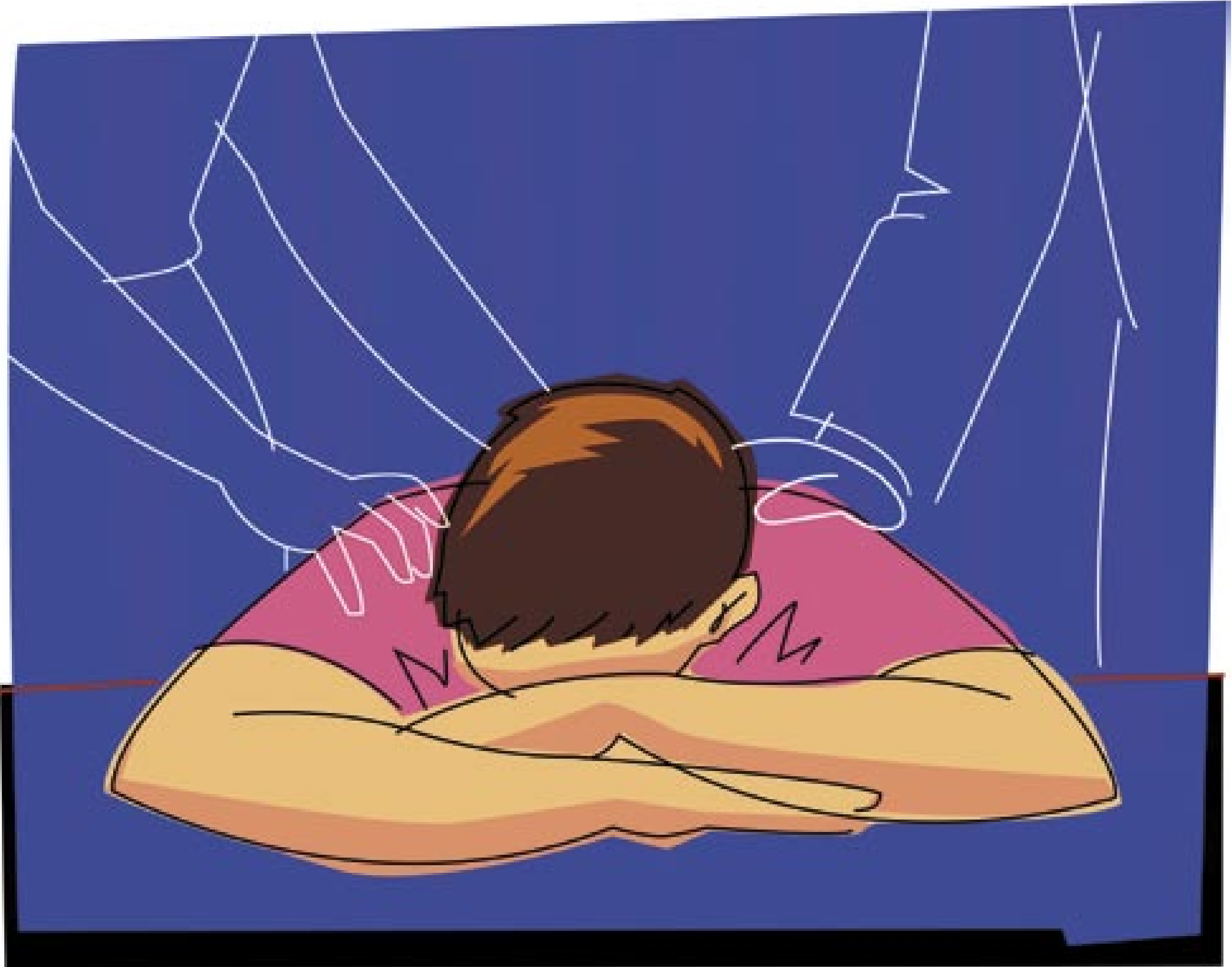

Depression at work

In the latest in our series looking at the emotions likely to be dealt with during coaching, **Gladeana McMahon** focuses on depression

Depression occurs in one in ten adults or 10 per cent of the population in Britain at any one time, according to the Office of National Statistics (2006). This means that, at any given time, a significant number of employees will be affected by the subsequent personal and organisational costs.

There are many types of conditions that come under the umbrella term of 'depression' (DSM, 1994) and the most common of these are:

Major depressive disorder

Clinical depression is another term for this condition. The symptoms of a major depressive episode last for most of the day, nearly every day, for at least two weeks and a person experiences either a depressed mood or a noticeable decrease in interest or pleasure in all or most activities.

For an episode to be diagnosed as clinical depression, there must be at least four additional symptoms, such as a significant weight loss/gain or a decrease/increase in appetite; difficulty sleeping or increased sleeping; excessive movement or slowing down associated with mental tension (observed by others); fatigue or loss of energy; feeling worthless or excessive guilt; difficulty thinking, concentrating or making decisions; repeatedly thinking about death or suicide; trying to attempt suicide, or planning to commit suicide.

Dysthymic disorder

This is when a person feels a constantly-depressed mood for at least two years, accompanied by

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at least two additional symptoms such as decrease or increase in eating; difficulty sleeping or increase in sleeping; low energy or fatigue; low self-esteem; difficulty concentrating or making decisions, or feeling hopeless.

This type of depression is described as having symptoms that are as persistent as, but less severe than, major depression.

Bipolar disorder

This was originally known as manic depression and includes periods of mania and depression. Changes between these two states can be rapid and sometimes only mania is present, without any depressive episodes.

A manic episode consists of a persistent, extreme, elevated or irritable mood, which lasts for at least one week with at least three of the following: inflated self-esteem or self-importance; decreased need for sleep; more talkative than usual or compelled to keep talking; experiencing racing thoughts or ideas; easily distracted; increase in goal-orientated activity; excessive movement, or excessive involvement in potentially risky, pleasurable behaviour (eg over-spending, unwise business investments).

Symptoms can be severe enough to warrant hospitalisation to prevent harm to self or others, or include psychotic features such as hallucinations and delusions.

Post natal depression

This is a major depressive episode that occurs after having a baby, in which symptoms usually begin within four weeks of giving birth and can vary in intensity and duration.

Seasonal affective disorder (SAD)

This type of depressive disorder is characterised by episodes of major depression that occur during the autumn or winter.

Anxiety depression

This is not an official type of depression (as defined by the DSM), however anxiety often also occurs with depression. In this case, a depressed individual may also experience anxiety symptoms such as panic attacks.

Chronic depression

This relates to a major depressive episode that lasts for at least two years.

Situational or reactive depression

Depressive symptoms develop in response to a specific, stressful situation or event, such as job loss or the end of a relationship. These symptoms occur within three months of the event and last no longer than six months, providing there are no other debilitating factors. Depressive symptoms cause significant distress and/or impair a person's usual functioning at work or in relationships.

When coaching someone who is experiencing, or has recently experienced, some type of depression, it is important that the coach has the type of psychological background that provides the clinical knowledge required of such a condition

Given the prevalence of depression in the adult population and the impact it has on individuals and those around them, it is not surprising that colleague relationships and the resultant impact on profitability and day-to-day working practices are of concern to organisations.

As with all the other potentially debilitating emotions such as anger and anxiety, there is some evidence to suggest a genetic component. However, an individual's emotional response is also based on factors such as family history, stressful life events, thinking style, learned behaviour, poor coping skills, individual personality and lack of social support (Williams 2001).

The best approach to dealing with depression is cognitive behavioural therapy (CBT). Both the National Institute for Clinical Excellence and the NHS has recommended CBT as the treatment of choice when working with such conditions.

In more recent years, many of the skills associated with CBT have been brought into the realm of coaching under what is called cognitive behavioural coaching or CBC (McMahon 2007).

CBC is based on psychological principles and on numerous research studies. It examines situations, thoughts, emotions, behaviours and the effects they have on physiology. By working with what someone thinks about himself, the world and other people in general and exploring how thoughts and feelings fuel depression, what triggers individual responses and what strategies are needed to deal with these, he is enabled to think, feel and act in a healthier and more appropriate manner.

The four areas that cognitive behavioural coaching covers are physical impact, thoughts, feelings and behaviours (Neenan, Dryden 2001. McMahon 2007).

However, when coaching someone who is experiencing, or has recently experienced, some type of depression, it is important that the coach has the psychological background to provide the clinical knowledge required of such a condition. This is where those people who come

from the fields of psychology or counselling, and who are also competent in the field of coaching psychology, come into their own (Palmer, Whybrow 2007).

It is important that the coach understands the diagnosis associated with the type of depression the individual is, or has, experienced and, as such individuals may be on prescribed medication, the effects of this and the professional ethics and practicalities of liaising with the medical practitioner responsible for the person concerned.

The fact that someone is still at work, or has been deemed fit to return to work, usually indicates that he is seen as being well enough to continue with his normal day-to-day activities, even if he is still vulnerable to some extent.

Physical impact

This part of the programme focuses on aspects such as lifestyle and takes into account diet, relaxation and exercise. Research into the relationship between exercise and depression has demonstrated the significant physiological benefits of exercise on mood (Strawbridge 2002).

Diet plays a part as people experiencing depression often do not want to eat or else may turn for comfort to foods high in sugar and fat in an attempt to elevate their low mood. As both of these factors have a negative impact on blood sugar levels, and as fluctuating blood sugar levels have a negative effect on mood, it is important to consider these factors (Cox, McCall, Kovatchev, Sarwat, Llag, Tan 2001).

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Thoughts

In the 1960s, US psychiatrist Aaron Temkin Beck noticed his patients tended to engage in "internal dialogue" as if they were talking to themselves. He realised there was a link between thoughts and feelings and he created the term "automatic thoughts" to describe emotion-filled thoughts that pop into the mind.

Beck found that people weren't always fully aware of such thoughts, but could learn to identify and report them. If a person was feeling upset in some way, his thoughts were usually negative and self-defeating.

Beck discovered that by helping individuals identify these thoughts, they were able to understand and overcome their particular difficulties and he spent his early years developing a model of CBT for working with depression (Curwen, Ruddell, Palmer 2000). Cognitive therapy (CT) was born and this later included more behavioural aspects to become CBT.

The individual is introduced to the concept of core beliefs, life rules and negative automatic thoughts. Core beliefs relate to those beliefs we have formed about ourselves, others and the world in general from the messages we receive in early life. Life rules relate to the ways in which we enact our core beliefs in normal day-to-day life, and negative automatic thoughts relate to the thoughts that are triggered in the situations being faced. For example, a life rule of "*I must get everything right otherwise it will be awful*" manifests itself when someone is struggling with a new task in thoughts such as *"I am pretty useless and should be able to understand how to do this"*.

When working with people who have experienced depression or who are low in mood, there are a range of strategies that can be used to help them identify and counter their self-defeating thinking. One such model is called the A,B,C,D,E Model (Seligman 2006), an adaptation of the dysfunctional thoughts technique (Beck 1995) that helps individuals capture negative thoughts, evaluate them and turn them around into a more realistic and self-enhancing way of seeing the world and their situation.

> If a person was feeling upset in some way, his thoughts were usually negative and self-defeating

The A,B,C,D,E Model

A = Adversity

Everyone faces difficult situations and this stage is used to define what the situation is. The individual is asked to think about the situation, the parties involved and be as concrete as possible in describing the event in question.

B = Beliefs

Here, the individual is asked to capture the thoughts that are going around in his mind and to write down everything he can think about in relation to the situation without any form of censorship.

C = Consequences

The individual is asked to consider the consequences of his thoughts and the resulting feelings and associated behaviours.

D = Dispute

The next part of the process looks for some evidence to counter what the individual is thinking and he is asked what other explanation(s) there could be? If there is more than one possibility, a discussion takes place around why the person chooses to think the worst when an alternative explanation is possible.

E = Energy

To complete the exercise, the individual is asked to think about how changing his thoughts changes the way he feels and how, in turn, this can generate a series of different and more positive outcomes. *(See figure 1)*

This exercise can be applied to any situation and gives the individual the chance to capture his thoughts and change these to ones that are more effective. In addition, attention is also given to 'cognitive distortions', which relate to the ways in which the individual perceives situations. For example, 'all or nothing' thinking is where the individual sees everything in extreme terms and 'personalisation and blame' is where he takes responsibility for everything regardless of whether he is responsible.

Figure 1
A,B,C,D,E

Stages	Taking Stock
Adversity	*I did not handle my team meeting well*
Beliefs	*I should be able to do this – it's pretty basic stuff and I am just not competent*
Consequences	*I feel awful and don't want to do any of the work I should be doing. I just want to go home.*
Dispute	*I've been pretty successful in my career, so maybe I am not useless. My energy is low and I am finding things difficult. I would not be this hard on someone else or blame myself if I had been physically unwell so why am I doing that now? Two of my team members did say that they found our discussions useful so maybe I am being harder on myself than I need to be.*
Energy	*When I started to think about alternative reasons, I felt so much better. Why make myself feel bad? Perhaps I need to think about pacing myself in a more realistic manner.*

Feelings

When feeling depression, individuals often experience a range of emotions such as sadness, loneliness, inadequacy and self-

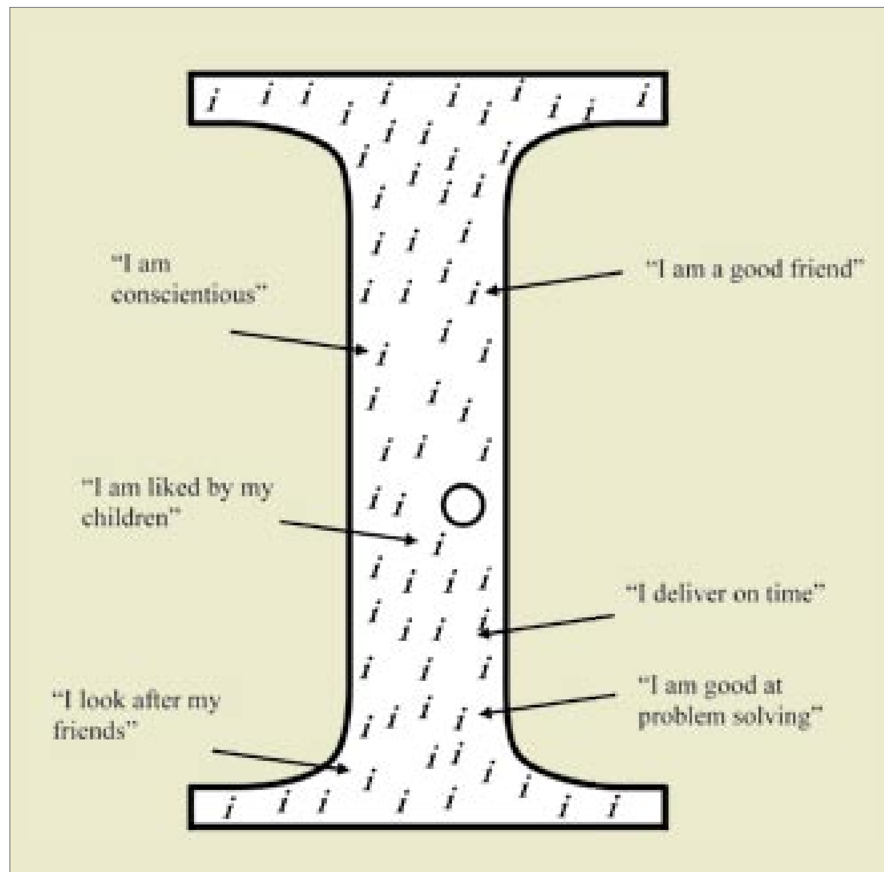

Figure 2
Big I, Little I exercise

loathing. While there are many exercises that can be used, the one called "big I, little I" helps a person identify his positive characteristics and what he is good at.

The person draws the outline of a large I, as a representation of the whole of his self, and then fills it in with lots of little Is, representing the different parts that go to make up the individual. For example, 'I am kind', 'I care', 'I can sing', 'I can cook', 'I have a good sense of humour', 'I am known for delivering on time', 'my colleagues like me'.

Behaviours

Depressed individuals tend to want to hide away from people and from life in general; the more they can be encouraged to engage with those around them, the faster the recovery. In addition, depression tends to make people become more self-centred and self-focussed; one exercise, taken from positive psychology (Seligman 2003), can prove useful in countering these tendencies.

Here the individual is asked to engage in three acts of random kindness a day. These could be as small as opening a door for someone or smiling at someone on the train.

Alternatively, buying the *Big Issue* or giving blood (as long as he is not on any form of medication) will give him the sense that he belongs to a broader community.

All of these activities encourage the individual to engage with others and to think about more than the way he is feeling.

There is no doubt that depression is debilitating. However, most individuals only ever experience one depressive episode and, if the person concerned can be helped to develop additional psychological resilience, this increases his chances of falling into this category. ■

References

1 *Surveys of Psychiatric Morbidity among Adults in Great Britain* Office for National Statistics, 2006

2 *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) fourth edition, American Psychiatric Association, 1994

3 Williams C *Overcoming Depression, a Five Areas Approach* Hodder Arnold, 2001

4 McMahon G and Leimon A *Performance Coaching for Dummies* John Wiley & Sons, 1997

5 Neenan M and Dryden W *Life Coaching, a Cognitive Behavioural Approach* Brunner-Routledge, 2001

6 McMahon G "Understanding cognitive behavioural coaching" *Training Journal* January 2007, p53-57

7 Palmer S and Whybrow A *Handbook of Coaching Psychology* Routledge, 2007

8 Strawbridge W J *et al* "Physical activity reduces the risk of subsequent depression for older adults" *American Journal of Epidemiology* 2002, 156(4) p328-34

9 Cox D J, McCall A, Kovatchev B, Sarwat S, Llag L L and Tan M H *Effects of Blood Glucose Rate of Changes on Perceived Mood and Cognitive Symptoms in Insulin-Treated Type 2 Diabetes* Diabetes Care, 2001

10 Curwen B, Ruddell P and Palmer S *Brief Cognitive Therapy* Sage Publications, 2000

11 Seligman M *Learned Optimism: How to Change Your Mind and Your Life* Vintage Books, 2006

12 Beck J S *Cognitive Therapy Basics and Beyond* Guildford Press, 1995

13 Seligman M *Authentic Happiness* Nicholas Brealey Publishing 2003

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