



DEPRESSION

A COUNSELLING PERSPECTIVE

Dr Mike Sheldon



DEPRESSION – A COUNSELLING PERSPECTIVE

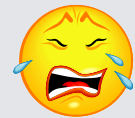
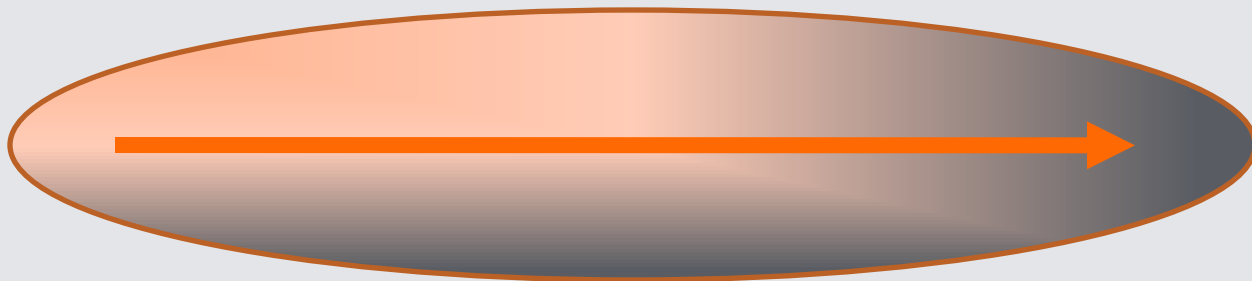
- Dr Michael Sheldon
 - MB, BS, FRCGP, MICGP, BA, FACC, DipTheol
- General Practitioner
- Academic – teaching communication skills
- Counsellor – ACC
- Ministry in YWAM
- Traumatic life events
- Whole Person Medicine

WHAT IS DEPRESSION?

- Emotional illness
- Normal mood swings
- Character weakness
- Chemical imbalance
- Psychiatric illness
- Malevolent spirits
- Demon possession
- Spiritual illness

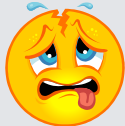
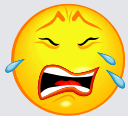
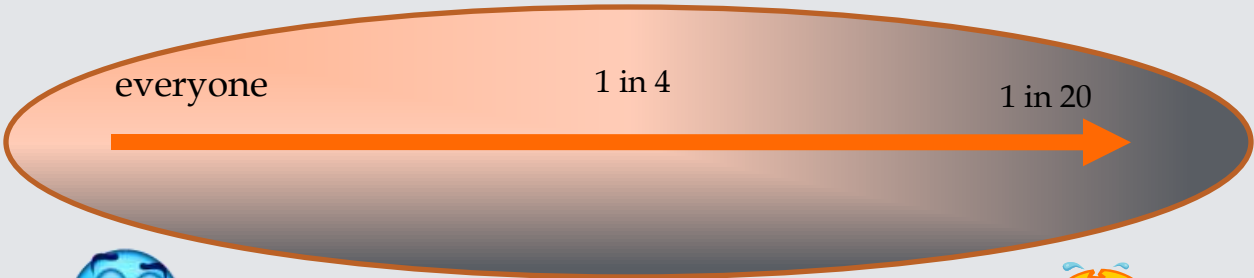
- “Mad, Bad or Sad”

THE “SAUSAGE” OF DEPRESSION

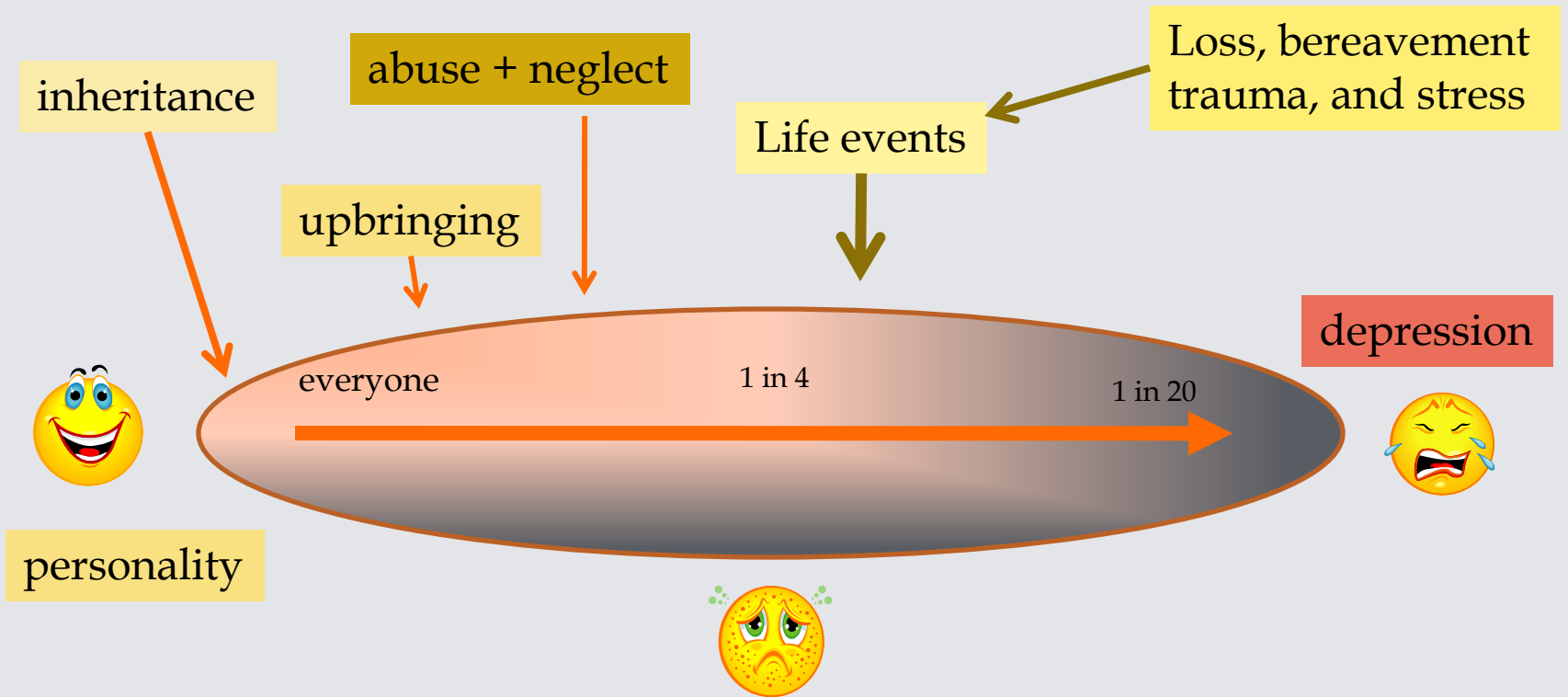


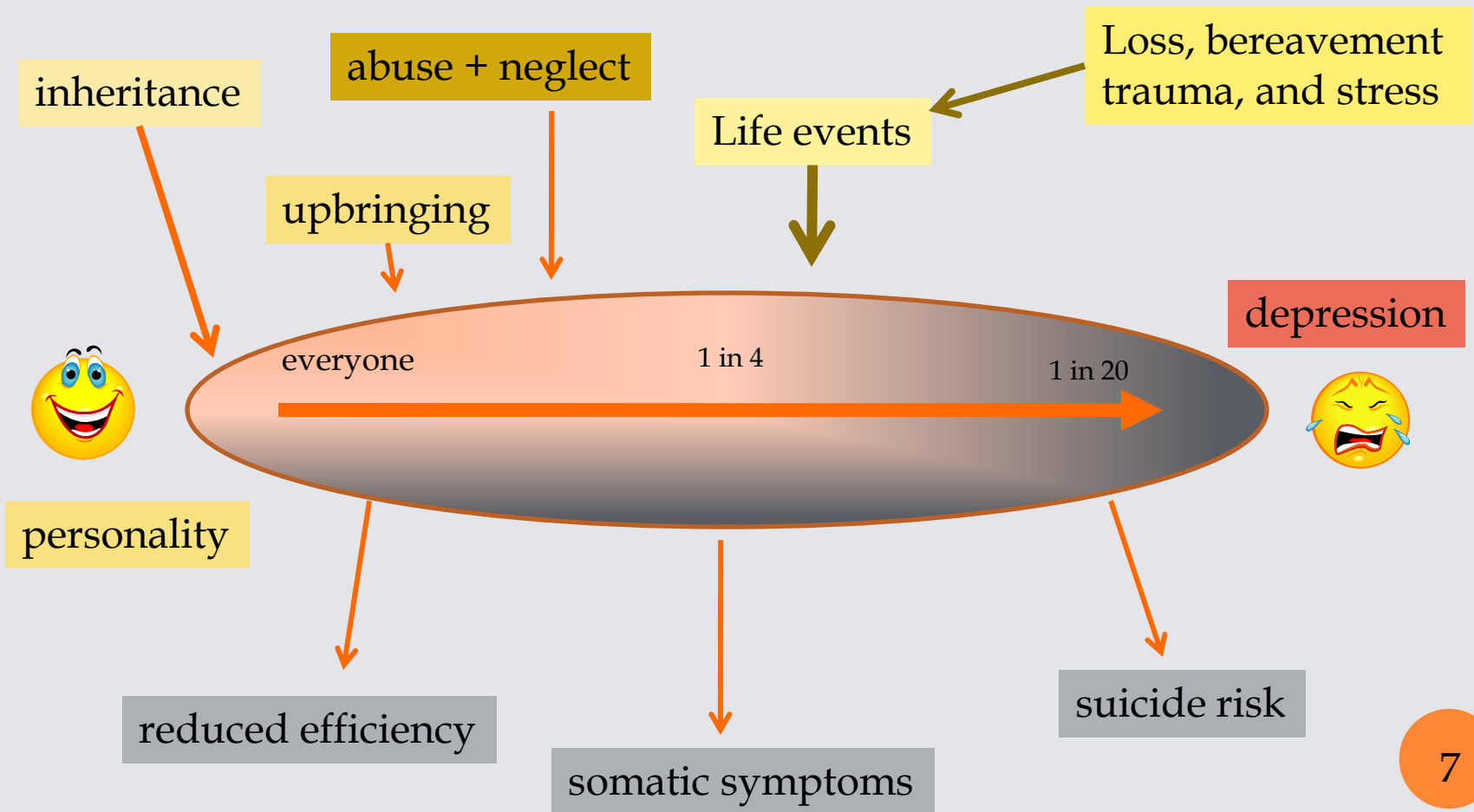
low mood

depression

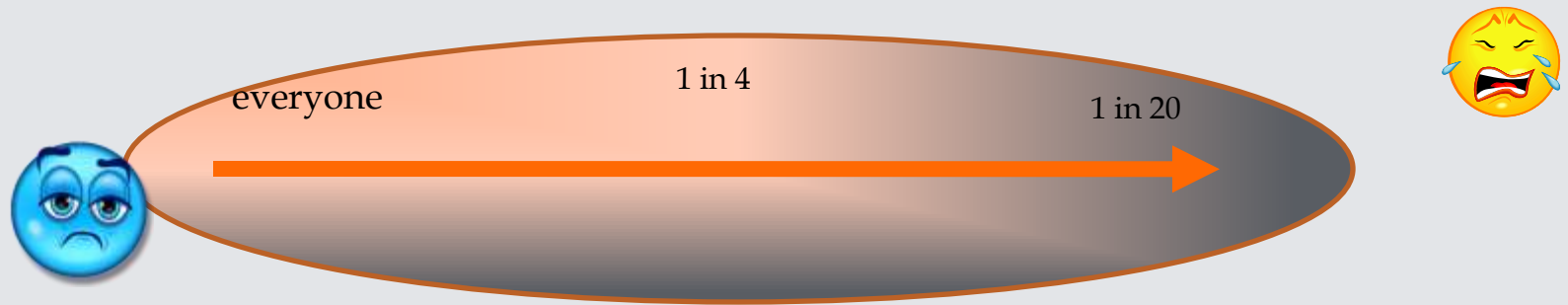


distress





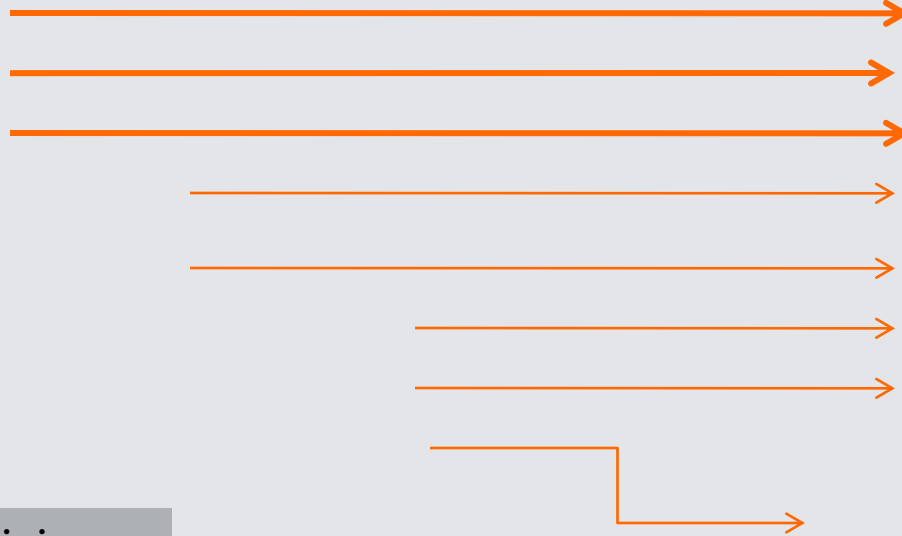
DEPRESSED MOOD SWINGS



Low mood

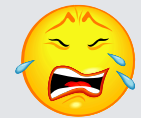
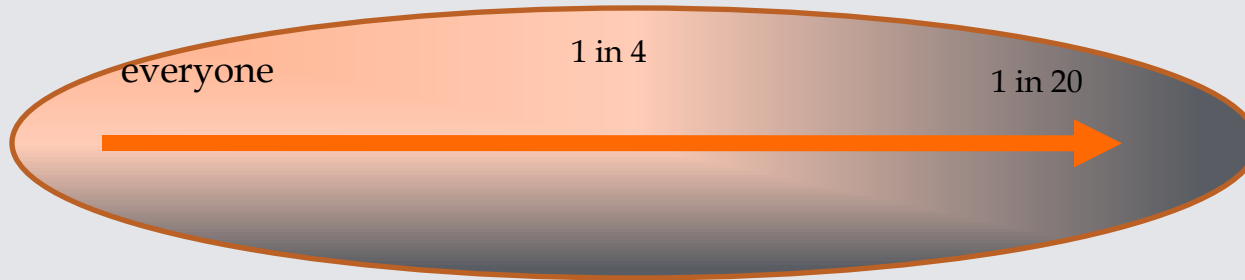
Lack of concentration

Low self-image



reduced efficiency

“SOMATIC” PHASE



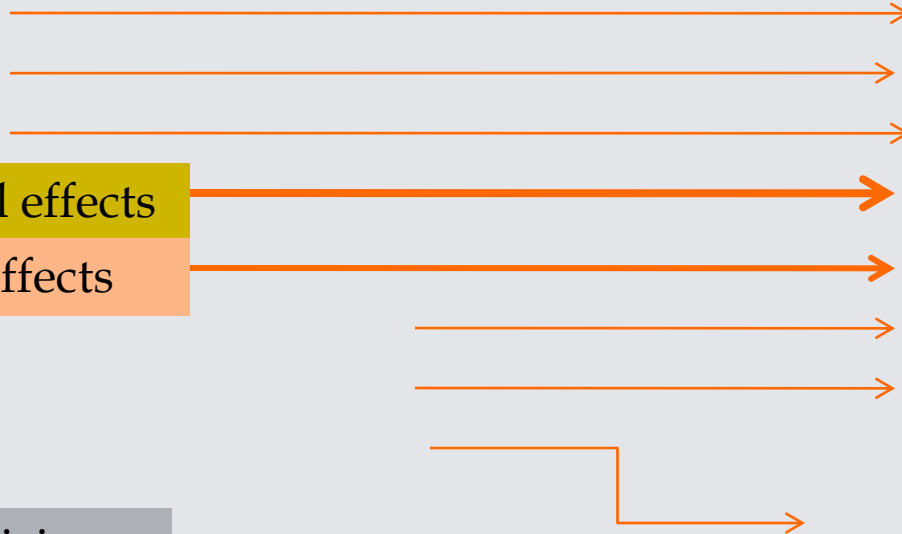
Low mood

Lack of concentration

Low self-image

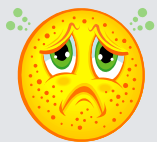
Emotional effects

Physical effects

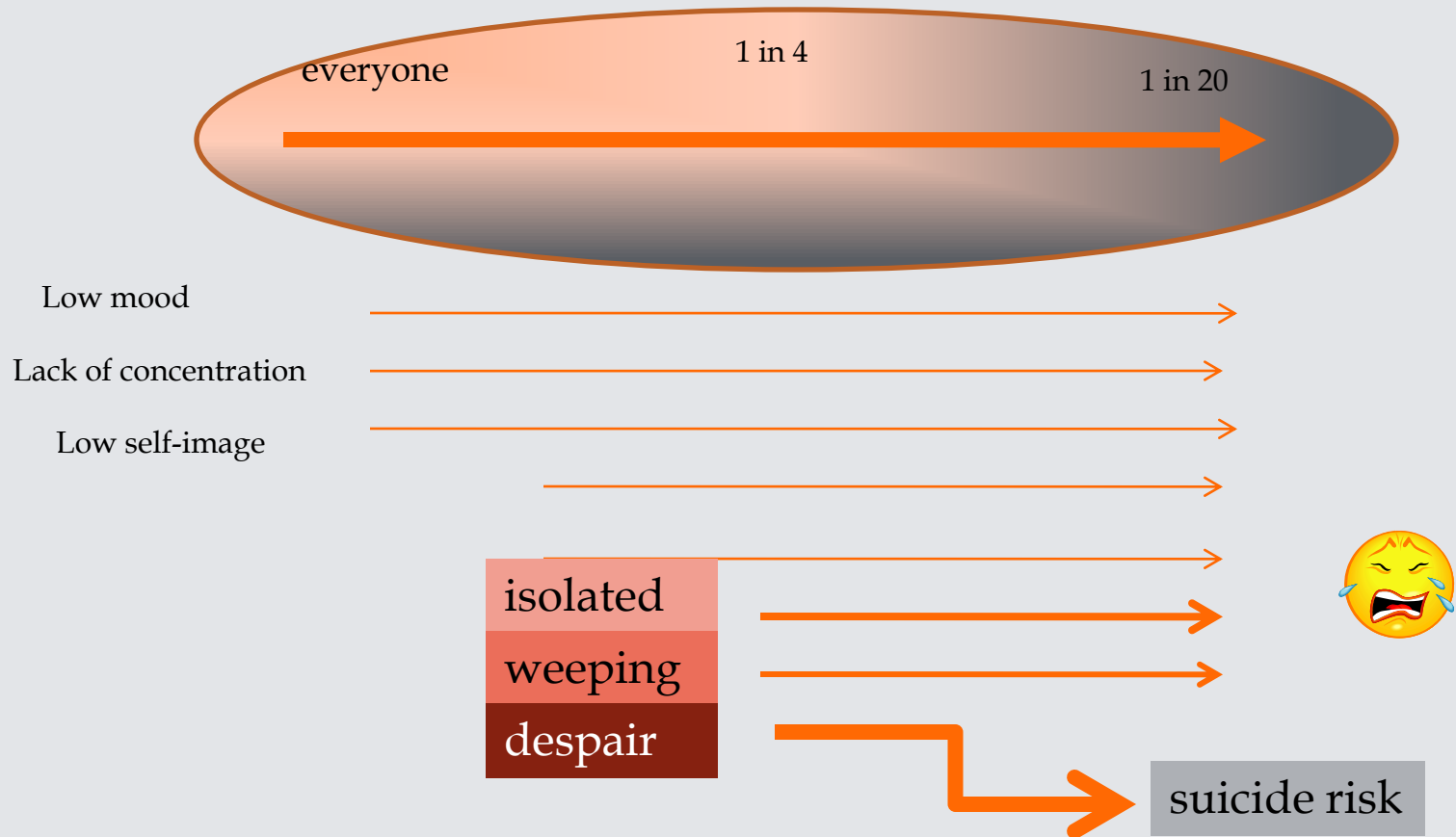


reduced efficiency

somatic symptoms



MAJOR DEPRESSION



TYPES OF DEPRESSION

- Endogenous or Reactive
 - unknown cause - reaction to adverse events
- Neurotic or Psychotic
 - mild malfunctioning - major disorder
- Bipolar disorder
 - mania - depression
- Dysthymia
- Mental illness associated with -
 - Anxiety
 - Addictions
 - PTSD

DYSTHYMIA

- **From Wikipedia, the free encyclopedia**
- **Dysthymia** is a chronic mood disorder which falls within the depression spectrum. It is considered a chronic depression, but with less severity than major depressive disorder. This disorder tends to be a chronic, long-lasting illness. Dysthymia is a type of low-grade depression.

Harvard Health Publications states that, “the Greek word dysthymia means ‘bad state of mind’ or ‘ill humor’.

As one of the two chief forms of clinical depression, it usually has fewer or less serious symptoms than major depression but lasts longer. At least three-quarters of patients with dysthymia also have a chronic physical illness or another psychiatric disorder such as one of the anxiety disorders, drug addiction, or alcoholism”.

The Primary Care Journal says that dysthymia “affects approximately 3% of the population and is associated with significant functional impairment”. Harvard health Publications says: "The rate of depression in the families of people with dysthymia is as high as 50% for the early-onset form of the disorder." "Most people with dysthymia can't tell for sure when they first became depressed".

SPECIAL GROUPS

- Children
- Adolescence
 - Boys – depressed
 - Girls – eating disorders
- Pregnancy and birth
- Marriage and family
- Mid-life crisis
- Severe Life Events (changes)
- Old age

- Depression is less of a mental illness and more of a PERSON ILLNESS
- It usually starts in the spirit, spreads to the mind and then involves the body
- There are many –
 - Predispositions
 - Aggravating factors
 - Direct causes

PREDISPOSING FACTORS IN DEPRESSION

- Personality type
- Genetic makeup
- Family inheritance
- Upbringing
- Life style

AGGRAVATING FACTORS IN DEPRESSION

- Poor self-image
- Neglect in childhood
- Physical and sexual abuse
- Alcohol and drug use
- Stress
- Anxiety state
- Guilt
- Life events

CAUSES OF DEPRESSION

- Life events
 - Any loss
 - Grief
 - Bereavement
 - Relationships
 - Moving
 - Job issues
- Unknown physical mechanisms
 - Are these hardware or software changes?
 - Hard-wired or open to re-programming?

CLINICAL FEATURES OF “EARLY DEPRESSION”

- Changed mood
- Changed thinking
- Changed motivation
- Change in physical functioning

ASSESSMENT OF SUICIDE RISK

- Start with gentle, open ended questions
- We all have suicidal thoughts at times
- Show trust and acceptance to overcome shame
- Look for associated risk factors -

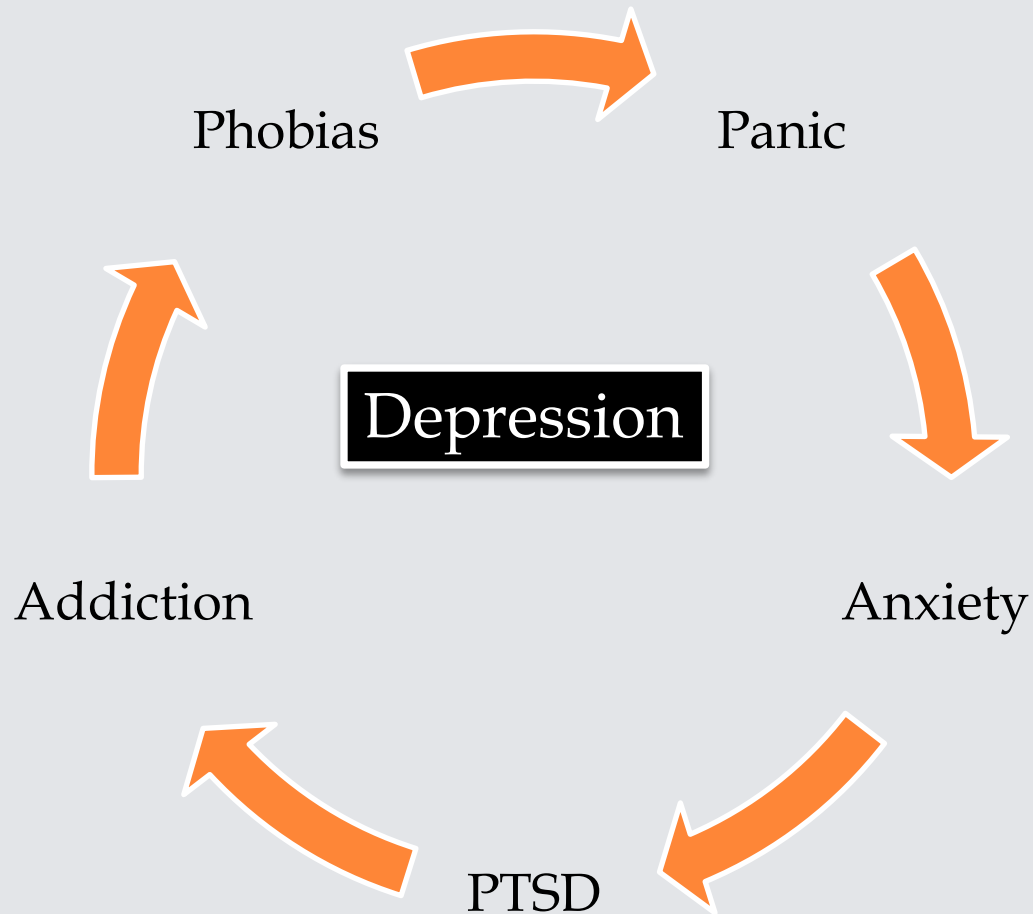
SUICIDE – ASSOCIATED RISK FACTORS - MEN

- Hopeless and worthless feelings
- Sleep disturbance
- Pain and poor physical health
- Loneliness
- Loss
- Alcohol
- Family History
- Previous suicide attempt

SUICIDE – ASSOCIATED RISKS IN WOMEN

- Death of mother when a child
- Parental separation, especially before 12 yrs old
- Poor close relationships
- No work or children

DEPRESSION MAY BE LINKED TO OTHER MENTAL ILLNESSES



SO HOW HEALTHY AM I?

- Mood
 - Paranoia
 - Obsessions
 - Anxieties
 - Fears
-
- How do I deal with these?
 - How did my upbringing affect me?

SMALL GROUP DISCUSSIONS

- Groups of 3 (more than 2 and less than 5)
- Confidential
- Cover with prayer
- Sharing of self in a trusting relationship
- Be honest
- No pressure to share anything
- Take the freedom to “pass” if appropriate
- Finish with giving it all to God



SESSION 2

Managing Depression

MANAGEMENT OF DEPRESSION

- 1 Build a trusting relationship
- 2 Be-friend
- 3 Listen
- 4 Support
- 5 Encourage
- 6 Talking therapies
- 7 Behaviour Therapy
- 8 Spiritual engagement
- 9 Medication
- 10 Referral

1 BUILDING TRUSTING RELATIONSHIPS

- Essential first requirement
- Core counselling competencies
 - Acceptance (Compassion or love)
 - Build trust (Confidentiality)
 - Non-judgemental
 - Appropriate sharing of self
- Commitment to the journey

2 BE-FRIEND

- Story of Johannes Facius
 - He describes how friends took him in and walked through the illness with him.
- “What a friend we have in Jesus”
 - But the presence of Jesus is usually absent at the beginning of depression, so we must be Jesus for them.
- Make no judgements

3 LISTENING

- Who do you listen to?
- Patient
 - Words
 - Method of communicating
 - Body language
- Story
- Person
- Carers and relatives
- God

LISTENING SKILLS – NARRATIVE MEDICINE

- Ability to actively listen is the core of help in mental illness.
- Skills of listening
 - Pay attention
 - Be interested
 - Be concerned
 - Be in relationship
 - Sharing
 - Go with them on the journey

IMPORTANCE OF NARRATIVE

- Life is a story
- Who do we tell our story to?
- Do we know what our story is?
- The more we tell, the more we understand
- Can we change our story?

- Narrative medicine helps the patient to make sense of their pain and suffering so that they can cope with it. It gives them the power to change their story to a healthier one.

TELLING THE STORY

- Telling their story increases a person's understanding of their health.
- Importance of language – verbal, non-verbal and emotional.
- The more times the story is told the nearer it can come to the truth.
- The story is told within the context of a trusting relationship

SEEKING THE TRUTH

- As the person increases in their understanding of the truth about their health issues so they have the power to become healthier
- They can then better adapt, cope, make allowances, take action, seek appropriate help, make better decisions etc.

4 SUPPORTING

- Be there and available
- Give time, but keep boundaries
- Be committed to the whole journey
- Expect set-backs
- Have hope in your own heart
- Encourage self-help as appropriate

5 ENCOURAGING

- Relate to them as a person not a patient
- Being a friend is probably the most important thing you can do.
- Praise their successes
- Commiserate with their failures
- Keep hope alive

6 TALKING THERAPIES

- Self-help groups
- Medical consultation with nurse or doctor
- Counselling in NHS
- Brief intervention therapy
- Counselling for special problems (eg marriage)
- Psychology
- Clinical psychotherapy
- Psychiatry

7 BEHAVIOUR THERAPY

- CBT is the flavour of the month

“An individual’s emotional response to an event or experience is largely determined by the conscious meaning placed upon it”

Beck 1979

It’s what we perceive that is important.

We all have bad experiences, what we think about them in our hearts determines how we react.

CBT OUTLINE

○ Behavioural Techniques

- Weekly activity scheduling
- Mastery and Pleasure ratings
- Graded task assignments
- Task Assignment

○ Cognitive techniques

- Eliciting automatic thoughts
 - Emotion - Dysfunctional schema - negative automatic thought
- Testing automatic thoughts
- Identifying and modifying schemas

8 SPIRITUAL ENGAGEMENT

- Be wary of the two extremes –
 - Leaving God out of it altogether
 - Believing that it all has a spiritual dimension
- Pray silently and listen to God, both for the patient and for yourself.
- The joy of “words of understanding and wisdom”, but be careful how you use them.

- We need to move from the “Cure of minds” to the “Care of souls”
- Where the soul is the whole person
- The spirit cannot be divorced from the person, everything has a spiritual dimension.
- Counselling is the exploration of the EXPERIENCE and its MEANING
- Helping the client to understand the importance of the spiritual dimension
- We need to understand what the spirit is!

THE THREE WINDOWS

○ **Physical window**

- Normal 'medical model' view of problems, translated into a whole-person approach

○ **Psychological window**

- Normal psychological counselling viewpoint looking at mind, emotions and life events

○ **Spiritual window**

- Looking at the spiritual and religious aspects of a person's health problems

7 STAGE MODEL OF THE HUMAN SPIRIT

- 1 Self-image
- 2 Relationships with others
- 3 Relating to the world
- 4 Moral and ethical practice
- 5 Purpose and meaning in life
- 6 Decisions, choices and Will
- 7 Belief and faith

1 SELF IMAGE

- Each person is a **unique** individual
- View of themselves and **self-understanding**
 - Realistic view of strengths and weaknesses
- Ability to “**love**” **self** and then others
- Ability to grow and **mature** and acquire **wisdom**

2 RELATIONSHIPS WITH OTHERS

- Family
- Friends
- Strangers

- Quality of ability to relate, to give and receive love, to mend broken relationships and relate appropriately in different situations

3 RELATING TO THE WORLD

- Locus of control – themselves or others?
- Attitudes to work
- Social responsibilities
- Cultural influences
- Creativity

4 MORALITY AND ETHICAL PRACTICE

- Basis of their personal ethics
- Are they based on external standards
- Attitude to religious standards of morality
- How aware are they of their conscience?
- Attempts to act morally and consequences

5 PURPOSE AND MEANING

- What hope do they have for the future?
- Priorities in life
- What fulfilments and disappointments have there been?
- What are the desires of their heart?
- What do they see as the purpose of life?

6 DECISIONS, CHOICES AND WILL

- Making good decisions
- This means understanding and making good choices
- Will Power to follow good path
- Perseverance
- Facing challenges

7 BELIEF AND FAITH (VALUES)

- What do they put their faith in (faith is belief in action)
- Concentrate of health and healing rather than everything in life
- Beliefs which were handed down to them
- What do they actually believe in ?
- How do they put their faith into practice?

- It is important to remember that we are not “treating” spiritual or religious problems, nor are we evangelising people.
- Our job is to help the person to explore their real problems and then empower them to seek the appropriate help they need to move towards health and maturity

9 MEDICATION

- There are many anti-depressant drugs
- Most trials show that they are of value
- Nearly all drugs have side-effects, which usually lessen with time
- Always encourage patients to comply with medical treatment, and see yourself as one part of the therapeutic armamentarium

10 REFERRAL

- Don't go out of your depth
- Most serious depressives need more than one line of treatment
- Always value a different opinion (even from a "Godless, mad psychiatrist")
- Never contradict medical advice, but you may need to help the patient make decisions about treatment

RELATIONSHIPS

- Between Counsellors and –
 - Medical Professionals
 - Secular Psychologists
 - Family members and carers
 - Clients (patients)

DISCUSSIONS IN SMALL GROUPS

- Bad experiences (about counselling or helping people with depression) I have had in the past
- Good experiences
- What training (knowledge, skills and attitudes) I need

SESSION 3

Counselling Skills

PRACTICING MY COUNSELLING SKILLS

- How do I grow as a whole person?
- What skills do I need to develop?
- How can I measure my progress?

SPECIAL ISSUES IN COUNSELLING

- Mood swings in the client
- Controlling emotions
- Dealing with inheritance
- Healing the past
- Dealing with Abuse
- Life events and stress

COMPLICATING ISSUES

- Somatisation
- Guilt
- Self-esteem
- Suicidal thoughts
- Hearing voices

WHERE IS GOD IN ALL OF THIS?

- In Christian counselling God is always present, but we have to wait for His timing
- We bring God (and Jesus) into the consultation in a non-threatening way
- God can deal with the anger, frustrations and doubts of both counsellee and counsellor

MANAGING RELIGIOUS ISSUES

- Active listening of the “true” story
- Non-judgemental hearing of the person
- Acknowledging their questions, doubts and fears
- Encouraging their quest
- Bring God into the relationship in an open way

DEALING WITH SPIRITUAL ISSUES

- Don't mix counselling with spiritual direction, evangelism or discipleship
- Have good referral routes mapped out in advance
- Make sure you have your own spiritual director and counselling supervisor
- Value in having a peer supervision group as well

VALUE OF SMALL GROUP SESSIONS

- We all have similar problems
- Testing of counselling skills in an environment which is constructively critical
- Learn to share yourself in appropriate ways
- Fulfills part of the need for supervision

LISTENING TO THE STORY

- In small groups – one is the “speaker”, one the “listener” and one the “observer”
- Take it in turns to be each
- Around 15 to 20 mins. of “Telling my story”
- “Listener” then summarises and gives feedback

- May need to take notes, the summary and agreement of “talker” and “listener” is important
- Then “observer” comments on positive aspects of the inter-action and may indicate possible areas of improvement.
- End with prayer

THESE SLIDES ON THE INTERNET

- Powerpoint and PDF version on –
- www.wphtrust.com
- On home page click “Resources Index”, then
 - “Teaching Resources”
 - “Index of Articles”
 - “Article 14 Depression – a counselling perspective”
 - Download as .pdf or powerpoint file