Depression

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ABSTRACT

Depression is a mood condition that is the second largest cause of disability globally. This chapter describes the characteristics and associated features of depression. It considers different ways of viewing depression, such as whether it is a medical disorder or a stress response. The chapter explores the relationship of both grief and suicidality with depression. Different responses to depression are described, including medical, psychological, and lifestyle interventions as well as the rationales for key interventions. Finally, this chapter describes generic recommendations for counsellors to consider when working with clients showing signs of depression.

Learning Objectives

- Identify and define depression.
- Explore the different theoretical models for depression.
- Evaluate the relationship between depression and suicide.
- Explore a framework for the responses to depression in a counselling setting.

INTRODUCTION

The words ‘depression’ or ‘depressed’ are often used by the public (and clients) to indicate a passing feeling or mood of sadness, lethargy, guilt, grief, or a low mood. In common usage, they are synonyms for feeling flat, down, or ‘having the blues’. The word depression, originating in Latin, literally means “to press down” (Reevy et al., 2010, p. 192). Depression is also used as a clinical term to suggest a particular type of mental disorder category, as described in the ICD-11 (World Health Organization, 2022), or DSM-5-TR (American Psychiatric Association [APA], 2022). The variation between the types of depression is usually related to duration, intensity, frequency, or contexts (e.g., post-partum depression that may occur with early motherhood). Depression is regarded to be globally the most prevalent mental disorder (Gotlib & Hammen, 2009) and the second largest cause of disability internationally (Ferrari et al., 2013). In counselling practice, clients often present with features associated with depression, whether these be severe enough to be classified as a disorder, or various degrees under the diagnostic threshold.

Depression is characterised by periods of low mood or sadness and/or a loss of pleasure or interest in previously enjoyed activities (APA, 2022). While it can lead to significant stress and impairment in life, it is most commonly a response to various difficulties or stressful life experiences that most people are likely to encounter at some stage in life (Reevy et al., 2010). These features were described as far back as Hippocrates

(Radden, 2003) as being part of melancholia, and while other disorders have come and gone, descriptions of depression remain consistent throughout the modern diagnostic editions (Frances, 2013). Indicators of depression typically include low mood, low interest in activities, or low ability to experience pleasure, weight changes, sleep disturbance, increased or decreased arousal, low energy, feelings of worthlessness (e.g., low self-esteem), diminished concentration, and preoccupation with death (APA, 2022). Many of these indicators will be experienced daily for at least a fortnight (World Health Organization, 2022) for it to be recognised as meeting the threshold for a depressive disorder. Additional features may be social withdrawal, negative thinking, irritability, rumination, worry, changes in levels of sexual motivation, and increased concern with physical complaints (APA, 2000, 2013, 2022).

Case study: The story

Note: Key details have been altered to preserve anonymity.

Tony had been a loyal, hard-working employee for the same company for 33 years. In fact, Tony came from a long line of hard workers, with his family owning a small grocery store when he was a child, which he started to work in by doing small jobs when he was six years old. Tony's reputation was well known to his fellow workers and customers, and he took pride in putting their needs first. Rarely would he take sick leave and would often take his work with him on holidays. Alice, Tony's spouse for nearly 17 years, has always been understanding of Tony's work ethic, and has been supportive. Tony gained weight and suffered from knee pain. This led to a double knee-placement and an extended time away from work. During this period, he became anxious about his future and whether he would be able to continue his work. Tony also started to feel a sense of worthlessness during this time, wondering if his employer would still need him, given that they had been 'surviving without him'. Over the previous two months prior to seeing his GP, Tony started to feel very low, despondent, and would find himself becoming tearful easily over little things. Tony was also having some thoughts about whether he was worth anything to others if he wasn't able to work, which lead to some 'scary thoughts' of suicide. Alice picked up on these things, and they both agreed to speak with Tony's GP.

DISTINGUISHING BETWEEN DEPRESSION AND GRIEF

Historically, mental health practitioners and researchers have had difficulty distinguishing between grief or bereavement, and clinical depression as per the criteria of the DSM (Cacciatore & Theilman, 2014). Like depression, grief can negatively impact functioning, have marked increases in negative emotions including sadness and guilt, sleep disturbances, lack of ability to experience pleasure, and may involve thoughts about death (Hall, 2013). Although they overlap in features and client experience, grief is understood as a natural adjustment response to loss, while major depressive disorder is viewed as a pathological syndrome. Grief and depression typically differ in that those with depression may have symptoms of low self-worth, excessive self-criticism, and intractable sadness whereas these are not normally present with grief. Grieving does not preclude the possibility of a depressive disorder, and the stress and grief of the loss can trigger major depression, but counsellors need to be careful that they do not automatically assume grieving people are depressed. To add to the complexity of assessment, counsellors also need to be aware of the concept of complicated grief that may have depression as a symptom. These grief reactions occur most of the day, nearly every day for at least a month. The individual experiences clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2022). Interpersonal Psychotherapy, an approach discussed later in this chapter, provides a simple formulation and way forward with complicated grief, by considering one's indicators of depression being 'caused' by unresolved grief, and that interventions that target this will help to relieve the person's depression (Weissman et al., 2018).

DEPRESSION AND SUICIDE

Suicide is a significant risk factor for clients with depression, with 90% of those who had completed suicides being retrospectively diagnosed with a psychiatric disorder, and two thirds of these being diagnosed with depression (Tanner, 2000, as cited in Berman, 2009). For people who have been hospitalised for mood disorders, the lifetime risk of suicide is 4%. For those who have been diagnosed but not hospitalised for mood disorders, including depression, the lifetime risk for completed suicide is 2%. The public lifetime risk is .5% (Bostwick & Pankratz, 2000). This would suggest that clients with depression are between four to eight times more likely to suicide in their lifetime than non-depressed individuals. Suicide risk assessment and prevention should be prioritised with depressed clients given their elevated risks.

DEPRESSION AND VARIOUS POPULATIONS

As a rule, rates of depression are higher for women than men (Chentsova-Dutton & Tsai, 2009). In Australia, 5.3% of men had symptoms of an affective disorder in a twelve-month period compared to 7.1% of females (ABS, 2008). This difference increases in more traditional gender role societies, however when the rates are closer, research has not yet clarified whether this is due to decreased depression in females or increased depression rates in men (Helgeson, 2012). One theory for the lower rates of depression identified in males is that the measures used might be increased sensitivity to depression symptoms more commonly expressed by females than more externalising expressions such as anger, aggression, and substance use that more men might display (Flaskerud, 2014).

Depression also affects children and adolescents, with 2.8% of children in Australia, from the ages between 4-17, reporting symptoms in a 12-month period (Lawrence et al., 2015). The symptoms are generally the same as adult depression, however more likely to be displayed as irritability or flat affect than a depressed mood, and their moods are more variable due to their ability to be influenced by what is happening around them (Stark et al., 2006). Children and adolescents may also display anger, guilt, and misery. They may withdraw from others, be difficult to soothe, and find it hard to be motivated, such as finding the energy to do homework. Additionally, they may display low self-esteem, and become suicidal (Huberty, 2012).

Indigenous Australians typically have higher rates of psychological distress (i.e., depression and anxiety), in contrast to non-Indigenous counterparts (Jorm et al., 2012). These higher rates of symptoms of depression and anxiety are believed to be related to social disadvantage, chronic physical health problems, unemployment, lower incomes, inter-generational trauma, and educational levels.

Depression rates vary depending on region and culture. Western cultures have higher incidents of depression than do many Asian cultures (Chentsova-Dutton & Tsai, 2009). Of those who move to Australia, refugees typically have double the rates of depression and anxiety than do labour migrants (Lindert et al., 2009). This increased incidence may be associated with higher rates of trauma from their country of origin.

It should be noted that depression is understood or spoken about differently in some other cultures. For example, several cultures report depression using physical rather than psychological language, such as focusing on changes in appetite, sleep, or the presence of headaches. Western clients tend to report their depressive psychological symptoms more so than referring to the physical symptoms (Chentsova-Dutton & Tsai, 2009). Some intercultural clients may refer to depressive symptoms as ‘problems of the heart’, nerves, or fatigue (Nezu et al., 2009).

MULTIFACED NATURE OF DEPRESSION

Depression interacts with biological and psychosocial domains. There is evidence of physiological pathways and vulnerabilities with depression, and it has been identified as being between 31% and 42% heritable (Sullivan et al., 2000). Additionally, depression has been associated with a range of life experiences and issues, such as addictions, suicidality, anxiety, stress, trauma, particular adverse early life experiences (such as abuse/

neglect/parental depression) (Bilfulco, 2009), personality, chronic pain and/or illness, some medical conditions and hormone changes, and some medications (APA, 2013; Berman, 2009; Goodman & Brand, 2009; Hammen, 2009; Hopko & Robertson, 2008; Johnson, 2009; Mustata & Gregory, 2009; Reevy et al., 2010; Sachdeva et al., 2009; Schwartz, 2009; Schwartz & Tripp, 2009). Additionally, while depression can be understood as a disorder in its own right, it can also be viewed as a symptom of other conditions, physical, chemical, and psychological (Gautam et al., 2017).

Depression's many potential pathways contribute in varying degrees to each presentation (Fang & Mao, 2019; Roose et al., 2013). It is important that counsellors are mindful potential contributors when doing assessments. Counsellors might refer clients to their GPs for medical evaluations in case the depression is predominantly linked with a medical condition. When depressive symptoms are presented with other life stressors or problems (e.g., such as addiction), the counsellor might collaboratively negotiate with the client what treatment needs to prioritise. Often addressing one area cascades a positive effect into other areas. For instance, addressing substance abuse may reduce the depression, and vice versa. The important thing is that the counsellor develops the treatment focus with the client, monitors treatment response, and adjusts as needed. An alternative is to address more than one area at a time, either as the sole intervention provider or as part of an intervention team where resources are available.

Depression is predominantly recognised and treated as a primary mental disorder within Western mental health systems, and is often treated with medication. Frances (2013), the former Chair of the DSM-IV Task Force, critiqued the diagnostic criteria for depression and how this has been used. He highlighted that while a diagnosis of major depressive disorder (MDD) is quite beneficial at helping people with severe depression gain access to treatment; it also readily captures people with normal emotional experiences (e.g., mild depression) and ignores the contextual role of life stressors. Sadness and stress have become medicalized and treated with medication, and in his mind, it has created a "false epidemic of MDD" (p. 154). Frances noted that the DSM-5 (APA, 2013) made progress in making the diagnosis harder for milder symptoms. A report by the United Nations Human Rights Council (2017) stated that the biological model of mental health disorders, including depression, have not shown sufficient evidence, claiming that "we have been sold a myth that the best solutions for addressing mental health challenges are medications" (p. 5-7). The report goes on further to say that "the crisis in mental health should be managed not as a crisis of individual conditions but as a crisis of social obstacles which hinders individual rights" (p.19). The DSM5-TR (APA, 2022) and ICD11 (WHO, 2022) have provided a common language and descriptions that enable classification of mental health issues including depression. This classification greatly assists in research, diagnosis, demarcating eligibility for services; and assists practitioners to varying degrees with case conceptualisation and treatment planning. An unfortunate by-product can be a form of medical reductionism that predominantly locates the pathology in the individual and decontextualises the symptoms.

Discuss with your class the potential benefits and risks associated with viewing and treating depression as a medical disorder or alternatively, viewing it primarily as a stress response? Is there a middle ground?

Case study: Returning to Tony's story

When we look at cases such as Tony's, would it not be reasonable to describe his experience of depression as also being a normal human reaction to a significant stressor in his life?

Initially, Tony needed a lot of support to address the loss of purpose in his life from his abrupt cessation of work. Tony had placed a lot of emphasis on his career over his adult life, and 'work' was a primary source of his identity. This resulted in a sense of hopelessness and worthlessness, and at times some suicidal thoughts. Tony felt very troubled by having these thoughts, and harshly judged himself for thinking in this way. He especially felt ashamed to tell Alice, who he had enjoyed a loving and happy partnership with for many years. Opening up to others helped to normalise his experience, and Tony began to see that support was there for him. Some sense of hope started to grow.

INTERVENTIONS FOR DEPRESSION

There have been many proposed theories of the aetiology (i.e., causes) of depression, and a few interventions associated with these theories. For this chapter, we will review several the more well-regarded and evidenced-based approaches from medication to different models of counselling. Some attention will also be given to alternative approaches, including those that address lifestyle factors associated with depressive symptoms.

MEDICATION

The most widely known medical treatment for depression is anti-depressants prescribed by general practitioners and psychiatrists. They are commonly the first treatment offered in medical contexts and may also be offered in combination with therapy. In terms of effectiveness with depression, medication is generally as effective as counselling, while it outperforms counselling with more prolonged or severe depression (Imel et al., 2008).

Antidepressants have come under criticism as researchers are recognising that typically only research that shows positive large effects are published, thus giving inflated average effect size across studies (Hougaard, 2010). In addition, antidepressant and psychotherapy outperform placebo pills slightly (Cuijpers et al., 2014). Both concerns seem to indicate that there is very little effect of the active ingredients in addition to placebo. Further evidence of the possible placebo nature of medication is the large effect of the prescriber of medication on outcome. Who the psychiatrist is has at least, if not more, impact on the outcomes of the treatment by medication or placebo pill (McKay et al., 2006). In other words, depending on which doctor the client is seeing will determine how effective their anti-depressant medication is. In the study just cited, the psychiatrist with the best results had better results with their placebo pill than 80% of the doctors who prescribed the active medication.

COUNSELLING FOR DEPRESSION

Counselling for depression is generally effective at reducing symptoms and improving life quality (Cuijpers et al., 2008; Hoyer et al., 2006; Lambert, 2013). While the debate over which specific therapy is most effective for depression continues, meta-analyses demonstrate that no bona fide therapy has been proven better than others (Cuijpers et al., 2012; Wampold et al., 2002; Weisz et al., 2006) despite various claims. Let us review some of the main counselling models and approaches.

Psychoanalytic model

The psychoanalytic model proposes that depression is the consequence of various forms of unconscious coping strategies in response to psychic pain (Leuzinger-Bohleber, 2015). Freud believed depression was an alternative manner of mourning the loss of a significant other. Rather than a progressive resolution to the loss of a loved one as most do in grief, the person gets stuck in ambivalence and inner conflict towards the object of loss, may lose awareness that they are mourning, and punishes a part of their ego (Mustata & Gregory, 2009; Taylor, 2008, 2015). This is where we get the saying that depression is anger turned inwards (Rehm, 2010). The aim of treatment is to help raise the awareness and insight of clients into their range of unconscious internal reactions and processes towards the loss and help them process their grief. Psychodynamic approaches comprise the more recent developments in the psychoanalytic word, to help clients to address specific internal or interpersonal conflicts. These psychodynamic psychotherapy approaches use the therapeutic alliance actively and constructively, such as the purposeful use of transference, to explore current or past dilemmas or conflicts collaboratively in the therapeutic process. This approach is more often long-term; however, short-term approaches have been developed and show efficacy in treating depression. Confrontation, as well as therapist interpretation, while ensuring an alliance is maintained, are core elements in this approach, with the goal to increase self-awareness, and the resolution of conflicts in the client's life.

Behavioural model

According to behaviourists, people choose behaviours to help them gain rewards and/or avoid distress. In this model, the assumption is that depressed people fail to receive sufficient positive incentives for healthy behaviours and will tend to withdraw from certain other behaviours and activities to avoid short term unpleasant events. Avoidance can additionally be problematic because avoiding potential for distress may also mean they fail to place themselves into situations whereby they gain longer term benefit (Spiegler & Guevremont, 2010).

The aim of the interventions is to help clients stop practising behaviours consistent with depression, and act more with behaviours that are inconsistent with depression. Staying home from work may avoid the risks of facing one's work pressures, but it may also reinforce feelings of hopelessness, thus feeding feelings of depression. Practicing depressive behaviour will simply become a self-defeating cycle, whereas practicing what might be deemed 'healthy behaviours' are more likely to lead to enhanced thinking and moods (Lejuez et al., 2001).

Intervention consists of having clients identify the various situations they avoid and the behaviours that are reinforced through such avoidance, identifying life goals, and then identifying strategies to engage in positive behaviours that are likely to be reinforced and lead to the clients' longer-term goals (Spiegler & Guevremont, 2010). For instance, job seekers can become demoralised and depressed when their efforts at finding work continue to be unsuccessful. They may engage in behaviours that avoid the short-term risk of rejection, but in doing so, may find themselves less likely to achieve the longer-term satisfaction accompanied by securing employment. The behavioural counsellor, using the strategy of **behavioural activation**, might help them develop a stronger awareness of the longer-term goals, activities to help them progress towards the goals, and also develop or identify reinforcements associated with activities that contribute to finding employment. In contemporary psychotherapy, most behavioural approaches have been absorbed into the more well-known cognitive behaviour therapy tradition.

Learned helplessness

Learned helplessness is a variant in the behavioural school. Martin Seligman discovered that when dogs were taught that a tone was accompanied by a shock, rather than trying to avoid the shock, the dogs took no evasive action but simply whimpered. He speculated that they were conditioned to expect they could avoid the shocks and hence resigned themselves to receive them. Seligman generalised the implications of this to depression, in that humans who believed that their actions, based on previous learning, were ineffective and could not reduce suffering, would simply resign themselves and choose to be helpless. Given that this generalising and depression does not apply to all people who experience uncontrollable events, Seligman proposed that it was linked to whether a person believed the negative experience was somehow linked to their self-worth (Reevy et al., 2010).

Intervention involves helping the client learn new skills to gain more mastery over situations, helping them exercise greater control where they can, helping them aim for achievable rather than unrealistic goals. It helps them appraise cause and effect for positive and negative situations more realistically (Rehm, 2010).

Case study: Tony begins to move towards a rich and meaningful life

Initial stabilisation was achieved through increased exercise and pleasurable activities such as gardening and cooking. Tony was willing to progress further in therapy by clarifying his values. Tony identified strong connections with family and friends and found a lot of satisfaction in regularly gathering with those he loved and cared about. Social gatherings or visits were planned for weekends.

Cognitive behaviour therapy models

Cognitive therapy (founded by Aaron Beck) and rational emotive behaviour therapy (founded by Albert Ellis) are the two main schools of cognitive behaviour therapy approaches. Aaron Beck proposed that faulty cognition with a bias towards negativity causes and maintains depression. Cognitive therapy argues that it is not so much what happens to a person that makes them depressed, but that people feel depressed as a result of tending to engage in patterns of thinking and beliefs about the events, themselves, and the world generally, with a negative bias (Blackburn et al., 2006). While one person may experience failing in an exam as disappointing but nonetheless a prompt to study harder, a depressed person might view it as evidence that they are never going to succeed, that they might as well give up, and that they are a born loser. Cognitive behaviour therapy (CBT) is the umbrella label for cognitive and behavioural approaches, and combines aspects of both. CBT is often described as a focussed approach, where counsellors work with clients to address their faulty cognitions, which are the basis for their difficult emotions, or maladaptive behaviours. Cognitive techniques include addressing the person's faulty thinking patterns through cognitive restructuring. For example, treatment may involve helping clients learn to recognise the difference between functional and dysfunctional thoughts, helping them monitor their thoughts, and learn to replace their dysfunctional thinking and beliefs with more adaptive alternatives. The behavioural aspects of this approach are drawn from behaviourist theory, and use techniques such as exposure, activity scheduling, and behaviour modification. Relaxation training is also prescribed. Skills training, like assertiveness, or stress management, are also key components of this approach. An important initial step when intervening with depression is pleasant activity scheduling (also referred to as behavioural activation). This involves helping the client to identify pleasant activities, and those that also provide challenge, and then setting goals together to increase these by creating a weekly schedule comprising these activities. Although this seems like a very behaviourally oriented approach (and it is!), it has become a standard in treatment for depression in CBT. While it has been acknowledged previously that all approaches hold similar efficacy, it must be noted that CBT has demonstrated especially good efficacy with treating depression and is supported in Australia under Medicare as a recommended approach (The Australian Psychological Society [APS], 2018).

Mindfulness-based cognitive therapy (MBCT) is a newer approach, derived from CBT, which emphasises mindfulness-based meditation as a core treatment for depression, and has shown promising signs especially for treating recurrent depression (Kahl et al., 2012). It focusses on interrupting ruminative patterns of thinking which are often associated with depressive relapse. The main difference between traditional CBT and MBCT is that the latter focuses more on changing one's relationship with their thoughts, by noticing and observing inner dialogues, rather than challenging or changing thinking patterns through cognitive restructuring. Clients are helped to see themselves as 'having' thoughts, or experiencing difficult emotions, rather than believing their thoughts as being real or factual.

Acceptance and commitment therapy (pronounced ACT), similar to MBCT, is regarded as part of the third wave of cognitive behavioural therapies. ACT was developed by Stephen Hayes and colleagues, following their work on relational frame theory, which explored the contextual theory of language and cognition. While acknowledging, and in some cases borrowing, from already efficacious approaches in CBT, its primary difference is in the way that it approaches thoughts, feelings, and behaviours. ACT sees the context and function of private experiences as the primary target of intervention, helping a client to develop greater acceptance for their subjective distress, rather than working towards symptom reduction. ACT argues that clients can work towards improved quality of life, as opposed to a life restricted by avoidance of painful thoughts and experiences. Specifically, when applied to depression, rather than focusing on the content of the

depressed person's thoughts, ACT focuses on helping to develop a different relationship with their thoughts. It does not aim to replace dysfunctional thoughts with functional thoughts as does traditional CBT, but rather, clients are taught to dispassionately observe both their thoughts and feelings. This skill is referred to as cognitive defusion. In ACT, the goal is not to directly 'reduce' depressive symptoms, but to assist clients to accept their inner experiences regardless of how undesirable they might be (rather than adjusting their lives trying to avoid such experiences), and to see them simply as experiences rather than evidence of something more important. For instance, if the client has a thought "you will never be any good", rather than fighting with it, trying to ignore it, or worse, believing it as a truth, the client might simply say "Thank you mind for that thought" and get on with what they were doing. This deemphasises the speculated significance of internal experiences and frees up energy for the client to live life according to their life values (Siddiqui et al., 2009). Being more values-guided also enables clients to relinquish destructive patterns of behaviour and make decisions that are consistent with their values. A simple example of this for a client experiencing depression might be, rather than withdrawal from friends and family, clients might learn to take action toward a more rich and meaningful life, and be more socially engaged with those that matter. This might be despite some difficult feelings persisting when clients initially try to re-engage with their world. Clients are challenged to be willing to work towards a life of purpose, and at times, allow space for any difficult feelings or thoughts that might accompany them.

Interpersonal therapy

Interpersonal therapy (IPT) was initially developed in the 1970s as a control treatment for research on the effectiveness of anti-depressants (Klerman et al., 2017). However, unexpectedly, the approach itself was shown to have effectiveness, and was further developed into the model now referred to as IPT (Klerman et al., 2017). The assumption of IPT is that problems in a person's interpersonal relationships are interrelated with depression, and if specifically targeted interventions, will see an amelioration of depressive symptoms (Klerman et al., 2017). IPT is a structured approach, often described as a brief intervention, lasting for a prescribed number of sessions, commonly up to 10. The time limited nature of IPT is seen as an active ingredient in the treatment (Klerman, et al., 2017). The main goal is to help clients understand that their current interpersonal difficulties are directly associated with their depression. Its main emphasis is to help clients develop more effective communication skills, more effective mechanisms for expressing emotions, and more realistic expectations of relationships (Robertson et al., 2008). Sessions often include skills training for resolving interpersonal disputes, managing role transitions, dealing with grief or loss, and addressing interpersonal and social deficits by such strategies as improving communications skills through practice and role play with the counsellor. IPT has been found to have good efficacy in treating depression and is supported in Australia under Medicare as a recommended approach (APS, 2018).

Case study: Small steps

Tony identified how much his health had declined, and his recent knee surgery and obesity, caused him to see how little care he had given to himself over the years. This was often due to work over-prioritisation. Tony chose to take committed action towards improving his health through better exercise and diet. Progress was slow, and it was a hard battle, but over time Tony increased his exercise through regular walking, developed a good diet supported by his GP, and lost a significant amount of weight. Over time, Tony also decided to start playing social badminton, which he had discovered in his local area. This also helped to increase his social connection.

ALTERNATIVE INTERVENTIONS

Not every client wants to seek psychological or medical treatment alone but may want to add or seek alternative interventions for depression.

Exercise is viewed by some as a form of intervention that can be used by itself or in conjunction with medication or counselling. It provides similar depressive symptom reducing effects to antidepressant medication (Daley, 2008; Dinas et al., 2011) at moderate levels of aerobic exercise, and is recommended for community mental health services, and placebo effects only for lower levels of exercise (Dunn et al., 2005). Pollock (2001) strongly recommends incorporating it as homework for most counselling approaches, although depressed clients understandably have issues initiating and sustaining exercise. Given that there may be health concerns that might inhibit a client's physical activity, it is suggested that they do so after consulting their GP or physical instructor first.

Some clients may prefer nutritional interventions to help reduce depression. There has been a gathering of strong support for interventions in diet (see foodandmoodcenter.org) as an additional intervention for depression, or something that can be done in conjunction with counselling. Other options might include supplements, such as St John's Wart, folic acid, and Omega-3. Typically, they are used in conjunction with other interventions. Some display mild benefit while others have not yet been established to be beneficial (Sarris et al., 2009).

Acupuncture has some evidence to suggest it may be effective in responding to depression (Wang et al., 2008) however the strength of the evidence and the research designs cannot provide any conclusiveness at this time (Wu et al., 2012).

Over the last decade, there has been a sharp rise in the availability of print and online self-help resources. Many of these have a strong evidence base, and a counsellor may choose to advocate these to their clients. Mobile Apps designed to help alleviate depression are also available such as the Headspace or MoodKit apps. Self-help without a therapist is helpful with depression, often giving equivalent results to psychotherapy (Norcross, 2000), though complicating factors such as severe depression or suicidality may lead to negative outcomes (Mains & Scogin, 2003).

Counsellor reflections

Over time, I have found addressing lifestyle factors to be a primary concern when working with clients experiencing depression. In the future, options like exercise and diet will no longer be considered adjuncts to counselling, or alternatives, but will be considered consistent with most approaches reviewed in this chapter. It will be commonplace in the initial stages of counselling to address any of these factors as a part of a course of intervening with depression. Whatever your approach, educating clients about the benefits of increasing exercise, eating a more wholesome diet, or getting better sleep, will assist in reducing depressive symptoms and improving overall well-being. [James]

GENERIC COUNSELLING SUGGESTIONS

Up until this point, specific treatment approaches have been considered, drawn from the basis of evidence in the literature. This section will address general principles that all counsellors might consider, irrespective of their therapeutic modality. These suggestions are given from the perspective of the author, on account of their experience in the counselling field.

Counsellors will commonly see clients experiencing depression. Some of these clients may be receiving treatment for depression from other mental health providers such as general practitioners and psychologists. Others will seek counsellors as the sole or primary mental health provider to address depression. They may seek counsellors to deal with other stressors in their life or perhaps they seek a different approach, such as a client centred approach in comparison to more prescriptive approaches. Some may seek counselling as an

alternative to medication or possibly to replace their existing anti-depressant medication. Counsellors who become aware of clients seeking to withdraw from medication without medical supervision should highlight that there can be negative health risks of unsupervised medication withdrawal and recommend that any changes to medication be discussed with their medical provider.

Counsellors may also see clients who have not been given a diagnosis of depression, yet the counsellor might suspect the client is impacted by depression. When counsellors suspect depression, they can follow up with the two Whooley screening questions (Whooley et al., 1997) . If the answer is affirmative to either question, the counsellor should consider recommending that the client consult with a medical doctor for further assessment, to screen for direct biological causes or other medical conditions that might be relevant.

Counsellors should regularly monitor for suicidality with depressed clients given that depression increases risk in this area. In addition, counsellors need to be mindful that when depressed clients appear to improve and have enhanced energy, this may be an indicator of increased suicidal risk (Rogers et al., 2018).

Counsellors can make two key mistakes working with clients with depression. The first is the attempt to help lift them out of depression by attempting to 'cheer them up' or encouraging them to 'look on the bright side'. While the goals of seeking to enhance mood and help reduce negative thinking are both worthy, any such attempts are naïve and will often meet with resistance and communicate to the client that the counsellor is unwilling to understand and empathise.

The second mistake is almost the opposite. In this scenario, the counsellor joins with the client and actively reflects and paraphrases the client as they talk about their depression. As the counsellor reflects the feelings accurately, the client's mood in the session lowers and the depressive thinking and feeling increase. While closely tracking clients with many issues is helpful, close reflective listening with clients with depressed moods can intensify the experience of depression and hopelessness. An alternative is to balance paraphrasing of depressive content with reframing towards what they implicitly hope for. If a client comments that they feel as though they are spiralling into hopelessness, rather than reflecting and amplifying the hopeless feelings, the counsellor might reframe "you're wanting things to start improving" thereby tapping into the implied hope for change. By strategically choosing when to paraphrase and when to reframe towards client goals, the counsellor can balance hearing the 'depression story' and inviting interest in the story of the client's desire for change.

When working with a client with depression, we would recommend that practitioners monitor the client's experience and response to treatment. Is the counselling having a positive impact on the client? There are various formal feedback measures that counsellors can use to gather this evidence. The Outcome Rating Scale (ORS) (Miller & Duncan, 2000, 2004) and Session Rating Scales (SRS) (Miller & Duncan, 2000, 2004) enable counsellors to track client outcomes and also to measure the strength of the therapeutic relationship, each and every session. Utilising these measures enables counsellors to check the client's progress and also the client's satisfaction with the intervention itself. This enables the counsellor and client to collaboratively discuss adjustments if positive change or treatment fit is not occurring. A recommended text to become familiar with the use of the ORS and SRS is *On becoming a better therapist* (Duncan, 2014).

Case study: Every story has an ending and a beginning

Tony continued to attend therapy following his initial recovery and stabilisation. These sessions were used to support the changes that Tony had made, and to help prevent relapse. After a six-month period of meeting at 4 to 6 week intervals, it was agreed that no further sessions were required. Of course, ending therapy may be the beginning of a new approach to life for our clients. Managing mental health is an ongoing challenge. The following email from Tony best describes this:

> This is Tony. If you remember me, you helped me heaps, to deal with my depression & anxiety. I just wanted to give you a quick update on me.
> If you remember, I had double knee replacements (both at same time) which were a success. I finally was able to get back on my bike end of Jan (after approx 7 years).

> I ride downtown and home again twice a week now.
> I am traveling quite well, and more of a happy chappy these days. Still enjoying the same things as when I saw you last – gardening, cooking, some reading, and my weekly Thursday morning badminton (it's great fun and very social). I also recently joined a walking group on a Tues morning.
> As I wanted to do some volunteer work that wasn't too taxing, I'm in the process of becoming a volunteer driver which just involves drivers to pick elderly people up from their homes and drive them to medical appointments or shopping centers, etc. It may be 3 or 4 hrs once or twice a week. I'll see how I go.
> Anyway, enough about me. Hope you and your family are well,
> Thanks again for all your help.
> Tony

CONCLUSION

The impacts of depression can be very disabling and distressing for both the sufferer and their loved ones. With an expectation that depression will be on the rise in western society, counsellors need to be well equipped to help those who are suffering. There are multiple treatments available to clients both within a counselling context and in other healing orientations. Counsellors should appraise the literature and develop a range of options to find the best fit for clients, in a collaborative and client-focused approach.

RECOMMENDED RESOURCES

This chapter has introduced students to some basic general information and principles for working with clients with depression. We would recommend students gain deeper knowledge by reading more thorough texts on counselling for depression (For example, see Gilbert, 2007; Sanders & Hill, 2014). This current chapter serves only as an introduction.

BOOKS ON COUNSELLING FOR DEPRESSION

Gilbert, P. (2007). *Psychotherapy and counselling for depression* (3rd ed.). Sage Publications.

Sanders, P., & Hill, A. (2014). *Counselling for depression: A person-centred and experiential approach to practice.* Sage Publications.

BOOK ON FEEDBACK INFORMED TREATMENT

Duncan, B. L. (2014). *On becoming a better therapist* (2nd ed.). American Psychological Association

WEBSITE LISTING MOBILE APPS FOR DEPRESSION AND OTHER DISORDERS

The Best Depression Apps

Learning activities

What about you?

1. What do you think are the strengths and weaknesses of each counselling approach?
2. Which of the above counselling models do you feel most aligns with you?

3. What do you know about the role that lifestyle factors such as sleep, diet, and exercise play in the experience of depressive symptoms?

GLOSSARY OF TERMS

DSM—the DSM is the abbreviation for the Diagnostic and Statistical Manual of Mental Disorders. This text is classification guide for psychiatric disorders and is used within clinical psychology, psychiatry, and research. The current manual is in its 5-TR edition.

ICD—the ICD is the abbreviation for the International Classification of Diseases. It is now in its 11th edition. It is accessible from World Health Organization ICD web page.

medical model—this is the paradigm that approaches mental health with similar assumptions as used in treating physical medical conditions. It assumes specific clusters of psychological distress and impairment reflect underlying disorders that must be correctly diagnosed and treated.

melancholia—this is an ancient term used to describe what is understood as depression. It is rarely used in modern times.

rumination—a negative emotional mood state with a process of repetitive mental focus on one's problems without resolving them

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Currently, James' focus is on his private practice work, specialising in assisting men with improving their mental health and relationships. James is especially passionate about advocacy for better physical and mental well-being amongst men and is a member of the Australian Men's Health Forum. James also serves as a non-executive board member of The Fathering Project. In addition to his therapy work, James also provides supervision to psychologists and enjoys supporting professionals working in health and allied health to assist with preventing burnout and compassion fatigue.

James enjoys family time with his wife Michelle and their four children. In his spare time, James enjoys music, cooking, bushwalking, and travel. He is a member of an award winning a 'Capella singing group, Monday Nights.

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