Volunteer befriending as an intervention for depression

Implications for bereavement care

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OVER THE LAST 30 YEARS there has been increasing acceptance that many episodes of major depressive disorder are preceded by severe loss experience. In researching the influence of life events on mental health, we identified some factors which seemed to foster resilience to depression. On the basis of these findings, we set up and monitored an intervention involving volunteer befriending with two groups of women to see if this could prevent depression and aid recovery. Though only a few of the women in the project had been bereaved, the positive effects of the befriending have interesting implications for those planning bereavement care services.

Many kinds of loss can precipitate major depressive disorder: a long-term separation, perhaps, a rift in a core relationship, or even a material loss, say of a job, a residence or of financial resources. A depression may also stem from the loss of a cherished idea and feelings of loss of hope, powerlessness, and humiliation may follow, but the common theme in depression seems to involve loss and, particularly, a sense of the depleted self. From this perspective, it makes sense to ask whether the ways in which people are helped with their depression can also provide useful ideas for those who work with bereaved people.

A model of depressive disorder

Factors involved in onset

Our research began with a series of studies looking at the life events (ie significant losses) that preceded depression in the general population and in psychiatric patients. However, it quickly expanded into an attempt to map what made some more vulnerable than others to these experiences.

Emotional support

One of the first things identified as protective was the availability of an emotionally supportive confidant, especially if they lived in the same household. Women with such a friend or relative (usually a marital partner) were four times less likely to develop clinical depression after a severe loss that those who had no confidant or who were in contact with a confidant less than weekly. Those in touch at least weekly with a non-live-in confidant were twice as likely to become depressed as those in the first group, but only half as likely to do so as those without any access to a confidant. Another factor that seemed to render women more vulnerable to depression after a severe loss was having lost their mother (but not their father) in childhood, either by death or by long-term separation.

In our book, *The Social Origins of Depression*[1], we suggested that the woman's sense of self is reflected by the support of the friend or relative in whom she confided. It was as if the partner now, and perhaps the mother in childhood, acted as mirrors while they listened, reflecting back an image of someone worth talking to, someone they cared about and whose company they valued. The mother's role was thus seen as an early source of the child's self-esteem (or perhaps in some cases of their self-derogation), and this sense of self would continue much the same into adulthood unless modified by the support (or further derogation) of a new close relationship.

EDITOR'S NOTE

At a time when antidepressants and professional cognitive therapies are widely regarded as the only treatments for clinical depression, it is refreshing to find that volunteers still have a role to play.

Tirril Harris (along with her colleague George Brown), is widely respected for the quality of her research into the causes and treatment of clinical depression. Here she summarises the results of important studies, which have shown that losses are common precursors of clinical depression. She goes on to demonstrate how well-trained and supported volunteers can make a substantial, and statistically significant, difference. She advocates a more active involvement with the lives of her clients than is generally sanctioned in bereavement services. The editors welcome correspondence on this topic. CMP

Social factors

Two other vulnerability factors involved social roles: work outside the home was protective, and the presence of more than two children under age 15 seemed to make women more vulnerable to depressive onset. Again, the explanation seemed to lie in the sense of self and the idea that our identities become richer or poorer according to the number of roles we inhabit,

Some sense of emotional impoverishment would be expected after the sort of severe losses we had heard described, but those with fewer initial resources of self-worth – fewer 'role-identities' – would be more likely to generalise this sense. The result would be not just depressed mood but also the cluster of other symptoms which arise when depression really takes hold: loss of concentration, lack of enjoyment of usual interests, lack of energy, disturbed sleep, and loss of appetite and weight.

In focusing on this 'generalisation of hopelessness' we were following in the footsteps of Aaron Beck[2], the founder of cognitive behavioural therapy, who identified what he called the cognitive triad of depressive disorder, where the self comes to seem worthless, the world pointless and the future completely hopeless. We argued that a woman unable to confide in her marital partner, without a job and trapped in the home by small children so that she has no opportunity to see herself as successful in other ways, might be more likely to generalise her sense of failure after a major loss and plunge into a clinical depression.

Testing the theories

To test these theories we devised a study to measure the initial sense of self in 400 women from Islington, north London, and then looked again a year later to see whether those who with a more negative evaluation of themselves were more likely to have become depressed if they had undergone a severe loss.

It was not easy to develop a way of measuring this sense of self. We looked not just at general statements about whether the women accepted how they were, or how much they wished they were different, but also at how they saw and valued first their attributes such as efficiency, sympathetic tendencies, intelligence, attractiveness and confidence. We also looked at their performance in a wide range of roles such as parent, marital partner, friend, worker, neighbour, sibling and carer to older parents. The results at follow-up interview confirmed our ideas about sense of self. Among those with one of the severe loss experiences, those who had scored as having negative evaluation of self a year earlier were three times more likely to have become depressed. We were also able to see how those with early loss of mother, or with lack of a current emotionally supportive relationship, were more likely to have this low self-esteem.

Furthermore in another study in Walthamstow, east London, designed to explore the effects of early maternal loss, we identified a key feature of the childhood experiences of those who later suffered depression in adulthood, namely that the replacement care after mother had left or died was lacking in emotional concern. In later studies, particularly of depressed psychiatric patients, we actually came across childhoods where abuse and rejection were the clear depressogenic factors, but the importance of simple neglect must not be underestimated, endowing children from early in life with an image of themselves as of little worth, as reflected by uncaring caregivers.

Factors involved in recovery/ improvement from depression

One of the encouraging aspects of these studies was that we were also able to follow people as they came out of depression, some with and some without professional help. The process of recovery/improvement seemed to be the mirror image of the onset process. We coined the term 'fresh-start events' for experiences which heralded new hope in a situation of ongoing deprivation, such as finding a job after a long time unemployed, being re-housed, undertaking a training course after being stuck in a humdrum job, meeting a new partner, or reconciling with an old friend or relative. These often occurred within a few months but they occurred significantly less often among those whose depression did not improve[3]. Reduction in the severity of ongoing problems such as debts, severe overcrowding and tensions or conflict in relationships also emerged as important in the pre-recovery period, all, as it were, a 'fresh-start' experience even without an actual 'event'. If people had an emotionally supportive confidant this also increased chances of recovery. If people had had a neglectful or abusive childhood this increased the chances that the depression would last more than a year.

Implications of the model for therapeutic intervention

Although the role of severe loss in causing depression stood out so prominently, this is not a factor readily amenable to therapeutic intervention, so we looked at working on vulnerability factors. If a genuinely supportive relationship could be provided, with enough regular contact, it might be possible to prevent development of a full clinical depression. The relationship might also speed the process of recovery, particularly if a fresh-start experience could be engineered. In some ways allotting this key role to social support corresponded to the theory behind professional counselling, with its stress on empathy and unconditional positive regard. It also echoed the perspective of attachment psychoanalytical psychotherapy based on John Bowlby's work[4], in which a sensitive, responsive person creates a relationship with a client to provide a secure base that can act as a foundation for therapeutic change. Professional therapy and counselling services are expensive and not readily available, but a more accessible alternative might be to find volunteers who provide similar support by acting as befrienders. A scheme in America called Big Sisters, with a slightly wider focus than depression, already had some reputation for success.

Assessing volunteer befriending

We have carried out two studies of volunteer befriending – both involving women and female volunteers and operated by charities. With Choice, a branch of the Family Welfare Association, the intervention involved women who had already been depressed for at least one year, exploring whether befriending speeded up recovery; and

with Newpin (the New Parent Infant Network), women undergoing an experience which renders them especially susceptible to depression, namely childbirth, were befriended to see whether this could prevent depression. In each case the befriending couples had to meet a minimum of once weekly for at least an hour, though they were at liberty to meet more often or for longer. Although they were free to do whatever they chose together, there was an expectation that the volunteer should encourage her befriendee to come to trust her enough to confide her intimate feelings and concerns.

'The key difference was that the befriender might accompany her befriendee on that dreaded hospital visit, or to help her explain things to solicitors'

While this aspect was perhaps modelled on the professional supportive services mentioned in the last section, the key difference between those and a befriender was that the latter was not office-bound, that she might accompany her befriendee on that dreaded hospital visit, or help her explain things to solicitors or Council officials.

Another key difference was that, unlike professional services, most of the volunteers opted to be accessible on the telephone should a crisis arise out of office hours. Although few did actually phone their befriender late at night, when re-interviewed at the end of the project many of the depressed women mentioned how reassuring this availability had been.

The befriending period was for one year (in the case of Newpin it started when the women were about six-seven months pregnant and lasted till the babies were about nine months so that they could get to know the befriender before the most vulnerable time, the few weeks immediately after the birth). The volunteer befrienders were recruited through local advertisements and given an initial training of about 30 hours in listening skills, and information about postnatal and other depression. During the befriending period there were support groups with other befrienders, supervised by a social worker. At the end of the 12 months, if the two individuals wished to remain friends – which was frequently the case – this was permitted.

The two projects did not include anyone who had recently started some form of psychological treatment, so that we could eliminate this variable. But if a woman had been in treatment already for over a year we reasoned the introduction of befriending would be something new that could be separated from the effects of the ongoing service. Once befriending started, however, no one was 'forbidden' to seek additional help elsewhere and it was possible to control for the few who later did at the stage of data analysis. The projects were randomised controlled trials, with sealed envelopes assigning the women either to the intervention group or the waiting-list control group. The research team interviewed all the women at the beginning and end of the one-year period, and, in the Choice study, the volunteers also. The interviews covered all the factors already identified by the theoretical model of depression such as life events and losses, self-evaluation, other possible confiding relationships in the women's social networks, attachment style, childhood experience of care and abuse, as well, of course, as the symptoms of depression. Both projects can be counted successful in so far as the intervention was associated with lower depression. In the first project, nearly twice as many recovered from clinical depression after the Choice befriending as did without it[5]. And among those receiving the Newpin befriending, only about half as many became depressed as those without it.

Some examples of the befriending relationship

Choice 011, a 32-year-old single woman whose mother had died when she was 13, had been mildly depressed since the death of her father but, two years later, developed major depression triggered by romantic complications involving work colleagues. Her relationship with the first volunteer she was matched with was not a success, but she was totally positive about the second, B. She said 'She's been a really useful, regular, tolerant outlet for me. Sometimes I think 'oh, I don't want to waste her time' and 'oh, I'm busy, I should stay at work' but I always, always, always feel better when I leave her. I can't praise her highly enough for listening and being constructive and having a brilliant memory cos I can't remember anything but she remembers things I've said. She's somebody that I can tell secrets that I haven't got anybody else to tell and she's always good humoured and seems to understand the context of it. She understands what we're doing and why and doesn't make any big deal out of it. She tells me her problems too and I just have the utmost respect for her as well as liking her tremendously.'

001 recovered from her depression after telling her boss (an ex-boyfriend who had left her for someone else) that she did not want to have so much responsibility at work, and he accepted this. It seems that her talks with B had given her the strength to confront her boss and also to accept the behaviour of various other boyfriends.

NEWPIN 021, a 36 year old, originally from Ethiopia, with a second baby, said at baseline interview that she felt you had to have known someone for a pretty long time in order to become a close friend. She was introduced to M, a white British woman, and came to confide everything in her, feeling they had an almost instant rapport but that the bond between them strengthened over time. 'I feel she really understands, has a lot of insight because she has two children as well and knows how she would feel.' M helped 021 write letters to the Council about being rehoused and came to support her viewing a possible new flat. She said she had relied on M for childcare but that she has reciprocated and looked after M's child. She feels they will remain close friends despite the formal ending of her participation in the Newpin project; she would feel terrible if M moved out of London now.

NEWPIN 002, a 22-year-old student originally from Somalia was matched with P, a West Indian with a 5-year-old. When asked if it made a difference that they originated from such diverse ethnic backgrounds she said 'No, it's the person that counts'. 002 said P was 'nice', different from others she knew. P was optimistic when the

baby was in the special care baby unit and persuaded 002 that he was getting better. That was why she could confide in her. P encouraged her to go out, helping carry the push-chair down the long flight of stairs, and advised her about feeding the baby. P also talked openly with 002 about her boyfriend and about her son giving her a hard time. 002 went to the Newpin drop-in centre and enjoyed it but found it hard to get to from her home, so P helped her to find another mothers' group. 002 had had to be reminded that the befriending was time limited and felt sad about that, but P had said that even if they were not going to meet face-to-face so regularly, 'we are still friends – nothing will ever change that. Any problems, just ring me'. At follow up interview they were planning to meet again later.

Implications for bereavement care

In practice most of the women in the two projects had not experienced recent bereavement. Drawing out implications is therefore only possible on the basis of assuming the similarity between coping with loss by death and coping with the other severe losses which had brought about the depressions in the Choice sample, and which were to bring them about in the Newpin control group (without befriending).

What stood out about the befriending process in many of the follow-up interviews was how readily the women understood what they needed in terms of supportive listening (see also Edwards *et al*[6]). This is something which bereavement supporters, such as those from Cruse Bereavement Care in the UK, are already quite expert in giving. Another aspect of such listening, often mentioned, was how helpful it had been to hear of the volunteers' own experiences of loss, especially when it was also explained how they had overcome the distress these had caused. Of course, to tell clients about the therapists' own experiences is not traditional counselling practice but many reported feeling a sense of pride that they had been the recipient of such intimate information and they were often very respectful of its confidentiality. One befriendee mentioned that one of the things she had most valued about her befriender was her honesty and her refusal to appear 'posher or better than me' despite the manifest class difference between them. This permitted mutuality of interaction is perhaps one of the chief differences between befriending and the professional services offered for depression.

Another implication arising here is the empowering function of listening to someone else. A number of Choice befriendees who had recovered went on to become volunteers in a later phase of the project, and this transition has been built in to the Newpin system by the founder, Ann Jenkins, who believed that such volunteers might prove even more supportive than those who had not been through the process of depressed motherhood. While our two projects did not last long enough for us to be able to test this properly (ie with enough women making this role transition), we did note a parallel phenomenon concerning those volunteers who gave not just 'good' emotional support to their befrienders but 'markedly good' support. Out of 49 volunteers, 12 offered such high quality support and 11 of their 12 befriendees recovered from their depression. An above-average proportion of these 12 volunteers were secure in their current relationships and self-image despite an early life of the kind that usually promotes insecurity in adulthood ('earned security' in attachment theory terms).

Other differences between volunteer befriending and more traditional counselling services have already been hinted at above – the 24-hour availability, the flexibility of location regarding the setting and the willingness to accompany the befriendee outside it in order to facilitate the solution of day-to-day problems (thus promoting fresh-start experiences). Particularly important here were volunteers who introduced their befriendees to new social circles, such as clubs, choirs or churches, helping them into a whole new network of friends whom they might never have had the confidence to encounter on their own.

One final difference between befriending and traditional counselling is the issue of ending. Although the befriending couple acknowledge that the initial period is for a limited period only, and work on (or talk together about) reaching that time-point and how things between them are going to change, there is no compulsion to stop meeting completely. This might possibly ease things for clients who, though considerably helped by the first year of the procedure, have not completed the resolution of their distress and have not yet found another attachment figure. From an attachment theory perspective, at whatever age or stage we are, it is this sense of there being at least one person there who cares enough to hear us out that keeps us going through adversity. The gradual nature of the ending with befriending may thus have advantages. But in the end the overall message is probably that whether psychotherapy, counselling or befriending is considered, it is the attunement of the relationship – whether the client feels understood and cared for – that is likely to be the crucial therapeutic ingredient. ●

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