Counseling Depression
Understanding Its Causes and Cures[1]

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"Depression is anger turned inward."[2] That sounds so simple -- so easy to resolve. But is it really that easy, and, is the cause so simple?

Before modern psychology, depression was often called "melancholia." It was believed that depression had something to do with the "black bile" produced by the body (hence, melan (black) cholia (bile)). Medical doctors used techniques that we would find less than appropriate today in order to adjust the amounts of black bile in the body.

Introductory Notes

When we say someone is "depressed," we are usually speaking of a vague symptomology. The person is sad or blue. They may have some physical issues like eating disturbances or sleeping problems. They may also be experiencing interpersonal issues like an unwillingness to interact fully with others. Their thoughts may be jumbled and confused and the person may find it hard to think straight or to concentrate.

These symptoms really don't get us very far in a clear understanding of what is happening inside of the individual. That fact makes effective treatment of "depression" very hard. Unless we have a clearer understanding of exactly what the root cause of the depression is, we cannot effectively treat it.

Whatever the cause of an individual's depression is, it can be classified now as a medical disorder. The professional psychological and medical world has recognized that depression is much more than a person having an attitude that they need to "shake off." Depression is real. It

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[1] A significant amount of the information found in this article was compiled from a volume from the Mayo Clinic on the topic of depression. Every therapist who deals with depression on a regular basis should consider purchasing the book. Kramlinger, Keith M.D., Editor. ***Mayo Clinic on Depression***. Mayo Clinic, Rochester, MN. 2001.

[2] Carter, Les Ph.D. and Minirith, Frank M.D. ***The Freedom from Depression Workbook***. Thomas Nelson Publishers, Nashville, TN. 1995. P. 17. Much more will be said about the association between anger and depression later in this article.

can be lethal under the right mix of circumstances. It can also lead to patterns in brain chemistry that become harder and harder to reverse as time goes on.

For that reason, any counselor or therapist who encounters a "depressed" person should take a comprehensive inventory of that individual so that they can better assess the severity of the depression and the origins of the depression. These steps will better enable the therapist to formulate a plan to effectively deal with the individual's depression.

Depression might be purely situational -- related to events that are transpiring in a person's life. It might be biochemical, related to hormonal imbalances in the brain. It might be due to a medical condition such as diabetes or heart disease. It might be a combination of all three. Even worse, sometimes we don't know which one came first. That complicates treatment of depression significantly.

Generally, depression causes changes in a person's mood (i.e. sadness), in their cognition (lack of concentration), in their physical state (sleep and eating disruptions) and in their behaviors (self-respect and esteem issues).

Fifteen Signs of Depression

The Counseling and Assessment Software measures the degree to which a person is experiencing depression on the QuikTest Assessment. That Assessment contains fifteen items related to depression.

Whenever a therapist encounters an individual that is experiencing depression, QuikTest should be administered. This 10 minute Assessment will allow the therapist to see the severity of the individual's depression very quickly. Once QuikTest is administered, the therapist may wish to review each of the fifteen items with the individual to discuss particular situations about each of those items.

The fifteen items that measure depression form the QuikTest Assessment are:

- I have feelings of failure.
- I have feelings that no one really loves me.
- I am happy.
- I can't think quickly.
- I feel worn out.
- I tend to worry.
- I feel low or blue.
- I am satisfied.
- I feel that life is a burden.
- I don't desire to talk.
- I feel unable to cope.
- I lack confidence in self.
- I feel lonely.

- I am critical.
- I don't feel like working.

DSM Diagnostic Criteria

An important step in healing depression is properly understanding exactly what is wrong with the client. We have already mentioned that the term "depression" is very vague. It offers no exact symptomology by which we can diagnose the individual. And, the way that we diagnose the individual will most assuredly have an impact on the way that we treat them.

Therefore, the second step in the assessment process (after we have determined the severity of the disorder) is to determine more fully what type of disorder the individual is suffering from.

While it might appear that depression is the main issue in a client's mental and psychological disorder, that might not be the case. The therapist should carefully examine the next section of this article. Depression may not be the primary factor at all. Some other Disorder may be primary and depression may only be a secondary characteristic of that primary Disorder. That fact will significantly alter any effective treatment plan for the client.

The DSM IV contains four major Disorders that all include depressive symptomology. Other criteria associated with each of these Disorders will help us understand exactly what is affecting the client.

Let's look briefly at each of these Disorders.[3]

Major Depression (296.20)

The essential feature of a Major Depressive Disorder is a clinical course that is characterized by one or more Major Depressive Episodes without a history of Manic, Mixed, or Hypomanic Episodes. The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. At least four sub-criteria must be met over that 2-week period of time. Therapists must consult the DSM-IV for further defining criteria. This subtype is used in cases where there has not been a previous history of a Major Depressive Disorder. [There are additional Major Depression diagnoses. This one has been chosen as an example.]

Dysthymia (300.4)

The essential feature of Dysthymic Disorder is a chronically depressed mood that occurs for most of the day more days than not for at least 2 years. At least 2 more criteria must be met. Therapists must consult the DSM-IV for additional criteria so that Dysthymic Disorder may be differentiated from a Major Depressive Episode.

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[3] The therapist is strongly encouraged to consult the full DSM IV descriptions for each of these disorders. It is imperative for the therapist who deals with depression on a regular basis to fully understand each of these disorders so that proper diagnosis and treatment can be made quickly. The information provided in this article is only a brief summary and comparison of the Disorders and should not be considered as a complete synopsis of each Disorder.

Adjustment Disorders (309.x)

The essential feature of an Adjustment Disorder is a psychological response to an identifiable stressor or stressors that results in the development of clinically significant emotional or behavioral symptoms. This subtype should be used when the predominant manifestations are symptoms such as depressed mood, tearfulness, or feelings of hopefulness. [There are additional Adjustment Disorders. This Disorder has been chosen since it has depressive symptomology.]

Bipolar Disorder (296.50)

The essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. The therapist must consult the DSM-IV for further criteria. This subtype is used when the most recent episode has been a depressed episode. [There are additional diagnoses related to Bipolar Disorder. This Disorder has been chosen since it has depressive symptomology].

Clinical Disorders Often Associated with Depression

Anxiety Disorders

It seems odd at first that depression and anxiety can co-exist in a client. It would appear that if they are depressed they would not be able to be anxious. Depression tends to slow down the individual's body and thought processes while anxiety sends them racing.

Though it might at first seem almost contradictory for both conditions to co-exist, that is in fact a very real possibility. Many people who suffer from depression also have significant anxiety factors present also.[4]

Theoretically, here's how both depression and anxiety co-exist.

Depression acts to slow the individual down. They don't move as fast. They don't think as fast. They don't feel like communicating and engaging others. The brain "knows" that something is not right. Therefore, the brain releases hormones to counteract the depressive symptomology. Those hormones often result in anxiety symptoms.

The presence of both anxiety and depression in a person (which is very common) can be compared to a car. The driver is sitting in the car with the engine on, their foot is on the gas racing the engine, and the car is still in neutral -- they aren't going anywhere. The engine is racing but the car is not moving. The same is true for the person experiencing both anxiety and depression at the same time.

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[4] The reader is reminded that QuikTest (from the Counseling and Assessment Software) is a measurement of both anxiety and depression. The therapist who uses QuikTest will be able to see the levels of both anxiety and depression immediately. This may help significantly in the whole diagnostic process as the therapist looks for these Disorders often associated with depression.

When a person is experiencing both of these issues at the same time, usually one or the other will be dominant at any given time. Also, usually one or the other will be the predominant factor. Either depression will be predominant and anxiety will be a secondary factor, or anxiety will be predominant and depression will be a secondary factor. It is critical to the proper treatment of the client for the therapist to determine which disorder is predominant.

The therapist will want to examine the results from QuikTest carefully. Usually, the therapist will see that either the depression score or the anxiety score is elevated significantly above the other. The highest score (if there is one) may be the predominant factor. It should point the therapist in the right diagnostic direction.

Here is a brief overview of some of the Anxiety Disorders that might accompany some form of depression.

Generalized Anxiety Disorder (300.02)

The essential feature of Generalized Anxiety Disorder is excessive anxiety and worry, occurring more days than not for a period of at least 6 months, about a number of events or activities. The individual finds it difficult to control the worry.

Social Phobia (300.23) (DSM III - Social Anxiety Disorder)

The essential feature of Social Phobia is a marked and persistent fear of social or performance situations in which embarrassment may occur. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response.

One third of all individuals suffering from Social Phobia also experience depression. If a person can be diagnosed with Social Phobia and they have accompanying depression, the proper course of long-term treatment would be to treat the Social Phobia. Treatment of the associated depression would be secondary since depression is not the root cause of the individual's mental disorder. Reduction in the depressive symptomology, however, will prove greatly beneficial in the effective treatment of the Social Phobia. Therefore, reducing the depression levels of someone suffering from Social Phobia is important.

Panic Disorder (300.01)

The essential feature of Panic Disorder is the presence of recurrent, unexpected Panic Attacks followed by at least 1 month of persistent concern about having another Panic Attack, worry about the possible implications or consequences of the Panic Attacks, or a significant behavioral change related to the attacks. This subtype is used when Agoraphobia is not associated with the Panic Attacks. [There are additional Panic Disorders in the DSM IV. This one has been presented as an example.]

Fifty percent of all individuals suffering from Panic Disorder also suffer from depression in some form.

Obsessive-Compulsive Disorder (300.3)

The essential features of Obsessive-Compulsive Disorder are recurrent obsessions or compulsions that are severe enough to be time consuming or cause marked distress or significant impairment.

Eating Disorders

Anorexia nervosa (307.1)

The essential features of Anorexia Nervosa are that the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body.

Bulimia Nervosa (307.51)

The essential features of Bulimia Nervosa are binge eating and inappropriate compensatory methods to prevent weight gain.

Body Dysmorphic Disorder (300.7)

The essential feature of Body Dysmorphic Disorder is a preoccupation with a defect in appearance.

Personality Disorders

Borderline Personality Disorder (301.83)

The essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts. Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment. The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with realistic time-limited separation or when there are unavoidable changes in plans.

Obsessive-Compulsive Personality Disorder (301.4)

The essential feature of Obsessive-Compulsive Personality Disorder is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency. The pattern begins by early adulthood and is present in a variety of contexts. Individuals with Obsessive-Compulsive Personality Disorder attempt to maintain a sense of control through painstaking attention to rules, trivial details, procedures, lists, schedules, or form to the extent that the major point of the activity is lost. They are excessively careful and

prone to repetition, paying extraordinary attention to detail and repetition, paying extraordinary attention to detail and repeatedly checking for possible mistakes

Physical Issues Associated with Depression

Hormonal Issues

Changes in hormones in the body can bring about depression. In such cases, the therapist may work very hard in therapy sessions to help the client through their depression. Yet, the therapist may see little or no results since the primary cause of the depression is hormonal in nature.

Any therapy for depression that goes on for some time without results should be a "red flag" to the therapist. This is especially true where the therapist cannot specifically determine a reason why there are no results. This should be an indication to the therapist that the client may need to have a thorough medical exam to look for physical causes to the depression.

Here is a simple list of some of the most significant hormone issues that can cause or contribute to depression.

- **Thyroid issues** -- Both hyperthyroidism and hypothyroidism can contribute to depression.
- **Adrenal Issues** -- The adrenal gland is located near the kidneys -- excess cortisol (a hormone) directly effects brain function and can contribute greatly to depressive moods.
- **Stress hormones** -- Pituitary peptides are often produced in the brain of individuals who suffer from prolonged stress. This condition (often accompanied by anxiety issues) can lead to a person being worn out and depressed.
- **Sex hormones** -- Increases or decreases in both estrogen and testosterone are a major cause of a biological imbalance that can lead to depression. As a person approaches mid-life, these hormones naturally decrease in the body. The therapist should be aware of the age of a depressed person and take this issue into consideration.

Other Medical Issues Associated with Depression

Almost any serious or long-term medical condition can contribute to depression in the medical patient. There are three medical issues, however, that are very often associated with depression. Those medical issues are diabetes, heart disease, and cancer.

The fact that medical issues can be associated with depression should be a good reason for the therapist to make a complete assessment of the individual who comes into counseling. The therapist should always inquire about the medical condition of the client and should code any medical issues on Axis III of the DSM IV diagnosis. That information may become vital in later counseling sessions.

Secondary Depression

The client experiencing a depressive episode may also be experiencing a medical issue. If they are experiencing a diagnosable medical condition (diabetes, heart disease, cancer, or any other significant health threatening medical condition) the depression that they are suffering would be considered secondary. The physical malady would be considered the primary medical condition.

Comorbid Depression

Comorbid Depression is a condition wherein a depressive diagnosis can be made and another DSM IV diagnosis is also present. For example, if a person is suffering from a Major Depressive Episode (Major Depression) and they are suffering from Panic Disorder at the same time, that condition would be termed Comorbid Depression.[5]

Medications

More frequently than ever, the medical community chooses to deal with depression with drugs. Sometimes, medical doctors prescribe drugs for depression without recommending that the patient even consult a therapist for counseling. In my opinion, such behavior is blatantly irresponsible on the part of the medical community. If a medical doctor prescribes psychotropic drug agents to a patient, then the patient must also be referred to psychological care.

There is a very high likelihood that the issues that have brought about the depression in the patient's life have something to do with behavior or with the way they relate to the world. Very rarely is a depressed individual's condition purely medical in the sense that only brain chemistry is causing the depression. In those cases where other issues contribute to the depression, simply tossing drugs at the depression will not work. Worse yet, it may only complicate the patient's whole psychological condition.

There may be occasions where drug therapy for psychological and mental disorders is absolutely mandatory. On other occasions, such medication may be beneficial to the speeding of a client's recovery. Those decisions, however, should not be made by medical doctors acting without consultation from a qualified professional in the psychological fields.

Selective Serotonin Reuptake Inhibitors (SSRI)

Among the medical community, the "drug of choice" for dealing with depression is a class of five agents called ***Selective Serotonin Reuptake Inhibitors*** (SSRI or simply SRI for short). Among the most popular drugs in that class are the agents commonly called ***Zoloft*** and ***Paxil***.

Without becoming overly technical, these drugs act by stopping the neurotransmitter serotonin from returning to its home cell -- the cell from which it came. Thus, the drug is called a serotonin reuptake inhibitor. Medical science has determined that this event occurs many times in cases of

[5] Comorbidity, however, is not a recognized and coded Disorder. It is only used as a clinical definition of the client's overall condition.

depression. Although it might seem reasonable to stop the reuptake of serotonin, that simple process may not be a "cure" at all for the problem.

The real question is "why" is serotonin returning? What is causing this physical event to transpire? Is this a purely physical event or is something else happening that is causing it? And, if something else is causing it, is it a good idea to prevent what appears to be a natural physical reaction from happening? Will a change in the levels of depression through therapy also reduce serotonin reuptake? All of these questions go largely unanswered by the medical community.

Any therapist who is counseling an individual using a SSRI should be aware that there are some rather serious side effects attributed to that class of drugs. One of the most well known of those effects is sexual. Approximately 30% of all individuals on SSRI drugs report severe sexual side effects including loss of desire and other sexual complications. Gastrointestinal side effects are also widely reported. It would be very wise for the therapist counseling an individual taking an SSRI to completely research all potential side effects of the drug class. Some of those side effects are psychological and mental in nature and may very well interfere with the progress of therapy itself.

SSRI drugs also interact with some common herbs (some of which may be used by depressed individuals). The most common interaction is with St. John's Wart -- an over-the-counter herb commonly used by depressed individuals for relief of depression. The reaction between SSRIs and some herbs may be fatal. Very innocently, a therapist could tell a client to go to a health food store and pick up St. John's Wart to help them relax not realizing that their suggestion may kill the client.

SSRIs may also interact seriously with other antidepressants and with alcohol.

Other Drug Classifications

Other drug classes are used less commonly than SSRIs for treatment of depression. Those classes include:

- Mixed reuptake inhibitors -- which block more than just serotonin
- Receptor blockers
- Enzyme Inhibitors

When a therapist encounters a new drug substance it is prudent for them to fully and completely explore all of the effects that the drug has.

The Drug Debate

The debate over medication of depression will not end any time soon. Obviously, if an individual is depressed enough that they are having a hard time functioning in society and the drug seems to relieve some of the tension, then the drug is probably worth taking for a period of time. If, however, the individual is not actively seeking therapy -- or worse yet, has not even been assessed by a therapist -- the drug has far too many dangers to continue taking it.

The medical community and the psychological community need to work hand-in-hand with clients to determine the proper medication course for the client. The general rules for use of drugs in psychotherapy may be considered as follows:

- If the drug is being used to treat a purely medical condition, then obviously it should be continued.
- If the drug is being used to prevent self-harm and the real possibility of self-harm exists without the drug, then the drug should be continued.
- If the drug is being used to arrest a psychotic condition that will otherwise result if the drug is not used, then the drug should be continued.
- If the drug is being used for relief from unpleasant emotional states for the client, the drug should only be proscribed if the client's condition will prohibit them from functioning effectively in life.
- If a client is not willing to participate in therapeutic screening prior to long-term drug prescription for psychological issues, then it is questionable if the medical community should allow the drug use.
- The drug should not be used in cases where the client can bear the emotional discomfort and engage in therapy to promote the healing process. The negative feelings and emotions are actually advantageous in the therapy process and will help the therapist get at the core issues faster. This is only the case where the client is able to bear the negative emotions and discomfort without self-harm or significant disruption of life.
- Prior to prescribing long-term psychoaffective agents (such as the SSRI category of drugs) medical doctors should work with the therapeutic community to see if drugs of shorter duration can be used -- drugs such as anxiolytics.

The Therapeutic Process

Goals in Counseling

As we have already discussed, the first step in the assessment of an apparently depressed individual is to determine the severity of the depression. That step should also include the measurement of anxiety levels to determine if anxiety is also a factor.

Once we determine the severity of the problem, the next step should be to sort through the actual Disorders in the DSM IV that might apply to the individual. The purpose of this step is to help the therapist determine the proper and most effective treatment method for the client.

After it has been determined that the individual is indeed suffering from a depressive disorder of some type, and after the therapist has determined that at least some of the depression is caused by factors not solely associated with physiology, the therapist should begin the process of helping the client out of their depression.

The mire of depression is an endless cycle. While it may "go away" by itself over time, it is more reasonable for the therapist to educate the client about things that they can do to "short circuit" the depression cycle. It is entirely possible for most depressed individuals (except for those

whose depression is purely physiological) to fight off the depression. The primary means of doing so is through knowledge of how depression works and what breaks the cycle. Thus, the first step in helping a client overcome depression is to educate them about the whole depressive cycle.

Educating the Client

It is critically important to educate a depressed person about depression. The more they know about it, the more they will be able to help themselves recover from it. Much of what follows in this article may be helpful for the client to understand. The therapist should strive to educate the client about the following issues and practices:

- Give the client general information about how depression "works"
- Tell the client what their specific depressive diagnosis is (if the therapist feels such information is beneficial to the client)
- Educate the client how to change their negative thoughts, beliefs, attitudes, and relationships
- Help the client understand their emotions
- Teach the client to express emotions properly without suppressing them and without over expressing them
- Educate the client about the effects of repressed anger and depression
- Once the client experiences significant recovery from depression, they should be instructed about warning signs of recurring depression in the future

Explaining Common Depression Triggers

It may be helpful for the therapist to explain some of the common triggers of depression to the client, if the client falls within one of those common groups. This effort on the part of the therapist may give some relief to the client who may be thinking that "something is wrong with them." It is often helpful for a client to understand that others in similar situations suffer from depression.

Common depression triggers include:

- Physical illness
- Moral indiscretion
- Change in medication
- Grief due to death of a significant person or other significant loss
- Significant life change event (retirement, job loss, residential change, beginning or ending school, etc)
- Mid-life issues -- issues that trigger thoughts about one's mortality (birth of a child, empty nest, etc).

How the Depressed Person Views Their World

An individual who is depressed will typically view the world and their relationship to it using some or all of the "techniques" found below. Read through these carefully. Discuss them with the client, especially through examples. Determine which "techniques" the client uses and help them discover ways to stop using these techniques.[6] These techniques will both cause depression and will perpetuate it once it has started. These relational techniques facilitate the continuation of depression.

Catastrophizing. When a client looks at the world in this manner, they always anticipate the worst in any situation. Sometimes this way of looking at the world will become self-fulfilling. Many times when a person expects the worst, they will subliminally engineer a way for the worst to happen.

This is a key factor in the perpetuation of depression. When a client looks at the world through catastrophic eyes, they will usually tag on other of the relational techniques when a "catastrophic event" occurs.

For example, an individual expects that a bad thing will happen. It does. They may then Overgeneralize. They may also Personalize, Emotionalize, and Filter all at the same time. Catastrophizing is an effective means of continuing the depressive cycle. It must be located by the therapist and eliminated as a means by which the client relates to his or her world.

The therapist must help the client eliminate catastrophic thinking early in the therapeutic process. A effective therapeutic method would be to discuss a broad range of events in the client's life. The therapist should look for events that could have been catastrophic but turned out good in the end. This will help reinforce to the client that not all events end catastrophically.

Elimination of catastrophic thinking patterns is key to success in the fight against depression simply because catastrophic thinking cascades into other relational techniques that perpetuate the depressive cycle.

Overgeneralizing. Often a depressed person will make the assumption that a single bad event is only the beginning of a series of bad events to come in the future. Thus, when something bad does happen, they tend to cascade a whole series of bad events that will transpire. The depressed person tends to emotionally "live out" the whole string of bad events, even though they have not yet happened.

The client must be instructed that bad events may be local events and not signals of a whole series of bad things to come. The goal of the therapist should be to bring reality to a single bad event and to bring it into it's rightful perspective. If it is possible, the therapist should isolate the single bad event and help the client separate it from all other events.

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[6] These relational techniques are all found in: Kramlinger, Keith M.D., Editor. ***Mayo Clinic on Depression.*** Mayo Clinic, Rochester, MN. 2001.

Personalizing. Depressed individuals tend to "take everything personally." Depending on the personality type of the individual this type of behavior may be quite extreme. This relational technique of a depressed person often works hand-in-hand with Emotionalizing. The individual who personalizes "assumes ownership" for things that do not belong to them emotionally.

An example of extreme personalizing would be related to events that no one has control over. For example, the depressed person realizes that they need some "down time" away from work and home responsibilities. They plan a day with their spouse at an outdoor place (a park, a beach, etc). When the day arrives, it rains all day. The individual who personalizes that event will say something like, "I knew I shouldn't have planned to go to the beach. I knew it wouldn't work out…"

The goal of the therapist must be to put events that the individual has no control over in perspective so that the client realizes not to assign personal emotional "ownership" to an event they cannot control.

All-or-nothing. Often, the depressed individual will see all life events as "black or white." The danger in this thinking is that bad events are usually turned into catastrophic events. And, for the depressed person, good events may be whisked away out of sight and memory.

The therapist should help the all-or-nothing depressed person to come toward a middle ground on things that transpire in life so that not everything is seen as being to one extreme or the other.

Emotionalizing. A most common affect of a depressed person is to be overly emotional. Events that would usually not elicit extreme emotions become occasions for many tears. The depressed individual is usually ruled by their emotions. And, those emotions are often inappropriate.

The goal of the therapist in dealing with an emotionalizing depressed client should be to place emotion back under the control of the reasoning capabilities of the person. The therapist should educate the person about their current state of allowing their emotions to run their reasoning capabilities and help the client to turn those faculties around so that the client's emotions are filtered through their reasoning capabilities.

Depressed client "prefer" to allow emotions to rule the intellect since depression is self-perpetuating and excluding reason from the equation gives them the license they need to continue on in the depressive cycle. This process must be cut off by examples in therapy and it must be lived out in daily life. Until emotionalizing is stopped depression cannot be totally reversed.

Filtering. Depression can be "beneficial" to a client in the sense that their depression sometimes gives them attention that they don't believe they would otherwise get from others. For the individual who is caught in a self-perpetuating depressive cycle and who "needs" to stay depressed to gain attention from others, filtering is an effective mechanism by which depression can be prolonged. The person who uses filtering tends to filter out the good things in life and focuses on the bad things

It should be the goal of the therapist to point out the good things that the client is filtering out so that the process of self-perpetuating depression can be short-circuited.

Things the Client Must Learn to Practice

The therapist should strive to enforce the following practices in the life of the depressed person. These practices will accentuate the healing process. The more closely the client engages these practices, the more rapidly they will see progress toward recovery from depression. The therapist should look for the inverse of each of these practices in the client's life and help them to make decisions to reverse negative practices that will slow the healing process.

The client should refrain from the following behaviors while in therapy for treatment of depression:

- The client should not engage in self-blame. This is even true where self-blame might be appropriate (e.g. a client's significant moral misbehavior that may have contributed to the depressive cycle). Even though there may be significant grounds for blame, the whole engagement of self-blame is counterproductive since it does not lead to a positive and complete resolution to the issue.
- A client must agree to follow treatment protocols exactly and as completely as they possibly can. When a client doesn't follow protocols and do the exercises assigned in therapy, the whole therapeutic process is undermined.
- In spite of the depression, a client must "fight" to stay positive -- even though the whole reason they are in therapy is because they have lost the ability to be positive. They must fight to recover a positive focus in life.
- The client must refrain from any and all major life decisions during the process of therapy for depression. Major life decisions -- even positive ones -- create stress (especially regarding brain functioning) that may prevent the healing process from moving forward.
- The depressed individual should simplify life while they are in therapy. As much "baggage" as possible should be removed.
- The client should become more active physically. This will be a very hard thing for a client to undertake since depression will make the client want to sit in front of the TV all day long. Instead of sitting in front of the TV, the client should take a walk.
- The client must recognize progress. The therapist should look for positive progress each time they see the client. There should be meaningful discussion about that progress to reassure the client that they are moving in the right direction. The smallest sign of progress may be the biggest turning point in the thinking of the client.

Anger and Depression

We started this whole discussion about depression with what appeared to be such a simplistic statement: "Depression is anger turned inward."[7] While that statement is rather simplistic and seems to imply that all depression is simply inside out anger, the statement is worth noting.

It is highly unlikely that the authors of that statement (both respected doctors) truly believe that every single case of depression is the result of internalized anger. It is true that a significant part of depression that is not brought on by other primary factors (e.g. physical issues purely related to brain chemistry) is the result of bottled up anger that has not been properly expressed.

When an individual is suffering from depression that is not a purely biochemical event, the therapist will probably be able to locate some type of resentments or repressed anger on the part of the client. That anger may be justifiable or unjustifiable. It doesn't really matter. The simple fact that the person is angry at someone or something and has repressed their anger will make them a prime candidate for depression.

All anger must be released by any individual to prevent the possibility of depression in the present or the future. A person who holds grudges or resentments is destined for a depressive episode sometime in their future.

The real issue regarding depression and anger is not the anger. It is the fact that the anger has been suppressed or buried deep within the client. Maybe there were absolutely justifiable reasons for the individual to be angry. Chances are, however, the depressed individual never expressed their anger appropriately.

The case of justifiable anger that has been buried is probably the most difficult for the therapist to rectify in the mind of the client. The client knows they were wronged by someone else. They know that there anger has justification in sound reasoning. There is good reason to be angry.

The problem that the therapist faces is instructing the client that the anger was indeed justified at the time of the "angering event" but at the present time it is not justified since the event is over. The client most likely was angered by a person or a situation that harmed them in some way. They never confronted the individual or the situation while it was still reasonable to do so. They buried their anger about the situation. Each time the situation arises (or a similar situation) the anger festers up again. They experience an "instant replay" of the original event.

Since they didn't deal with the individual or the situation while it was reasonable to do so, the problem is now more complicated. The anger that the client has buried deep inside cannot probably be expressed in the way that it should have been when it was justified. That means that even when the client finally "lets go" of the angering event, they will not have a complete resolution to the anger.

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[7] Carter, Les Ph.D. and Minirith, Frank M.D. ***The Freedom from Depression Workbook***. Thomas Nelson Publishers, Nashville, TN. 1995. P. 17.

This is a difficult issue for therapists to deal with since they must "convince" the client to fully let go of the anger without the rectification that the client knows that they are entitled to.

Since anger is many times an issue with depressed clients, it is best for the therapist to instruct the client in some type of anger management so as to prevent them burying of anger in the future.[8]

Below are some of the topics that a therapist may wish to engage when they feel that a client has significant anger issues associated with their depression:

- A client must learn to manage anger without repressing it.
- A client must learn to identify "anger triggers" -- things that make them angry.
- A client must learn to recognize signs of emerging anger.
- A client must learn to set a "time out" for themselves before they express their anger.
- A client must learn how to cognitively respond to an event that angers them. Anger must become a cognitive choice. If anger is not a cognitive choice, then guilt may be the result (which will also perpetuate the depression cycle).
- A client should look for creative ways to release anger's energy.
- A client should learn not to attack another person out of anger (verbally or physically). The result will be guilt. Once an individual attacks out of anger, however, a continuing result may be the repression of anger to avoid the guilt associated with explosive anger. Both of these instances perpetuate the depressive cycle.
- A client must learn the principles of forgiveness -- especially the release of the "guilty party" when there is nothing that the client can do about what angered them in the first place. Many people afflicted with anger management problems feel that someone or something must always be to blame for everything that happens that they don't like. If they cannot release their anger toward the guilty party, they repress it and consequently become more and more angry at the smallest things. Angry clients must learn the hard lesson of letting things go. The only other recourse is to be stuck in a depressive cycle that will not end.

Exploring the Client's Issues More Completely

When a client's depression issues seem complex -- especially when they are long-term depressive trends -- the therapist will want to explore issues as completely as possible to root out all issues that might perpetuate depression.

- Unresolved guilt issues
- Conflicts with individuals that are unresolved
- Disputes with individuals that are continuing
- Transitions and life changes (child left the home, death of someone significant, job change, etc)

[8] It is also important for the therapist to help a client determine why they buried the anger in the first place. Self-esteem issues may come into play, if the client doesn't feel worthy to express themselves regarding situations that anger them.

- Medical issues other than those already specified as contributors to depression
- Family issues
- Stress related to work environment, home environment, living conditions, or financial issues (See Axis IV of the DSM)

Suicide and Depression

Suicide is a very real factor that each therapist needs to consider when working with depressed individuals. Below is a summary of factors that contribute to the risk of suicide.

Suicide Risk Factors

- Depression -- 50% of all suicide victims are clinically depressed at the time of their suicide
- Previous suicide attempt -- 20% - 50% of all successful suicides have attempted previously and been unsuccessful
- Substance abuse -- Current substance abuse of any type is a contributing factor to suicide
- Family history of depression -- A history of depression is another indicator of potential for suicide
- Male gender -- Out of 30,000 suicides yearly, 24,000 are male. Although females attempt suicide, males succeed much more often
- Access to a firearm -- Firearms are one of the leading methods of suicide

Warning Signs of Suicide

There are some warning signs that usually accompany a suicide attempt.[9] The therapist should be aware, however, that not all suicide attempts include warning signs. Each attempt certainly doesn't have all of these signs.

Some of the leading signs are:

- Suicidal threats and insinuations
- Social withdrawal
- Mood swings
- Personality changes
- Risky behavior
- Giving away possessions
- Beginning to recover from depression

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[9] QuikTest Assessment screens for seven of the greatest suicide factors. The score for those factors is contained in the report under the heading of ***Personal Safety***. When dealing with depression, the therapist should pay close attention to the ***Personal Safety*** score of QuikTest.

Other Significant Factors in Healing Depression

There are a few other factors that play a minor role in the healing process of a depressed individual. Although these elements are minor, they may help speed the healing process. They are:

- Diet adjustments -- It may be appropriate for individual to make adjustments to their diet while in therapy to eat a more balanced and a more healthy diet. Junk food contributes to stresses on the body that only accentuate the problems that a person is already experiencing.
- Exercise -- Exercise is always a healing thing. A person who is depressed may find it helpful to increase their activity level.
- Sleep -- Sleep is almost always an issue with depressed people. They either get too much or not enough. It is not uncommon for a person who is depressed to sleep 12 hours per day. It is also not uncommon for them to spend most nights restless and half awake. It is important for an individual in therapy for depression to get 7 to 8 hours of sleep per day -- no more and no less. The individual may need to see a medical doctor for sleeping medication, if they have a problem sleeping. Sleep is very important to proper recovery from depression.

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