Person-Centred Experiential Counselling *for* Depression

2nd Edition

DAVID MURPHY

bacp
British Association for
Counselling & Psychotherapy

SAGE
Los Angeles | London | New Delhi
Singapore | Washington DC | Boston

Los Angeles | London | New Delhi
Singapore | Washington DC | Melbourne

SAGE Publications Ltd
1 Oliver's Yard
55 City Road
London EC1Y 1SP

SAGE Publications Inc.
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road
New Delhi 110 044

SAGE Publications Asia-Pacific Pte Ltd
3 Church Street
#10-04 Samsung Hub
Singapore 049483

First edition © Pete Sanders and Andy Hill, published 2014.
Reprinted 2015, 2016 (twice), 2017 (twice), 2018

This second edition published 2019

Editor: Susannah Trefgarne
Assistant editor: Talulah Hall
Production editor: Rachel Burrows
Copyeditor: Solveig Gardner Servian
Proofreader: Brian McDowell
Indexer: Gary Kirby
Marketing manager: Samantha Glorioso
Cover design: Sheila Tong
Typeset by: C&M Digitals (P) Ltd, Chennai, India
Printed in the UK

Library of Congress Control Number: 2018967072

British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library.

ISBN 978-1-5264-4680-0
ISBN 978-1-5264-4681-7 (pbk)

Contents

3

The Person-Centred Experiential Theory of Depression

Chapter overview

- The phenomenology of depression
- The nature of the self
  - The self as a concept
  - The self as an organism
  - The pluralistic self
- Self-discrepancy
  - Higgins's self-discrepancy theory
  - Self-discrepancy and depression
- Other self-configuration dialogues
  - Conflict splits
  - Self-critical dialogues
  - Other problematic psychological processes related to depression
    - Emotional overwhelm
    - Problematic reaction points
    - Meaning protests
    - Unfinished business
- The nature of emotions

The previous chapter provided a general grounding in the development of PCE therapy as an evolution of the person-centred paradigm and specifically introduced the core theory and elements that go into making up this approach. This chapter assembles and examines in more depth those aspects of theory which relate directly to the practice of therapy with clients who experience depression.

Before looking at the theoretical underpinning of the experience of depression, we must remind ourselves that although the PCE theory of personality and psychological distress is a universal theory, this does not prevent us selecting a set of client experiences (the phenomenology of depression) and turning our attention to examining the specific elements of theory which help us understand those experiences, how they are formed and what might be useful to clients experiencing such phenomena.

This chapter[1] first presents the description of experiences that are most commonly clustered together and given a label of 'depression'. It then describes the theoretical basis of PCE-CfD by presenting four cornerstones of the approach to the experience of depression:

- the nature of the self
- self-discrepancy
- self-configuration
- the nature of emotions.

These are elucidated further by proposing ten hypotheses that can be empirically tested.

The phenomenology of depression

The term 'depression' is commonly used within everyday language and is generally understood to refer to persistent low mood that is accompanied by a feeling which is experienced as hopelessness and helplessness in anticipating a change in the low mood. However, whilst common features prevail many people will experience the phenomenology of depression as quite specific to them. As we have outlined in Chapter 1, the PCE approach does not rely on the use of diagnosis and is instead premised on a growth metaphor. Nevertheless, for practitioners working in healthcare settings where the language draws upon a medicalised vernacular it is useful to be able to understand what is meant by such terms as major depressive disorder (MDD). MDD is described in the DSM-5 (APA, 2013: 160–61) as:

a. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning;

[1]This chapter also draws on the first edition of the textbook and therefore acknowledges Sanders and Hill (2014) as the creators of much of the content.

at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

i. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful). (Note: In children and adolescents, can be irritable mood.)
ii. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
iii. Significant weight loss when not dieting, or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
iv. Insomnia or hypersomnia nearly every day.
v. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
vi. Fatigue or loss of energy nearly every day.
vii. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
viii. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
ix. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

b. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
c. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode.

Note: Responses to a significant loss (e.g. bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgement based on the individual's history and the cultural norms for the expression of distress in the context of loss.

d. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

e. There has never been a manic episode or a hypomanic episode.

   Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Within the DSM-5 there are in fact a number of 'depressive disorders' that are considered specific and differentiable conditions. These include 'disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder' (APA, 2013: 155). The DSM-5 claims that all these variations of experience share the experiencing of sadness, emptiness or irritable mood that come with somatic and cognitive changes to the capacity to function properly. However, as is typical of medicalised models of distress, the root causes of such experiences are considered to stem from various sources. It is also the case that these different experiences of depression can last for a variable period and might have specific times in the life cycle when they appear.

Here we are primarily concerned with what is described above as the major depressive variation on experience. For the sake of theoretical integrity, any attempt to help a client is reasonably expected to be preceded by an adequate explanation of the phenomenology of the client's experiences. This might be in the form of a heuristic description as to how the experience might have arisen, and this is set in accordance with the theory. The theory must also be mapped directly on to a coherent rationale for therapeutic practice. In the sections that follow, this heuristic is presented for PCE-CfD to account for the experience of depression within the context of the theory of distress that informs the therapeutic practice.

The nature of the self

The term 'self', as used widely in psychology and everyday life, has many meanings. It has been pointed out by many writers that the self is an ethnocentric construct originally accepted uncritically by Western psychology (see Cushman, 1995). Non-person-centred psychologies view the self in ways with varying degrees of overlap in understanding; self-psychology, developed by psychoanalyst Heinz Kohut in the 1960s, whilst of peripheral interest, is too firmly rooted in the 'deficiency' model of psychoanalysis to be helpful in an explication of PCE-CfD theory (Kohut, 1971). Tudor and Merry (2002/2006: 125–6) identify three ways in which the term is used in person-centred psychology and provide over 30 entries with 'self' as part of the entry. Tudor and Worrall (2006: 101–135) also comprehensively explore the wide range of meanings of the term and their implications in person-centred and experiential psychologies. Here the construct of self is presented through descriptions and

discussions only so far as to lay out the foundations of the PCE-CfD conceptualisation of depression.

The self as a concept

As stated in Chapter 2, Rogers (1951: 497) described the self in developmental terms as a portion of the perceptual field of the infant which is concerned with awareness of being, the pattern of perceptions of the 'I' or 'me', plus the values attached to the emerging concepts and perceptions. In 1959 (p. 200) Rogers reinforces the perceptual nature of the self with important consequences for personality and change: the self is i) a concept, a stable, consistent,[2] durable set of I/me-related perceptions; ii) a perception, a concept, a *process,* primarily an experiential response to the world,[3] including the internal world (so it is reflexive); and iii) therefore amenable to change, since its 'natural' state is adaptation.

> *PCE-CfD Theory of Depression*, Hypothesis 1: The phenomenology of depression can result from rigidity within the self-structure arising as a result of threat to the integrity of the self-concept.

Since a well-functioning self is a fluid and adaptive process, assimilating and accommodating experiences and organising responses to them, any rigidity will restrict the potential range of experiences and consequent responses to the world. This rigidity will affect both the range of possible perceptions which can be admitted to awareness and the range of responses which might be made as a result. The structure of the self may become rigid because of threat. This can arise in several ways, not only in sudden intense moments of threat, such as accidental trauma or deliberate abuse, but also by the drip-drip of negative comments and criticisms from others. Threat can also arise from within the self-structure, as suggested in Chapter 2. The self as a reflexive process can and will turn experiences back upon itself, so healthy, fluid self-processes can be impeded and curtailed by other impaired self-processes, such as intrusive thoughts, anxiety and so on, especially when these specifically target elements of the self (e.g. when intrusive critical thoughts recur whenever the individual experiences pleasure).

At a quite simple and straightforward level, these threats (both intense and repetitive) can result in patterned restrictions of perception and response

[2]It is important to explain that the self is both permanently fluid and adaptable, yet consistent and stable. That is to say that I experience myself as being the same person this morning as I was when I went to bed last night. There is a day-to-day, week-to-week, year-to-year consistency in the self. The self is fluid *and* stable.

[3]Note: whenever the term 'world' is used in this chapter, it will be meaning both the external environment (including relationships) and the internal world of meanings of the person.

which become configured and experienced as depression. Further detail on problematic psychological factors will be given later, but at a general level, threat can result in the following processes which can create a fertile psychological substrate for depression:

- limited and limiting outlook, leading to a feeling of loss of agency and helplessness
- reduced range of responses which can be experienced as restricted capacity for experiencing emotions
- pervasive feelings of negativity (e.g. self-blame) when experiences are variously selectively filtered and targeted
- social and experiential withdrawal resulting from these restrictions on experiencing.

The self as organism

Rogers also uses the term 'self' in relation to the organism; indeed, Tudor and Worrall (2006: 125–6) assert that Rogers conflates the concepts of self and organism. Some writers (although not Rogers himself) use the term 'organismic self' – originally Seeman (1983) in his work describing organismic integration as the epitome of health – and it is often popularly used to mean the true self, one that is inherent or originating in the organism. The problems associated with this cluster of concepts are carefully dissected by Tudor and Worrall (2006: 125–6); however, for the purposes of laying down the theoretical foundation of PCE-CfD, there is no need to reproduce them here.

The notion of self as part of an integrated organism does allow us to establish the importance to PCE-CfD of the internal and physiological, or in this case we might say 'integrated' wisdom of the client.

> *PCE-CfD Theory of Depression*, Hypothesis 2: Some aspects of depression can result from the embodied self.

Locating the self as an organismic phenomenon allows us to emphasise the *embodied* nature of the self. As a result, we can see two processes important to the understanding of the genesis of depression.

First is the inclusion of bodily feelings in the palette of experiences available for work in therapy. Since the individual is an integrated organism, with all domains acting in concert (whether this is clear to an observer or not), psychological tension can be embodied. Elements of experience are embodied with a psychological referent, a tag, clue or handle, which points to the meaning of the bodily sensation. There is no formula or taxonomy of embodied feelings in PCE-CfD. Each is unique and is even likely to change from moment to moment. Given the commonality in the descriptive vocabulary, figurative language and metaphor used by clients when asked to describe the feelings of 'depression', we might speculate that when people talk of 'pain', 'heaviness', 'lack of energy' or 'feeling dead inside', they are expressing their undifferentiated

and fuzzy awareness of embodied experience. It is also the case that the experience of depression can include more direct, concrete somatisation of distress, such as weight loss or weight gain. This is explained in PCE-CfD as the human organism acting as an organised whole; clients and their experiences are best understood as an indivisible entity. Somatisation such as weight gain or loss can itself add secondarily to the distress experienced, and we find people experiencing a downward spiral of helplessness and feeling out of control.

Second is the straightforward notion that experiential elements of the self-structure can involve embodied feelings. So, for example, there might be an alignment of distressing elements, some of which might be embodied. In some cases, people ascribe more credence, importance or even 'wisdom' to embodied feelings. A client might feel unable to get out of bed because they have no physical energy and their feelings of helplessness would be redoubled if they believe there is nothing to get out of bed for. Of course, some people give bodily sensations less importance or are likely to dismiss them altogether, thereby reinforcing the injunction to empathically follow the client in question rather than taking ready-made recipes for understanding into the therapy session.

As easy as it is to see the reinforcement of distressing self-related experiences, there is also the possibility of discrepancy between a bodily sensation and a thought. So, in contrast to the example above, a client might feel unable to get out of bed because they have no physical energy, whilst becoming further distressed by thinking 'this is not like me, I am never like this, I don't feel like myself any more, why can't I do the simplest of things like getting out of bed?' This most basic example of a discrepancy between parts of the self is used here simply to illustrate a possible dynamic involving an embodied element of the self.[4] It is also an example of a much larger category of intrapersonal events which are called 'self-discrepancies' and will be detailed below.

It is possible to see how these most simple of individual intrapersonal processes might aggregate to form an experience specific enough to be labelled as depression and severe enough to bring a person to their GP. Since a very high proportion of people experiencing depression have suicidal thoughts, the aggregation of more 'simple' processes clearly is sufficiently severe to make people think about killing themselves.

The pluralistic self

Although not explicitly addressed in Rogers' original work, the notion of the self as a pluralistic system or matrix rather than a unitary entity is of central importance not only to PCE-CfD theory, but also to the developing PCE theory of the 21st century. There are several strands of PCE theory which rest upon understanding the self as comprising subselves, parts, configurations, voices, schemas

[4]Client statements can be understood to be *signposts* to specific intra- and inter-personal problems, in this case pointing to embodied self-discrepancies.

and so on. There are both similarities and differences between the PCE understandings of what Mearns (1999; Mearns and Thorne, 2000) calls 'configurations', and, for example, constructs such as 'objects' in object relations theory and 'ego states' in transactional analysis, but no comparisons are made here, limiting ourselves to the range of PCE understandings. For the purposes of simplicity and unifying vocabulary in PCE-CfD we will use the term 'configurations' to describe this phenomenon. Although this is Mearns' term, concepts very similar if not identical to configurations of self have been developed in parallel over many years in different strands of PCE psychology.

We need go no further than an everyday conversation to seek validity for the construct, since there can be few conversations in which a person does not spontaneously say something like 'I can't decide: a part of me wants to and a part of me doesn't', 'Sometimes I enjoy it and other times I don't, I'm like two different people', or 'When asked to do it, I always have this debate inside: one me says "do it", another me says "don't do it", and the me that often wins is the one that says "wait and see, it'll blow over"'.

The experience of several parts of the self, or even several selves, is a common one with which almost everyone can identify, as is the experience of these parts in conversation or dialogue, often representing different points of view, different options or different aims.

> *PCE-CfD Theory of Depression*, Hypothesis 3: Symptoms of depression can result from problematic dialogue between parts of the self.

This general statement about everyday experience of parts of the self is necessary to draw attention to the differences between PCE-CfD and more classical person-centred theory. PCE-CfD deliberately posits the notion of a pluralistic self and takes elements of emotion-focused theory to support and explain the symptoms of depression, as described below. From classical person-centred theory, PCE-CfD takes the notion of discrepancy between self and experience sometimes written about as the discrepancy between the real and ideal self. These elements of theory are consonant to the extent that it is easy to present this as a coherent theoretical position requiring little adjustment for most counsellors encountering PCE-CfD practice for the first time. This will be explored in more detail in the section on 'self-discrepancy' below.

Self-discrepancy can also be linked to the broader tradition of experiential therapies and EFT, as in the notion of dialogue between different self-configurations. There is a variety of dialogue dynamics between the aims or modus operandi of different self-configurations other than simple conflicts. Discussions, arguments and disagreements are commonplace and whilst possibly less immediately disruptive than discrepancies, they can set a distressing, tedious or hopeless backdrop to day-to-day life, or aggregate feelings in a drip-drip fashion which eventually and dramatically break when the load gets too great. These are explored in detail in the 'other self-configuration dialogues' section.

On the other hand, psychotherapy has little concern for agreements between self-configurations. It could be argued that subselves develop by necessity to provide us with psychological balance (e.g. an individual needs a

balance of self-criticism and self-belief to stop themselves from becoming narcissistic). This would be a natural expression of a well-developed holistically functioning organism. Problems arise when subselves get out of balance or become fixed and polarised in their positions.

This discussion of the nature of the self gives us the general platform from which to understand the detail of the PCE-CfD conceptualisation of depression. It also contributes the basic intrapersonal architecture within which distress can arise in the form of symptoms of depression. Now let's look inside this structure to the more detailed intrapersonal dynamics that may lead to depression.

Self-discrepancy

The term 'self-discrepancy' is taken from the work of Neill Watson (Watson, Bryan & Thrash, 2010), who in turn took the term from 'self-discrepancy theory' developed by Edward Tory Higgins (Higgins, 1987). Watson and his colleagues further developed the notion by integrating the ideas of Rogers and Higgins.

Self-discrepancy is a succinct phrase under which to gather the various – sometimes subtly different – expressions of discrepancies within the self-structure which lead to psychological tension as outlined originally by Rogers (1951) and later elaborated by others in PCE theory. Rogers used the term 'incongruence' to describe the single source of psychological tension (see Chapter 2), but in PCE-CfD it is acknowledged that a more broadly-based range of self-discrepancies are considered to be precursors for experiences which might be diagnosed as depression. Watson and his colleagues particularly aligned self-discrepancy with depression and developed instruments to measure how levels of self-discrepancy might be associated with depression.

The PCE-CfD conceptualisation of depression embraces the self-discrepancy definitions used by Watson et al. (2010) at a conceptual level. Watson and his colleagues first restate Rogers' theory: introjection of conditions of worth leads to undifferentiated psychological tension (anxiety and/or depression) generated by a real–ideal discrepancy. Let us look now at the self-discrepancy theory in more detail.

Higgins' self-discrepancy theory

Higgins (1987) distinguishes between domains of self and standpoints on the self to create a complex matrix of possible self-objects and their interactions. Domains of the self are:

- *the actual self*: representations or experiences of the attributes you (or someone else, another) thinks that you possess
- *the ideal self*: experiences of the attributes that you (or another) would like you, ideally, to possess (hopes and aspirations for you)
- *the ought self*: experiences of the attributes that you (or another) believes you ought to possess (a representation of your duty and responsibilities).

The standpoints on the self are:

- experiences from your own standpoint
- the standpoints of another or others.

So, the domains of the self (actual, idea and ought) can be seen from either of the two standpoints (own and other). Importantly, we can translate both the domains and standpoints into Rogers' personality theory by understanding that all 'own' representations are congruent symbolisations of experiences, while all 'other' representations are possible introjects leading to distortions.

Thus, Higgins' self-discrepancy theory uses a matrix of self-objects based on the experiences of the owner of the self (authentic experience) versus the perceptions or demands of a significant other (introjected values). The matrix of possible interactions is a more detailed, systematic elaboration of Rogers' notions of congruence.

Higgins' self-discrepancy theory and depression

Within the matrix Higgins proposes two types of discrepancy important to PCE-CfD: i) actual or real self vs. the *ideal* self: the self you or others *want* you to be (real–ideal: RI); and ii) actual or real self vs. the self you think (or have been told) you *ought* to be (real–ought: RO).

He then goes on to propose a link between sets of discrepancies and concomitant outcomes, for example:

- own ideal self/other ideal self is associated with depression
- own ought self/other ought self is associated with shame and anxiety.

Higgins' contribution of the RO discrepancy and discriminating the differences between the discrepancies and the experience of anxiety or depression is an interesting and useful elaboration of theory. Furthermore, both RI and RO discrepancies have been measured in, and validated by, a number of studies (see Watson et al., 2010).

Finally, and parenthetically, it is acknowledged in theory literature, diagnostic manuals and clinical settings that many clients receive mixed anxiety and depression diagnoses and report overlapping symptoms and experiences of depression and anxiety. This is entirely concordant with PCE-CfD explanations of idiosyncratic combinations of client experiences being due to unique elaborate patterns of introjected values discrepant with authentic experiences.

The entire edifice of Higgins' self-discrepancy theory is unnecessary for understanding the PCE-CfD conceptualisation. As a perceptual theory, PCE-CfD takes the key notion that conflict between the way we experience ourselves and the way we ideally want to be is an important archetypal self-discrepancy in the genesis of depression and that there is some evidence to establish the validity of this (Watson et al., 2010). As a phenomenological theory, PCE-CfD does not adopt Higgins' discrepancy theory as a diagnostic or

treatment tool. The experience of the client is paramount, and the therapist follows the client in order to understand the unique network of associations and meanings that go to make up their lived experience of depression and works with that, even though it might contradict any and all theories.

In summary, PCE-CfD theory proposes that self-discrepancy is one starting point, a template from which to build possible understanding, or a signpost from which to explore the client's world. The signpost points to a theoretical starting point from which we consider the idea that personality is composed of many self-aspects in relation to each other. That starting point in theory leads to a number of possibilities, including distressing intrapersonal processes where one aspect is, for example, excessively critical of another, constantly suppresses another, regularly interrupts another, or experiences the absence of another.

> *PCE-CfD Theory of Depression*, Hypothesis 4: Symptoms of depression can uniquely result from the discrepancy between a person's real or actual self and their introjected ideal self.

Discrepancies or incongruence between parts of the self can be experienced by the individual person as a fixed state, in the same way that some people describe depression as a global and permanent state of being. PCE-CfD practice accepts the client's fatalistic apprehension of their world, whilst understanding that these global, totalising experiences are often maintained by micro-processes that can fix our general mood or sense of who we are. In both Chapters 4 and 5, it is shown how this translates into the PCE-CfD therapeutic stance.

The purpose of identifying and working with self-discrepancies of this type is to reduce the tension by any one or a combination of means – many of which will be managed by clients themselves. Sometimes awareness alone is sufficient; sometimes the origin of the ideal self or ought self can be uncovered, revisited and revised, effectively removing the tyranny of who the client wants to be or thinks they ought to be. We will explore the practice issues involved and again look at examples in Chapters 5 and 6.

Higgins' (1987) and Watson et al.'s (2010) contributions through the self-discrepancy theory are valuable extensions to the theory of personality and distress. It should be noted that when developing conditions of worth within the self-structure there will be many sources from which they can be introjected. What this means is that the 'other' source is often initially likely to be caregivers but soon the sources can extend to include friends, other authorities such as teachers in schools, then peer groups and aspects of culture including popular and more traditional elements such as religion and attitudinal prejudices including all forms of discrimination which may be interpersonal or institutional. Hence, the discrepancies that people might experience are often likely to be multiple in kind and form a complex set of intrapersonal relationships. For the PCE-CfD therapist it is essential to remain open to the complexity and not rush to assuming that the 'reason' for the client's distress is easy to understand and/or formulate. Humans are complex beings and

there are always more intricate and highly differentiated ways of knowing ourselves.

There are other types of discrepant dialogue between configurations of self that make significant contributions to the PCE-CfD conceptualisation of depression, and these can be grouped under the heading 'other self-configuration dialogues'.

Other self-configuration dialogues

As has been shown, there is a common-sense basis for understanding dialogues between two or more configurations of self. These configurations are not 'multiple personalities' in the clinically accepted sense of the term (for detailed analysis of the difference, see DSM-5, compared with a discussion in terms of EFT, see Elliott, Watson, Goldman & Greenberg, 2004), but they can be experienced as distinct entities with their own agendas, aims and characteristics. Nor are they 'voices' as in the commonly used term 'hearing voices' describing a symptom of psychosis, but they are often experienced as having a voice, and they might even generate subvocal expressions, particularly negative ones. However, there is an immensely helpful metaphor of voice that was used by Stiles, Meshot, Anderson & Sloan (1992) in conceptualising these self-configurations that refer to 'problematic experiences' where each experience has a representative voice that is difficult to assimilate into the gestalt of the self-structure. It does not require a leap of imagination to appreciate the reality of dialogue between these elements, since i) practitioners with scant experience will have encountered clients describing such experiences, and ii) most people with a modicum of self-awareness will in some sense share the experience.

In some psychotherapeutic approaches we find a taxonomy of configurations of self. The most basic of these is to sort them into 'pathological' and 'healthy', 'adaptive' and 'maladaptive' or, in PCE terms, those that are 'for growth' and those that are 'not for growth'. PCE-CfD does not assign a value to self-configurations from an external frame of reference. In PCE-CfD, the 'problem' resides in the lived distress which follows from the level of tension and nature of the incongruence itself and any further value is attached by the client; that is, the client decides on the importance and meaning of the tension. Many, if not most people live with some level of tension due to self-discrepancy or incongruence. The degree and type of conflict and the resultant amount of disturbance is what brings people to seek help.

As a phenomenological approach, the first position in PCE-CfD – both in theory and in practice – is to let the description of the nature and explanation of the function reside with the client in question. Furthermore, in the context of the in-session practice of PCE-CfD, 'off the shelf' psychiatric diagnoses are regarded as potentially stigmatising and antitherapeutic. However, it is instructive to understand that there are some well-defined, commonly experienced patterns of self-configuration and resultant dialogue which are associated with the experience of the symptoms of depression. Hence PCE-CfD incorporates

the concepts of conflict splits and self–inner-critic dialogue derived from EFT (Elliott et al., 2004).

Conflict splits

To acknowledge the origin (EFT) of the importance of this cluster of processes, the vocabulary is retained and the term 'conflict-splits' is used, as it is almost self-explanatory. Some theorists and approaches understand the dynamics between differing aspects of the self as 'splits', and when two elements of the self are in opposition this is known as a 'conflict-split'. PCE-CfD theory does not identify any self-elements as maladaptive or adaptive per se. Rather, it is the emotional responses to conflict between self-elements that produce distress or can be 'maladaptive' in terms of EFT theory.

In PCE-CfD, a conflict split is most simply expressed as an oppositional clash between two aspects or elements of the self. Rather than look for specific self-elements (ideal self, ought self and real self) in a conflict split, we just acknowledge and accept that two aspects are in conflict without naming or valuing either of them more than the other. Conflict splits are often out of, or barely on the edge of, the client's awareness so the first step is to help bring them more clearly into awareness if possible. Sometimes the client is readily able to do this themselves when they experience therapist empathic understanding and clarification. However, simply becoming aware of the conflicting configurations is often not sufficient to resolve the conflict. The therapeutic task is to clarify and differentiate the oppositional configurations and then encourage contact and dialogue between them. In the subsequent chapters on practice, this is shown through process-facilitative responses by the therapist to actively help clients process these conflicts.

> *PCE-CfD Theory of Depression*, Hypothesis 5: Symptoms of depression can result from conflicts between parts of the self that result in shutting down of experiencing, withdrawal, and feelings of guilt, unworthiness, hopelessness, helplessness, blame and so on.

Some conflict splits are more characteristic of depression, particularly those that result in the client shutting down experiencing or feeling guilty, blameworthy, unworthy, helpless or any of the other long list of experiences associated with the phenomenology of depression. For example, the critical self can beat down on the experiencing self to the point where the latter feels defeated and hopeless or totally collapses. Under these circumstances, the critical self can be experienced as the part that verbalises the 'shoulds', 'oughts' and evaluations of the self. This is one way Rogers' constructs of introjections and conditions of worth play out in the plural self.

This conflict and tension, which is a continuing process that maintains depression, is not a static state. Again, we see a relentless process of both wearing down resistance of adaptive parts of the self and aggregation of psychological tension over a prolonged period. The following are highly stylised

examples, but for illustration, conflict splits expressed in everyday language might include:

> 'I am ambitious and want to apply for the job – you're too useless to get anywhere or do anything.'
>
> 'I feel bullied by her – you're not a real man – a real man can't be bullied by a woman.'
>
> 'I am being suffocated in this relationship – you are no good on your own.'

And the mechanics of the links between conflict splits and depression can work like this, for example:

> 'I am ambitious and want to apply for the job – you're too useless to get anywhere or do anything.'
>
> - Can lead to paralysis, fear of rejection and a feeling of hopelessness: 'It's useless applying for jobs, I'll never get one.'
>
> 'I feel bullied by her – you're not a real man – a real man can't be bullied by a woman.'
>
> - Can lead to a feeling of self-loathing: 'If I can't stand up to her I'm not a real man, I'm a useless feeble, excuse of a man.'
>
> 'I am being suffocated in this relationship – you are no good on your own.'
>
> - Can lead to a feeling of helplessness: 'I have stopped thinking about the future because I know I'll not be able to change anything for the better.'

PCE-CfD holds that depression may result when the relationship between different aspects of the self is hostile (e.g. where a person experiences a punitive 'inner-critic') or oppressive (e.g. where an aspect of the self is suppressed or silenced). And to all these possible outcomes we can add the feeling of failure. It is not uncommon for people to have more than one conflict split and for these to have been persistent and pervasive, seeping into everyday life over many months.

Self-critical dialogues

A self-configuration that is relentlessly, negatively, evaluative is a common experience. Like other experiential therapies, in PCE-CfD this is called the 'inner-critic' or 'critical-self'. It is highlighted because, although several therapeutic approaches consider it a simple matter to 'reframe' the criticism as concern, exaggerated protection and so on, in PCE-CfD it is acknowledged that the unyielding, universal taint that can be brought by a critical-self can be a foundation for depression. Such a foundation can be long-standing and particularly stubborn. Even when brought into full awareness it can persist as an

obstacle to fulfilled living unless actively worked with employing specific interventions.

Most experienced therapists will have encountered clients with vigorous inner-critics and might have wrestled with their own in personal therapy. It is a common experience and one that is occasionally alluded to in everyday conversation, for example 'Stop beating yourself up' and so on.

Examples of self-critical dialogue include:

'I know I passed my exams – but it was only just a pass; that's not good enough.'

- A double-edged sword and can lead to a pervasive feeling of being not good enough. This can lead to perfectionism – useful up to a point, but beyond this can lead to a self-destructive spiral.

'My boyfriend says he loves me but I'm not attractive. In fact when I look in the mirror I wince, I'm so ugly. He must be blind or stupid.'

- The client's inner-critic puts down the client and, importantly, significant others in order to maintain the logic of the negative self-image. This invalidates positive messages from outside as well as inside – represented in theory by Rogers' processes of denial and distortion of experience (Rogers, 1959: 205).

'I just can't get that voice that says "you are a failure" out of my head.'

- A stubborn and relentless feeling of failure will wear the client down and lead to feelings of hopelessness and helplessness, preventing them from being able to move on and self-heal.

'I wanted to be a dancer but wasn't disciplined enough. I'll never be really happy, but it's my fault.'

- Self-blame can be generalised to taint the future as well as explain past failures. It also sets up failures in the present.

A common feature of these critical-self messages is their totalising nature. They put a negative, unpleasant spin on the past, present and future, defeating hope and agency, and limiting the range of experiences – not only are positive experiences made less likely, but the palette of experience is reduced from vivid colours to plain grey. They invalidate all sources of affirmation from inside the person and from others. Having such an overactive inner-critic can also be a lonely, isolating experience, especially if the critic is shaming.

Shafran, Cooper and Fairburn (2002) suggest that a degree of self-criticism provides essential balance to the personality, a basis for self-improvement, and prevents the individual becoming complacent. From a PCE-CfD perspective the problem is the imbalance between elements of self-structure, not the fact that there are several self-configurations: an inner-critic configuration balanced by a resilient and self-believing configuration would not necessarily lead to psychological tension and distress. On the other hand, classical person-centred theory has it that people with little incongruence in the self-structure

have a natural balance between the individual and the social and are inherently 'more understanding of others and ... more accepting of others as separate individuals' (Rogers, 1951: 520). This understanding of Rogers' original work renders the notion of the adaptive, or balancing, inner-critic unnecessary.

Either version of theory is supported by PCE-CfD practice in which the client's lived experience of psychological tension, their self-generated therapeutic tasks and collaborative, creative work with the counsellor are the drivers for therapeutic processes.

Other problematic psychological processes related to depression

PCE-CfD embraces a range of process-facilitating responses that are organised into a coherent theoretical framework. A further group, taken mostly from EFT, do not obviously spring from dialogues or discrepancies between self-configurations. In PCE-CfD most of these are best thought of simply as problematic psychological processes which have been identified through client observation and research (Elliott et al., 2004). They range from uncomplicated psychological processes which can block progress and suggest a simple method of resolution, to more fundamental processes requiring more extensive work.

These processes are listed here to give theory coordinates for specific potential features which commonly occur in experiences of depression. This will then allow us to map the theory on to practice in later chapters.

Emotional overwhelm

> *PCE-CfD Theory of Depression*, Hypothesis 6: Depression can be the result of, or exacerbated by, emotions that are too overwhelming to be faced or worked with in therapy.

Starting at the more theoretically elementary end of the continuum, PCE-CfD specifically acknowledges that people can get stuck, in life and therapy, in the face of overwhelming emotion (e.g. as a result of grief or a reaction to trauma etc.).

This overwhelm can present problems in two ways. First, the person may get frozen like a rabbit in headlights, unable to engage with an emotion because they sense the sheer scale of the emotional response that awaits them and then, quite reasonably, avoid it at all costs or simply come to an emotional standstill. In PCE-CfD theory and practice we do not cast an individual's behaviour as 'avoidant' or 'resistant'. We understand that we are all doing the best we can to survive and maintain ourselves in the face of difficult experiences. From Rogers' (1961: 125–59) 'process conception of psychotherapy' we know that until Stage 5 (out of seven) the immediate, present experience of feelings is mistrusted and feared.

This gives the first set of theory coordinates for which PCE-CfD practice must have a strategy.

Second, we know that sometimes people do try to engage with their emotions. They know that feelings are important and somehow represent a road to health if only they were not so scary, dark and simply huge. They make repeated attempts to let their feelings flow, and indeed they might spend hours weeping, but seem unable to move on – on each attempt they experience the full depth of their feelings, only to feel brief relief and return to square one.

The difficulty here is that whilst they have experienced their emotions, they have not worked with them, no change has taken place, no realignment or other adjustments in the self-structure have spontaneously occurred. In PCE-CfD theory, experience itself is not necessarily a change process – it might be for a few people, but for many more, some other change process must be engaged. One problem is that the sheer depth and size of the emotions involved mean that they are too big to be worked with – they need to be cut down to a digestible size.

Another problem can be the masking of a helpful, adaptive emotion by a more intense unhelpful maladaptive emotion. What is 'helpful' or 'unhelpful' is uniquely determined by the context and personal responses of the client in question. PCE-CfD practice provides appropriate ways of working with both scenarios of emotional overwhelm, which will be explored throughout the next few chapters focusing on practice.

Problematic reaction points

> *PCE-CfD Theory of Depression*, Hypothesis 7: Some aspects of depression can be the result of, or exacerbated by, puzzling, unexplained experiences which feel exaggerated or out of character.

There is the tendency for some clients to get stuck in the experience of having an unexplainable, uncharacteristic reaction to a situation. This experience can be understood at two levels. First is when the client feels a deep sense of their reaction being *absolutely* uncharacteristic, behaviourally or emotionally, indeed so out-of-character that the reaction doesn't seem to belong to them. Such experiences can be frightening to the extent that the person will avoid them, often at great cost in terms of shutting off areas of experience, avoiding activities and situations. Feeling inauthentic, incongruent, and having the immediate sense that everyone can see that you are not who you say you are, may lead to intrapersonal, interpersonal and social withdrawal. This simply adds to the common experience of feeling that they are watching their lives from a third-person position. Problematic reaction points can also result in self-criticism, possibly adding further fuel to an already active internal inner-critic (above). The problem is that when the client is not inhabiting their experience, that is not agentically in touch with it, the client cannot gain any purchase on the problematic behaviour in order to change it.

Rogers (1951) connects this kind of experience with a self-structure based on the introjection of values and the subsequent denial of 'organic experiences and needs which have not been symbolized' (p. 509). This links to the PCE-CfD understanding of the embodied self – organic needs and experiences can be thought of as bodily needs and experiences. In the case of problematic reaction points, the client is unable to inhabit their experience. There is such dissonance between the bodily needs and the lived sense of introjected self that the bodily experiences seem so alien as to be 'not me', and the shock of this can stop a client in their tracks. This raises an immediate anxiety and a sustained shadow is cast over the trustworthiness of experience, leading to withdrawal on many levels, as explained above.

Second is a much more superficial experience where the reaction may be puzzling, nagging or unclear, feel somewhat uncharacteristic, over-exaggerated, and can cause a persistent anxiety or cast a dark shadow of doubt on a situation, relationship or any life event, causing the person to avoid thinking about or otherwise engaging with the experience. In EFT these problematic reaction points are considered to be not only a driver of some symptoms of depression, they can also be an obstacle to progress in therapy or a presenting problem; that is, the client begins therapy by bringing this puzzle, possibly one that has been nagging at them for some time, making them feel low.

Meaning protests

> *PCE-CfD Theory of Depression*, Hypothesis 8: Some aspects of depression can be the result of having a cherished belief about the world destroyed.

Many readers will recognise that moment in our lives when something challenges or destroys a cherished belief about the world or life. The more central the belief is to our sense of self or identity, the greater will the reaction be. The feelings of shock, surprise, injustice, outrage, violation and anger can feel overwhelming and disabling. Sometimes it is such a violation of our understanding of life that the feelings can persevere for a long time, taint almost all experiences and shake our faith. The resultant constellation of feelings is called a 'meaning protest'. Nothing short of the meaning for living has been shaken.

In terms of personality theory, it might be that such a belief has been incorporated into the self-structure by a process of authentic organismic evaluation. In such cases the belief would be expected to be flexible and therefore reviewable in the light of subsequent changes in circumstance. Alternatively, beliefs can be introjected: that is, taken in under threat, whole, from the experience of significant others, along with the values put on them by others. With regard to meaning protests the key point is not whether the belief is introjected or the result of organismic evaluation. The problem arises simply because the belief is 'cherished' (i.e. central to the self-structure). Whilst we might expect authentically incorporated experiences to remain reviewable, up to a point, we also know that the whole self-structure can

become rigid as a result of threat, so we must expect a reaction of distress when any cherished belief is destroyed. How flexible the self-structure is at the time of the challenge is the important matter.

Beliefs that provide a foundation against which the unfolding narrative of our lives is set might be something like: 'true love lasts forever'; 'a job is for life'; 'good people do not get ill and die'; 'the world is a safe place'; 'parents die before their children'. A belief about the world that is central to our identity might be: 'every man in this town has worked in the widget-making trade'; or 'a woman is only fulfilled when she has children'. Redundancy, bereavement, illness, disability, trauma and so on are the typical triggers for challenging such beliefs.

If such a belief is at the centre of our self, then the whole self-structure can feel shaken and collapse, and although we might refer to the result generically as 'psychological tension', it often leads to the experience of depression. For many people, the symptoms are also intractable. The psychological balance engendered by a cherished belief central to our understanding of justice, relationships, life itself, is not easily restored once destroyed. Even if the meaning protest is not a keystone in the self-structure, essential to its structure, it can still unleash a temporary tsunami of outrage. At the peak of this tidal wave of feelings, there can be a collapse, resulting in symptoms of depression which can outlast the outrage. Other clients may not be fully aware of exactly what the cherished belief is that has been violated. They just have a dull sense that something is wrong. Naming the meaning protest then expressing outrage and upset are often sufficient for the client to experience release and resolution, facilitated by empathic following. Meaning protests often leave lasting impressions, and sometimes these are sufficiently distressing to be a cause of depression that needs attention in therapy.

Unfinished business

> *PCE-CfD Theory of Depression*, Hypothesis 9: Some aspects of depression can be the result of particular types of incompletely processed life events.

'Unfinished business' is used to describe any issue which remains unresolved, coupled with associated unresolved emotions. Clients often report symptoms of depression beginning after distressing life events that have not been processed sufficiently to render them benign and allow the person to move on (e.g. redundancy, neglect, abandonment, bullying or other abuse, relationship breakdown, bereavement, etc.).

Many unfinished business scenarios involve another person, such as a deceased friend, partner or relative; a work colleague, manager; friend; current or ex-partner; parent; or authority figure such as a past teacher.

Some therapeutic approaches propose that unfinished business in adult life is a replayed archaic dynamic, a vestige of a past relationship, most likely a poor care-giving relationship in infancy that resulted in an attachment injury. In PCE-CfD theory it is unnecessary to ascribe any particular cause to unfinished

business since, when offered the therapeutic conditions, some clients will be able to describe the circumstances surrounding unfinished business and let any meaning unfold. Resolution can follow spontaneously. For those whose experience remains unresolved and painful, more active techniques can be offered. These are explained further in the next few chapters focusing on the practice of PCE-CfD.

The nature of emotions

> *PCE-CfD Theory of Depression*, Hypothesis 10: Some aspects of depression can be the result of inappropriate and unhelpful learned emotions.

PCE-CfD conceptualises depression as resulting from particular types of emotional experience and emotional processes. This means that in practice the therapeutic focus should be on the client's feelings and emotions.

The relationship between emotion and psychological growth and wellbeing has been carefully established in the previous two chapters from a theoretical point of view and is worth briefly repeating here in our discussion of depression and PCE concepts. Regardless of the depressive processes experienced by clients (self-discrepancy, self-critical dialogues, unfinished business etc.), a core issue is how clients relate to their emotional experience. From the PCE-CfD point of view, greater openness to feelings is associated with lower levels of depression and better psychological health, but in supporting clients, counsellors should be alert to the nuances and subtleties of how feelings are expressed. For example, to regularly experience core maladaptive feelings of worthlessness is likely to result in unsatisfying, unpleasant responses and behaviour sets that will beget further unfulfilling, uncomfortable and noxious cycles of experience, reinforcing depressive symptoms. Similarly, to express unhelpful secondary reactive emotions, such as guilt as opposed to helpful, adaptive anger, can deprive clients of the resources necessary to assert themselves and get their needs met. Using emotional expression to manipulate others can also have negative consequences, such as the type of unhappy interpersonal relationships that are often associated with depression.

In EFT it is understood that there is an optimal level of emotional arousal for processing emotion, and difficulties in achieving this are often associated with anxiety and depression. These elaborations of understanding of emotions are of interest as the background to PCE-CfD theory and practice. It is important for PCE-CfD practitioners to understand that being emotional does not itself necessarily have any therapeutic benefit for clients: the quality and the kind of emotional arousal is important. The PCE-CfD definition of emotional wellbeing is a client restored to open, authentic processing of fluid adaptive emotions – a life facilitated by fit-for-purpose emotions which change according to circumstances. PCE-CfD puts the definitions of such value-laden terms as 'maladaptive', 'satisfying' and 'fulfilling' firmly in the control of the client. In terms of emotion, the prime therapeutic task of the PCE-CfD practitioner

is to try to enter the client's world of emotions and their meanings without any hint of judgement.

This chapter has provided a coherent and accessible theoretical account for the phenomenon of depression. The sections above also offer the coordinates for practice and articulate the theory with the action of the PCE-CfD therapist. In summary, this chapter has considered the theoretical account of depression for PCE-CfD and reviewed the application of the theory to practice. The theory of depression as developed by Sanders and Hill (2014) is robust whilst the evidence base might be said to be emerging.

Competences covered in this chapter

- **B1** – Knowledge of the philosophy and principles that inform the therapeutic approach
- **B2** – Knowledge of person-centred theories of human growth and development and the origins of psychological distress
- **B4** – Knowledge of the PCE conceptualisation of depression
- **S3** – Ability to help clients reflect on and develop emotional meanings
- **S4** – Ability to help clients make sense of experiences that are confusing and distressing

(Competences are listed in Appendix 1)