful

The client then places an X on the line to show the degree of success/failure he/she thinks applies to them. Often this is put close to the failure end. The counsellor then discusses various other behaviours that might rate as greater failures to illuminate how the person's construct is rather narrow. Or, for example, suppose someone places a mark at the end of the line of bad–good indicating they feel totally bad. One might then ask 'so where would you put Hitler?' The idea here is (a) to help people understand how, in depression, it is so easy to lose perspective and the importance of working hard to regain it, and (b) how the inner bully is often a crude black and white thinker and labeller. One can talk in terms of focusing on the achievements or the failures, the glass that is half-full or half-empty. Again the technique is to help the client understand the nature of their absolutistic thinking, and a great deal of discussion is also involved.

DISTINGUISHING SELF-RATING FROM BEHAVIOURAL RATING This is a very common problem in depression and is often reinforced culturally. Basically, it is 'if my performance is imperfect then "I" (as a person) am a failure' (Ellis, 1977a,b). Here again one teaches the damage of global self-rating, and negative self-labelling. You can use the *part-self* approach to talk about there being many aspects of self that one can call 'little i's' rather than one big or global 'I'. This aids in illustrating how a client may be making global generalizations about themselves from single events.

Sometimes we call this kind of self-rating from performance outcomes the IT–ME confusion. I only accept ME if I do IT well. Or I only like myself if I am succeeding at X. IT–ME confusions often lie behind ideas of worth(lessness) and also self-labelling. Hence we try to teach self-understanding and acceptance, and again much discussion can be given over to this issue (Gilbert, 2000).

IT–ME confusions are perhaps part of Western culture; they are very common and the counsellor should be clear in his/her own mind about this. As Fennell (1989: 205) says, this is a case of physician heal thy self. In training counsellors I have found that many find this a basic problem: 'But surely your worth is dependent on how competent you are!' they say to me. Counsellors who have this basic belief may have problems in helping their clients change such beliefs.

REATTRIBUTION TRAINING In depression there can be much personalization for bad outcomes. The inner critical part of self often goes in for a lot of blaming. 'It's my fault that Fred/Sally left me.' Simple interventions can involve looking at the evidence for and against the attribution. Another technique is to draw a circle and allocate various aspects of causality to slices of the circle (see Gilbert, 2000, page 141). In this way one derives a picture of how events often have many causes. However, again there can be complications. For example, a depressed client may say 'If I blame others then I would be in a rage and that makes me feel bad about myself.' Hence self-blame can have a protective function (see Chapter 7). Indeed, the way self-blame stops one expressing anger at others can be explored in many ways (e.g. as defensive exclusion: as a child the client has learnt not to be critical of others and therefore ignores other people's bad behaviour towards them; Bowlby, 1980). So when self-blame arises it is always useful to keep in mind whether this is concerned with interpersonal events or not, the former being more complex. The advantages–disadvantages approach can also be used to explore the issue of 'not taking the blame' (see above and Gilbert, 2000).

The other distinction to be aware of is attribution for causes and attributions for changes or solutions. For example, people can feel ashamed of depression because they attribute the cause to themselves. Cause and solution can be linked in the following ways:

1 It is not my fault I am depressed and there is nothing I can do to change.
2 It is my fault I am depressed and there is nothing I can do to change.
3 It is not my fault I am depressed but I can take steps to overcome depression.
4 It is my fault I am depressed and I can take steps to change.

The causes of depression, and vulnerability to it, can arise from many sources, e.g. post-viral infections, hostile marriages, poor

early experiences, and so forth. Getting caught up in self-blaming for causing depression is not helpful. Thus the counsellor tends to endorse a multi-factor causal model (Gilbert, 1992, 1995, 2000). Nevertheless, helping clients recognize that by putting themselves down they may maintain and worsen their depression is not to be taken as evidence of personal blame for depression. Dryden (1989d) points out that helping clients take responsibility for their cognitions is a central part of the counselling endeavour. The match between client and counsellor attribution for depression can be a source of difficulty that interferes with therapeutic work (for an illuminating discussion see Jack and Williams, 1991).

The other distinction that can be made in attributions, which is similar to the IT–ME confusion, is the distinction between blaming one's character and blaming one's behaviour. Generally, character (personal attributes and qualities) self-blame is more depressogenic than behavioural self-blame (Janoff-Bulman, 1979; Janoff-Bulman and Hecker, 1988). For example, Janoff-Bulman found that, in women who had been raped, character self-blame (it was something about me that invited it) was more commonly associated with depression than behavioural self-blame (it was something I did – like walk in the wrong part of town). Andrews (1998) gives a very good review of this work in relation to shame and depression. Dryden (1989d) suggests that there are three levels of self-blame: blaming self, blaming traits and blaming behaviour. These vary in terms of the global qualities of self-blame.

ATTITUDES TO FEELINGS Sometimes in depression there is much resentment, envy and anger under the surface (Gilbert, 1992, 2000) but the person has difficulty in coping with these feelings because they see it as evidence of a bad self (i.e are ashamed for these feelings – the inner critic tells them it is bad to feel these things). Some people feel that they do not have the right to be angry, while others feel that anger makes them unlovable, thus anger cues an internal attack and the client takes a defensive position to it, e.g. 'I am a horrible or ungrateful person to feel this kind of anger' (Gilbert, 2000). The counsellor helps the client accept his/her resentment and to recognize that very often this relates to painful disappointment. In many cases I have found a cycle of disappointment cuing anger, anger cuing bad self-experience, and bad self-experiences cuing fears of abandonment and loss. This goes around in the person's mind leading to much confusion and distress. An empathic counsellor always has an ear open for disappointment, whether this be of an ideal self, or a hoped for outcome/event, and allows the grief and anger to be explored.

Generally, it is useful to explore what ignites negative feelings, and especially the beliefs involved. Then to de-shame them if people are ashamed of them; to explore how the issues that generate strong negative emotions (like anger) could be tackled in different ways such as via assertiveness training (see Chapter 8). Sometimes irritability is part of being stressed or becoming depressed and sometimes may even relate to medication. So it is important to explore the origins of anger (and other negative affects), e.g. is increased anger arousal new? Does it seem related to life events or mood change? In working with attitudes to feelings much depends on the person and situation.

Here's a complex (but not uncommon) example that illustrates how to break problems down, empathize with unspoken feelings, de-shame anger and reduce guilt. Having spoken with Oliver I had a view of his marital conflicts.

Oliver: We have been married over twenty years and I love my wife but she fusses around me and wants me to go out more. I just get angry with her and then feel guilty. She is only trying to help but sometimes the atmosphere is tense. It's all my fault.

Counsellor: There seems to be a number of different things happening here. First, you say your wife feels that if you could do more that might be helpful and she might be right about that. However, you resent the suggestion and feel that she thinks you are not making enough effort. You then feel shamed and angry and then guilty for being angry?

Oliver: Yes. That is a typical way it goes.

Counsellor: Okay well first I think depressed people will only do more if they can see that in the long run it will help and I am not sure that you do? So we will need to work together on that to see what kinds of things you think will be helpful. [Counsellor thinks here of using the advantages–disadvantages technique, see below.] If it is helpful we could invite your wife to a meeting or two to explore this. The problem here may be that you feel you have to do things to please the other person and not because you yourself see it as important. If you go along with her suggestions you feel you are merely submitting to her requests and you resent that?

Oliver: I guess that's true. I do feel I ought to give in and do what she says.

Now this is a typical issue in depression. Helpful suggestions by others may or may not be seen as helpful but things the depressed person should *submit* to to please the other person and this issue needs to be clarified (see Chapter 2). But feeling one needs to submit invariably produces anger and resentment.

Counsellor: Feeling you have to submit but you don't want to, will naturally produce resentment and resistance. Without wanting to it

can become a clash of wills. There is nothing bad about you for feeling like this but of course it does produce an undesired effect – the bad atmosphere. So what we can do here is explore with both of you when it would be helpful to encourage you more and when not. As to when to do more, this can be explored here in our therapy together (e.g. by using activity scheduling). Secondly, both you and your wife are angry *with the depression* – and that too is only natural. The trick is how to form a bond against the common problem – the depression – rather than against you. Do you have any thoughts about that?

Oliver: Well I guess I need to talk to her more about my depression and how I feel. I do tend to shut her out. I just feel I should pull myself out of this and stop being such a pain and worry to her.

Counsellor: Sharing your feelings with your wife and 'not shutting her out' would certainly be worth exploring and get the evidence to see if it helps. Also, you know, your anger could be seen as a kind of resistance that is actually about you trying to hold to your self-integrity and not simply do what others want. Sure, it does not produce the effects you want but at least it shows you are no push over?

Oliver: (after some thought) Hm. I suppose that's true. There is a part of me that thinks I don't want to be pushed around anymore.

As I have noted before no client will change if they see disadvantages in changing. Let's look then at Oliver with this technique. One of the disadvantages of doing more was that he saw it as simply evidence that he submits to what others want him to do.

Doing more: going out

Advantages	*Disadvantages*
Might feel better.	Only doing what I am told/ submissive.
Regain old enjoyments.	Feel tired and anxious.
Could spend more time with wife.	Probably boring to be with.
	Not much of a conversationalist when out these days.
	Feel under pressure to have 'interesting conversations' → feel worse.

This helped Oliver gain more insight to how his resistance to change was routed in a desire not to submit and simply to do what he was told or to be treated like a child. I had to be careful of this when working with him as what I thought was collaborative he sometimes took as me suggesting what he should do and him having to go along with it.

In a joint session with his wife we explored how the depression would take some time to change in a step by step way, that the activity scheduling would be done in the therapy and how they could share feelings without each feeling ashamed and resentful. Helping his wife feel less 'shut out,' clarifying the nature of depression, while relieving her of responsibility to help Oliver change, and acknowledging that resentment and anger are often part of the frustrations of being depressed, did much to ease the tensions at home. It enabled Oliver to start to take more control over his depression rather than feeling he had to do what his wife said (submit) to please her. And by understanding the nature of his anger he became less ashamed and guilty of it. In fact his anger was re-labelled as a kind of strength to resist submitting.

Now of course these snippets of interaction are actually part of an ongoing relationship, and I was able to make these kinds of intervention because I knew Oliver had had ongoing life difficulties of feeling 'he had to submit' going right back to a dominant mother. But I hope they give some insight into working with conflicts and emotions in relationships.

IDENTIFYING THE SHOULDS, OUGHTS AND MUSTS Self-critical thoughts are usually (like the superego) full of 'should' and 'oughts'. They issue instructions. There are many forms of 'must' that can 'surface' as people become depressed: I have to be loved, I must be perfect. Or as in Oliver's case 'I should not feel angry with people who are only trying to help me', etc. The main concern here is to change a 'must', 'ought' or 'should' into an 'I'd like/prefer to.' Hence it is changing *commands or demands* into preferences. One can engage the depressed client in discussion of their 'life's rule book' or our 'personal contracts with life', pointing out that 'musts' lead to certain feelings of compulsion and lack of freedom. Or one can simply ask, 'Why do you think you *must* be loved?' and in this way elicit an underlying belief such as 'Without love I'm worthless.' Hence the worthless idea leads to the compulsion to be loved. Thus 'oughts', 'shoulds' and 'musts' are often driven by some underlying self-evaluative concept. However, in this kind of situation it is important that the counsellor does not convey the view that there is something unacceptable in the *strong desire* to have a loving relationship, or control one's anger – far from it. Rather, the focus is on the sense of worthlessness (the inner attack) not the desire. Indeed, counselling may involve helping the person acquire skills that make it more likely they can form intimate and meaningful relationships – that may be a counselling goal!

Also, the idea that life would be meaningless without success or love can be an issue. Here again one does not suggest that the goal is undesirable, rather the focus is on the global evaluations and the dismissal of other sources of positive rewards. In such cases mourning may be involved as counselling unfolds, especially if these desires are highly idealized (see Chapter 8; Gilbert, 2000).

The counsellor will also use his/her empathy to recognize when a client is using the words of should, ought or must in a relative way or in an absolutistic way. We often use should and ought words in normal, everyday language but this does not mean we see them as absolute 'musts'. Thus clients can be asked to rate the degree of belief in their 'musts' and 'shoulds'.

Key issues 5.2 Challenging negative self-cognitions and feelings

1 Identify the typical feelings associated with self-criticism and self-attacking, e.g. anger, contempt, hostility.
2 Clarify the stress inducing and mood depressing affects of these cognitions and feelings.
3 Teach the nature of 'part-selves' such that the client can identify the 'voice of' their internal critic or shamer.
4 Use visualization as appropriate.
5 Teach the client how to fight back and also undermine the logic and accusations of the self-critical or self-attacking thoughts.

Developing inner warmth and positive schemata

A central issue in working with depressed people is the degree to which one works against the negative self-attacking thoughts, schemata and attitudes, and/or promotes positive schemata and attitudes. Now, of course, in reality one does both and these are in no way mutually exclusive endeavours. Nevertheless, it is easy to gain the impression that cognitive counselling is about disputing the negative and dysfunctional. However, many aspects above are concerned with enabling the development of (sometimes new) skills and schemata, and in this sense there is a degree of growth and health promotion.

INNER WARMTH Many therapists have noted that a key element in depression is to shift the person from a self-critical and hostile self-relationship to a more positive and nurturing one – especially at

times of disappointment (Gilbert, 2000). As noted above, negative thoughts in depression are not just negative in content but also in their emotions. This is to say when people think negatively about themselves these thoughts are often aggressive, angry and contemptuous. Recall Jane, the woman who bought the wrong size dress (above). When she criticized herself the 'voice' of her self-criticism was angry and contemptuous. If we are to challenge her negative self-critical thinking then it is important to identify the degree of anger in her self-attack, to discuss the way these kinds of hostile signals can be stress increasing, and how, learning to have more inner warmth and compassion when things don't work out, can be soothing and stress reducing.

When I help people to challenge their negative thinking I therefore often attend to the affective or *emotional tone of the challenge itself*. What we want to avoid is the person challenging in cold or negative tones, e.g. 'Come on; you are being irrational; pull yourself together and look at the evidence – stupid!' In other words challenging is in the tone of self-criticism.

Let's recall the challenges for the woman who bought the wrong size of dress. These were:

1 It seemed to fit in the shop, but I was in a rush.
2 I can probably take it back.
3 Having a dress that is slightly too tight doesn't make me 'fat'.
4 Even if I am heavier than I would like to be many millions of women feel similarly – thanks to the media!
5 There is no link between body size and abilities.
6 Being a rushed mother who tries hard for her family and occasionally buys things that don't fit means only that I am a rushed mother who occasionally buys things that don't fit – nothing more.

A useful technique is to ask her to read through these alternative thoughts while trying to impute as much warm and compassionate feeling tones into them as is possible. Make sure the person understands the reasons for this – that generating warm inner tones is going to be stress reducing while hostile ones will be stress increasing. Thus one is not attempting to teach just *any* kind of rationality (e.g. a cold or hostile form of rationality) but a compassionate one (Gilbert, 2000, in press b). Ask 'How does it feel when you do this? What might the blocks be to doing this? Explore and challenge negative beliefs that might stop a person becoming more compassionate and self-accepting (e.g. I would be letting myself off the hook, it seems silly or weak). Be prepared to spend

some time rehearsing this so that the person really gets the hang of the warm inner tones to challenging.

COMPASSIONATE VERSUS BULLYING It is useful to discuss how life is often disappointing and at times harsh. When things go wrong our inner critics and bullies are all too ready to go on the attack, fuelled by the feelings of disappointment and frustration. It is at these times we need to have inner warmth and support. Rationalizing is a key way to undermining the logic, black and white thinking and labelling of self-criticism. But sometimes we can do more in terms of empowering that side of the self and introducing more positive signals.

THE INNER HELPER To counteract the 'inner bully' it can be useful to ask people to engage in new visualizations when they are in the process of challenging their negative (self-attacking) thoughts. To aid this it is sometimes useful to help the client develop a sense of an inner friend or helper. Elsewhere (Gilbert, in press b) I have offered further discussion of the role of the inner helper. Many of these techniques have been referred to as ego-strengthening by other types of therapist, and in working with depressed clients it can be useful to have some insight into these (e.g. see Frederick and McNeal, 1999).

To use this technique ask the person to imagine, or generate an inner fantasy of, an (imagined) person who they feel is kind, strong and helpful. Ask 'What are their qualities? What do they *sound* like when giving support? When you challenge your negative thoughts using the rational techniques we have learnt together can you image the inner figure giving you of their support and kindness?' Clarify that you are working together to find that which can stand up to and keep in check the inner critic or bully.

One person thought of his 'inner Buddha' and that when he challenged his negative thoughts he felt that his inner Buddha could help him 'find peace and calmness.' As with all such techniques it is important to stay closely with what the person finds as helpful. Not all people take to this approach so stay with the evidence of what is useful to the person you are working with.

Asking people to visualize conversations with their inner helper also serves as a distraction from the self-attacking and disappointment they may be feeling. In this sense it utilizes different functions of mind and some do find it calming.

THE FRIEND TECHNIQUE Another way of working with more self-supportive thoughts is with the friend technique. This involves

helping the depressed client change his/her perspective on him/herself by considering interactions with a friend. One can use questions like 'Would you say this to a friend?' If you elicit a hostile internal dialogue (e.g. I failed to get the job, nobody will respect me, I'm a complete bum) then say, 'Imagine a friend sitting in this chair. She/he has told you of the same event you have told me. What would you say to them?' You can help the client see the negative impact on a friend if they were as critical to their friend as they are to themselves. However, the key issue is to facilitate a more nurturing self-dialogue when things are not going well. By thinking how they might help a friend can help to generate alternative, helpful and supportive ideas and thoughts: 'Oh, if this happened to a friend I would be understanding. I would probably say . . . .'

THE THERAPEUTIC RELATIONSHIP In some cases the therapeutic relationship can be the most important source of developing new positive schemata of trust, acceptance and self-esteem. By empathy and listening, one enables the client to experience a helpful and accepting relationship. In this way the client internalizes greater self-acceptance via the acceptance and understanding of the counsellor. Kohut (1977) has stressed the importance of mirroring the client and allowing a certain idealization. In evolutionary theory the client experiences the counsellor as someone who is prepared to invest resources in them, such as time, care, energy, skill and efforts to understand and recognize (Gilbert, 1992; Gilbert and Bailey, in press), and this in itself can be internalized as an important source of self-esteem (Gilbert, 1989, 1992). The point is that we should not underestimate the counselling relationship as a major source for the development of self-acceptance. Hence it is useful to be attentive to various factors that may reduce the client's ability to internalize the experience of this positive relationship. Experiences such as strong envy of the counsellor or unresolved doubts about the acceptability of the client in the eyes of the counsellor (e.g. shame) can significantly block the development of positive schemata of the self and lead to disqualifying the experience (e.g. 'It's only a job to my counsellor; they are too distant/neutral to be able to understand or accept me', etc.). We will explore this in more detail in Chapter 8. The point is, then, that transference beliefs and experiences sometimes need to be addressed so that the client is able to internalize the positive qualities of the therapeutic relationship.

NOTING THE VALUED ATTRIBUTES When clients are depressed they often exclude their positive attributes. For example, a client felt

bad because of anger. So we made a list of all the negative attributes and hurt, and alongside made a list of all the positive attributes. In the positive list were things like, 'I try to care for others. I'm a loyal person. I don't purposefully cheat others. Others often turn to me for advice. I'm approachable.' This enabled him to see that while there were things he did not like about himself, there were also things that he did value in himself and that he was disqualifying these attributes. Also we looked at anger as secondary to disappointment. The counsellor may look to see how the client can increase the list of positive attributes. All human beings need some degree of approval and respect and such positive signals are important for health (Gilbert, 1992). Helping clients see their more positive qualities can be helpful, especially if they are validated by the counsellor and mirrored.

ALL THAT I AM Sometimes clients see their depression as more real, i.e. having cognitions like 'This is the real me.' Here it is useful to discuss the fact that in all of us we have the potential for becoming depressed and outline the typical internal beliefs that go with depression. Depression is no more or less real than joy, happiness, love, compassion, interest, humour or other internal experiences. Humans are mosaics of possibilities and feelings. Hence the counselling changes the construct from 'This is the real me' to 'This is only one part of my inner, human potential.' Again, the counsellor is indicating the complexity and variety of internal experience and breaking up black and white thinking about the self.

Key issues 5.3 Developing inner warmth

1 The counsellor seeks to change the hostile, aggressive thinking style into a warmer, more forgiving and supportive one.
2 The client may need to practice this in therapy by rehearsing challenges in a warm and supportive way.
3 Working with visualization, such as the inner helper, can aid distraction from hostile self-attacking and also deliver more supportive internal signals.
4 Helping people focus on their positives as well as negatives.

Working with core beliefs and schemata

There is much overlap between working on specific thoughts and behaviours and looking at schemata and core beliefs since these cannot be neatly separated out. However, schemata are related to

more basic and often long lived basic views and inner models of self and others (see Chapter 2).

IDENTIFY MAIN SCHEMATA These may be for approval or achievement (see Chapter 2). Try to crystallize this in the counselling discussion. One may wish to refer to it as 'your/my approval schemata'. Explore how (say) approval schemata (e.g. I am unlovable) becomes easily triggered in various situations (e.g. at times of conflict or in social situations) and generates strong feelings.

Young et al. (1993) have given a listing of typical schemata that occur in depression and other disorders. They outline how one can work with these in the cognitive model. These include those of: abandonment, mistrust, personal defectiveness schema and so on. Having a grasp of these can be helpful. Young and Klosko (1993) have also written a self help-book for challenging and working with each of the schema they have identified.

SCHEMATA LEAD TO ROLES It is useful to explore how certain kinds of schemata (e.g. abandonment, achievement, or inferiority schema) lead to certain kinds of interpersonal behaviour which may be overplayed or avoided (see pages 45–8). For example, a schema of 'I am unlovable' may lead to the avoidance of conflict and/or an overly submissive and compliant style. A schema that 'others will always abandon me' may lead to avoidance of intimate relationships or high sensitivity to cues of rejection.

SCHEMATA AND AFFECT Help the client recognize that schemata can be part of what we feel at the core/centre of ourselves (Guidano and Liotti, 1983; Young et al., 1993). Therefore, if these are aroused or threatened, they will generate high arousal and strong feelings. Hence clients may need much work and repetition in order to change. When there is strong affect, help the client recognize this may be schemata or core belief driven.

THE DIMENSION OF CONTROL Helping clients gain control over feelings and internal meaning can be worked with as 'developing the positive or developing strength and ability.' This can lead to increased self-efficacy and self-acceptance. Hence control is not only about reducing dysfunctional behaviour and attitudes but also developing positive attributes.

POWER Related to control is power; that is, the ability to see oneself as being able to influence outcomes, especially interpersonal ones. Power is different from control in that one may not

be able to control an outcome as one would like, but this does not mean one is powerless. There are things one can do to exert choice over the outcome. For example, a suicidal depressed man felt very angry with how his employers had responded to his time off work; they wanted him to resign. While he was preoccupied with the unfairness of it and the need to fight them, he felt powerless, overwhelmed and subordinate to them. Once he accepted that there was in reality little he could do (after talking to his union), he began to explore how he could turn it into an advantage, to see if he could get redundancy pay, which he successfully negotiated. He did not have to control the outcome in order to exert power in the situation and try to gain some advantage. Key cognitions here were, 'I must not let them treat me this way. If I do I am a weak, useless person.'

Also involved can be turning what is seen as a weakness into a strength. For example, the above person had hated his job but felt he had to stay in it to prove himself. Thoughts of moving on were seen as weak, an escape and an admission of defeat. Reconstruing escape as a strength and a sign of flexibility was helpful and counteracted feelings of powerlessness. In other words, if one has tried to make something successful and it does not work out, then leaving and finding a new opportunity is useful. It is the cognitions that 'one has to prove oneself' or that leaving a difficult situation is a sign of defeat, weakness, inadequacy or inferiority, that is often inhibiting. These cognitions often produce the feelings of entrapment and depression. Much depends on the case, however. In some situations it may in practice be very difficult to change a situation. In other cases, a depressed client may not have really tried to make a success of a situation or relationship, thinking it would fail from the outset (see Chapter 2).

AWARENESS OF DEVELOPMENTAL ABILITIES Some clients are not capable of abstract thinking but are still at a stage of more concrete thinking (Rosen, 1989; McCullough, 2000). A counsellor needs to be aware of the cognitive and conceptual abilities of the client. Sometimes one is helping this maturation process (Gilbert, 1995). Consequently, only engage in interventions that a client will understand and is capable of.

MATURATION It has become clear in recent years that in many ways cognitive counselling can aid maturation. This occurs because as a person changes in counselling, they are not just reprogramming themselves, but gaining deeper insight into the causes and origins of their self–other experiences and judgements. They may become

more trusting of others and less critical of themselves. In ways that research is yet to make clear, there can be a more integrated sense of self that emerges out of the counselling experience. With maturation, attitudes and schemata become more flexible and varied. There is an evolution and growth of the self (Kegan, 1982). There has been a growing recognition that sometimes clients are not at a sufficiently developed stage in their maturation process to cope with complex interventions and the counsellor needs to have some awareness of this (Beck et al., 1990). Also, efforts are being made to integrate cognitive approaches with developmental concepts derived from Piaget and Erikson (see Freeman et al., 1989; Mahoney and Gabriel, 1987; McCullough, 2000). These efforts now represent different schools of cognitive counselling, e.g. the rationalists and the constructionists. Mahoney and Gabriel (1987) offer a good introduction to these issues.

GROWTH Although it is painful, some clients can turn their depression into an opportunity for growth and become 'better than before' (Gut, 1989). Here the counsellor draws attention to their increased insights and understanding, their new skill for controlling depressed feelings, and so on. One may ask 'What has your depression taught you; how have you changed?' This turns depression as a weakness (and shameful) into depression as an opportunity. However, these aspects normally come when progress is well under way. In the early days a person may see nothing positive in being depressed and it is not a good idea to explore this too early in counselling.

Sometimes we become disturbed because we have failed to engage a developmental challenge. We cling to old ways of thinking and behaving because they seem safe. Thus change can be seen and discussed as a developmental challenge, a chance to move forward and grow. Sometimes clients come through a depression not just to return to their old premorbid styles but changed in major ways.

Concluding comments

This chapter has explored various ways that you can challenge negative thinking, self-attacking and introduce more positive tones in a client's thinking styles. These are in the spirit of reducing the *negative and increasing the positive* and regaining perspective (see pages 191–6). On the rational side one looks at the evidence for and against a particular belief or view, and helps the person generate alternative views, reattribute causes, and

develop new coping options. However, at times it is also important to help people develop more inner warmth, especially to the ways they cope with frustrations and set backs. Warm and supportive inner signals are more likely to be emotionally and physiologically soothing and it is important to share these ideas so that people understand the purpose of the exercise. It is important then to help clients *challenge in a warm, supportive and compassionate way*. One might ask 'How does the challenge *sound* to you when you run it through in your mind? Does it seem warm and reassuring or cold, rational, aloof, distant or angry?' The more you can help clients develop inner warmth in their challenges the more effective they tend to be.

As emphasized all the way through, however, do not be so mesmerized by techniques that you lose sight of the basic counselling skills (Chapter 1). Counselling is a process where the relationship you form with your client is paramount.

PART II

THE APPLICATION OF COGNITIVE INTERPERSONAL COUNSELLING

6

Beginning and Engaging the Depressed Client

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 relationship, 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 enactments.
10 Homework and alternative role enactments.

Making this kind of list is helpful for clarification 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 important when it comes to saying goodbye. Secondly, all therapies have a certain course, e.g. beginnings, middles and endings/termination. Beginnings are taken up with getting to know the client and the nature of the current difficulties, 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 counselling – 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 affiliative clients, or over friendliness with more reserved personalities, may not be comfortable for them. Different types of counselling will proceed in different ways. The client needs to know the kind of role relationship they will share with the counsellor. For example, some therapies are relatively free-floating 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 difficult. However, the techniques of change cannot be used without 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 established. 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 counsellor 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 oneself to be personally threatening, this does not mean that the depressed client will experience you as non-threatening. Interpersonal 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 first time there are various hopes and fears of the first attendance. One can create an opportunity 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 first 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 I want you to tell me what to do.
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 first 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 first 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 undertaking counselling.
3 Avoid providing false reassurances or making control statements, 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 find 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 counselling, the counsellor may begin to start to explore the current situation and what has brought the client into counselling. Counsellors 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 understood 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 specific interventions. 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 financial difficulties. 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 difficult 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 reflection 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 difficulties.' These are defensive responses by the counsellor.

Let us return to Peter who has conflicts with his wife. The underlying theme is feeling that others do not appreciate his internal struggle and difficulty. 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 financial 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 difficulties, 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 significant 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 significant 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 figures. 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 first 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 competitiveness (Fennell, 1989). Obtaining an outline of basic experiences and attitudes to significant 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 fills me up.
Counsellor: [*pausing and watching to see if this idea is starting to activate significant feelings for the client. The counsellor gets the feeling of something she is struggling with.*] Maybe that feeling of filling 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 first 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 platitudes, or switching immediately to cognitive reconstruing.

It is possible that a client might reveal a horrific 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 interested 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 introduced two new ideas of (a) lovability and (b) gender. The counsellor 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 flow 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 difficult 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 specific 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 specific 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 difficult situation, or go with the worst.
3 If working with historical data, explore past significant 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 hypothesizing 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 collaborative 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 counselling 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 first 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 find 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 first 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 find 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 desensitization.

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

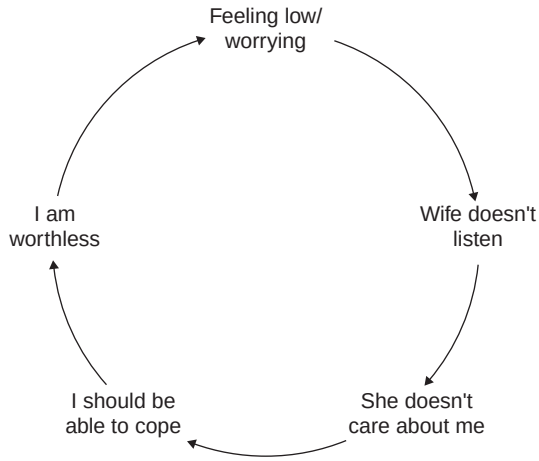


Figure 6.1 *The inference chain and emotions in Peter's case*

chain, to tackle the worst thing first, 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 withdraws 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 identified, 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 recognize 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. Sometimes memories of being put down come to mind.

Counsellor: Can you see how, when you feel unrecognized and disappointed 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 worthlessness 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 specific 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 reflecting 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 worthless. 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 challenging 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 specifically 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 flash 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 acknowledge 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 evidence, 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 find it helpful, others do not. Sometimes it is helpful to write out flash 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 *disconfirming* ideas they might have. For example, a client would see the value of the flash 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 observing 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 increasing 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 irrational! 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 reflect 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 financial 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 specific 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 film 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 homework 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 experiments.
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.

Concluding comments

In this chapter we have looked at the basic introductions to counselling the depressed client and the importance of developing a therapeutic alliance (Egan, 1998; Dryden, 1989a,b) that is focused on the self and its internal relationship. In depression it can be useful to keep the self-relationship as the central issue. In this way the counsellor is less likely to get lost in various details of a client's difficulties. This does not mean that one ignores the interpretations of other people with whom one is interacting (Gilbert, 1992), instead it is fostering a self-belief system which is valuing and supporting rather than attacking and undermining (Gilbert, 2000). Homework, in the early stages, needs to be agreed as being helpful and achievable. It also enables a client to regain hope and control by increasing the level of positive rewardable behaviour.

7

Working with Interpersonal Problems of Depressed Clients I: Approval, Achievement, Assertiveness and Rebellion

This chapter and the next explore the counselling process once counselling is underway. It will focus in on various self-evaluations which are especially related to social cognitions and feelings – of how one sees oneself in relation to others. In that sense we will focus on *cognitive–interpersonal dimensions*. Before that we should note some typical procedures that can help to give structure to sessions:

1 Checking on mood at the beginning of each session. Has it got worse, stayed the same or improved?
2 The counsellor will review homework or role enactment experiments outside counselling.
3 The counsellor will check for any critical events between sessions.
4 Feelings and ideas about previous sessions will be explored, e.g. 'Did you have any new thoughts this week arising from our last meeting?'
5 Together, counsellor and client will then set an agenda and priorities for the session.

The above occurs (usually) in the first ten minutes or so of the session. The structure should not be overly prescribed, however, as this may allow for avoiding key themes. A clue to this problem can be obtained if the client tends to leave the important material to the last five minutes. As counselling progresses, more information will arise as to the key interpersonal areas that are problematic and these will tend to present as repetitive themes, e.g. need for approval/recognition, assertiveness, etc. (see Chapter 2).

This chapter will explore how to work with some central self-schemata and core beliefs, beginning with approval. We will use the approach of advantages–disadvantages. Some cognitive counsellors ask clients to rate (in percentages or numbers) the degree of the advantage or disadvantage (e.g. see Blackburn and Davidson, 1995), but some clients may see this as too intellectual. And in my view one should also check on frequency and the extent of dwelling on certain thoughts. In the approach here we will focus on the meaning and discussion of meaning.

Approval seeking

Many theories of depression see (excessive) needs for approval as playing a central role in vulnerability and maintenance of depression (see Chapter 2). When approval seeking relates to an intimate domain this often takes the form of needs to confirm one's lovability and to stay in a close relationship with another (Beck, 1983; Bowlby, 1980). When approval needs operate in a less intimate domain social approval needs are focused on recognition of talent and ability. These are, however, not mutually exclusive. Loss of needed, intimate relationships often involves the affects of yearning and proximity seeking. Those focused on more social domains do not involve the same yearning for proximity. In dealing with dependency, the counsellor should be clear about the distinction between genuine emotional dependency and other forms (e.g. economic). Often dependency is secondary to a feeling of inferiority. The example below looks at a case of intimate dependency.

On the surface, Sally seemed to have a need for intense relationships with men and much reassurance once in them. She had become depressed when a long-standing relationship (with Fred) had broken down. She understood the basis of the cognitive approach and had made some early gains in her counselling. Nevertheless, on core issues she seemed rather stuck. At this point we used the advantages (gains) and disadvantages (losses) procedure to help articulate the difficulty (see pages 100–2). The following dialogue highlights how the counsellor can use a technique but must stay open to the affective changes that occur in the session.

Sally: I just never seem to be able to make a success of relationships. I mean I thought that Fred and I were doing okay but it ended like all the others.

Counsellor: Did Fred tell you why he was breaking up?

Sally: Well, he mentioned that maybe I was too intense. Like I needed too much reassurance. I wanted to be with him all the time. This

seemed to me how lovers should be. I didn't like him looking at other women and, like I said before, we did sometimes have rows over this.

The counsellor might note the possibility of black and white thinking here, i.e. 'Either I am with a lover all the time or we don't have a loving relationship.' This is implied, if not stated clearly. For Sally, working on black and white thinking has only been marginally helpful.

Counsellor: Do you think Fred had a point?
Sally: Probably. Yes.
Counsellor: Is that something we might continue to work on?
Sally: Maybe, but I don't think I can be any different. I have tried really, but I just seem to get taken over by the relationship, like it is everything to me.
Counsellor: Sounds like there are some basic ideas about changing and not being able to. What about if we look at the advantages and disadvantages of changing, or if you like the gains and losses. Perhaps we can get a clearer idea of what this is about. I'm going to draw two columns and call one 'advantages' and the other 'disadvantages'. Okay? [*Sally nods*] Now, what would be the advantages of changing, becoming less intense and needy in the relationship?
Sally: Well, it would certainly make things easier I guess.
Counsellor: Okay, that's our first advantage. It would make things easier. Anything else?
Sally: I might hold onto my man.
[*The counsellor notes the words 'hold onto'. As we mentioned (Chapter 3) key words can be markers for underlying basic beliefs.*]
Counsellor: You might hold onto a man. Any other advantages?
Sally: [*thinks*] No, can't think of any.
Counsellor: Fine, let's just stop here for a moment. Suppose you did find it possible to be less intense and needy, how would that affect you? I mean, what would be the benefits for you, how would you be different, like inside you? [*Here the counsellor is helping to focus more on the internal self-experience.*]
Sally: I wouldn't get so jealous.
Counsellor: Would that feel better?
Sally: Oh yes. I hate feeling jealous, it really cuts me up you know.
Counsellor: Okay, so becoming less jealous might be a help. Anything else, like how your thoughts or fantasies might go?
[*Note how the counsellor is having to draw out advantages with questions.*]
Sally: Oh, yeah, that. Yeah, I wouldn't spend so much time fantasizing or worrying about the relationship. Like I told you before, they kind of take me over and I spend all my time thinking about the relationship, mainly if it's going to work out and what will happen if it doesn't.
Counsellor: So if you became less intense and needy then you might have less worrying thoughts about the relationship. What about you?

I mean how might you come to think about yourself – your own person-ness.

Sally: Hmm, I've been thinking about that since I saw you and talked to Jackie about it. I do feel bad about myself when things don't work out, like I've put so much effort into it and it goes wrong, so maybe it's me. I get confused with that.

Counsellor: What kinds of ideas do you have about you?

Sally: It's difficult to put into words but somewhere I feel I must be unlovable. [*Note how the counsellor has had to ask more than once to help Sally get to her beliefs about herself when the relationship does not work. Then comes the idea 'maybe I'm not lovable'.*]

Counsellor: Are there any other thoughts or feelings about yourself?

Sally: I guess I'm angry with myself. I look back and see what I did wrong. I think of how I was jealous and at times demanding, and wish I could be more relaxed, not so needy you know. Part of me would like to be more independent. [*After further discussion on these general themes the counsellor summarizes.*]

Counsellor: Let's go over some of the advantages of becoming less intense. The relationship might be easier. You'd feel less jealous; you might be able to maintain the relationship; you might get less angry with you and feel better about yourself; you may become more independent. How does that sound?

Sally: Well, when you lay it out like that it sounds silly to get so involved and I suppose I do lose something.

Counsellor: [*smiling*] I think I see a 'but' on your face though.

Sally: You make it sound so logical but I can't help it. It's my heart that rules me.

Here Sally acknowledges the logic of change yet is not convinced. Counsellors should not be discouraged by this. Thus we must move to the disadvantages. Indeed, in working with depressed clients, helping them see the advantages of change may be less important than working with the disadvantages. Thus spending more time looking at the disadvantages may be valuable. This turned out to be important in Sally's case.

Counsellor: [*smiles*] You're right, of course. We are approaching the issue in a reasonably logical way but our feelings don't always obey logic. Still, maybe as you say, you can see that it is not all gains in having an intense relationship. Anyhow we can come back to this. Let's focus on the aspect that you mention here again about being taken over by the relationship.

Now the counsellor has already explored inference chains on relationships and found that Sally's sense of feeling good about herself is very much related to having a man love her (i.e. close intimate relationships). She is also competitive in love, hence her

jealousy. She has beliefs such as 'If a man loves me I must be as good or better than other women.' At the same time, however, she often feels vulnerable because this good sense of self can be taken away from her if the relationship fails. Sally has not been able to make a lot of progress with simple alternative thinking so the problem can be approached from a different direction and we can try to engage Sally more fully in understanding the benefits and losses to her of changing her basic attitudes.

Counsellor: So far we have looked at a few advantages of becoming less intense in relationships with men, but now let's think about the disadvantages. What would you lose?
Sally: The first thing that springs to mind, even as we were going through the advantages, was that it wouldn't be natural.
Counsellor: Natural?
Sally: It wouldn't be me, like I'd either be pretending or that I didn't care that much.
Counsellor: So it's the intense feeling that makes it seem real and natural?
Sally: Yes.
Counsellor: Okay, what other disadvantages are there?
Sally: I wouldn't be sure if this was the right man for me. Like I'd be wasting my time.
[*The counsellor thinks about the statement 'right man for me', and considers the possibility of looking at the evidence that emotions are the best way to make such judgements. However, at this point it is decided to focus on internal feelings.*]
Counsellor: How would you feel inside?
Sally: [*thinking*] Kind of empty about it, I guess.
Counsellor: Empty. Without the intensity it would feel empty?
Sally: I think so.
Counsellor: How about you? What would your experience of you be? [*Again, note how the counsellor returns to the self-evaluation.*]
Sally: The same empty feeling.

At this point the client touches affect and her mood seems to become more sad. This is picked up in her nonverbal behaviour and slowed speech. These affective pointers (Greenberg and Safran, 1987) are important to stay with. So even though we are using a fairly structured technique we remain sensitive to the affective changes in the session. We also want to explore if these feelings are coming from some aroused schema and/or memories – what has caused this shift in affect?

Counsellor: That's interesting, Sally. Without the intense feeling in the relationship it feels empty and you feel empty in it. Can you remember having these feelings before, like in childhood?

Sally: [*Speech rate slows down and talks more deliberately.*] As I think about it, it reminds me of my Dad. Poor old Dad, he had to work long hours and was often away from home. I just got this image of waiting at the window for him to come home and then mother would say I'd have to go to bed or he wasn't coming home that night. I really used to miss him 'cos on the occasions when he was there he would spend a lot of time with me and it was really good, like really good and exciting. He'd take me out, unlike Mum. I hated him going away again, life seemed more dull. Later, they got divorced and secretly I really hoped I could go and live with him but Mum wanted us to stay with her. She needed us I suppose, but I wanted to be with Dad.

The client has spontaneously made a link with the past, noting various memories. Safran and Segal (1990) suggest that working with historical data is important, especially if explored in the course of counselling, in the presence of affect, and when it emerges spontaneously. Thus, we cannot let this opportunity go by.

Counsellor: Sounds like he really liked being with you when he was home?
Sally: Sometimes I thought he enjoyed being with me more than Mum. They didn't get on at all. He didn't talk about it much but I always felt on his side.
Counsellor: Against Mum?
Sally: Yeah, perhaps.

The counsellor notes the possible competition with mother for father's affection. It runs through his mind that this might have something to do with her competitive style and preparedness to drop female friends whenever a man came along. But since the focus is on the need for intensity we stay with this theme.

Counsellor: Sounds like you longed for that intensity to be there all the time; to be with Dad.
Sally: [*nods sadly*]
Counsellor: Do you think those experiences might have anything to do with what happens with you today in relationships?
Sally: I'd never thought of that. [*Pause*] I can see that.
Counsellor: You look sad.
Sally: I was just remembering how lonely I used to feel and how much I wished he'd come home.

At this point, while using an advantages–disadvantages approach, we have tapped into an underlying memory of a need for intensity and closeness, and how there is both a desire to recapture closeness, and also a fear of losing it. In attachment theory (e.g. Liotti, 1988, in press) this might be seen as an anxious attachment to father that has set a template for anxious attachment

to men. However, the point is, there does seem to be some early schemata here and these are going to need work to help Sally change her interpersonal style with lovers.

It is important then that the counsellor does not use the techniques of counselling simply as 'techniques' but crafts them into a therapeutic relationship. They are not a recipe to help people understand at only a rational level the nature of their difficulties but also to engage emotional experience. So one wants to try to bring this emotional experience into the list of disadvantages.

Counsellor: Okay, Sally, perhaps we can see how this need for intensity may have something to do with your past experience with Dad. But I guess that this may turn out to be an advantage. I mean if some of the need for intensity is coming from a disappointing relationship with Dad, then it might be helpful to try to help with this disappointment rather than you carrying it from one relationship to another.

[*Here the counsellor is directing attention to Sally's interpersonal style.*]

Sally: I hadn't seen that, but sitting here it makes sense. Are you saying that I am trying to recapture something?

Counsellor: What do you think?

Sally: I think I have known that but yet haven't been aware of it. [*Pause*] Oh, that sounds silly doesn't it?

Counsellor: [*gently*] I wouldn't say silly at all. It seems more about making connections. Something we feel but like it's in the background, not clear.

Sally: Yes, that's how it is, in the background, not clear.

We then had a discussion of what we mean by 'being in the background' and how some of our ideas and feelings get connected within us without consciously recognizing it. In essence, Sally had a belief which said 'I must have a close relationship with a man to be happy.' This came from a real experience of being happy when she was close to her father.

Counsellor: So we are saying that a disadvantage of giving up the need for intensity may mean that you feel less able to recapture something, to use your words.

We spent about twenty minutes in emotional discussion around this theme trying to clarify it and articulate the basic beliefs. The focus remained the disadvantage of losing intensity in relationships with men. It is not only the connection with the past that was important here, but the link (with the memory) of intense emptiness and loss. At the end of this part of the session the counsellor returned to the basic task. We had both gained more insight into the feared losses associated with changing and giving up intensity. At times Sally's sadness was intense.

Counsellor: Okay, Sally, let's look on our paper and see what we've got here. First, you see that intensity in relationships is not all good now. Therefore you recognize some potential benefits from becoming less intense. I would direct your attention to your style of relating. However, there are many disadvantages in making this change. First, it may make the relationship feel unnatural or unreal and this links to a feeling of emptiness. That in turn reminds you of your relationship with your father. So, although at a logical level, you can understand that there are advantages to becoming less intense and needy, at an emotional level it does not feel like a gain, but a pretty big loss. Now nobody will change if they feel inside they are heading for a loss.

Sally: [*slightly tearful*] Yeah, I must say I have been trying to follow through in counselling but that has been the feeling. I know I want to change and part of me knows what we've been doing is sensible but inside I don't want to change, like I am leaving something important behind.

Counsellor: Do you think you are clearer about what you might be leaving behind?

Sally: The kind of relationship I wanted with Dad [*cries gently*].

At this point the counsellor is silent, allowing Sally to be aware of the pain of the insight. Later the counsellor emphasizes the belief 'I must have an intense relationship to be happy', and summarizes what has taken place.

As counselling progressed, Sally began to reach a certain anger at her father who had been idealized. She had not been able to contact this before because her positive feelings for him had been special and an important source of self-esteem. Now this is not at all uncommon in idealized relationships when there has actually been considerable loss and distance. Making contact with the anger can be helpful. It helped Sally understand that often, in intimate relationships, she also felt resentful without really knowing why. She began to explore the fear of being alone and left behind. Without intensity, she might be left like mother, alone and somewhat bitter. So again the techniques of counselling were ways of helping her gain insight and make important changes in self understanding and interpersonal relationships. One of her homeworks was to try to look at ordinary friendships with men and the feelings she had about them. We also looked at other ways of evaluating what kind of relationship she wanted with a man, e.g. honesty, respect, sharing pleasant activities, etc.

As counselling progresses one is gradually weaving together various themes and illuminating basic schemata and memories, such that they become available for reworking in the present situation.

Achievement

The need for achievement is also common in depression (see Chapter 2). Let us look at Dan who showed this strongly. Dan had a need for approval, but it did not manifest as intimate or proximity needs as did Sally's. Rather it was a need to be recognized as talented and able. Let us now consider Dan using the same technique of advantages–disadvantages (gains–losses).

Counsellor: You were saying earlier, Dan, that you felt a great need to achieve things and felt that much of your life had been a failure. Over the past few sessions we have looked at the evidence for this and also how you would talk to a friend. Has that changed things?

Dan: I can see what you are driving at and it sort of makes sense. I do punish myself a lot but it's so automatic that it's difficult to change.

Counsellor: Well, let's look at this from a different perspective for a moment. We can make a list of the gains and losses to changing the need for success. I'll come and sit next to you and we can write them out together. [*Does so*] Now, let's look at the advantages first. What might be the advantages of changing this drive for success?

Dan: I would be more relaxed about things and less anxious.

Counsellor: Anything else?

The following advantages were then elicited. 'I'd be less hard on myself. I'd be easier to live with. If I was less tense I might get less depressed. Life might be more fun.'

Counsellor: Okay, let us now look at the disadvantages.

These were the disadvantages: I might become sloppy. I might end up lazy. Might lose respect (he took secret pride from others calling him a perfectionist. He also took secret pride from feeling superior to others). I might lose my purpose in life and life would become empty and pointless.

Counsellor: It is understandable why you would find it difficult to change if these are the likely consequences. Counselling must seem a bit confusing to you if you think that by changing your style you are going to feel worse, like empty and pointless.

Dan: [*long pause as Dan looks over the list*] Yes. That makes sense. I kind of know what you are saying but it has never seemed a right fit for me, like I was frightened of letting go of something. I have felt confused really.

From here counselling began to work more closely with the fears and the sense of superiority that Dan maintained from his perfectionism, and the fear of letting go. There was some mourning of the failure of recognition of early life and a movement to look at life with regard to more pleasurable activities. Black and white thinking was explored many times in terms of a fear of

becoming more sloppy and losing respect. Each time we were able to keep in mind the fear of change.

In these cases the counsellor needs to empathize with the (sometimes desperate) feelings of need for recognition and to be valued. In cognitive terms these are the 'I must' beliefs. It is not the case that these clients want to be cared for or necessarily crave an intense intimate relationship. More often they are seeking a sense of personal value and have worked out various tactics for trying to achieve it. If the counsellor does not recognize this need for value and moves too quickly to challenge, the client can feel misunderstood. Further, the counsellor should be alert to the disappointment and grief of not having felt valued that goes with these themes. Counsellors can sometimes miss the difficult struggle for respect and a sense of personal value that have often been important life goals (see Gilbert, 1992, ch. 7).

In both Sally's and Dan's cases the counsellor often returns to self-evaluation. Why must you be loved or valued? Slowly the client can turn a 'must' into a preference. The key is helping the person to avoid self-attacking or self-downing if the preferences do not come about. If one can stop the self-attacking and maintain a reasonably stable self-relationship, then depression might be less likely. This is a central focus of rational emotive therapy (see also Greenberg et al., 1990, 1993). Let us now review our thoughts about one of the most commonly used techniques: advantages–disadvantages.

Key issues 7.1 Working on advantages–disadvantages

1 The counsellor may have to draw out the advantages and help people to list these. (See pages 100–3).
2 The counsellor uses questions to help clients articulate how they might think about themselves differently through changing.
3 It is common, however, that working with the advantages of change is not always helpful. People often know what might be in their best interests, but do not do it.
4 Consequently, looking at the disadvantages of change can be more powerful.
5 The counsellor can draw out the negative self-beliefs, self-experiences and basic fears and losses that might arise from change.
6 If clients spontaneously report memories or images from the past that are linked with negative emotions, the counsellor should explore these. Sometimes the advantages–disadvantages is the focus for the whole session.

Assertiveness

There is good evidence that assertiveness is often a problem in depression (Arrindell et al., 1988). In my self-help book (Gilbert, 2000) there are two chapters devoted to anger and assertiveness. Commonly, depressed people with problems with anger and assertiveness will either carry considerable resentment and then label themselves as bad for feeling resentful, or feel weak for not standing up for themselves and/or they may have explosions of anger and then feel guilty and even more depressed and inhibited. Obviously, assertiveness is an interpersonal style that has various social outcomes. Why are depressed clients not more assertive? It can be a basic skill deficit and this requires education in line with normal social skills training. However, there can also be a number of perceived disadvantages to becoming more assertive, most often loss of approval or abandonment. In some cases the lack of assertiveness has been the source of positive self-esteem (I am good because I'm not pushy). In fact, we can identify a number of basic themes that maintain a person in a submissive non-assertive state. The counsellor should explore the various reasons for inhibited assertiveness in depression. Below are listed some typical reasons.

FEAR OF COUNTER-ATTACK Here the person is fearful of being overwhelmed by the counter-response. There may be a fear they will become tongue-tied, mind go blank, look silly or forget what they want to say – others may overpower them, be quicker, etc. There can be a fear of loss of poise, or of asserting themselves badly and being subject to shame. We should also not forget that, more commonly than we would like to acknowledge, there can also be a fear of put-down or even injury by a more powerful other. Hence the basic fear is that they will come off the worst.

LOSS OF CONTROL Assertiveness can be physiologically arousing and some clients become fearful of this arousal in themselves. They may worry that they will lose control or say something extreme or shameful. Hence internal physiological cues can act as assertiveness inhibitors.

FEAR OF ABANDONMENT In these cases, clients fear that others will come to dislike them or abandon them if they are assertive. This normally applies to more intimate and friendship type relationships. Further, this is associated with ideas that they would not be able to cope alone, they would become worthless, unlovable or incapable.

RIGHTS Some clients are unclear about their personal rights. They are apt to make various excuses for others' bad behaviour towards them or take the attitude 'Others are more important than me.' They feel guilty at putting themselves first or owning their own needs. They have a (superficially) over-caring attitude to others, but this is not always without a certain resentment that others do not (without them having to ask) recognize their needs. Although they allow themselves to be treated as doormats they would like others to respect them without having to assert themselves.

SELF-BLAME It is not uncommon that clients blame themselves for conflict in some situations. Even women who are suffering from abuse at home may still blame themselves for it (Andrews and Brewin, 1990). Sometimes self-blame is a highly protective strategy for it reduces the chances of retaliation but it also increases depression, i.e. self-blame may inhibit their desire for revenge – and self-blamers are less likely to 'fight back' in conflict situations.

POSITIVE SELF AND COMPETITIVENESS Some clients suggest that they do not like assertive people and regard them as selfish. Hence they can feel good about themselves if they refrain from behaving like those 'selfish others'. In a way the lack of assertiveness is taken as evidence of a good self and a caring non-selfishness. To become more assertive threatens becoming similar to people they do not like, and losing a certain satisfaction with self that they are nicer than other people.

In any one case, each or all of these possibilities can be present. The client might also feel anger at what they see as other people's selfishness. They may have beliefs such as 'Others should not behave like that, they should know that it is wrong. I expect/demand people to behave as I think is right.' Clients might also have a wish for revenge. The advantages–disadvantages procedure usually reveals fairly quickly which themes are most problematic and counselling can be tailored accordingly. It can also be useful to role play situations such that clients can learn the behaviours associated with adaptive assertiveness and deal with negative cognitions that may arise. Often this is best handled in structured assertiveness groups. Many women who have been depressed attest to the benefits of these groups (see Dickson, 1982).

Assertiveness, attractiveness and initiation

A particular problem with some depressed clients is that they do not initiate things that are positively reinforcing. In a factor analysis, Arrindell et al. (1988) found that assertiveness had at least

four components: (a) display of negative feelings, involving standing up for oneself and engaging in conflict; (b) expression of and dealing with personal limitations, involving a readiness to admit mistakes and deficits; (c) initiating assertiveness, involving making one's opinion known; (d) praising others and accepting praise.

One of the clear findings from research is that depressed clients are not much fun to be with (Segrin and Abramson, 1994). This in part is because they do not initiate positive interactions. There are various reasons for this – fear of rejection or attracting too much attention. Another reason may be high self-focused attention (e.g. see Pyszczynski and Greenberg, 1987). Resentment may also be important. For example, it is not uncommon to find that an individual does not initiate sex out of resentment towards the partner. Complying with sex, on the other hand, can give a sense of power and being needed. But initiation is an important social skill and our flow of positive social interaction depends on it. We could call this enthusiasm.

John was rather anxious about initiating social interactions. His wife found him difficult. He would sometimes sulk about the house and expect her to be sensitive and talk to him about what was on his mind (usually some minor grievance). If she made an enquiry, there would have to be a little ritual of denial that there was anything wrong followed by his wife insisting that there was. He would play the game of making her 'force it out of him'. When his wife tired of this 'game' he became more resentful, attributing it to lack of care. Sulking can be quite a problem in some cases of depression (Dryden, 1992).

In sexual relationships it was a similar story. He would prefer his wife to initiate sexual contact and had to have clear signals that she desired sex. This again put a burden on his wife. Homework involved: (a) learning to give up the game of 'You have got to make me speak of my grievance as a test of your care'; (b) initiating at least one positive interaction per day; and (c) making his desire for sexual contact clear and 'up front'. For this John's wife was invited to counselling and he was surprised to learn how much she resented having to do all the emotional work.

Social explorative behaviour shows itself as taking interest in, and showing appreciation of, others. If one is initiating questions, ideas (or even sex) and generally exploring another person's viewpoint, then one is showing interest (see Heard and Lake, 1986, for discussion of the importance of this mutual, valuing interactional style). Being the recipient of interest is positively rewarding. It is not uncommon to find that rather passive individuals have histories of authoritarian parenting. A lack of socially explorative

behaviour is unattractive, but too much initiation (e.g. sexual advances) and following one's own agendas/goals is also unattractive and is seen as dominating. Too much interest in another can be intrusive. So it is a tricky balance and clients need to learn how to be sensitive to their partners, e.g. to accept a refusal of sexual contact gracefully without building up resentment or ideas like 'Right that's the last time I am going to make a pass at you.' These kinds of difficulty suggest a rather fragile sense of self.

It is, however, very common to find that significant others in the client's life are not valuing or appreciating of the client. It is common to find depressed clients (especially women) are living with emotionally neglectful or domineering partners. Interpersonal and evolutionary theory (Gilbert, 1992) suggests that we are not socially decontextualized beings, and all of us need at least some degree of positive signals of value from others. This is why social support comes out so strongly as a factor in both depression and recovery. Criticism by spouse is a predictor of relapse (Hooley and Teasdale, 1989).

Key issues 7.2 Assertiveness

1 Assertiveness is much more than just standing up for oneself in situations of conflict. It involves also positive initiations.
2 The counsellor can recognize that the client may have various fears of assertiveness (e.g. of the counter-attack or fear of rejection). These need to be made clear.
3 Lack of assertive behaviour often leads to resentment and this needs to be acknowledged.
4 Part of adaptive assertive behaviour is the ability to initiate positive behaviours and state clearly one's preferences. Sometimes depressed clients see this as selfish and think that they should do what others want.
5 Sulking can be a problem in depression and may be associated with fear of open assertive behaviour, and for a sense of power that can be gained from withholding.
6 Counsellors may offer role play exercises to help clients explore their negative thoughts while enacting assertive roles.

Rebellion

Joe was diagnosed as a chronic, mild depressive. He had seen a number of counsellors. He presented as a superficially pleasant and compliant client who appeared to do the homework agreed. On the surface he should have progressed well, but did not. In fact, he feigned agreement but had a passive aggressive style and

was full of 'yes buts'. Previous counsellors had become frustrated with him. He could not understand why others eventually got angry or lost interest in helping him. Thus, counselling focused early on, on issues of compliance. The counsellor noted that when Joe spoke of minor rebellions at school his eyes lit up and he become more 'emotionally expressive' during counselling.

The counsellor pointed this out. Could that spark be used to engage Joe? It was agreed that Joe should begin to argue during counselling why he should not do homework. It was agreed he would work on non-compliance. Once permission had been given for this 'rebellion', Joe took to counselling with vigour. The focus become his ability to resist others, including the counsellor.

Counsellor: We agreed that you monitor some of your thoughts about doing jobs about the house. Is it likely that you will?
Joe: [*with a slight smile*] I might, but knowing me I probably won't.
Counsellor: Good, so you will rebel. How does that feel?
Joe: [*pause, then cautiously*] I guess I feel a little bit stronger than you.
Counsellor: Is that okay or does that feeling worry you at all?
Joe: I know you say it is alright for me to rebel if I want to, but I think you will reject me if I go on like this. Sooner or later I am going to have to give in, aren't I, and work at counselling?
Counsellor: Hmm. [*pause, watching Joe's nonverbal behaviour*] You look puzzled.
Joe: I can't believe you are encouraging me to rebel against this counselling. The other counsellors told me I had to work in the counselling or I wouldn't get better and you're telling me I don't have to.
Counsellor: It is not so much whether you work or not but how we work together. When you rebel we see you struggling to stay you. I would like to work with the rebel inside you not against it. Would you like to talk to the rebel inside?

After some discussion Joe agreed, just for the 'hell of it'. At this point we wrote on a card the typical thoughts the 'rebel' had. 'They can't make me do things. They will never get to me. They don't really understand – all smart arses every one.'

The tone of counselling at this point was like a game, sort of playful, but nevertheless, with the serious intent of eliciting basic beliefs and attitudes. Also, you will note that there were various envy elements in this theme (see Chapter 8). Joe was then encouraged to answer back at the schema. 'Okay, maybe others have put me down but aren't I cutting off my nose to spite my face? I mean I might be able to resist others but that's not much fun in the end.' The counsellor also helped Joe to see the positive side of the rebel and talked openly that rebels had (sometimes) important uses, but they had to be part of the self and not running the whole show.

Whether Joe was convinced by 'the technique' or not, it changed his attitude to counselling. By validating the rebel and bringing it into sessions, he began gradually to be more open and hard working. Had the rebel in him not been acknowledged then counselling may have been difficult. Still this was a slow process. One could easily see how his more rebellious attitude would elicit anger in others and this in turn would reinforce his need to rebel, to hang on to his sense of self. His depression was of a passive–aggressive kind. The two chair technique (pages 84–6) could have been explored.

Much discussion focused on Joe's sense of strength and renewed vigour in being encouraged to rebel. Homework and other counselling procedures were seen as vehicles to help Joe internalize a stronger sense of self. Rebelling at counselling became 'Doing it my (his) way'. Slowly, Joe began to give up his pleasant but passive resistance and engaged in more collaborative work. This case is cited to help counsellors see that one should try to work with their client's internal experience and not apply techniques because they seem logical or the correct way to do things. It is not unusual that openly helping clients rebel and become assertive is an important factor in change and here the counsellor may need to facilitate a certain degree of rebellion in the counselling which is safe and does not result in rejection.

Another area where it is very important to 'enable the rebel to speak' is in binge problems. Depressed clients who binge drink or binge eat are rarely doing it for comfort. Often the trigger is disappointment, frustration or the feeling of being put down or marginalized which is associated with rage. The thoughts associated with bingeing may be 'Sod it, I've had enough. I'll show them. What do I care? They can't make me do XYZ. I'll make them feel bad – look what they made me do, etc.' At these times counsellors should be very cautious not to try to challenge by being punitive. Also, be sensitive to the shame that might follow when the patient is sober or out of the binge state. Try to be sensitive and not humiliate the client (unfortunately, a possible outcome). Rather, enable the client to verbalize their frustration and anger as the trigger, their desire to rebel and 'break out', to work out alternative behaviours for such anger, to recognize disappointment, and help the client recognize the rebel may be working against them rather than for them.

Concluding comments

This chapter has looked at various interpersonal themes and issues, and how the cognitive 'techniques' of Chapters 4 and 5 can

be integrated with an understanding of the client's interpersonal style. The self-experience remains a central focus but there is also a focus on how the client acts in his/her social world. When using techniques, try to stay with the client's emotional experience, and elicit affect where appropriate.

It is particularly appropriate to work with the fears (disadvantages) of changing. If clients are given the opportunity to really explore these fears and disadvantages it is my experience that they move more easily through the process of change. Some forms of passive resistance can be difficult and this is why acting this out (e.g. the two chair technique described on pages 84–6) can be helpful. Usually resistance is related to unaddressed fears or dilemmas of changing (e.g. addressing anger). Most important is to avoid shaming or blaming people for their resistance or passivity.

8

Working With Interpersonal Problems of Depressed Clients II: Shame, Guilt, Ideals and Envy

Shame

In the last few years there has been an enormous growth of interest in shame (Gilbert and Andrews, 1998; Lewis, 1986, 1987a, b; S. Miller, 1996; Tangney and Fischer, 1995). Shame is now regarded as one of the most powerful and potentially problematic issues in counselling because it often involves concealing things or being unable to process shameful information. Shame is a multifaceted experience which has various aspects and components. These include:

1 *An internal self-evaluative component* Beliefs and feelings that one is inferior, inadequate or flawed. Many of our self-attacking thoughts (e.g. I am useless, no good, a bad person, a failure) are in essence shaming thoughts and self-evaluations.
2 *A social or external evaluative component* Beliefs that others see the self as inferior, bad, inadequate and flawed; that is, others are looking down on the self with a condemning or contemptuous view. This is linked to stigma.
3 *An emotional component* The emotions and feelings recruited in shame are various but include anxiety, anger and disgust in the self and self contempt.
4 *A behavioural component* There is a strong urge to hide, avoid exposure and run away or (when anger is the emotion) retaliate against the one who is 'exposing' the self as inferior, weak or bad.

When we experience shame we can have negative thoughts and feelings about ourselves and negative beliefs and feelings about what we think others think and feel about us. Given that

counselling and therapy is often the time we will have to 'open up' and discuss the painful things of life (our failures and traumas) it is not surprising that therapy can be a time of the most acute experiences of shame. Those working with shame may benefit from keeping in mind two basic facts of human psychology. First, we are all highly motivated to conceal negative information about the self and try to promote positive self-presentations to others (Leary, 1995). Second, acts of concealment may aid self-presentation but it can also be highly detrimental to health (Pennebaker, 1997).

Feelings of intense shame can play a role in a variety of problems including depression, anxiety, violence, eating disorders and personality disorders (Gilbert, 1998c). Shame can be focused on many aspects of the self. For example, we can feel ashamed of our bodies (body shame – as is common in some eating disorders, but also the more typical feelings of being too fat or the wrong shape or old looking); our feelings (e.g. anger or sexual desires) and our behaviours (e.g. history of stealing, or lying). Shame can also significantly interfere with therapeutic relationships, especially when people try to cover up what they feel ashamed about, or have been unable to process or work through emotional episodes rich in shame (S. Miller, 1996). Shame can result in important experiences going undisclosed. For example, adult survivors of child sexual abuse can go through counselling without the abuse being addressed (Jehu, 1988, personal communication). Some see shame as one of depression's primary associated affects (e.g. Mollon, 1984; Mollon and Parry, 1984). And there is a relationship between shame, sexual abuse and chronic depression (Andrews, 1998). Shame can also produce powerful feelings of helplessness in both counsellor and client. Issues of 'stuckness' can sometimes hint at underlying shame. Here are some examples of shame.

Donna had a difficult third session where she started to discuss abuse. The therapist felt she had been supportive but Donna didn't come back. Subsequently, the therapist discovered that having revealed this history, Donna could not face the therapist again. Sometimes a 'successful' session uncovers shame and this is the dangerous time for avoidance. Therapists can warn patients of this and not to reveal too fast.

David had long worried about his sexual orientation and had kept it hidden from his friends and parents. In doing so, he felt cut off from others, different and bad and found it desperately painful to discuss in therapy. He just wanted to be 'rid of it'.

Janet had put on weight due to medication and was now 'disgusted' with her body. 'I feel trapped in a horrible alien body' she said, and could not stand for her husband to see or touch it.

This added further to her shame for she felt she was failing as a wife and greatly missed their previous sexual life.

Sandra felt exhausted by the birth of her child and at times had feelings of wanting to run away and even harm her baby son. She could not tell anyone for they would think she was mad and bad.

Much that passes in rational emotive counselling as shame is in fact embarrassment (Klass, 1990). Embarrassment overlaps with shame (both are concerned with self-presentation or 'how one lives in the mind of another'; Gilbert, 1992). But embarrassment is a much less severe affect (R. Miller, 1996). Hence shame-attacking exercises which involve acting in mildly embarrassing ways (e.g. speaking to a stranger as if they were a friend, or going to town with one's hair in a mess or dressed untidily) are inappropriate in severe depressive-shame. In this section we focus more on the issue of the experience of severe shame in the counselling relationship. In all cases, whether shame is mild or severe, empathic responses to the shame experience, efforts to raise self-esteem and stop self-downing remain key elements in the treatment.

Shame motivates concealment but concealment inhibits the assimilation of negative information about this self and has physiological affects (Pennebaker, 1988, 1997). If people can work through experiences that they have not shared before and develop new meanings this can be highly therapeutic (Pennebaker, 1997). Various writers have also noted the *shame-rage spiral* (Lewis, 1987a; Nathanson, 1987; Schore, 1991, 1998). A similar idea is Dryden's (1989c) concept of complex inference chains (see Chapter 3). Here the cognitions of being evaluated negatively activate anger or rage. Typical cognitions are 'I hate/fear the counsellor finding out 'this' about me. If he/she discovers how bad I am then he/she will reject me. This will confirm that I am a bad/unworthy person. But if he/she doesn't find out, then I can't overcome these problems. So I feel angry and let down by the counsellor who is not helping me.' Or there might be thoughts such as 'I feel rage in this situation but I know it is inappropriate therefore I must be bad' (Gilbert, 1998c). Thus shame motivates the desire to conceal and hide from view but it is also associated with a sense of badness and powerlessness. Even in post traumatic stress disorder shame can play a major role especially if people are ashamed of how they reacted or have coped (Lee, 1999, personal communication).

Working with shame

A typical shame problem can be in revealing the intensity of internal feelings. Mary found it extremely difficult to cry in

counselling. When she did so she would cover her face with both hands and push back her tears. It was difficult to work with emotional material because she was deeply shame-prone about her feelings. The focus in the early counselling was one of listening and trying not to engage her shame too quickly, on the assumption that before an empathic relationship had developed she might find it overwhelming and avoid counselling altogether. Gradually, however, the counsellor felt able to draw attention to the shame aspect.

Counsellor: I note that you try to push back your tears at times.
Mary: [*slightly angrily*] I have cried so much I don't want to cry here.

Because of the affects generated in previous sessions, I felt if I drew further attention to it I might be almost persecuting her in some way. Also I felt pushed out from her pain. This counter-transference persecutory feeling in the counsellor is not uncommon in severe shame cases.

Counsellor: [*gently*] Could we think about that a moment. What would crying here mean to you; I mean really letting go?
Mary: I would feel vulnerable and exposed. It's a stupid thing to do and doesn't do any good.
Counsellor: Stupid?

The fear of revealing powerful feelings is a common problem in some depressions and can say much about the internal self-structure and self–other schema. Many questions arise in the counsellor's mind at this point. Has the person been punished in the past for showing strong feelings of distress? In Mary's case the answer was almost certainly yes. Is the person angry with herself for having such feelings and is she trying to deny them? Does crying make her feel small/inferior in the eyes of the counsellor and in her own eyes?

From a technique point of view the counsellor tries to explore the disadvantages of crying and letting go of feelings; that is, the meaning of sharing feelings, but in a less structured way than discussed earlier. Here the counsellor has a choice of focus: (a) to reflect 'doesn't do any good'; or (b) the issue of vulnerability and exposure. If the former is chosen the discussion might become intellectualized. Alternatively, it might lead to discussion of previous experiences of being rejected. Hence, when a client gives two messages like this, the counsellor uses his/her judgement as to which aspect to focus on. 'Stupid' felt like a more self-evaluative concern and therefore this was the choice for reflection.

Mary: [*crying*] I can't stand to feel like this.
Counsellor: Because you feel exposed?
Mary: [*nods*]
Counsellor: Could you say more about feeling exposed?

This enables the client to talk more about the feelings and attitudes to crying rather than going into what the tears may be about and is therefore (possibly) less threatening.

Mary: [*silence and then*] I feel it is somehow a weakness.
Counsellor: [*gently*] Why are tears and distress a weakness?
Mary: Because others can hurt you if they know your weakness. They might appear concerned but inside you know they are thinking you are pathetic.

Here Mary articulates basic mistrust of others and how they would respond to her distress. She cannot trust empathy responses from others, even if they are given. Does this apply to the therapeutic relationship? If it does it will make her ability to deal with high levels of distress very difficult. So we need to check this out.

Counsellor: Would that be the same here, like I might see you as pathetic?
Mary: I don't know. [*Looks up and sideways*] Why wouldn't you? You must get lots of stupid females bawling their eyes out.

Here the client reveals a desire not to be like those 'other bawling females', not to appear weak and stupid. How can the counsellor help here? Because the session has been moving to the discussion of emotionally painful material, emotion is activated in both counsellor and client. Can the counsellor contain it and not get defensive or feel persecutory? At this point, containment is just about staying with Mary and not pushing too hard. At the same time the counsellor wants to try to convey a recognition of pain and inner conflict and, if possible, focus on the underlying negative self-evaluation. I know Mary has difficulties coping with the feelings of shame, that is crying in front of the counsellor, because she has told me that she can and does cry on her own. There also appears to be an increasing emergence of a rage–shame spiral (e.g. her somewhat aggressive statement of 'Why wouldn't you?')

Counsellor: [*gently*] I sense these painful feelings have been with you for a long time and they are deeply powerful for you. Maybe you are beginning to explore and understand them a little. Do they remind you of anything?
Mary: [*beginning to cry more openly but also angry*] My father used to tease me if I cried. He'd call me poor little baby face or cry baby. I hated him for that. I really hated him. Nobody seemed to care why I cried and I just couldn't do anything.

Linking with the past had opened the opportunity to direct attention away from the present, and focus on painful memories.

Counsellor: Hmm, so it is horrible when people don't recognize your feelings and put you down. That feels a very lonely place to be. [*Pause, then gently*] Mary, these feelings are painful to you because maybe you have never been able to share them before. But you are a human being and can feel hurt, deep hurt, and that doesn't make you weak, it makes you a feeling human being.

Here the counsellor has tried to empathize with her experience and gives her a positive construction of feelings – being a feeling human being. It is an attempt to rescue the self from internal attack and rage. More important, the counsellor truly believes this and it is not said 'matter of fact'. Mary was able to listen to this intervention and after a long pause of quiet crying with hands over her face said:

Mary: I guess you are the only person that thinks so. [*Looks at the counsellor*] I think most of the time I hold back on feelings. Some think I'm cold maybe, but I'm not. I just find it hard to show my feelings. It wasn't done in our family.

Mary then went on to talk in more depth about her family experience, as the counsellor quietly listened. A history of emotional neglect began to come through. Here the affect remained high but not overwhelming. At the end of the session the counsellor repeated the positive statement of feelings.

Counsellor: Well, Mary, given what you have said it is more than understandable why you have difficulty showing your feelings and yet in your heart you do feel things intensely. Perhaps as we work together we can see this and help you reclaim those emotional bits that you had to bury.
Mary: [*softly*] Yes, I've done a lot of burying of things.

This is a recognition of her experience of hiding, concealing or splitting off, even from herself. Such an acknowledgement is an important change.

Counsellor: And this was because you viewed them as bad and weak. You have labelled yourself bad when you have strong feelings. Almost like your father did. Also you did not want to be in a position where you could be hurt or feel small.
Mary: Yes, that is how it has been.
Counsellor: Do you think it is time for you to have another look at this? Perhaps as a child burying feelings was self-protective and helpful. But things can be different now.

Here the counsellor points to the fact that at one time her coping behaviour may have been adaptive and again is not a sign of weakness or stupidity (see Chapter 5 for other ways to intervene).

Mary: Hmm.
Counsellor: So the first person to focus on is you and how you down yourself when you think about having strong feelings.

Deep shame is never easy to work with. Sometimes it lies behind emotional avoidance noted by clients' statements 'it's too painful to think about', although not all emotional avoidance is shame based. So we can only offer a few guidelines. First, shame clients can stir up various feelings in the counsellor as a result of their need to conceal and especially if this is associated with rage. Clients can have a certain prickliness about them. However, the counsellor needs clearly to recognize these as part of the shame experience and think about the rage, loneliness and the fear of rejection that goes with the shame experience. Second, the counsellor needs to convey to the client that he/she senses and is trying to understand the struggle and the risk which the client feels is great. Third, the counsellor tries to make contact with the loneliness and emptiness of the client. If the therapeutic relationship is good, the recognition of loneliness can form a bridge to the shame issue. Finally, the counsellor is aware of the self-dislike and self-blame that are part of shame and these will be a source of work later in counselling. However, these points are only guides and there is much in this case that could take us through many chapters.

Schema change in shame

Once the counsellor and client have set up a good working alliance on shame (the client understands it and knows that the counsellor understands what happens in shame), it may then become possible to engage some shame-reducing work. Here the two chairs technique can be helpful. For example, for Mary we were able to elicit an internal dialogue and inference chain that went like this:

You should control your feelings. It's weak to cry, bad to feel rage. Paul will think you are pathetic. You are pathetic when you cry.

Gradually, Mary began to identify how paralysed she felt under this kind of attack; how this was the same feeling she had as a child and became able to verbalize her feelings of helplessness and anger at this internal experience. She practised arguing with

her father in role play. It was also possible to write some flash cards that she felt helped to challenge her feelings.

Crying is a sign of hurt not weakness.
If friends cry I would try to offer them comfort.
I can learn to work with my pain rather than hiding from it.
I have never allowed myself to cry without also attacking myself so I don't yet know if crying and caring for myself will be healing for me.
My father told me not to cry but I don't have to treat myself like he treated me.
What evidence do I have that Paul is likely to think like my father?

Another technique we used employed imagery. When Mary was in touch with some of her feelings of shame coming from early childhood, she imagined herself as the child coming into the counselling room saying 'Dad has been horrible to me.' Mary imagined herself putting her arm around the child and comforting her. In this way she was able to begin to activate a more nurturant mentality to herself (Gilbert, 1989, in press b). Of course, this was only an aspect of the work on her difficulties but it provided for a more self-accepting attitude to herself and allowed us to work on very emotional material. Slowly, she found that as she was able to express her feelings in the counselling she cried less on her own. Over the year in counselling, the rather depressed, brittle, angry and at times silent woman who came through the door on her first day, softened.

Yet another possibility that we could have explored would have been the current schema, contributing life experiences and alternative constructions. All these approaches help in that they enable the person to be more focused on their internal meaning. Having things written down gives a focus and clarity to internal meaning-making processes and also helps to distance from the experiences. It may also be that this kind of repetition of the meaning of shame works as a kind of *desensitization*.

Another aspect to shame that I did not focus on with Mary then but would today is to work more actively on developing 'a warm voice and feelings' to the challenges to shame (see Chapter 5, this volume; Gilbert, 2000; in press b). The internal self attacks are often hostile in shame and very unsupportive. So one has to check that the challenges to shame (e.g. crying is a sign of hurt not weakness) are experienced internally as comforting and warm rather than critical or coldly rational. This in itself can take much work.

The black hole of shame

Shame can paralyse our thinking (mind goes blank) and behaviour and all we want to do is run away or hide – wish the ground would open up and we could slip away. In some cases of shame a client may fall into a state that can be described as a 'black hole'. For example, Jane had serious shame about her physical appearance, especially the shape of her body. This was an issue she wanted to discuss but each time we approached it her mind went blank and she began to feel highly scrutinized and very aware of being looked at. So overwhelming was this feeling that she felt paralysed. Her head would go down and she simply could not speak, while her main impulse was to run from the room. Ideas rushed through her mind, few of which she could focus on. These are intense states of inhibition.

This difficulty in verbalizing feelings might, by some counsellors, be seen as a problem of very early schema of the self which formed before language (e.g. Young et al., 1993), thus making articulation of feeling difficult. However, it is equally possible that it results from high levels of internal inhibition (Gilbert, 1992, 1998c). Counsellors sometimes wonder whether it is helpful to speak or remain silent in these situations. In my view the counsellor has to use empathic awareness to decide if a client is gradually working out of the state of inhibition or whether they are lost in it. In the latter case, the counsellor may need to do the work, for sometimes these states are not easy to get out of and sitting waiting for the client to speak tends to push the silence into an unhelpful position. Equally, going too quickly after self-evaluations can miss contact with the internal experience and the client simply switches off.

With these kinds of problem the counsellor can separate the first from subsequent occasions. Sometimes one can be taken by surprise when the black hole appears. Here the counsellor walks a difficult line between helping the client out of the black hole, and yet not interfering in a potentially important self-helping or self-recovery process. The empathic response can be helpful when it first appears.

Jane had sat in her chair for a long time unable to respond to the counsellor, trying to cut him out.

Counsellor: This feels like a very painful state for you, Jane, especially with me sitting here looking at you. Maybe you are frightened of what I'm thinking.

Jane: [*makes a slight head movement and half shrug*]

Counsellor: [*softly*] Okay, Jane. Now I am going to talk to you a little. What I am thinking is that you are in a lot of pain right now. Perhaps

you have different emotions of anger, fear, loneliness, feeling cut off. I would like to help you out of that position. But maybe first it would be helpful if you had a better idea of what is going on in your mind and why. Would you allow me to try to explain some things about what we call shame and see if this helps?

Jane: [*nods*]

Counsellor: Like I said, we call this a deep shame experience. They can come for all kinds of reasons but often because people have put us down in the past, and we can become unable to accept or like ourselves. When this comes over us we can have all kinds of feelings. We may wish to run away, or feel anger at ourselves and others, even the counsellor for being here.

Knowledge of shame is sometimes helpful because the person can see that it is a symptom of pain and fear and not a specific abnormality about them; they are not stupid or weak, etc. After discussion of the shame experience, the client and counsellor may then discuss how they should work together if this state re-emerges in counselling. This is designed to help the client have more understanding and control in these situations. Thus some clients can indicate to the counsellor that they feel they are falling into the black hole and then the coping options worked out between them can be put into place. One client said 'It's been a great help knowing you understand my feelings and helping me understand what happens to me. I never realized what was happening. It just took me over.'

When severe shame feelings do arise, on later occasions, the counsellor might say something like 'Your feelings are trying to stop you from speaking. They are trying to protect you from ridicule and hurt perhaps. However, as we talked about before, you can say to these feelings "Thank you for your concern but I do not need your protection. I can gradually begin to explore these things now". If you think the black hole is getting too dark just stop for a moment, let's take stock and relax ourselves.'

In a sense this is a form of desensitization to the affects of deep shame via gradual exposure. Thus one is enabling a client to be less paralysed or overwhelmed by shame. Sooner or later, however, the client will need to talk about what it is they feel ashamed about. Fears may include previous sexual abuse, an abortion, homosexual feelings, aggressive feelings to children or to the counsellor, and so forth. If there is a good therapeutic relationship then usually the client has a wish to reveal and the counsellor can use this.

Counsellor: I might be wrong about this but I sense there is something that you would like to discuss but are frightened to. Now I don't want

to push you or anything, I just want you to know that this is how it seems to me.

Silence and other nonverbal signals to this statement usually suggest to the counsellor that he/she is on the right lines. Often the client will agree and then it is possible to explore further, but sometimes clients remain silent. The counsellor may then ask about fears of revealing, e.g. confidentiality or counsellor rejection. Just enabling the client to talk around the issue is helpful, but again this should not be undertaken without a good therapeutic relationship.

Counsellor: I sense that there is a great risk for you, but we don't have to explore it all in one go. Is there some aspect of it that you could discuss and share here?

If sexual abuse is suspected the counsellor might say:

Counsellor: You know, sometimes when we are young, people we trust do things to us that we sense is wrong or leaves us feeling ashamed. Maybe they interfere with us in some way. Has anything like that happened to you?

By careful and sensitive questioning that conveys an empathic awareness of the risks, the client can be helped to feel safe enough to reveal. Jehu (1988, 1989) has indicated how the cognitive approach can be used in cases of abuse. Family members in abuse cases may have used shame-invoking to inhibit the child from revealing to others, including telling the child that it was his/her fault or even denying that it happened at all. In one case the mother had not only denied the abuse, but had accused her daughter of being disgusting/terrible even to think that her father could have done such a thing. The experience of being disbelieved can be a powerful inhibitor of sharing feelings in counselling and is associated with feelings of shame and guilt in revealing, and also disgust at self.

Key issues 8.1 Shame

1 Shame is about seeing oneself as inferior, bad and rejectable in some way. Thus self-evaluation and negative self-experience are critical.
2 Shame motivates concealment and hiding.
3 Many of the emotions of shame happen involuntarily and are difficult to control. Thus, even if a person wishes to reveal, they might feel constrained from doing so (e.g. mind going blank, feeling paralysed and observed).

4 The counsellor can bring attention to the pain and fear of revealing (related to various beliefs and expectancies) and respond empathically to the patient's feeling state.
5 The counsellor starts a dialogue allowing the client to explore the shame experience but at the client's own pace. Sometimes clients will talk of having 'built up' to working on the shame problem.

Guilt

Guilt, like shame, is a powerful human emotion (Baumeister et al., 1994). It is often confused with shame, and clients may use the words shame and guilt interchangeably. But shame and guilt can be conceptualized as very different psychological processes. Unlike shame, the focus of guilt is on harm done to others and sometimes the self. Guilt tends to be focused on specific behaviours rather than global evaluations of the self as 'bad and flawed.' Anger at others is rare or non-existent and disgust has never been associated with guilt as it has for shame. Guilt can be associated with anxiety however, especially anxiety of doing harm. Importantly, guilt motivates desires to repair and atone for harm done rather than concealing, hiding, covering up and running away – as is the case for shame. There is also a difference in the power relationship. In shame, others are seen as more powerful and capable of rejecting the self. In guilt it is us who have used our power unwisely to hurt or let others down.

Guilt and shame can co-exist, as in the case when one's guilty behaviour might become known to another thus making one an object of rejection, scorn and put-down. Guilt usually involves ideas of 'I should not want this' (e.g. an affair, more food) or 'I should not have done this.' Guilt as a 'should not' attitude often relates to moral dilemmas. There are many types of guilt, two of which are:

1 Guilt about breaking one's own standards when these actions have little to do with other people (e.g. breaking a diet regime, spending money on oneself, having fantasies that break moral codes). Yalom (1980) talks of existential guilt – the guilt that comes from believing one has not supported oneself or has lived inauthentically.
2 Guilt about actions that affect other people which break down into acts of commission and acts of omission. Acts of commission are doing things that hurt another, e.g. having an affair with a married person, hitting children, etc. Acts of omission

are things that one feels one could have done to be helpful, but did not do. Not caring enough is a common guilt scenario.

Strong guilt feelings often act as entrapments. For example, the person who stays in a marriage out of guilt may feel trapped in it yet also resentful and hopeless. At the same time they may feel needed which gives them some sense of self-esteem and power. Dickson (1982) calls this the compassion trap, for individuals who have assertiveness problems associated with guilt, Dickson's book can be recommended reading on many counts.

Lynn O'Connor in San Francisco has also pointed out that people can feel guilt because they are better off than others. For example, survivors may feel guilty because they survived but others died or were hurt. Imagine you and a friend enter a beauty contest and you are both really keen. You win and your friend comes last! Your feelings of disappointment for your friend could lead to guilt. Sometimes people may even inhibit themselves so as not to hurt others, e.g. knowing that your friend will feel badly if you win, you don't enter. And guilt inducing (e.g. a parent constantly claiming how hurt they have been by a child's action) can lead to hyper-sensitivity to other's feelings to the point where one is not able to acknowledge or be assertive about one's own needs. People who always *have to* put the needs of others first are often susceptible to strong guilt feelings or fears that others won't like them if they do put their own needs first.

Working with guilt

Doris' father came to live with her when her mother died. At first Doris was pleased to be able to help, but weeks turned to months and there was no sign that her father was making plans to get his own place. Also, he gave her little money to cover his living expenses and she felt that she could not ask him for more because it was his 'pension'. Doris tried to make hints that her father should move but he turned things around by saying 'When you were in need we looked after you. I don't think I can cope on my own at the moment. Of course, if ever I thought you didn't want me any more then I would go.' Trying to induce guilt in others so that they will care for one in the way one wants is a common interpersonal tactic (Baumesiter et al., 1994). Perhaps, the father's own guilt feelings were turned into attacks or claims of helplessness. In any event Doris felt helpless to confront her father because she felt terribly guilty at 'pushing him out'.

In working with guilt, the counsellor explores self-blame and issues of rights in a relationship while acknowledging the

dilemmas. As Dickson (1982) points out, relating out of guilt can reduce the possible pleasures in the relationship. In mothers with young children, too much caring guilt can inhibit the pleasure of children, especially if these are associated with high standards in an effort to hold the title 'good mother'. Open discussion around these issues and efforts to share experiences with other mothers can be helpful in reducing guilt but from a cognitive and shame point of view it is the self-labelling that is an important source of focus.

Guilt (and shame) links in with cultural values. For example, for obvious financial reasons the governments of the past twenty years have encouraged people to care for their elderly parents. The fact that people now live much longer than they did a few hundred years ago (thanks to modern medicine) is not acknowledged. Some feel guilty at not wishing to carry this burden. Thus, cultures vary in terms of their guilt- and shame-inducing tactics (Murphy, 1978). Feminists have suggested that women have been so indoctrinated in the caring–loving role that guilt is a common problem.

Guilt, shame, entrapment and escape

Guilt and shame can often give rise to a sense of entrapment and desire to escape (see Chapter 2). In serious depression, for example, people may feel they are being a burden to others and the best way out is to kill themselves. When Tim lost his job he became depressed and felt he was letting his family down. He spent days just lying in bed or staring at the television. He became convinced that although his family would be sad for a while if he died, they would get over it and be much better off without him. The pain of his depression and guilt for being 'a let down' and a burden to them fuelled his suicidal escape feelings. Luckily his guilt over leaving his children also acted to stop him.

Guilt and shame can have more subtle effects on escape behaviour. Betty had grown up in a family where she had felt responsible for other's bad feelings. She married a man whom she felt was a 'good man' but someone for whom she felt not really good enough. If there were conflicts in the relationship she often had the thought that it was down to her and maybe he'd be better off without her. When there were financial problems she felt that because she could not get a job she was partly to blame. The problem is, of course, that no-one likes living in a situation where they often feel bad, shamed and/or guilty. In therapy she felt the only way she could stop feeling bad about herself was to live alone – free of responsibilities. These thoughts further compounded her guilt and sadness/emptiness. As she became more

depressed she emotionally withdrew from the relationship, which again led to feeling more guilty and fuelling escape wishes. So guilt is a double edged sword. It can keep us in relationships (guilty about leaving) but it can also motivate strong desires to escape because the relationship(s) often seems to activate strong feelings of not being good enough or being a burden in some way.

As noted in Chapter 2, when people have bad feelings about the self (e.g. guilt and shame) this will often activate desires to escape or avoid them. Basically, this is simply because we want to get away from aversive feelings and situations. So when working with shame and guilt it is often useful to explore escape behaviour (and possible guilt/shame about wanting to escape). In these situations it can be useful to indicate that escaping from that which is painful is only natural, i.e. de-shame escape wishes, and show that desires to escape are understandable. One can then work towards learning to cope with guilt and shame as 'normal' emotions of everyday life.

Affect toleration

Although counsellors will attempt to minimize the pain of these affects (shame and guilt) and challenge dysfunctional beliefs (negative self-attacking thoughts) that might be 'driving them', it is also the case that at times we simply have to learn to tolerate them. It is not possible to live a shame or guilt free life. These are part of normal human experience. Just as people with anxiety disorders may have to learn how to *tolerate anxiety* without taking immediate flight or catastrophizing, the same can be true of guilt and shame (or indeed any negative emotion). For Doris, for example, challenging her father did induce guilt feelings but she had to learn not to be overly inhibited by such feelings. We often have to do things that we feel bad about but know we need to do them anyway. For example, having to discipline a colleague at work is rarely easy. So we sometimes have to challenge the idea then that 'I should never feel shame or guilt'. Indeed, in small measure the ability to tolerate shame and guilt is helpful and those who cannot can be either very socially anxious, inhibited or even aggressive. Assertiveness (see Chapter 7) is especially vulnerable to being undermined by feelings of guilt and shame.

Betty had a lot of work to do on her attributional style for people's bad feelings and learn that things can't always go smoothly in relationships. She discovered how much she herself wanted to be loved by being seen as good. Part of her difficulties arose from disappointment at not being able to match these high ideals of: 'I need to be a person who others need and to whom I

always help and rescue. That makes me feel good and worthy. If I can't do that then I am not good enough and feel guilty.' Her first inclination, when problems arose that she would not be able to help others with, (especially her husband), was to think of escaping. She would also feel resentful that she was feeling guilty again (with thoughts like, 'Why do I have to feel so guilty again? This relationship is not working'). She would then feel guilty at feeling resentful.

In fact, shame and guilt are key areas where we are likely to find complex chains of thoughts and feelings that feed off each other. For example, one feels guilty when one wants to feel good and valued. One is then resentful of feeling guilty but ashamed of feeling resentful, then more depressed and ashamed at feeling depressed, etc. In such situations it is useful to draw out some of these interactions in circles and illuminate the interacting patterns. Each one is often fuelled by negative self-evaluations of one form or another.

Forgiveness

Perhaps one of the things that allow us to tolerate shame and guilt is some kind of inner forgiveness. We do not catastrophize the experience and can reconcile ourselves to the events that have caused it. Self-forgiveness is an important quality of inner caring and compassion. When people find forgiveness difficult they often use the concept of 'don't deserve.' There has been growing attention to the importance of a forgiveness triad (Enright, 1996). The triad involves being able to forgive others rather than ruminate on vengeful and often impotent rage; being able to be helped by receiving the forgiveness of others (e.g. not disqualifying it); and self-forgiveness (see also Freedman and Enright, 1996; McCullough et al., 1997 in regard to forgiving others). In rational emotive therapy forgiveness is part of self-acceptance. As Ellis has made clear many times, self-acceptance is not the same as self-love or self-approval – acceptance means the ability to tolerate negative emotions and events without launching harsh self-attacks.

Key issues 8.2 Guilt and forgiveness

1 Guilt in depression is often about trying to avoid harming.
2 What type of guilt does the person suffer:
   (a) about the self;
   (b) about acts of commission or omission?
3 Look for the 'shoulds', 'should nots', and the 'musts' in beliefs and attitudes.

4 Guilt can be a trap and lead to resentment, e.g. the compassion trap.
5 Explore cultural or social values that are maintaining guilt and discuss these with the client.
6 Explore the capacity to 'tolerate guilt' and use self-forgiveness and self-acceptance.

Ideals

Ideals are often powerful in depression, and often unrealistic (Moretti et al., 1990). Humans are future orientated. They plan with hopes, expectations and ideals related to positive outcomes. Our ideals involve a kind of matching to some internal standard, fantasy or template and can be the source of our 'shoulds', 'oughts' and 'musts'. They provide the source of information for how we would like things to be. They are the focus of various dysfunctional attitudes. We can have various types of ideals:

1 Ideals about how others should be, that is, our friends, lovers, spouse (e.g. understanding, fun, loving, accepting).
2 Ideals about how we should be (e.g. able, strong, anxiety free, competent, respected).
3 Ideals about how we should experience the world (e.g. fun, open, helpful).

Bibring (1953) based his early ego analytic theory of depression on the notion of ideals. Bibring suggested three types of ideals and aspirations which the (pre)depressive may seek:

1 The wish to be worthy and loved, and to avoid inferiority and unworthiness.
2 The wish to be strong, superior, secure, and to avoid being weak and insecure.
3 The wish to be loving and good and not aggressive, hateful or destructive.

In the last case, Bibring suggests that the awareness of internal aggressive impulses deals a blow to self-esteem. Bibring suggests that 'depression can be defined as the emotional correlate of a partial or complete collapse of the self-esteem of the ego, since it feels unable to live up to its aspirations . . . while they are strongly maintained' (Bibring, 1953: 25–6).

Becker (1979) points out that vulnerability to depression according to this model has a number of causes. These include:

'constitutional intolerance of persistent frustration, severe and prolonged helplessness, and developmental deficiencies in skill acquisition. These deficiencies are enhanced by the ego ideals which tend to be high and rigidly adhered to by depressives' (Becker, 1979: 324). Abramson et al. (1989) developed a theory of what they call *hopelessness depression* derived from the perceived failure to be able to reach goals, standards or ideals.

The problem with strong ideals is that they activate our old friend disappointment when outcomes or events fall too far below the ideal. Some try to defend against this with mottoes such as, 'Don't expect too much and you won't be disappointed.' The empathic response to failed ideals and hopes tunes into the experience of disappointment. However, as noted a number of times disappointment in itself need not be a problem if it does not activate self- or other-attacking, but for some this is exactly what happens.

Working with ideals

Ken was in his forties when I first saw him. He had been known to the psychiatric services for thirty years. When he was eight his parents moved to another part of the country. Although he felt he had been popular in his old school, things turned out differently in his new junior school. His accent marked him as different and he had trouble understanding the teachers. His elder brother (by five years), on the other hand, did well in his new senior school, quickly became integrated, went on school trips and played various sports for the school teams. Their adaptation could not have been more different. Ken developed panic attacks and had much time away from school and was eventually sent to a school for children with emotional difficulties. Here also he felt he did not fit in. A strong theme in his life was that of the outsider.

Ken had developed a strong fantasy that if someone could 'cure' his anxiety then he would be able to be like others, especially more like his brother who was successful both socially and in business. He idealized the medical profession but also had great rage at the way he thought he had been treated by them. When he was referred, he was having panic attacks at home and spending days in bed, and saying he would kill himself, it was all pointless. ECT was considered.

At first the counsellor listened to the story for Ken was too angry to start exploring his own attitudes and felt that no one had understood him. The panics were fairly classic and focused on fears of being unable to breathe and dying. These responded to basic cognitive behaviourial intervention of breathing control,

hyperventilation, gradual exposure and re-education (Clarke, 1999). He did so well in counselling that he bought a new car and went on a trip to the continent. But when he came back he went to bed, got depressed and became very angry.

The problem was formulated as a problem of unrealistic ideals. Ken had the fantasy that if his anxiety was cured he would become 'turbo charged' and would make up for many lost years. For many years he had developed a fantasy of what it would be like to be anxiety free and not an outsider. In this fantasy he would be like others, able to travel, able to be successful, and in his words 'rejoin the human race at last'. He imagined that normal people never suffered from anxiety. Also he had a hope that there would be some magic answer that would take the anxiety away, and that 'Once good it should stay good.' At this session he explained his trip. He had suffered anxiety on the trip over but had kept this under control.

We drew out two boxes that captured this situation. Ideal me=me without anxiety. Actual me=how I am now.

Ideal me	*Actual me*
Like others.	Not like others/different.
Able to enjoy life.	Life is miserable.
Confident/successful.	A failure.
Explorative.	Frightened.

I refer to the difference between these two as the 'disappointment gap' (Gilbert, 2000). When depression prone people suffer severe disappointment their anger is often directed at themselves (self-criticism for failing), or at others (e.g. for letting them down). They can become so disheartened they give up. Let's look at how Ken dealt with his trip.

Counsellor: As we have been talking it seems like you did quite a lot on your trip, but you feel disappointed with it. What happened when you got back?

Ken: I started to look back on it and thought, 'Why does it have to be so hard for me, always fighting this anxiety'? I should have enjoyed it more after all the effort I put into it. I should have done more. It's been a struggle. So I just went to bed and brooded on how bad it all was and what's the point.

Counsellor: From what we have discussed before it sounds like your experience did not match your ideal.

Ken: Oh yeah, it was far from that.

Counsellor: Okay, what went through your mind when you found that the trip was not matching your ideal.

Ken: I started to think I should be enjoying this more. If I were really better I would enjoy it more. If I felt better I would do more. I'll never get on top of this. It's all too late and too much effort.
Counsellor: That sounds like it was very disappointing to you.
Ken: Oh yes, very, terribly, but more so when I got back.
Counsellor: What did you say about you?
Ken: I've failed again. I just felt totally useless. After all the work we've done nothing has changed.
Counsellor: Let's go back to our two boxes for a moment and see if I have understood this. For many years you've had the fantasy of how things would be if you were better [*points to ideal box*]. But getting there is a struggle and this is disappointing to you. When you get disappointed you start to attack yourself saying that you are a failure and it's too late. That makes the actual you seem unchanged. Is that right?
Ken: Yes, absolutely.
Counsellor: Can we see how the disappointment of not reaching the ideal starts up this internal attack on yourself, and the more of a failure you feel the more anxious and depressed you get?
Ken: Hmm, yes.

In Ken's case we were able to work with the link joining the ideal, the disappointment and the self-attack. Later in the session we were able to explore the successes that had taken place on the trip and explore how Ken would disqualify the positive if it did not match up to an ideal. He saw it as 'destroying and ripping up the good things that happened to him.'

There were other issues such as the new self-schema of being able to travel and no longer being a victim to anxiety. His new sense of self was 'strange' to him and he worried that if he became well others would not be so interested in helping him. However, slowly Ken began to modify his ideal and gradually mourn lost opportunities. But this took a long time and counselling lasted well over a year.

So, 'shoulds' often point to ideals. The self-attacks come from the disappointment and this makes the person feel further away from the ideal. Unfortunately, these attacks, consequent to disappointment, and the failure of others to fulfil various needs for the client, can fuel aggression also. In one case a young man had very unrealistic fantasies of how a loving relationship would be (and was highly egocentric). When his lovers did not live up to his ideal image, he expressed his disappointment in violence. He had a lot of difficulty in giving up the ideal ('they should be . . .' thoughts) as his needs for constant attention were great.

Thus, counselling explores the 'shoulds', 'oughts' and 'musts' implicit in high ideals. It is helpful to be aware of the experience of disappointment that is consequent upon failing to reach high

ideals. Type A personalities (those rather competitive and time-urgent folk) can also have difficulty in changing their standards because this may mean that they will not be able to get to their ideal of being more special or superior to others (Gilbert, 1989). In these cases the advantages–disadvantages of changing ideals can be helpful. Thus in counselling a certain working through of disappointment is often necessary.

Key issues 8.3 Ideals

1 Ideals represent our hopes and aspirations of how we would like things to be. These can be drawn out by the counsellor with questions: 'how would you like it to be, how would you like yourself to be . . .?'
2 Depressed clients can have unrealistic ideals and feel a strong sense of disappointment when ideals are not achieved.
3 In cognitive approaches ideals may lead to depression if a person says to themself, 'I must have my ideal or I am bad and weak. If I cannot reach/have my ideal it is pointless'.
4 At times, depressed patients are so disappointed by failing to reach their ideals that they destroy the positive and engage in black and white thinking.
5 Helping clients recognize the thoughts and feelings that are triggered by the disappointment is a key to working with ideals.

Envy

Envy is different to jealousy and arises from feeling that others are better off than oneself (Parrott and Smith, 1993). Envy, like shame, arises out of self-other comparisons, and where the person feels they are in some sense inferior. Parrot and Smith (1993) found that envy involves: feeling inferior to the envied, longing, and resentment, but also disapproval of the emotion. Indeed, acknowledging envy can be shameful – so clients may not acknowledge this openly in therapy. In competitive cultures which stress individualism, envy is unfortunately rife (Gilbert, 1989, 1992). Smith et al. (1994) found that the hostile feelings of envy tend to relate to a sense of injustice – that the envied person has an *unfair* advantage. The depressive elements are related to the fact that those who have more of something or are superior in some way show up one's own inferiority – it is the negative social comparison and self-evaluations of envy that seem to be depressing (Gilbert, 1992). There are various forms of envy. As noted above, depressed people can also be ashamed of or fear their envy.

FEAR OF ONE'S OWN ENVY Anne's depression was related, she thought, to the menopause. She was angry that 'her hormones' were giving her such a hard time. She also had thoughts of wanting to bring other people down because she felt people didn't understand how bad she felt – and was fed with being given advice by friends of how 'they had coped with the menopause'. 'If only I can make them feel like I do, that would wipe the smile off their faces' she'd say. There were also various aggressive fantasies. But then she'd add 'Oh but I shouldn't think like that should I. I feel terrible about it.' So these feelings made her feel more isolated and she took them as evidence of a bad, unlovable self (i.e. a source of shame).

Anne: Until I got this depression, I never realized I could feel so vengeful. I see my friends having fun and I think I used to be like that. Why me? Why not them? I actually hate them for being happy. It's terrible. Perhaps I deserve this because inside I'm so nasty.
Counsellor: So you have two issues. One is your vengeful feelings, and the other is that you see this as evidence of you being nasty?
Anne: Yes. I hate to feel this burning resentment when I am with others.
Counsellor: So your resentment makes you feel different, not like others?
Anne: Oh yes, and so does my depression. I used to be like them. I rarely had time for depressed people. I know what they must be thinking about me now. But, of course, I try to hide it.

At this point Anne talked at length about the loss of her old self, and her anger at what had 'happened to her'. As we moved back to envy again, the counsellor tried to focus on the experience of envy, negative self-beliefs and loss of the 'happy self'.

Counsellor: Okay, let's think about envy for a moment. Suppose you could allow yourself to feel envy without saying this means you are nasty?
Anne: But it is nasty, Paul. It's so destructive. I don't want to feel this. I want to be well again.
Counsellor: Yes, that is our goal, but on the way we are trying to explore your negative ideas about yourself which right now focus on envy.
Anne: Hmm, I don't want to feel envy.
Counsellor: Well, let's draw it out.

The counsellor then draws a circle with the links: feel envy at being depressed, this means I'm nasty, feel worse about myself leading to more depression and more envious feelings.

Counsellor: You see, if we could work on the 'this means I'm nasty' that may help you feel less negative about yourself. It is a rather global

judgement which gives you the feeling of a lost good self that you had previously.

Anne: If I'm not nasty then what am I?

Counsellor: Well, let's think about alternatives? In general, why are people envious – oh, apart from being nasty [*client smiles*]?

Anne: [*thinks*] Hmm, I guess they feel one down or in need like we said before.

Counsellor: Does that seem reasonable, that people can feel envy when inside they feel needing of something?

Anne: Yes, I think so.

Counsellor: So supposing we applied those judgements to you and said your envious feelings reflect a need to be well and like others again, rather than as evidence of a nasty self?

Anne: I'd have to think about this.

Counsellor: Fine, [*smiles*] let's think about it.

The counsellor then worked with changing the self-judgement such that she began to reconsider envy in terms of feelings of need and being different from others and not as evidence of a nasty person. Envy became an unpleasant affect that was understandable rather than an internal experience that made her feel bad about herself. Gradually, as Anne began to accept her envy and other destructive feelings without attacking herself, she was able to talk more to her friends about her depression and gradually recovered. Later, she also revealed that my approach to her envy and my refusal to see it as evidence of her nastiness had helped her accept it and work it through.

ENVY OF THE COUNSELLOR Sometimes clients will feel intense envy of the therapist and have various ideas that the counsellor has a relatively easy and pain-free life – and compared to our clients there may be some truth to this. It is important that counsellors don't get defensive about this or try to show the client that 'hey my life is not so hot for me you know'. Rather it is useful to bring these feelings into the therapy and avoid shaming them – but at the same time to explore how they can be destructive of collaborative work. For example, Dean was struggling to do various bits of homework and I was trying to take him through it a step at a time. Our conversation went something like this.

Dean: Look, it's easy for you – you understand these things, you got degrees and all. But I don't. My life is tough – not like yours.

Counsellor: Hmm. Sounds like you feel disappointed you can't do it as you'd like and resentful that things seem tougher for you than for others. And it's easy for me.

Dean: Oh sure. I never get the breaks. It always seems so much easier for others. Like when I was at school. If only I had been brighter and not seen as a dumbo.

By depersonalizing the attack to a more general feeling of envy (resentment) we were able to explore this long-lived feeling of being less able than others (which we had met before in our work together). By empathizing with the disappointment I was then able to gradually work around to exploring the envy. I also tried to show I could cope with his envious attacks and not shame him for them.

Counsellor: I wonder how much your thoughts that 'it is easier for me' stops you from really taking from here things that might be useful to you?
Dean: Maybe.
Counsellor: Okay maybe its true it is easier for me – so what would you need from me to make things easier for you? I mean how could you use me more to your advantage?
Dean: [*Looks surprised*] I don't know. [*Pauses*] I guess I'd never thought of me being able to use you.
Counsellor: Sounds to me you have a choice. Either you can stay feeling envious and resentful, that I seem able to understand these things and you don't, or you can say 'I am going to make that therapist show me too'.

Noting a change in Dean's mood, I smiled and added 'you could say hey I am going to make that therapist really work for his money!' At this Dean gave a short smile. We had these sorts of conversations a number of times but I tried not to be defensive to his attacks but focus Dean on how he could use what was on offer, work collaboratively and tried to empower him in the therapy. It was a difficult therapy and Dean remained somewhat envious and distrustful of those in authority but he did become less depressed and able to focus on what he could do rather than what he couldn't. He also became more aware of his own shame (feeling inwardly a dumbo) and did a lot of work on healing that. By the end of therapy he was more affiliative, relaxed and able to acknowledge that 'on the whole the therapy had been a helpful experience' for him – and he was genuinely sad to leave it. I offer this snippet of a case of envy to alert counsellors to it. However, working with very envious people can be hard work and you'll need good supervision (see Horner, 1989 for a further discussion of envy in therapy).

FEAR OF IGNITING OTHER PEOPLE'S ENVIOUS ATTACKS In Ken's case, discussed above, some years before starting counselling he bought a new car but sold it three months later. When asked why, he said that while driving around he had the idea that others were looking at him thinking 'Where the hell did he get the money

from to buy that? Who does he think he is?' Thus, Ken had an acute sense of external persecution. His family history revealed much envy as part of the family dynamics.

Counsellor: Even if it is true that others would be envious of you, why would that mean you had to sell the car?
Ken: I wouldn't want them to think like that. They would try to put me down.
Counsellor: But suppose we said, look envy is part of life and we have to learn to cope with it rather than hide from that. What would you say?
Ken: Hmm, I am not sure about that.
Counsellor: Okay, let's look at the advantages and disadvantages of accepting other people's envy.

This revealed many advantages: 'I would be free to have what I want (cars, clothes, etc.). I would feel more in control of my life, not having to look over my shoulder. I would feel better and more hopeful.' However, the disadvantages were many: 'Others would think I was above my station. They might try to hurt or pull me down. They will think I'm okay and don't need help. They wouldn't want to help if I needed it. They might take pleasure in seeing me fall. I might become even more of an outsider.'

Counsellor: It sounds like you actually have a certain terror of success and changing.
Ken: Written down like that I see it. I do get very anxious about what others think if good things happen to me.
Counsellor: Yeah, but it's more than that, it's a belief that others will pull you down, won't help you and that you would not be able to cope with that.

Exploration of his history had revealed a father figure who had rarely praised Ken, in part because he was never as good as his brother and in part because, while the brother was seen as advancing the family and giving it pride, the father had not taken that view of Ken. Thus, when Ken had bought this new car and proudly shown it to his father, his father had simply commented that he could not see the point of Ken having a car like that in his situation. Also, the father had seemed mildly angry that this son, who had been anxious and depressed all these years, should have a new car.

Much discussion was given over to these aspects with the counsellor acting in an encouraging way (or in self-psychology terms, Wolf, 1988, a mirroring self-object). Thus, one homework for Ken was to begin to look at new cars and eventually buy one, which he did. Also he discussed openly with friends about his feelings and many of them said 'Good luck mate, if you can

afford it.' One of his friends said 'There's no pockets in shrouds' and this motto stuck. Thus, he sought out other sources of evidence. In some ways the fear of other people's envy can be seen as a form of need for approval. However, in envy it is not only disapproval that is feared but actual attacks, subsequent refusals of help and becoming isolated. In Ken's case there was a clear conflict between being seen as injured and needy and being successful and contented.

Key issues 8.4 Envy

1 Envy relates to powerful feelings and beliefs about being different from others and less than others in some way.
2 Envious feelings themselves often increase the sense of difference and of being an outsider.
3 The counsellor helps the client accept his/her envy, and recognize that it is often related to some feelings and beliefs about need rather than evidence of a bad or nasty self.
4 In some depressions, experiences of envy can be destructive of counselling if they are not acknowledged. At times, a client might feel envious of the counsellor (or counsellor's life style) and has difficulty working in an alliance.

Concluding comments

This and the previous chapter explored various self-evaluations which focus on how a client sees him/herself in relation to others. In that sense they are *cognitive interpersonal dimensions* – which has been the central approach of this book. Shame, guilt, unrealistic ideals, unfavourable social comparisons and envy are all powerful emotions and cognitions which can be very disruptive to all kinds of relationship including counselling. Behind many of these negative emotions and cognitions, that are liable to make depression worse, are self-attacks, avoidance, blocking and resistance. As we have seen though, self-attacking can take various forms (e.g. as in shame and guilt), ranging from self-attacking one's behaviour, specific traits (e.g. feelings or bodily appearance), through to attacking and disliking the whole sense of self.

However, counsellors can learn to spot these various emotions and typical self-devaluations and disappointments in the self. They can also spot the problems they are likely to cause in interpersonal relationships. As the cognitive model makes clear the meaning we give to events, especially interpersonal relationships, affect not only the things that are likely to trigger our emotions

but affects how we behave within these relationships. And as outlined in Chapter 2, this can set up self-defeating negative spirals of behaving, feeling and thinking.

When working with the interpersonal themes above remember that they can impinge on the therapy relationship. As in all such work, acting non-defensively and ensuring that you do not go beyond the limits of your expertise and experience is important. Counsellors can learn how to avoid activating resistance by not themselves behaving in a shaming, critical, defensive and patronizing manner. You can rarely predict in advance what kind of issues you will illuminate as you begin your work so it is important that you are able to recognize these kinds of issues. And if you find you are struggling with your work do seek advice and supervision and be prepared to pass clients to more experienced colleagues. There is no shame in this and I have done it many times.

9

Overview, Termination and Personal Reflections on Depression

Overview of interventions

When people come for counselling for depression they usually have a complex mixture of different problems. These problems are related to external difficulties and also internal styles of thinking and coping. We explored how to work with many of these aspects in this book. Figure 9.1 offers a brief overview which offers a conceptual map for assessment and intervention.

We need to keep in mind that depression can affect us biologically as much as psychologically and that these aspects constantly interact. For example, we know now that positive and negative signals can have a significant impact on various systems in the brain and in particular stress systems and systems that control mood, such as 5-HT (serotonin). These systems are affected by negative and positive signals in different ways. In very general terms negative signals such as losses and threats tend to increase stress and can adversely affect 5-HT, whereas positive signals (approval, love) tend to reduce stress and increase 5-HT. There are of course many complications to such general rules but a useful rule of thumb in working with depression is to try to *reduce the negative and increase the positive*.

Counselling is not an alternative to anti-depressant medications and in some cases drugs will be an important component of successful treatment. This is especially so when depressed people are exhausted by their depression, are sleep disturbed and anhedonic. For mild depressed states exercise can also be useful for reducing stress and boosting 5-HT, although this should only be suggested having discussed this with the client's GP. Recently there has also been interest in the herb St. John's Wort. The point is that we should not neglect the biological aspects of depression, but work closely with the client's doctor to plan good quality care and interventions to hit the depression from many angles – to

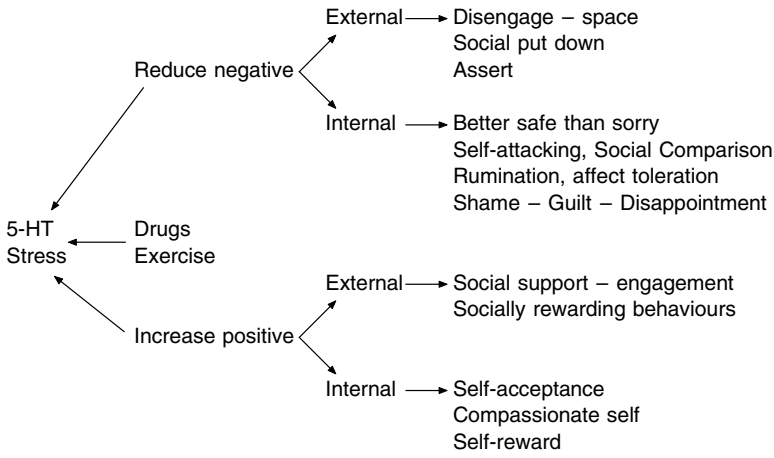


Figure 9.1 *Biopsychosocial interventions strategies*

reduce stress and boost mood. Having said this we can now review our thoughts on the psychological domains of depression.

Reducing the negative

External negative events

Depressed patients will often have a number of different external issues which increase the flow of negative signals to them. We have discussed a number of these in the previous chapters.

DISENGAGE – SPACE A key domain is the degree to which individuals feel trapped and have a strong wish to escape (Chapter 2). Some patients can feel very overwhelmed by responsibilities and demands, others can be subject to high levels of abuse and some individuals are simply unable to get enough help to allow them some respite (Gilbert, in press a). At times counselling will focus on helping people to disengage or at least space themselves sufficiently to give themselves opportunities for respite. This can often involve providing an opportunity to explore various dilemmas about taking 'time out'. There is also increasing concern that our western life styles are simply exhausting with our hectic and competitive work places and role strains. The key issue here is to explore issues of how they might like to reduce negative signals in their environment by the use of 'space'.

SOCIAL PUT-DOWN There is good evidence now that one predictor of onset and relapse is spouse criticism. It is important therefore to

explore the degree to which people are subject to criticism, put down, shame and guilt. And of course explore various forms of physical intimidation and abuse, although note that people may feel ashamed to admit this in the first instance. Not only does shaming and intimidation take place in families but increasingly we are aware that this can take place in work. People can feel trapped in not being able to give up their jobs because they need the money. Sometimes people stay in unrewarding or abusive situations/relationships out of guilt of leaving or negative beliefs that this is the best they can achieve. So it is important to explore the kinds of negative signal and situations people are subjected to and what stops them from moving on or away from them.

ASSERTIVENESS AND CONTROL Although spacing, escaping, respite and resting can be important it is also often the case that people may need to learn how to exert more control over negative signals and situations. Sometimes people can learn how to be assertive. This may be one of the most important interventions for depressed people. Assertiveness can be useful to help people deal with conflicts in their relationships or at work. As noted in this book it is useful to not only teach assertiveness skills but also explore the beliefs that stop people from acting assertively and then feeling victim to others' demands. These beliefs may include fears of being disliked or abandoned, shame, guilt or fears of others becoming more aggressive.

When people are depressed they may engage in unhelpful forms of avoidance. This may be the case for those who are very socially anxious. In these cases it is useful to work with their social anxiety. So at times one might help people *reduce* escape and avoidance behaviours.

Learning to exert more control over negative life events and situations may also be aided by problem solving approaches where people learn to break problems down rather then feeling overwhelmed. So the key message is that while at times people may need to explore how to space themselves from negative situations (e.g. abusive or exploitative others) at other times they can learn how to engage negative situations and cope better with them.

Internal negative signals

I discussed earlier that internal signals can operate on the brain, like external signals. Recall that we discussed how images of sex can activate various sex hormones in the body preparing oneself for sexual behaviour (Chapter 3). Negative thinking about oneself or one's future can therefore be detrimental to recovering

from stress or boosting mood. In the spirit of reducing the negative and boosting the positive, counsellors will therefore be attentive to, and intervene in, internal negative thinking.

BETTER SAFE THAN SORRY When people become depressed they will become more attentive to and affected by negative events and situations. It is useful to talk to patients about how cognitive distortions spring up so easily. Basically, under stress the brain is designed to look out for the negatives/threats. Also, under stress we need to react quickly rather than logically – which would take time. Fast versus slow–logical ways of thinking and analysing situations are probably controlled by different brain areas (Gilbert, 1998b). So cognitive distortions can arise from both early schema but also because of the brain's natural tendency to assume the worse in stressful situations. Of course, all this is rule of thumb and there are many exceptions but I think it helps depressed people avoid assuming they are 'stupid' to be irrational. It emphasizes the importance of taking account of the way the brain functions and it highlights the importance of practice. From here it is possible to clarify a key goal as being to reduce negative thinking – especially self-attacking.

NEGATIVE THINKING AND SOCIAL COMPARISON Self-attacking (e.g. telling oneself one is 'not good enough', useless, worthless or a failure) can have very serious effects on people's mood and physiology. This then can be an important aspect to target (see Chapter 5). Individuals who self-attack are going to be subject to major mood variations. Throughout this book we have spoken a lot about how to explore and work with self-attacking (and internal shaming). Social comparison is also a key cognition to target.

RUMINATION We know that when people become depressed they tend to ruminate about their difficulties. They find their mind wandering back over the negatives. This has an impact on mood and also stress. The more people ruminate on their sense of failure or inadequacy the more negative signals they are delivering to their emotional and stress systems, the worse they will feel and the more they will ruminate. Helping patients to reduce rumination or at least control it by techniques such as becoming more aware of rumination via monitoring thoughts and feelings, distraction, challenging and so forth is important.

AFFECT TOLERATION Sometimes people become depressed because they are not able to tolerate negative affects and try to avoid them.

This can be true for shame, social anxiety and guilt. Helping people learn to work through their negative emotions and tolerate them can be very important.

SHAME, GUILT AND DISAPPOINTMENT We have seen in Chapters 7 and 8 the way in which cognitions related to shame, guilt and disappointment can often have with them negative self-attacking aspects. It is useful therefore to explore issues of shame. However, remember that shame issues are often not easily revealed and this may take some development in your therapeutic relationship before you can work in this area. Coping with disappointment can be important to learn. A motto I use is that 'the secret of success is the ability to fail' (Gilbert, 2000).

Increasing the positive

Not only is it important to reduce the negative but also to increase the positive. Many depressed patients have lost the ability to create positivity both either externally (elicit supportive relationships) or internally (i.e. self-accepting).

External positive events

For some depressed people it is really important to look at the external environment and to engage in social support endeavours. Some depressed people are very socially isolated and linking them in with support, self-help groups and other support agencies can be paramount. It is also important to explore with people how they can increase the amount of socially rewarding behaviour (see Milne, 1999). This can be done by planning positive activities, as we saw in Chapter 4. It is important not to underestimate the role of positive enjoyable environmental inputs for some depressed patients.

Internal positive signals

As indicated throughout this book, treating depression is not only about reducing negativity or negative thinking, it is also about increasing compassionate and warm thinking. When people have self-critical thoughts, these thoughts are often delivered in an angry, aggressive, powerful and hostile way. Therefore, it is important to find ways in which to combat that aggressivity and degree of anger with self.

INNER WARMTH I have written elsewhere about the importance of compassionate self-approaches (Gilbert 2000; Gilbert, in press b). The idea here is that the client learns to challenge the negative thoughts but practising a warm voice; to challenge negative

thoughts in a warm way. This is not self-love; there may be many things one won't like about oneself but it is about self-acceptance. It is also about trying to help clients deliver internal signals that are potentially biologically powerful (see Chapter 5).

SELF-REWARD Depressed patients have often had a history where their negative behaviours have been punished and their positive behaviours have been ignored. It is therefore important to begin to institute self-rewarding strategies for depressed patients. This involves teaching them how to take pleasure in their small achievements of every day life, to focus on what they have done and can do rather than on what they can't. The practice of self-reward can be anything from giving themselves mild praise or a smile to an actual reward, such as buying themselves a small present, an item of clothing or whatever is rewarding.

Summary

This rough guide is designed to help you think through both your assessment and also your intervention strategies by conceptualizing depression as a need to increase the positive and reduce the negative at both internal and external levels. As you can see there are a number of different aspects one may need to keep in mind. For example, if you only work at the internal level for somebody who is clearly in a very abusive relationship, the abusiveness of that relationship may in the end undermine your efforts. What I am suggesting here is a biopsychosocial intervention approach where counsellors become aware of people's needs in terms of 'in mind, body and social world'. Counsellors should also be aware that patients who are very exhausted and are not sleeping should be referred to their GP for possible medication. Very exhausted patients have a lot of difficulty in being able to internalize therapy.

Termination

Termination of counselling with the depressed client follows some general principles (Ward, 1989). These general points can be relevant not only to the ending phase but throughout counselling.

NORMAL SADNESS In any relationship where there has been emotional sharing, support and encouragement, there can be sadness and reluctance at saying goodbye. The counsellor may be the first person with whom the client has shared certain aspects of their life, and their deeper thoughts.

REACTIVATING SCHEMATA An approaching termination can be a time when the client may re-experience fears of abandonment or coping alone. These can be addressed, not in order to prolong counselling, but to give new opportunities to work with the affects and beliefs of leaving and separating.

TERMINATION AS A PROCESS Preparing to leave is a process not a sudden cessation of counselling and therefore needs to be discussed before it actually occurs. Ending is a stage in a process and is planned for (Egan, 1998). The client's thoughts and feelings about 'life beyond counselling' are explored. In some short-term therapies, termination is an issue discussed right from the start as the counsellor negotiates the number of sessions.

FOLLOW-UP With many depressed clients it may be appropriate gradually to space the counselling sessions; for example, moving from (say) weekly to fortnightly to monthly and then to a six month follow-up. Many clients have chronic problems or have had severe episodes and it is inappropriate to terminate without this gradual process (McCullough, 2000). Some depressed clients show what is called 'a flight in health' but can relapse subsequently. This kind of gradual tailoring off may help avoid sudden relapses. It also allows the client to move from an intense working relationship to a less intense working relationship. Clients benefit from having the opportunity for a general review at some point distant to the intense period. Frank et al. (1989) compared drug treatment and interpersonal counselling for depression, and found that interpersonal counselling (only once a month) was the best predictor of length of interval to a relapse, i.e. the clients receiving it stayed well longer.

BOOSTER SESSIONS A counsellor can negotiate with the client the possibility of booster sessions. These may be either on an 'if and when' basis or planned into a follow-up. One needs to be aware of cultural attitudes towards independence which can result in ideas that once a client has left counselling they should never need help again. However, it is wise to make clear that booster sessions are not the same as re-entering counselling, and usually they are only one or a few in number. Of course, if a client has had a major relapse into depression then re-entering counselling may be appropriate, along with considerations of other treatment possibilities.

THE COUNSELLOR'S ATTITUDE TO TERMINATION Both counsellor and client can have 'separation work' to do. For example, during my own training, I found that addressing the issue of termination was

difficult and I had to work through my own thoughts and feelings at addressing this with clients. To some degree I had a problem with a hidden paternalistic attitude and caring guilt.

UNREALISTIC IDEALS Another aspect I had to face when training was unrealistic ideals about what the counselling could/should achieve. I had beliefs like 'People should be happy ever after'. I am very grateful for my supervision for helping me with this. Clients too can have unrealistic ideals of what 'being well' means. Thus, as indicated earlier, the counsellor and the client should discuss the aims and expectations of the counselling enterprise. Also clients and counsellors should be aware that in a sense one never stops the process. Self-monitoring, refusing to self-attack, treating self and others with compassion and respect, are all things that one continues to struggle with throughout life.

Questions about termination

There are certain obvious questions about termination. These include: (a) does the client feel better; (b) has he/she changed in the styles of thinking and relating; (c) has his/her self-esteem increased; (d) can he/she cope better with major life events, and so forth (Egan, 1998; Ward, 1989). However, termination might also arise from more negative influences, e.g. family are resistant to the client's attendance, financial or time constraints, problems and pressures of working with long-term cases in the National Health Service, poor relationship with the counsellor, feelings/beliefs of not getting anywhere. Negative client attitudes might include beliefs of being a burden (e.g. thinking that there are other clients who need the counsellor more). These issues need to be addressed openly and ways to cope with them negotiated.

Premature termination is normally defined as occurring when a client has an appointment but, without notice, does not attend further. In my practice, I normally try to contact the client and discuss his/her reasons for non-attendance, not (obviously) in an accusing way but to explore with the client potential difficulties. If a client is very depressed, is drinking heavily or may be a suicide risk, then other agencies need to be contacted (e.g. the general practitioner). Where possible, I leave it open for clients to attend while at the same time respecting their wishes. One has to make the balance between caring for the conflicts of the client in attending, yet without being coercive. I have the impression that contacting clients is helpful. However, the psychology of this may be different in a free system like the British National Health Service from an American or private service where people have to

pay. Sometimes shame is a factor in non-attendance. On the telephone the client may verbalize cognitions such as: (a) It's been a terrible week and I thought you'd get fed up with me; (b) I just couldn't face you after what we talked about last week; (c) I was too depressed to get out of bed and was too ashamed to call you; and even (d) I wanted to feel better before I saw you.

Where to now?

Recent research on depression has shown that many types of intervention and counselling are effective. Beckham (1990) has written a major overview of research into the psychological treatment of depression (see also Beckham and Leber, 1995). Findings suggest that many orientations, including psychoanalytic, cognitive, interpersonal and behavioural, show positive effects. Evidence suggests that the central variables are counsellor skill, client difficulty and characteristics of the dyadic interaction. Beckham also notes that it is difficult to make clear predictions of outcome because so many factors can be involved, e.g. possible biological dysfunctions, the importance of life events both as triggers of depression and (when positive) as recovery factors, and the quality of external support systems. For these reasons and others, I advocate the biopsychosocial approach (Gilbert, 1995).

Concern has been expressed in the psychological literature that some depressions become 'over-psychologized' (Goudsmit and Gadd, 1991), and that important biological factors are missed. Also the counsellor should be aware that there are many different forms of counselling which have a different focus. It is possible that some depressed clients will benefit from other ways of working with other types of counsellor, even if they do not benefit from this particular approach (Karasu, 1990). (See also Corey, 1991, and Dryden, 1990, for useful general overviews of different schools and models of counselling.)

Other factors to consider include premorbid functioning. First, to what extent is this depression the result of life events that have overloaded coping ability and produced a collapse of self-esteem? In these cases a client may respond rather quickly to counselling, pick up on the various techniques, and work towards health. However, a depression often reveals particular difficulties that have become embedded in a certain life style and interpersonal way of relating (McCullough, 2000). There may also be a sense of revisiting something, that is the depression seems to reactivate early schemata with their associated affects. This is entirely consistent with Beck's (1976) notion of latent schemata and more recent interpersonal

approaches (Safran, 1998; Safran and Segal, 1990). Hence counselling is something of a journey which includes development and maturational change. In this sense the counselling must adapt to the developmental abilities of the client (Katakis, 1989).

Training and supervision

Counsellor skill is a factor that is related to outcome. Thus it is important that counsellors should have access to good training opportunities. Many of the skills outlined here are best learned under supervision. Second, counsellors working with depressed clients should be familiar with the different theories of depression (Beckham and Leber, 1995; Gilbert, 1992). The role of personal counselling for the counsellor is a complex one, but many agree that some kind of personal experience is helpful (Dryden, 1991).

Counsellors should be aware of certain of their own cognitions that can make counselling difficult and also be a source of negative feelings. Some common, unhelpful counsellor beliefs are:

Beliefs about technique:

1 If a client isn't getting better my technique is wrong.
2 To help clients improve I must get to my techniques quickly.
3 I don't know my techniques well enough, therefore I can't help clients.
4 I don't seem to know what is going on with this client, therefore the counselling can't be helpful.
5 I must be able to help this person (or all clients) in order to regard myself as a good counsellor or even a good person.
6 If I can't help people then I am a no good person.
7 I must never feel anxious with a client (with heart rate going up, etc.).
8 I must like my clients.
9 I must never be moved to tears with a client.
10 I must never show a client I am confused and ask for clarity (i.e. I must cover my thoughts. Shame in the counsellor is an unacknowledged problem in my view).
11 I must constantly challenge clients.

Beliefs about the client:

1 Empathy and being with a client is not enough; they have to do some work.
2 If the client can't understand the techniques (or work with them) they won't get better.
3 If clients can't articulate their thoughts they won't get better.

4 If clients don't change quickly they won't change at all.
5 This client likes being depressed.
6 Depressed people are basically weak people (a more common automatic thought than is acknowledged).
7 I could never get that depressed myself.
8 This client is manipulative.

And, finally, 'If I have any of the above beliefs I am a bad person. I shouldn't have these beliefs – the book says so.' Frankly, we all have automatic thoughts like these at times. But if we can stay open, check them out, allow them to come into our awareness, talk them over with a colleague, rather than turning a blind eye to them, then we can be more helpful to ourselves and our clients. In essence this is about being in tune with the countertransference (Watkins, 1989b).

There are many other beliefs one can have in counselling and you can make it a point of interest, rather than fear and dread, to try to find them. How many negative thoughts did you have in your work today? If you treat yourself with compassion and honesty and do not demand that you are always a perfectly nice counsellor with perfectly pure thoughts, then you may become less anxious or demoralized with depressed clients.

To be proficient and stay proficient, requires an open capacity to learn via reading, studying, taking refresher courses, and discussion with other counsellors (Dryden, 1991). The cognitive counsellor remains open and knows that at all times there is more to be learnt, that counselling itself is a process and if we find that at times we are stumped or lost or make mistakes we can take this as a challenge rather than as a self-rebuke. Never put your own self-evaluations on the line in counselling for this may lead to defensiveness and needs for the client to get better to prove to you how good you are. Skovholt and Ronnestad (1992) have published a fascinating study of how therapists change over time. Becoming less focused on a client's need to change is a major part of professional development. Some clients remain difficult despite our best efforts. You may not be able to help everyone that walks through your door. Some will require different types of intervention, and some clients with chronic difficulties tax all therapies of whatever type.

Personal reflections

Most therapies for depression reflect theories of cause and/or maintaining factors. One theory that I am interested in is derived

from evolution theory. This (stated briefly) suggests that depression arises from loss of social power and inferiority. Most animals form dominance hierarchies and those at the bottom are biologically stressed, tend to be inhibited in their explorative behaviour and show similar (but not identical) biological patterns to depressed individuals. In humans, evaluations of self-esteem are related to status and how we feel others regard, value and treat us. It is inappropriate to spell this theory out here (see Gilbert, 1992) but to say simply that a positive sense of self is based on the signals of valuing we receive from others and give to ourselves (Brown and Harris, 1978, see especially chs 15 and 16).

The purely cognitive view, that we are in some sense socially decontextualized beings who disturb ourselves only by our thoughts, seems to be theoretically flawed, not supported by the evidence, and politically dubious. In child-rearing we know that neglect and hostile parenting can have major effects on the developing nervous system, the maturational process and subsequent vulnerability to mental ill health. Further, these negative early effects can be difficult to overcome. Thus, we should not neglect the role of the environment (and the way an environment can be down-putting, critical, hostile, inhibiting and/or neglectful). We are highly social animals, and our internal mental mechanisms evolved to live a social life. Being put down and feeling oneself to be inferior are often key elements in depression. Nevertheless, helping clients take responsibility for their own thoughts, avoid internalizing hostility and recognize the nature of their own self-attacks, give up self-attacking and recognize patterns of thinking (e.g. personalization, shame cognitions, global evaluating, black and white thinking, unrealistic ideals, etc.) is often a key to successful outcome.

It is understandable, therefore, why various forms of counselling that increase a client's self-esteem by sending signals of valuing their experience (listening, respecting, encouraging, supporting, teaching, sharing, Frank, 1982) can be effective. The cognitive–interpersonal approach goes further in directly helping the client identify self-downing, and the way that they make unreasonable demands on themselves and, at times, others. All these work on an internal self-valuing system.

Appendix 1: Typical Styles of Thinking

Here is a quick review of typical depressive cognitive styles. They are written in a way that can be shared with clients. When people become depressed they tend to see themselves in negative ways. They may see themselves as failures, inferior or worthless, their relationships as unfulfilling and the future as rather black. These thoughts and beliefs are often maintained by particular styles of thinking and make depression worse. When we are depressed we look on the black side of things and overestimate dangers and setbacks. Some of the more common depressive thinking styles include the following:

Jumping to conclusions When we are depressed we tend to jump to conclusions easily, particularly negative conclusions. For example, your friend is in an irritable mood so you conclude this is because she doesn't like you. The shop assistant gives you the wrong change and you conclude he/she takes you for a 'soft touch'.

Emotional reasoning Emotional reasoning is related to jumping to conclusions. This is when we go for 'gut reactions' to things: it is our first, immediate, emotional response. So if you get the 'feeling' that somebody doesn't like you, you assume that it is true rather than test the evidence for it. It is quite useful for both jumping to conclusions and emotional reasoning to practice generating alternatives. Do not assume that your emotions have necessarily given you an accurate view of the world.

Discounting the positive When we get depressed it is very easy to discount our positives. We are not able to focus on things we do have, only those that we don't. Discounting positives is often related to disappointment in not being able to achieve exactly what one wants. Even when people who are depressed achieve things they tend to discount it with the idea that 'anyone could do that' or 'I used to do so much more when I wasn't depressed'. However, remember overcoming depression is a step by step process and if you continually discount your positives it is going to be difficult to start moving up the ladder.

Disbelieving others When we become depressed it is very common to believe that others are only being nice because they want to appear good themselves. Depressed people often believe that individuals have one set of thoughts that they express outwards and a set of thoughts that they keep private. Depressed people and socially anxious people worry that the private thoughts of people are very

negative towards them. Again, however, it is important to explore this and not take it for granted.

Black and white thinking When we become depressed it becomes less easy for us to think about life in complex ways. Therefore we tend to become very black and white, that is 'either or' in our thinking. Either we are a success or we are a failure; either this relationship is good or it is a complete failure. It is useful to remind ourselves that most things in life are a bit of this, a bit of that, a bit of good, a bit of bad, a bit of black, a bit of white, rather than absolutes. When we become depressed we can forget this. So try thinking in shades of things; a bit of this, a bit of that. If you are thinking about relationships focus on the things that you like about them and things that you prefer as well as the things you dislike and try to conceptualize this as a complex mixture of different things rather than all good or all bad. Indeed, try to avoid using terms like good or bad. They, in themselves, imply that such things can exist, in an absolute way – which is rarely the case.

Self-criticism We may become depressed because we are disappointed in the way things have gone, for example how we look, or maybe achievements haven't worked out, or relationships haven't gone so well. We can become quite frustrated. This frustration can sometimes turn in on the self as if we believe that 'if only I had been different, looked different or behaved differently then everything would have worked out fine'. Self-criticism often generates negative emotions, particularly anger towards the self and this increases the 'stress' on your stress systems. That in turn will continually fuel the depression. One of the key things to learn is how to be less self-critical, and take the emotional sting out of the self-criticism. Learn to be caring and nurturing when times are hard or when you are disappointed. If you learn to develop a friendly attitude to yourself when things go badly this is going to put you in very good stead to be able to cope with the roller coaster ups and downs of life.

For more information on cognitive distortions and how to combat them see Gilbert (2000) *Overcoming Depression*.

Appendix 2: Sample Case Formulation Sheet

Early history (key relationships and meanings given to them)

Sees self as **Sees others as**

Depressive attitudes and rules for living

Key social behaviours that can maintain depression and/or increase vulnerability

Typical negative automatic thoughts and depressive thinking styles

Current symptoms

Appendix 3: Some Useful Challenges to Negative Automatic Thoughts

When challenging negative styles of thinking it is useful to keep in mind that you will want to *avoid* pitting yourself against your clients – getting into unhelpful debates. So you will need to explore with your clients what they can come to challenge and question and teach them how to challenge their own thinking. Some useful questions for this might be:

What is the evidence that supports your belief and what is the evidence that may not support it?
If you look at this event again is there anything you might be excluding or not focusing on?
How would you typically seek this if you were not depressed?
What alternatives might there be to this view?
What other explanations can you think of for this event?
What kind of thoughts would help you cope with this at the moment?
How would you like to see this, which helps you to control your depression?
How might you see this event in (say) six months' time?
How might we take a more complex and varied view of this?
If you had a friend, how would you help them see this?
How would you like someone who cared about you to help you see this differently?
If your thoughts were warm and compassionate, what would they be?
What are the advantages and disadvantages of thinking about this difficulty in this way?
What are the advantages and disadvantages of changing the way you think?
What are the fears of changes?
What do you see as your greatest blocks to change?
How could we break this problem down into smaller, step by step problems?
How could we generate step by step approaches to this difficulty?
If you overcame your depression, how might you look at this situation?
What might one learn from changing negative thoughts?

Appendix 4: Thought Monitoring and Challenging Form

Below are two worked examples using one particular thought form.

Triggering Events, Feelings or Images	Beliefs and Key Thoughts	Feelings	Alternative Challenges to Negative Thoughts	Degree of Feeling Change
Key questions to help you identify your thoughts *What actually happened?*	*What went through your mind?* *What are you thinking about yourself, and your future?* *What are you thinking about others?* *Rate degree of belief 0–100.*	*What are your main feelings and emotions?* *Rate degree of feelings 0–100.*	*What would you say to a friend?* *What alternatives might there be?* *What is the evidence against this view?* *How would you see this if you were not depressed?* *Rate degree of belief in alternatives 0–100.*	*Write down any degree of change in your feelings*
Example 1 Friend at work snubbed me.	He/she doesn't like me. Sees me as inedequate. 70%	Upset, hurt, angry, 60%	Probably nothing to do with me at all. Friend can be quite moody and I have seen him/her do this to others. 50%	 20%
Example 2 Forgot to take important file to work.	This is typical me. I am useless and a failure. 80%	Frustrated. Angry. 90%	I am bound to be a bit frustrated at this because it will hold up my work today. However, this does not make me useless. I won't even remember this event in three months time. Accept my frustrations and try to relax. 70%	 40%
Example 3 Just feeling down today.	I am always going to be depressed. Nothing will ever work for me. 70%	Depressed/ Fed up. 80%	Moods do go up and down. This is normal. However, I have had better days than today. I am disappointed but I can see the sense of working with my thoughts and in my heart I know if I keep going I'll feel better. 30%	 20%

THOUGHT MONITORING AND CHALLENGING FORM

Triggering Events, Feelings or Images	Beliefs and Key Thoughts	Feelings	Alternative Challenges to Negative Thoughts	Degree of Feeling Change
Key questions to help you identify your thoughts *What actually happened?*	*What went through your mind?* *What are you thinking about yourself, and your future?* *What are you thinking about others?* *Rate degree of belief 0–100.*	*What are your main feelings and emotions?* *Rate degree of feelings 0–100.*	*What would you say to a friend?* *What alternatives might there be?* *What is the evidence against this view?* *How would you see this if you were not depressed?* *Rate degree of belief in alternatives 0–100.*	*Write down any degree of change in your feelings*
Bought the wrong size dress.	I should have known that this dress would not fit me. It bulges all over the place. I am fat and stupid. 70%	Depressed. Angry. Disappointed. 70%	It seemed to fit in the shop but I was in a rush. I can probably take it back and change it. Having a dress that is slightly too tight doesn't make me fat or stupid. Even if I am heavier than I would like to be many millions of women feel similarly thanks to the media. There is no link between body size and abilities. If I had a friend who had this problem who I cared about I would be supportive and certainly not call them fat and stupid. Being a rushed mother who tries hard for her family and occasionally buys things that don't fit means I am rushed but not fat or stupid. 40%	20%

THOUGHT MONITORING AND CHALLENGING FORM

Triggering Events, Feelings or Images	Beliefs and Key Thoughts	Feelings	Alternative Challenges to Negative Thoughts	Degree of Feeling Change
Key questions to help you identify your thoughts *What actually happened?*	*What went through your mind?* *What are you thinking about yourself, and your future?* *What are you thinking about others?* *Rate degree of belief 0–100.*	*What are your main feelings and emotions?* *Rate degree of feelings 0–100.*	*What would you say to a friend?* *What alternatives might there be?* *What is the evidence against this view?* *How would you see this if you were not depressed?* *Rate degree of belief in alternatives 0–100.*	*Write down any degree of change in your feelings*

Writing things down – why this is important

It is important for cognitive counsellors to really get familiar with the procedures of writing things down. It is usually not enough for clients to simply understand the principles of challenging their negative thoughts and to do it in their heads. The reason for this is that the client won't spend enough time focusing on their thoughts and their efforts at challenging are likely to be arbitrary and haphazard. The importance of writing things down include:

Writing down and slowing down Helping patients to learn to write down their thoughts also helps them *slow* down their thoughts. This can be extremely important both for thought catching and for challenging.

Thought catching By slowing things down and helping people really focus on what is going through their minds they may be able to recognize all kinds of meanings and thoughts which would not become fully conscious had they not taken the time to try and write down their key thoughts. In other words, clients have to ask themselves questions such as 'how do I explain this feeling to myself?' 'how can I account for what I feel?' the more clients learn to do this the better they will be at thought catching.

Attention Writing down also provides an opportunity to focus and attend to the issues at hand. This attentional focusing is again an important function of cognitive therapy.

Gain a new perspective Seeing thoughts written out in front of the client may help them to see that their depression is pushing them into overly negative positions where they are losing perspective. Having things written in front of them allows clients to stand back and view it from a slight distance.

Thought challenging Writing down is also very important for exploring thought challenging. Firstly, it helps the client to focus on 'point by point' challenges such as 'what is the evidence', 'what might an alternative view be' 'what might I say to a friend?' If they have a list of challenging questions on the form in front of them then they can try to write out the alternatives to their negative thoughts.

It is important therefore that clients should be educated into the importance of slowing down, writing down, spending time working on challenging the way they think rather than trying to do it quickly and rush through it. It is also important to help clients recognize that there is a distinction between those automatic thoughts that pop into the mind very rapidly and the kind of thoughts that they dwell and ruminate on. The ruminative thoughts are particularly important for depression.

What type of thought form?

If you have read a number of books on cognitive therapy you will probably recognize that there are many types of thought form that you can use with your clients. It is very important that you understand the purpose of thought forms rather than to try and use forms off the shelf simply because the book says so. If

you feel proficient in your cognitive techniques then you may wish to read *Treating Complex Cases* (Tarrier et al., 1998). If you do, you will see a number of chapters by various authors tackling different types of problems where they will use a variety of thought forms. The reason for this is that forms should be designed to meet specific purposes – to do a job.

My general advice here is to keep it simple. Use whatever thought form suits the issue and don't struggle with forms that are too complex, either for you or your client. The most basic thought challenging form is simply two columns, this is where between you, you write out the negative thoughts in one column and then practise challenging them in the other. For example, it might look like this.

Negative Thoughts	**Challenging Thoughts**
I am feeling depressed and not able to do anything. There is a lot of work piling up on my desk. Nothing I do is going to make a lot of difference. Beliefs 80%	It's true I'm not feeling at my best right now and there is a lot of work to do, however, let's try and do say five or ten minutes and see how much I can get through. If I am able to do a little, this will be better than doing none. I am perhaps getting overwhelmed by thinking that I have to sort it all out in one go. That would be nice but it is not practical. I am going to start my 10 minutes now. What have I got to lose by trying? Beliefs 40%

Rate belief You will note at the bottom of the table that we can also rate how much a client believes in something they have written down. Some people find that if they learn to rate the extent of their beliefs they realize that their beliefs are not always black and white or if they are, then this is unrealistic. So as time passes they may begin to note that they feel more comfortable and believe more in their challenges.

Make your own thought forms As long as you understand the *principles* of cognitive therapy (e.g. identifying negative thinking that maintains or worsens a depression, and the importance of learning to challenge negative thinking in a way that the client finds acceptable and understandable) then you probably won't go far wrong. For example, you may wish to write out thought forms which are focused on the advantages or disadvantages of a belief. You might want to write out columns that have a focus on negative self evaluative thoughts (or the attacking part of self), or make a thought form looking at things in the past in one column, and things now and in the future in another column (see page 103). You may want to help clients

recognize their change in feelings after they have done thought challenging, in which case you would have three or four columns. This allows people to rate how much they feel their feelings have changed as a result of doing these challenging exercises. You might have a series of columns which are:

Negative Thoughts	**Challenging Thoughts**	**How I Feel Compared to Before**
I am feeling depressed and not able to do anything. There is a lot of work piling up on my desk. Nothing I do is going to make a lot of difference.	It's true that I'm not feeling at my best right now and there is a lot of work to do, however, let's try and do say five or ten minutes and see how much I can get through. If I am able to do a little, this will be better than doing none. I am perhaps getting overwhelmed by thinking that I have to sort it all out in one go. That would be nice but it is probably not practical. I am going to start with 10 minutes now. What have I got to lose by trying?	Having done a little, I realize that it is difficult but not impossible. I certainly feel I have made a small amount of progress, perhaps not as much as I would like, but at least I am a bit further forward. I feel maybe 5 to 10 per cent less down.

The thought form that has been supplied for you in this book (as given earlier in Appendix 4) is a very basic form, which can be used in many different ways. You may find it suits most of your purposes or you may wish to explore other kinds of forms. For example, Padesky and Greenberg (1995) in their book *Mind over Mood*, provide a number of other types of thought form that clients can use.

If you are providing thought forms for clients to take away it is useful if they are accompanied by a series of questions for the clients to put to themselves to monitor and catch their thoughts, as well as a series of questions that they can put to themselves to *challenge* those thoughts. Appendix 3 gives a selection of such challenges that can be used.

Some useful ideas

It is important to fill in whatever form you use with the client together in the first instance, and to check that they understand it. When clients understand the principles, it can be useful to leave the client alone for ten minutes or so during an

actual interview so they can practise doing thought forms themselves. Sometimes the counsellor's role is to provide opportunities for training and this can't happen unless the counsellor makes training opportunities available. If clients are having difficulties in doing thought forms on their own then leaving them in the room for five or ten minutes to practise by themselves can be a good way of helping them with that difficulty. One can then return to the room and see where their problems are in monitoring, challenging and writing down alternative thoughts. Explore how the client feels about this.

It is useful to ask clients to bring their own thought forms to the counselling session. This allows a number of things. First, it enables you to monitor the progress of the patient and explore how they are doing in their challenging. Second, it makes clear that this is an expectation of therapy. Remember that the 'shame of homework' is always a possibility here (see page 90). Check that clients are not filling in their thought forms just before they come to therapy to please you and to prove that they have done 'good homework'. Also remember that some clients will avoid doing homework or filling in forms in session because they are frightened of doing it incorrectly or being shamed by the therapist. It is therefore important to make sure that clients understand why they are doing this kind of work, take responsibility for it and are not carrying fears of being shamed for trying things out and experimenting (e.g. getting it wrong).

One can also help patients to focus on how their behaviour would change if they really believed their alternative thoughts. Could they try this behaviour change for a morning or afternoon, a day or week? With all these interventions practice is important.

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