

Self-Care Depression Program

Primary Care Manual



Mheccu

Authors:

Dan Bilsker, PhD
Randy Paterson, PhD

Mental Health Evaluation & Community Consultation Unit
2250 Wesbrook Mall
University of British Columbia
Vancouver, B.C. V6T 1W6
Canada

We gratefully acknowledge support of this project by the
Ministry of Health, Government of British Columbia, Canada

TABLE OF CONTENTS

GOAL OF THIS MANUAL	4
INTRODUCTION	5
RATIONALE FOR NONPHARMACOLOGICAL TREATMENT	7
WHO IS LIKELY TO BENEFIT?	8
REFERRING DEPRESSED PATIENTS FOR SPECIALIST CARE	8
A BIOPSYCHOSOCIAL MODEL OF DEPRESSION	10
THREE WAYS TO GET CONTROL OF DEPRESSION	15
Reactivating your life	15
Challenging negative thinking habits	18
Solving problems effectively	23
THE ROLE OF MEDICATION	26
THE ROAD AHEAD: RELAPSE PREVENTION STRATEGIES	27
CASE EXAMPLES	28
Case 1: A teacher in trouble	28
Case 2: The man with no life	29
NOTES	30
APPENDIX: LIFESTYLE INFORMATION	32

GOAL OF THIS MANUAL

The intent of this manual is to provide physicians and other primary care therapists with information, resources, and clinical guidelines to help them support their patients in applying the strategies of the Self-Care Depression Program. These strategies are based primarily on cognitive-behavioural principles. The program is intended as an enhancement of care, not as a replacement for other interventions (such as medication or psychotherapy) that have been demonstrated to be effective treatments for depression. It is designed for the following purposes:

- To enhance the effectiveness of antidepressant medication when this has been prescribed.
- To provide more flexibility in clinical approach when medication is not used or when patients choose not to accept antidepressant medication.
- To improve the durability of treatment gains by teaching patients specific skills likely to reduce the risk of relapse following successful treatment.

That said, some patients may choose not to use the program. Some others may not benefit due to the severity of their symptoms or the presence of comorbid disorders. Nevertheless, given the number of depressed patients seen in primary care, improved clinical response in even a minority would be a significant achievement.

This manual does not present extensive information on psychopharmacological interventions, as these are well described in other widely-available educational materials. The Patient Guide touches briefly on medication issues, however, and so this Manual reviews the points made there.

INTRODUCTION

Most treatment of depression, whether Major Depressive Disorder or Dysthymia, occurs within primary care.¹ Unfortunately, there are two main impediments to this approach. First, primary care providers have limited access to consultation or support from mental health specialists. Second, primary care providers have limited time to allocate to the treatment of mental disorders. They need tools that can be used in the course of normal practice to work more effectively with depressed patients.

The Self-Care Depression Program is such a tool. It has been designed by experts in evidence-based care to maximize the therapeutic impact of primary care on depression. It takes advantage of three crucial factors:

- First, primary care providers have substantial credibility with their patients. Primary care providers and patients have an ongoing relationship of trust and a history of fixing problems.
- Second, there is a considerable body of research evidence demonstrating that psychological intervention based on the principles of cognitive behavioural therapy is effective in the treatment of depression.²
- Third, it has been shown that individuals suffering from depression are able to utilize and benefit from self management materials.³ In fact, the clinical effect of self management materials can be fairly close, in some cases, to the effect of individual psychotherapy or pharmacological treatment.

The Patient Manual explains the nature of depression according to the best available research evidence. It provides a concise overview of three evidence-based change strategies, then guides the patient through the steps of each one. This Primary Care Manual gives a broader overview of the strategies and includes suggestions for clinical management.

The role of the primary care provider in the treatment process has been carefully considered, taking into account real limitations of time and specialist support. The intent is not to make the primary care provider into a psychotherapist. Instead, once a diagnosis has been established and communicated to the patient, the Self-Care Depression Program suggests the following elements:

1. **Provide the Patient Guide.** Review the contents briefly and recommend that the patient read and apply the guide. If pharmacotherapy is adopted in addition to the Self-Care Depression Program, it should be explained to the patient that the program works along with the medication and may well enhance its effectiveness. The section entitled “What causes depression?” may prove helpful in discussing the nature of depression with the patient. Although simply recommending the Self-Care program and encouraging the patient to follow it is appropriate, you may also wish to assist the patient in using the program. If so, the next two steps should be considered:
 - **Select a strategy.** Based on the specifics of the patient’s situation, select one of the three

main strategies (Behavioural Activation, Challenging Negative Thinking Habits, or Problem Solving). Review the basics of this strategy with the patient and help him or her set a concrete goal for the coming week.

- **Follow up.** At the next appointment, inquire about the outcome of the goal. Assist the patient in setting another. Inquire whether the patient has read the Patient Guide and answer any questions. Consider whether to continue emphasizing the selected strategy or to encourage work on another (or both).
2. **Consider a referral.** If necessary, consider referring the patient to an empirically-based psychotherapy outpatient program, private practitioner trained in CBT, or a psychiatrist. The section of this manual entitled “Referring Depressed Patients for Specialist Care” may be helpful.
 3. **Plan against relapse.** When the patient is recovering or has recovered, consider reviewing (or recommending the patient read) the relapse prevention strategies in the section of the Patient Guide entitled “The Road Ahead.”

RATIONALE FOR NONPHARMACOLOGICAL TREATMENT

Given that pharmacological treatment has been found to be effective for many cases of depression, why would the Self-Care Depression Program's cognitive-behavioural approach prove beneficial? There are several reasons.

- **Model inclusiveness.** The most widely-taught model holds that depression is the product of a neurochemical imbalance or dysfunction. There is limited empirical support for this proposition. The research evidence indicates that neurochemical changes are a *correlate* of depression, but this cannot be taken as proof that they are the sole cause.⁴ The single factor that best predicts a depressive episode (even better than family history) is a recent history of very stressful life events.⁵ Empirically identified factors in depression also include cognitive style⁶ and behavioural coping style.⁷
- **Outcome research data.** Outcome research indicates that cognitive-behavioural therapy (CBT) is equivalent in effectiveness to antidepressant therapy for most cases of major depression and other depressive disorders.⁸ Some research shows that a combination of pharmacological and nonpharmacological interventions is the most effective approach, especially for chronic cases.⁹ CBT has also been demonstrated to have lasting protective effects against relapse.¹⁰
- **Additive effects.** As noted above, medication plus nonpharmacological intervention has been shown to be maximally helpful for many patients. Medication alone may not be sufficient to resolve the psychosocial or lifestyle issues implicated in the origin of many cases of depression. Once mood is raised by medication, however, the patient may have the energy and resources necessary to commit to the task of life change.
- **Medication side effects.** Contrary to early reports, the newer antidepressants do have significant side effects in a significant proportion of patients. Careful research has found a rate of sexual dysfunction of up to 60% of patients treated with these antidepressants.¹¹ This often-unmentioned problem may be a primary cause of noncompliance/termination. Discontinuation of antidepressant medication can also be a difficult process with significant withdrawal symptoms.¹²
- **Patient aversion to medication.** Some patients are averse to managing their emotional pain with medication.¹³ They either refuse the medication outright, fail to fill prescriptions, take the medication intermittently, or cease taking it earlier than recommended. In primary care there is a significant rate of antidepressant discontinuation.¹⁴

Given these points, it seems advisable for primary care providers to have ready access to empirically-based nonpharmacological, as well as pharmacological, interventions.

WHO IS LIKELY TO BENEFIT?

The Self-Care Depression Program was designed primarily for patients meeting the diagnostic criteria for Major Depressive Disorder or Dysthymia. Patients can work on the material during an acute episode or during periods of remission. Here are some other considerations:

- Patients suffering from Bipolar Disorder may benefit from the program, but typically require pharmacological intervention and are likely to be best able to focus on the material during periods of remission.
- Individuals with concurrent drug or alcohol abuse may need to address these difficulties before they are able to benefit from the program.
- Those with difficulties reading may benefit most if a family member is able to work through the Patient Guide with them.
- Patients exhibiting depression with psychotic features are unlikely to benefit from the program while they are in this state – though once these symptoms abate they may well benefit.

REFERRING DEPRESSED PATIENTS FOR SPECIALIST CARE

This program represents an empirically based enhancement to the primary care management of depression based on the principles of cognitive behavioural therapy (CBT). This form of therapy has received strong empirical support as an effective treatment for depression (as has interpersonal psychotherapy). The Self-Care Depression Program represents only a limited version of cognitive behavioural intervention, however. Some patients will require additional resources in order to resolve a depressive episode. Here are some suggestions for further work.

- Some cases involve difficult diagnostic questions or comorbid conditions, or clearly require a more ambitious or intensive form of intervention than can be offered in a primary care setting. For these individuals, referral to a psychiatrist or mental health team should be considered. Acutely distressed patients at risk for suicide may require inpatient care.
- The Self-Care Depression Program is primarily self-guided, and so is not equivalent to CBT provided by an experienced mental health specialist with adequate training in this treatment method. For depressed patients who are not able to apply the strategies of this program effectively, the next step to a more intensive level of intervention might involve referral to cognitive behavioural group program. An example of this is the *Changeways* group depression treatment program.¹

¹ See the website www.Changeways.com.

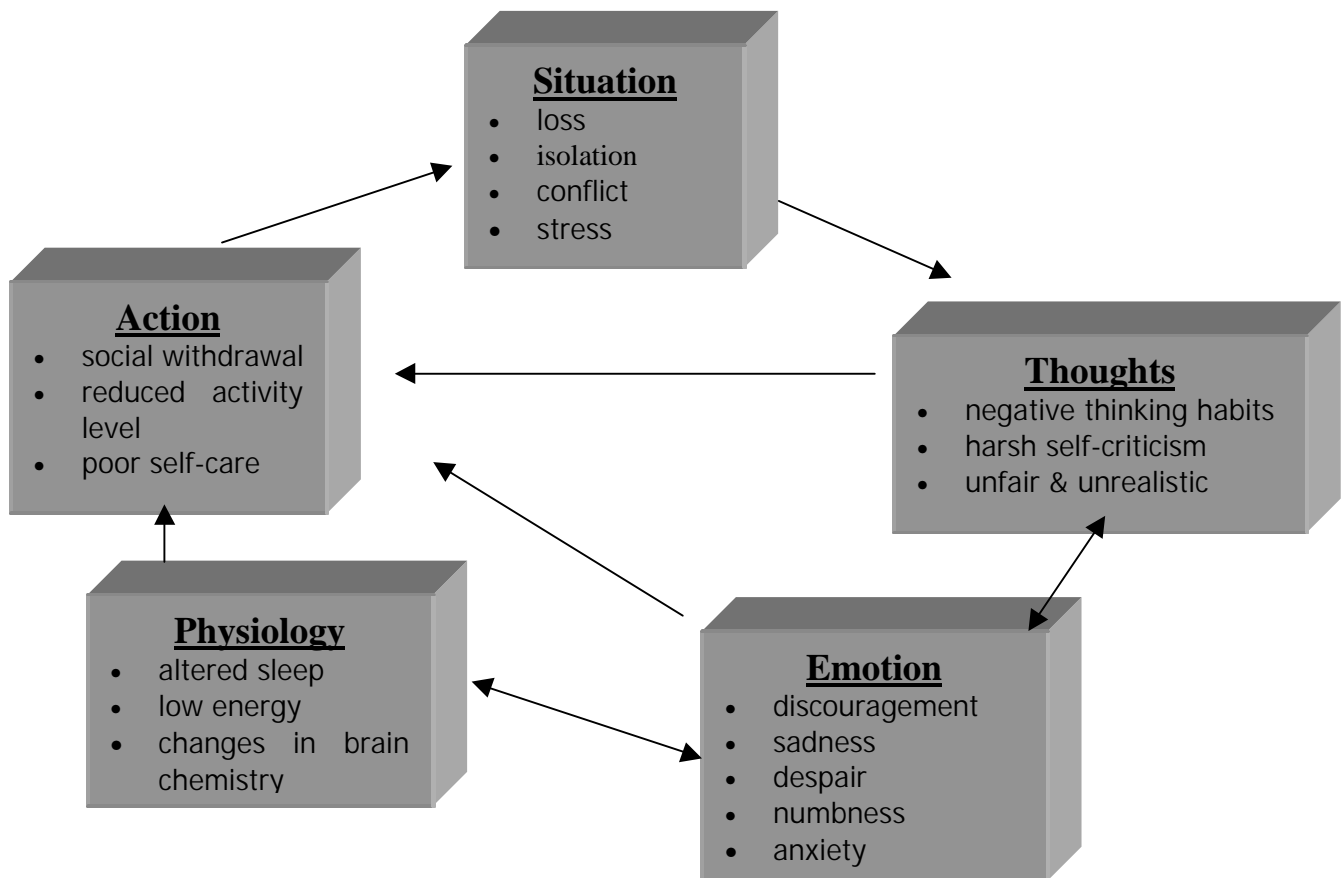
If a cognitive behavioural group program is unavailable or inappropriate for a given patient, consideration should be given to referral to a practitioner of individual cognitive behavioural or interpersonal psychotherapy (which generally requires 8-15 sessions). Many psychologists and some psychiatrists and other mental health professionals have received appropriate training in this method of therapy. Many depressed individuals benefit substantially from this form of treatment. **The research evidence does not support the specific effectiveness of supportive or psychodynamic counselling for depression.**¹⁵

A BIOPSYCHOSOCIAL MODEL OF DEPRESSION

Depression is a complex interaction of various factors in the patient's life: thoughts, emotions, behaviour, physiology, and the life situation. Each factor is implicated in three ways:

- Causes (or risk factors) are implicated in each area.
- Symptoms appear in each area.
- Treatments can target each area.

Because of the interconnected nature of the areas, changes in one can often produce changes in the others – whether these changes are declines or improvements. This can lead to a spiraling (or snowballing) effect. The goal of treatment is to get the factors to spiral in a positive direction.



On the following pages we will consider each of these factors separately.

Situation

Depression is often triggered by difficult life situations that the person finds stressful or even devastating. If attempts to cope with the situation by improving or accepting it are not successful, the person may begin to feel overwhelmed and hopeless. The risk of a depressive episode is then greatly increased. Situations found to be associated with depression include:

- **Major life events, particularly involving loss.** Events such as the death of a loved one, moving, divorce, financial setbacks, and job loss are major disruptions in one's life and have been linked to subsequent depression.
- **Lack of social contact.** Social isolation is a significant risk factor for depression.
- **Relationship conflict.** Periods of turbulence in personal relationships, whether marital or family, are extremely stressful and can contribute to the onset of depression.
- **Stress related to employment.** Employment stress can take the form of employment insecurity (not knowing whether one's position will continue), friction with supervisors or co-workers, or overwork.
- **Stress related to physical health.** Links to depression appear to be strongest for health problems that are chronic, cause substantial pain or disability, and have only a limited response to treatment. As well, certain physical disorders or their treatments can in some cases trigger depression directly via their effects on the body (e.g., hypothyroidism).

Thoughts

Each of us is affected differently by outside events, depending on how we interpret or make sense of those events. Imagine two people walking into a party. One person is naturally outgoing, anticipates enjoying herself a great deal, and interprets the group of partygoers as friendly and receptive. The other dreads social gatherings, anticipates feeling miserable, and experiences people as judgmental and rejecting. Each one interprets the world in characteristic ways. These interpretations determine how events are experienced. Clinical and research evidence has shown that depressed individuals have particular ways of interpreting the world that can trigger or worsen the experience of depression. They tend to:

- See the current situation in an unrealistically pessimistic way, emphasizing aspects of the situation that are negative or threatening and ignoring aspects that are more positive or promising.
- Think about themselves in a very critical fashion, judging themselves in a harsh and unfair manner.
- Anticipate a future that is bleak and disappointing, exaggerating the likelihood of very negative outcomes.

This set of biases is called the *Negative Triad*: thinking in an unfair and unrealistically negative way about one's current situation, self, and future.

These ways of thinking often find their origins in childhood. Some people grow up in families where only negative and critical things are said, or where children are discouraged from saying positive things about themselves and are rewarded for being self-critical. Whatever the origin of these thinking styles, they can become ingrained habits with significant influence on one's experience of the world.

Not surprisingly, these ways of thinking about the world increase the negative impact of difficult life situations and predispose people to negative emotional states. Someone who sees events in this biased way can become discouraged or despondent even when things are going fairly well. The cognitive restructuring method described in this manual works by helping the patient to modify the biased interpretive habits that can initiate and maintain depression.

Emotion

Depression initially involves feelings of discouragement and sadness, often triggered by unsuccessful attempts to cope with difficult life situations. However, as the depression develops, these feelings of unhappiness give way to more severe and painful kinds of emotional experience. The depressed individual is overcome by a sense of despair, a pervasive mood of hopeless misery. A Toronto newspaper columnist who suffered from depression described this emotional state as being "in the jaws of the black dogs". Severe anxiety (physical tension, worry, and a sense of impending doom) often accompanies these depressed feelings.

Some depressed people experience a general sense of emotional numbness, an inability to feel anything – as though the psychological pain had become so intense that the mind simply switched off the emotional response mechanism. The analogy of a *circuit-breaker* is an effective way to describe this concept to patients.

Recall that depressed people interpret the world in an unrealistically pessimistic way and judge themselves in a harsh and unfair manner. The emotions they feel are based on this biased way of interpreting their lives. If their thoughts about the world are unrealistic and negatively biased, then their emotions will also be unrealistic and negatively biased.

It may be hard for some patients to think about emotions as being unrealistic. Imagine a person who firmly believes that airplane travel is extremely dangerous and that planes are falling out of the sky frequently: he will fear and avoid flying. However, this person's fear is based on a false belief about airplane safety and is therefore unrealistic and inappropriate to the situation. Similarly, depressed individuals typically maintain beliefs about the world and themselves that are unrealistic and lead to unrealistic negative emotions.

Antidepressant medications as well as the cognitive and behavioural strategies described below can generate substantial improvement in the emotional state of depressed individuals.

Physiology

The diagnostic criteria make it clear that depression is often accompanied by a variety of physical symptoms. Some of these may contribute to the development of the depression, while others are consequences of it. Some may appear once the depression has begun, and then serve to make it worse.

One of the most powerful physical changes that accompanies depression is impaired sleep. Usually this involves an inability to get enough sleep, whether the person has difficulty falling asleep, wakes repeatedly during the night, or awakens much too early. Sometimes the person may suffer from hypersomnia, the tendency to sleep too much. Hypersomnia may arise from a desire to retreat from the world into sleep, or from a fatigue so pervasive that there never seems to be enough sleep. When sleep is *non-restorative* – that is, the person does not awaken feeling refreshed and rested – it becomes harder to face the day and deal with problems. Depressed people often feel that they lack energy and are exhausted by everyday activities.

Other physical changes include loss of appetite, decreased libido, weight loss or gain, and lack of energy. Each of these symptoms can have a negative impact on the patient's life or perspective, and so serve to maintain or exacerbate the depression.

The physiological changes associated with depression make it harder to cope with life problems or even to follow the steps of a depression management program like this one. Antidepressant or other medications can often be very helpful in restoring sleep and regaining the patient's sense of physical energy, allowing the patient to participate actively in learning and trying out the new skills needed to overcome depression.

Action

Depressed people often act in maladaptive ways in attempting to cope with their suffering. A strategy they commonly employ is to reduce their general activity level. This occurs for three main reasons:

- They experience a pervasive sense of fatigue.
- Activities no longer yield rewards and seem unimportant. Most depressed people suffer from *anhedonia*, the inability to have fun or get enjoyment from things. Why would you go to the movies, engage in hobbies, or do the things you used to enjoy if you didn't think you would enjoy them?
- The depressed person often lacks motivation and feels unable to initiate activity.

The result is that depressed individuals spend much less time doing things they once found to be sources of positive feeling and increased self-esteem. This only serves to reinforce the depression. It also provides ample time for brooding upon their current predicament and all the things they have done wrong, further deepening the depressed mood.

Activity reductions may also be important contributors to the original onset of depression. Various alterations in one's life situation (job loss, change in marital status, becoming a parent, etc.) can make it difficult to maintain activities that had been important sources of emotional reward and self-care. This, in turn, may trigger a gradual slide into discouragement, dysphoria, and, eventually, depression.

The main kinds of activity reduction that take place in depression are:

- **Social withdrawal.** Social invitations are refused, phone calls are ignored, and habitual get-togethers with family or friends somehow just don't happen. Isolation is a strong contributor to depressed mood, removing the person from the interpersonal warmth and sense of connection which are basic to all of us. Depressed people often believe that others would have no interest in their company, given how miserable or emotionally flat they are feeling. Interestingly, depressed people often state that they have been willing listeners to others' difficulties, but they do not expect a similar supportive response. With regard to these kinds of unrealistic expectations and false beliefs, see the cognitive restructuring section later in this manual.
- **Reduction in self-care activities.** Depressed people will often substantially reduce their amount of exercise, whether this involves fitness activities such as jogging or simply walking around the neighbourhood. Eliminating exercise contributes to depression by removing a source of physical well-being and increased self-esteem. Eating habits are often disrupted, whether this involves inadequate intake due to a lack of appetite ("forgetting to eat"), or binge eating as a form of self-comfort. Personal grooming habits may also suffer, potentially reinforcing the negative self-concept.
- **Reduction in rewarding activities.** Hobbies, sports, travel, and so on may all be avoided. Depressed persons usually feel too tired or unmotivated to pursue these activities, and the less they participate in them, the less they feel able to do so. They develop the habit of being inactive. As a result, the depressed person no longer receives the stimulation and personal satisfaction provided by these activities, further contributing to the sense of discouragement.
- **Neglecting small duties.** The depressed person often procrastinates in carrying out the small tasks we all have to do: running errands, taking out the garbage, cleaning house, caring for the garden, and so on. Failing to complete these tasks adds to the depressed person's sense of inadequacy and lack of control over life. It also creates friction with others and further strains the depressed person's relationships.

THREE WAYS TO GET CONTROL OF DEPRESSION

The Patient Guide describes how depression affects all areas of one's life, and how each area is related to all of the others. The recommended strategy is to work on changing more than one area at a time. The goal is to have positive changes in each area producing beneficial effects on the others, resulting in a "spiral effect" in which improvement breeds improvement.

The treatment approach advocated in this manual covers three primary areas: behavioural activation, challenging negative thinking, and effective problem solving. Medication is acknowledged as another valid and useful approach but is not covered in depth.

As discussed in the Introduction, it is suggested that the physician begin by selecting one of these three areas for review. Usually this will be the first section, "Reactivating Your Life". In subsequent appointments the physician can review progress with the area previously discussed, and if possible introduce one or both of the remaining two areas.

Reactivating your life

This intervention is typically referred to as *activity scheduling* or *behavioural activation* in the research literature. The kinds of activity reduction described earlier (reductions in social involvement, self-care, personally rewarding activities, and small duties) represent attempts by the depressed individual to cope with exhaustion, discouragement, and loss of control. It is important to explain to the patient that, although these coping attempts may seem helpful in the short term, in the long run they worsen the depression. The depressed person may be compared to someone who experiences a muscle injury: the natural tendency to immobilize the affected limb must be countered by teaching the importance of continued movement and encouraging rehabilitation through gradually increasing activity.

It may be helpful to explain to the patient how reductions in activity contribute to the development of depression. Care must be taken, however, to ensure that the individual does not use this explanation to engage in self-blame for having caused the depression. Normalize activity reduction by noting it as a standard and expected symptom of depression. Where appropriate, reassure patients that they were simply doing their best to cope with a difficult life situation. Often activity reduction seems like the appropriate self-care strategy (based on experience with other ailments such as the flu), even though it ultimately has a negative effect. As well, some patients have never been taught to make rewarding and self-care activities a high priority in their lives; pointing this out can offer the patient permission to engage in self-care.

The Patient Guide leads the reader through a series of five steps in the goal-setting process. The physician can assist by reviewing the steps with the patient and encouraging completion of the exercise. Here are the steps:

Step 1: What activities could be increased?

The first step in activity scheduling is to identify activities that would be feasible and helpful to increase. The patient is asked to identify activities from each of 4 identified areas:

1. **Involvement with family and friends.** Social involvement is valuable because it helps the patient to regain a sense of interpersonal connection, receive reassurance and emotional support, and be distracted from ruminating upon depressive themes.
2. **Self-care.** Activities such as exercise and eating properly can directly enhance the patient's sense of physical well-being and help to foster a sense of personal competence.
3. **Personally rewarding activities.** Formerly rewarding activities are important because they re-engage the patient with his or her life, and provide a badly needed source of reinforcement as the anhedonia lifts.
4. **Small duties.** Performance of the minor tasks of life can enhance the patient's sense of control and competence and also can reduce friction with others in the immediate social environment

Step 2: Choose two of these activities

The second step is for patients to identify specific activities from their list. Only two target activities are chosen in the first week. It is often helpful to begin with one activity from the *Self-Care* area (such as increased walking, or eating a small meal in the morning) and one from *Involvement with Family & Friends*. Patients must be willing to entertain the idea that inactivity may be contributing to the problem. If they don't, then further review of the biopsychosocial model may be appropriate.

Step 3: Set realistic goals

The third step is to set a specific goal for each of the two selected activities. With the patient taking the lead, set a *realistic* goal for the next couple of weeks in each of the two areas selected. The activity must require a small change in the patient's behavior so that the change is feasible and likely to give the patient a success experience. Depressed individuals typically experience their life situation as one of pervasive failure, so that even a small success in completing the chosen task can be very beneficial.

Ensure that the patient "owns" this activity goal – that it is the patient's goal and not the physician's. Setting goals for behavioral change is a *collaborative* activity and the patient must agree with the designated goal. If patients find the explanation unacceptable or are unwilling or unable to participate in identifying activity goals, they may not be ready for the intervention. Fortunately, this type of reaction is rare.

Patients must often be discouraged from setting goals that are too ambitious. For example, a patient who has become almost completely inactive may propose the goal of working out at a fitness club five times per week. These “New Year’s resolutions” rarely work out: even when people are able to raise themselves to this level of activity, it soon leads to discontinuation and a return to inaction, along with a renewed sense of discouragement about the possibility of change.

If a patient identifies a goal that is likely to be beneficial, but which he or she may or may not be able to carry out, one can suggest making information-gathering the goal instead. For example, if a patient sees taking a continuing education course as beneficial but feels doubtful of her capacity to follow through, have her begin simply by gathering information about available courses that might be relevant to her interests. Once the person has initiated action by gathering information, it often becomes easier to proceed to subsequent steps.

Activity goals must be *specific, realistic, and scheduled*. The goal must be stated in a concrete way, specifying just what activity is to be completed, when it should be carried out, and how often. For example, one might set the goal of walking for 20 minutes on Monday and Wednesday afternoons at 3 o’clock. It is helpful if the patient has a schedule book in which the goal can be noted. Encourage the patient to treat scheduled activities as *appointments*. Just as your patient would not casually skip a medical appointment, this appointment should be viewed as a serious undertaking.

The table below shows a few examples using the format in the Patient Guide:

Activity	How often?	When during the week?
Walking with wife - 20 minutes	2x per week	Mon and Wed evening around 8 pm
Meeting a friend for coffee	1x per week	Saturday afternoon after lunch

Step 4: Carry out your goals

The fourth step is to carry out the activity goals. Explain to patients that they should not wait until they “feel like” carrying out their goals. Instead, they should complete goals according to the schedule that they have set. Depression impairs motivation. If one waits to carry out an activity until the desire arises, very little will get done.

Even activities that previously had been sources of considerable pleasure are unlikely to be enjoyable early in treatment. As one gradually increases the activity level, motivation and enjoyment typically return. In the meantime, patients should carry out goals because they are scheduled, not because they are enjoyable. In the early stage of treatment, the reward for completing assigned activities comes from recognizing one’s successes, checking off the scheduled items, and knowing that one is doing something helpful to resolve the depression.

Step 5: Review your goals

The fifth step is to review the goals after one or two weeks. If a goal was not carried out, make it simpler or identify the barriers that kept it from being completed. Work collaboratively to figure out whether this might have been an inappropriate goal, whether it was set at an unrealistically high level, or whether steps must be taken to make the goal more feasible (for example, a walking goal might be easier if a friend or spouse would join in).

As initial activity goals are met, set new goals. These new goals should involve a gradual increase in the frequency of selected activities, or the addition of a new activity, perhaps from another of the areas. Only a limited number of goals should be set. In the early stage of treatment, the patient should be working on only two or three goal areas. Praise all progress and efforts to carry out goals. The general approach explained to patients for setting and implementing goals is as follows:

- Set your goals
- Write them into your schedule
- Check off each goal as you do it
- Praise yourself each time
- Review the goals every two weeks to decide if they need changing and whether you are ready to add a new goal.

Challenging negative thinking habits

This section of the Patient Guide is more commonly known in the literature as *cognitive restructuring*. As described above, a negatively biased thinking style is a common feature of depression. It acts both to initiate and to maintain depressive episodes. The *negative triad* we identified (negative beliefs about oneself, the situation, and the future) has a powerful impact on a person's emotional experience and is an important target for intervention.

Step 1: Learn to identify negatively biased thoughts.

The first step in changing this maladaptive cognitive style is to teach the patient about negatively biased thoughts. Explain that negative thoughts are usually *unfair* (patients evaluate themselves in a harsh and undeserved manner) and *unrealistic* (patients perceive themselves, their present situation, and their future in a pessimistic and inaccurate fashion). The Patient Guide provides a table of common forms of distorted thinking in depression (reproduced below). This is used to help patients recognize their own negatively biased thinking.

Filtering. Only looking at the bad, never the good. Because all you see is the negative, your whole life can appear to be negative.

Overgeneralization. One negative event is the start of a never-ending pattern. If one friend leaves you, they all will. If you fail the first time, you'll fail every time.

All or Nothing Thinking. You are either fat or thin, smart or stupid, tidy or a slob, depressed or happy, and so on. There is no in-between. Gradual progress is never enough because only a complete change will do. *"Who cares that I did half of it? It's still not finished!"*

Catastrophizing. A small disappointment is a disaster. You got a bad haircut so your entire month is ruined. As a result, you react to the imagined catastrophe (a terrible month) rather than to the little event (bad haircut).

Labeling. You talk to yourself in a harsh way, calling yourself names like "idiot", "loser", or whatever the worst insults are for you. You talk to yourself in a way you would never talk to anyone else.

Mindreading. You know what others are thinking about you, and it's always negative. So you react to what you think they think without bothering to ask.

Fortune Telling. You know what the future will bring, and it's usually negative. Nothing will work out, so why bother trying? Result: You bring

about the future you fear.

Perfectionism. It's only good enough if it's perfect. And because you can't make it perfect, you're never satisfied and can never take pride in anything.

Shoulds. You know how the world should be, and it isn't like that. You know what you should be like, and you aren't. Result: You are constantly disappointed and angry with yourself and with everyone around you.

Step 2: Recognize your own negative thoughts and how they trigger depressed mood.

The second step is to help the patient recognize negative thoughts and to discover how these thoughts can trigger depressed mood. Depressed individuals often are unaware of their own interpretations of events. They may perceive only that a particular event was followed by a decline in mood. Sometimes the patient is aware only of a diffuse misery, and has great difficulty relating this to any particular thoughts or situations.

In order to identify negative thoughts:

- Ask the patient to think of a situation in which he or she felt depressed or upset.
- Have the patient try to recollect what he or she was thinking about as the emotion developed. What did the event mean to the patient? For example, a friend canceling a get-together might cause a patient to think that the friend is no longer interested in the relationship, that the patient is unlikable, and that he or she will always be alone.

The Patient Guide gives patients the following exercise (in Step Two):

Although depression can seem like a constant dark cloud, it actually varies over the course of the day. Every time your mood sinks just a little bit deeper, ask yourself this important question: *"What was going through my mind just then?"*

What were you thinking about? What were you reacting to? Write this down. For example, perhaps getting on the bus one morning you suddenly felt a deepening of the gloom you've been feeling. What was going through your mind just then? Perhaps you noticed that everyone on the bus was facing you, and it occurred to you that they were probably judging you negatively. Excellent! Write it down.

Patients are encouraged to observe their own thoughts through the week, especially when

they notice their mood becoming more depressed, and to write down negatively biased or distorted thoughts. Patients will generally find that certain types of negative thoughts occur again and again, in slightly modified forms. These are their own characteristic depressive themes (e.g., “I’m ugly” or “I’m incompetent”). When the patient learns to challenge and modify some of the negative thoughts in specific situations, the impact tends to generalize across situations sharing the same theme.

Step 3: Challenge these negatively distorted thoughts and replace them with more fair and realistic ones.

The third step is to challenge distorted thoughts and replace them with fair and realistic ones. The most powerful way to accomplish this is to use the Three-Column Method. Here’s an example (from the Patient Guide):

Situation	Negative Thought	Fair and Realistic Thought
Friend cancels lunch date.	She doesn't like me. (<i>Mindreading</i>)	I don't know why she cancelled; maybe something urgent came up. It's only lunch.
	No one likes me. I'm unlikable. (<i>Overgeneralization</i>)	Some people do seem to like me, so I must be likable.
	The world is a cold and rejecting place. (<i>Catastrophizing</i>)	This lunch doesn't mean much about the world as a whole. I've been accepted before.
	I'll always be alone. (<i>Fortune Telling</i>)	I can't tell the future. One lunch doesn't mean no one will ever like me.

Depressed individuals often have difficulty coming up with fair and realistic ways of thinking about a situation, even when they have been able to identify the distorted or biased quality of their current thinking. Some techniques for helping the patient to identify more balanced thoughts are as follows:

- **What evidence do you have?** Does the evidence support the negative thought? Could you gather new evidence to clarify the situation? For example, imagine a patient who believes he is utterly incompetent at his job. You could encourage this patient to examine the available evidence such as formal job evaluations or informal feedback. The goal would be to see whether the evidence supports the uniformly negative view, or whether another view (having some positive aspects, or being an average performer) might fit the data better. Alternatively, the patient might consider the performance of co-workers in an objective way to find out how his performance actually compares and what reasonable expectations would

be. Based on this evidence, the patient has a basis for modifying his interpretation of the situation to make it more fair and realistic.

- **What would you say to a friend in the same situation with the same thoughts?** Depressed individuals tend to judge themselves more harshly and more unrealistically than they would judge a friend or even a stranger. Often they find it easier to come up with fair and realistic interpretations if they imagine a friend in the same situation. “What would you say if your best friend was in this situation and said they were thinking this way?”
- **What is a less extreme way of looking at the situation?** Depressed individuals often tend to engage in all-or-nothing (black-and-white, perfect-or-awful) thinking without realizing they are doing so. When this is pointed out to them, they are generally able to recognize that this type of thinking is not very helpful, so they can be asked to find an “in-between” (shades of grey) way of thinking about the situation.
- **What are the consequences of thinking in this way? Is there another way of thinking about the situation that has better consequences?** For example, calling yourself derogatory names like “idiot” may have the consequence of causing you to feel more discouraged and therefore to give up. Giving yourself encouragement and a fair evaluation is likely to result in a better outcome.

Once a patient has articulated ways of thinking about upsetting situations that are more fair and realistic, it is time to begin applying these skills to situations as they occur. This involves:

1. Identifying trigger situations – recurrent situations that frequently occasion negative thinking.
2. Rehearsing the new ways of thinking *while in the trigger situations*.

Patients often report that more realistic, balanced thinking sounds “false” or artificial the first few times they use it – even when they know it is true. They should be told that it requires practice for the new kind of thinking to *feel* true – just as it takes time for any new skill (such as driving a car) to feel comfortable and natural. With time it begins to seem natural to think about one’s life situation in a fair and realistic manner.

Solving problems effectively

This section of the Patient Guide is more commonly known in the literature as *structured problem solving*. Depressed individuals usually have considerable difficulty coping successfully with difficult life problems. They often experience these situations as overwhelmingly difficult and tend not to apply effective problem solving methods, with the result that they feel even more helpless and out of control. Difficulties may be seen at all stages of the process: Objectively evaluating the nature of a problem, realistically estimating the resources they can bring to bear on the problem, systematically generating and evaluating possible solutions, and implementing an action plan to address the problem.

As with reduced activity, unsuccessful attempts to cope with life problems and the resulting experience of being overwhelmed is a major contributor to the onset of depression. This is not to say that all depressive episodes are preceded by major life problems, but difficulty in resolving significant problems is often a trigger for the onset of depression.

Given that each person experiences the impact of life problems differently, one cannot judge from the outside which problems are major stressors and which are small or trivial ones. For one person, being terminated from a job would be a small challenge of moderate stress, while for another the loss of a job might pose a fundamental challenge to the self-image and sense of meaning.

The Patient Guide describes a five-step problem solving process.

Step 1: Identify your problems

The first step in the Patient Guide asks the patient to make a list of current problems. Sometimes the patient will initially report only a diffuse and overwhelming misery, with little awareness of any precipitating situational factors. “It came out of nowhere.” Further examination will typically reveal incidents and experiences that contributed to the depression.

One approach is to ask the patient to identify “the most difficult problems you’re dealing with now”, focusing on only a few if the person lists too many problems. Another approach is to have patients review the onset of the depression in some detail, helping them identify the significant events that were happening as they began to feel more depressed.

Step Two: Pick a problem

If patients attempt to solve all of their problems at once they will certainly fail. This step encourages the patient to select just one problem to work on initially.

The following page provides the instruction given for Step Two in the Patient Guide.

Now select one problem from the list you have made. It should be a problem that you really want to solve, and one that seems reasonably solvable. Later on you can get to the ones that may seem more difficult. Which problem would you like to work on first?

Most depressed patients feel incapable of solving problems, despite having dealt with a great number of problems over the course of their lives. It is useful to identify previous crises or problem situations the patient has handled successfully. This can give the patient ideas about how he or she might cope more effectively with the current set of problems, bring past success experiences to mind, and make the important point that treatment will focus on strengths as well as symptoms.

You may also need to identify the patient's current supports. Is there a supportive partner, a close friend or a family member with whom the patient could discuss difficulties? Are there other professionals available to help (e.g. clergy)?

The patient is then encouraged to come up with several possible actions that may help the problem a small distance toward a resolution – even if these ideas seem at first to be unrealistic. Patients will often underestimate their own capacity for effective action while overestimating barriers.

Step 3: Choose one

The patient is encouraged to choose the best (or perhaps the least bad) action. There are no fixed rules about how to make this choice. The patient should look over the possible actions, evaluate the advantages and disadvantages of each, then choose one. It should be an action that moves the person at least part-way toward a solution. A limited time is set for this decision so that it doesn't drag on. Patients can be reminded that if they discover that their idea really isn't working, they can try something else.

During an appointment, assist the patient in selecting a problem. Review the proposed actions and work collaboratively with the patient to decide which of the solutions is likely to work most effectively overall, even if it is only the best of a bad lot.

Step 4: Make an action plan

The chosen solution is then used as the basis for developing a concrete plan of action. The goal should be readily achievable by the patient in the short term and should not be overly difficult. Especially in the initial stage of treatment, depressed individuals are not able to carry out complex or challenging actions. It is often helpful to break the solution down into small parts that can be implemented with relative ease. It is important to get the patient *started* on constructive action. Gathering information is often a good starting point. The action plan should have four characteristics, summarized by the acronym "MAST".

- **Manageable.** It's better to accomplish a goal that is too small than to fail at an ambitious one! Bad example: *For my first time out, run a marathon.* Better example: *Walk one block.*
- **Action-oriented.** The plan should state what the patient will *do*, not how he or she will think or feel while doing it. We have a certain amount of control over what we do but much less control over our emotions and thoughts. Bad example: *Spend a pleasant hour with my children.* Better example: *Spend one hour with my children.*
- **Specific.** It should be very clear what the patient needs to do. Bad example: *Get in shape.* Better example: *Phone the community centre to find out whether they teach yoga.*
- **Time-limited.** The plan should take only a short time to carry out. Bad example: *Keep finances in order from now on.* Better example: *Spend 20 minutes looking for income tax receipts.*

Step 5: Evaluate and Move On

In the session after some kind of action has been assigned, it is helpful to review the outcome. What went right and what went wrong? Based on this, what has the patient learned about the problem? Should the plan be changed? Results of this first goal can be used as a springboard for the next one: either continue the goal, revise and try again, or take a new approach.

The Patient Guide suggests the following:

Use your experience to plan your next step. You have three main options:

- **Keep going.** Example: Spend another 20 minutes finding the papers.
- **Revise your goal and try again.** Example: Cleaning the garage for three hours was too difficult, so plan to work on it for just one hour instead.
- **Take a new approach.** Perhaps you learned something useful from your first effort that suggests another way of handling the issue. Example: Talking face to face with Aunt Sarah didn't work, so write her a letter instead.

THE ROLE OF MEDICATION

The Patient Guide does not attempt to cover psychopharmacological approaches to depression in any detail. It is anticipated that the physician will wish to tailor the information on medication for the individual patient. Nevertheless, a brief discussion of the topic seems appropriate, given that medication may well be a part of the treatment plan.

Review the points made in this section of the Patient Manual to determine whether any need clarification, given the particular patient's situation.

The section begins with a statement that medication is an appropriate part of depression treatment in many cases. It then provides a maxim with which most prescribing physicians will have little quarrel: *Medication is seldom a complete treatment for mood problems.* The intent here is to get patients beyond the idea that they need simply take medication and wait. Most will need to do more – such as make use of some of the strategies in this program.

Four bulleted points follow in the Patient Guide:

- **Different medications work for different people.** This statement is designed to deal with two problems. First, many patients compare their medications with those of others without a full understanding of the reasons behind medication selection. “My physician put me on Effexor and it worked great; why didn't yours?” Second, many patients wonder why finding an effective agent isn't always easy.
- **Never stop taking medication suddenly.** This is an obvious problem. Many patients precipitously stop taking medication and experience rebound effects.
- **Certain people benefit from taking a medication over the long term.** Some patients will benefit from maintenance pharmacotherapy and should be informed that this is a possibility.
- **It can be tempting to stop taking a medication as soon as you get the level of improvement you want.** Many patients are willing to take medication only until they achieve a reasonable mood, then they hope to stop the medication as soon as possible. They may require an explanation of the desirability of dose maintenance until the mood has been stable for some months.

Finally, the manual acknowledges that some patients are treated without pharmacological intervention.

THE ROAD AHEAD: RELAPSE PREVENTION STRATEGIES

Upwards of 50% of patients who undergo a major depressive episode will at some point have a second. Having had a second episode, the chance of a third rises to 70% or above. Consequently, it is worthwhile to spend some time helping patients plan ahead, both to reduce the risk of relapse and to ensure that subsequent episodes are dealt with as soon as possible.

This section of the Patient Manual includes a variety of recommendations, most of which are fairly straightforward. It can be worthwhile for the physician to encourage patients to read this material, and some time can be spent helping patients to think of strategies that fit their own situations.

Keep up your efforts

This section advises patients to maintain their self-care, keep challenging their negative thinking, and continue problem-solving efforts even when they feel well.

Plan ahead for stress

Stress is inevitable in everyone's life, and yet many of us approach stressful times with little more than a hope that we will be able to manage them. This section advocates a more active approach involving brainstorming in advance about how best to cope with predictable stressors.

Create a Mood Emergency Action Plan

Given that many patients who have had a major depressive episode will have another, it is a good idea to make an advance plan for coping should this occur. In part, this may reduce the severity and duration of a subsequent episode. But part of the rationale for this idea is that having a reasonable plan may reduce some of the fear of relapse. Given that this ongoing fear may contribute to the risk of relapse, having a plan may actually lower the relapse risk.

In most cases the Action Plan will involve making an appointment with the general practitioner as soon as possible. Discuss your own policy and views regarding this. Make it clear to the patient that you do not want them to wait until the mood is intractable before seeing you. Stress that it is easier to get to work before the depression has reached its maximum intensity. Discuss whether the patient might be well advised to give permission to selected family or friends to tell them (or you or another caregiver) when their mood seems to be declining.

CASE EXAMPLES

The following are two case examples of the program in use. The first describes the use of the program with a typical depressed patient. The second provides the background and invites you to make the recommendations.

Case 1: A teacher in trouble

Mary is a married teacher in her mid-30s who came to her family physician with symptoms of depression. She had recently transferred to an inner city school, attracted to the challenge of the work. She found that she could not accomplish what had previously been her norm, though she worked long hours. She began to experience impaired sleep and ruminative worry. She criticized herself in a harsh manner for not doing as well as she expected. Her mood dropped and she began to slide into the depressed range. This made it more difficult to perform her job and she became even more self-critical and depressed.

Mary's family physician provided her with the Self-Care Depression Program Patient Guide and prescribed an antidepressant medication. The latter helped her sleep and reduced her emotional suffering, although she experienced loss of sexual interest, a medication side effect.

Mary found the first two strategies in the Patient Guide particularly helpful. When she read through the section on *Reactivating your life*, she realized that she had been avoiding her friends since she took the job and especially since she became depressed. She set the goal of meeting a friend once a week for tea. Later on she increased this to include other social activities. She also realized that she had been eating too little, forgetting to eat breakfast or lunch, and becoming tired and light-headed from hunger. She assigned herself the goal of eating a small breakfast each day. After the first month, she added moderate exercise as a goal, and began to attend the local fitness center once per week, then eventually twice per week.

When she read through the section on *Challenging negative thinking*, Mary recognized several of the cognitive distortions: first, she had a very self-critical way of thinking, labeling herself as "incompetent". Second, she usually expected herself to perform perfectly, telling herself "you aren't good enough, you can't meet the standard". Third, she ignored praise from others, filtering out supportive messages and focusing on critical ones. She used the cognitive challenging method to come up with more fair and realistic ways of thinking about herself and her situation. The questions from the self-care guide were useful tools:

- *What evidence do you have?* Mary had received positive evaluations in her job, and a colleague she trusted told her she was doing as well as possible in the situation.
- *What would you say to a friend in the same situation?* She immediately saw that she would never talk to a friend the way she talked to herself ("that would be mean and unfair"). She wrote out the fair and supportive words she would say to a friend in a similar crisis, then practiced saying them to herself whenever she noticed the self-criticism start.

- *What is a less extreme way of looking at the situation?* She wrote down some more realistic thoughts about the job situation, then reminded herself of these whenever she noticed the unrealistic negative thoughts.

The combination of antidepressant medication and using these self-care methods led to a gradual improvement in her depression, a more fair and accepting attitude towards herself, more realistic self-expectations and more enjoyment of her life. The antidepressant medication was gradually reduced, then discontinued at six months. She continued to use the self-care methods in order to maintain her positive changes and make it less likely that depression would happen again.

Case 2: The man with no life

A 35 year old unmarried man, employed as a graphic designer, has been experiencing depressive symptomatology over the past 2 weeks. He has had one prior depressive episode. He indicates that he mainly feels worthwhile when he is at work. He does little besides watch TV in his leisure time. He has several friends, but he gradually withdrew from them as he became more depressed. Over the last two weeks he has found it hard to concentrate at work. His self-care has deteriorated in that he has not been eating regularly.

What might you consider doing?

Medication: _____

Activity Scheduling: _____

Cognitive Challenging: _____

Structured Problem Solving: _____

NOTES

1. Regier DA, Narrow WE, Rae DS et al. The de facto US mental and addictive disorders services system: epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psych*, 1993, 50: 85-94; Shepherd M, Wilkinson G. Primary care as the middle ground for psychiatric epidemiology. *Psychol Med*, 1988, 18: 263-267
2. Shulberg HC, Katon WJ, Simon GE et al. Best clinical practice: guidelines for managing Major Depression in primary medical care. *J Clin Psychiatry*, 1999, 60 (suppl 7): 19 – 26.
3. Gould RA, Clum GA. A meta-analysis of self-help treatment approaches. *Clinical Psychology Review*, 1993, 13: 169-186; Shearer LS, Kaplin Adams G.; Cuijpers P. Bibliotherapy in unipolar depression: a meta-analysis. *J Behavioural Therapy and Experimental Psychiatry*, 1997, 28: 139-147; Nonpharmacological aids in the treatment of depression. *American Family Physician*, 1993, 47: 435-441; Kiely BG, McPherson IG. Stress self-help packages in primary care: a controlled trial evaluation. *J Royal Coll Gen Practitioners*, 1986, 36: 307-309.; Jamison C, Scogin F. The outcome of cognitive bibliotherapy with depressed adults. *J Consulting and Clinical Psychology*, 1995, 63: 644-650; Ackerson, J, Scogin, F, McKendree-Smith, N, Lyman, RD. Cognitive bibliotherapy for mild and moderate adolescent depressive symptomatology. *J Consulting and Clinical Psychology*, 1998, 66, 685-690; Scogin, F, Jamison, C, Davis, N. Two-year follow-up of bibliotherapy for depression in older adults. *J Consulting and Clinical Psychology*, 1990, 58, 665-667; Smith, NM, Floyd, MR, Scogin, F, Jamison, CS. Three-year follow-up of bibliotherapy for depression. *J Consulting and Clinical Psychology*, 1997, 65, 324-327.
4. There is a tendency in the literature that reviews putative biological causes for depression to focus upon promising or suggestive findings and recent methodological advances, rather than to summarize what has in fact been well established. It requires attentive reading to determine the state of our established knowledge in this area. Following are papers (with selected quotes) which review the neurochemical dysfunction theory of depression:
 - Akiskal HS, In Kaplan HI & Sadock BJ, *Comprehensive Textbook of Psychiatry*, 1995, p. 1076: "Despite three decades of extensive research and indirect evidence, however, it has not been proved that a deficiency or excess of biogenic amines in specific brain structures is necessary or sufficient for the occurrence of mood disorders.";
 - Hirschfield RM, History and evolution of the monoamine hypothesis of depression, *J Clin Psychiatry*, 2000, 61 Suppl 6, 4-6: "the pathophysiology of depression itself remains unknown";
 - Syvalahti E. Monoaminergic mechanisms in affective disorders, *Medical Biology*, 1987, 65:89-96: "studies have failed to identify a robust metabolic disorder in depressive patients as a group";
 - Richelson E, Biological basis of depression and therapeutic relevance, *Journal of Clinical Psychiatry*, 1991, 52 Suppl, 4-10: "although most antidepressant drugs in use today have been available for decades, their mechanism of action in treating depression has not been established. In addition, theories about the biological causes of depression have not been proven."
5. There has been considerable research over the last decade demonstrating the substantial relationship between stressful life events and the onset of depressive episodes. Kendler KS, Kessler RC, Neale MC, Heath AC, Eaves LJ, The prediction of major depression in women: toward an integrated etiologic model. *Am J Psychiatry* 1993 Aug;150(8):1139-48.; Kendler KS, Karkowski LM, Prescott CA Causal relationship between stressful life events and the onset of major depression. *Am J Psychiatry* 1999 Jun;156(6):837-4; Sherrill JT, Anderson B, Frank E et al. Is life stress more likely to provoke depressive episodes in women than in men? *Depression & Anxiety* 1997;6(3):95-105.
6. The relationship between cognitive style and depression has been examined in a number of studies and a significant relationship has been demonstrated. Mazure CM, Bruce ML, Maciejewski PK, Jacobs SC Adverse life events and cognitive-personality characteristics in the prediction of major depression and antidepressant response. *Am J Psychiatry* 2000 Jun;157(6):896-903; Alloy LB,

- Abramson LY, Whitehouse WG et al. Depressogenic cognitive styles: predictive validity, information processing and personality characteristics, and developmental origins. *Behav Res Ther* 1999 Jun;37(6):503-3.
7. Various studies have demonstrated that certain types of behavioral or coping styles are predisposing factors with regard to the onset of depression. Rohde P, Lewinsohn PM, Tilson M, Seeley JR. Dimensionality of coping and its relation to depression. *J Pers Soc Psychology*, 1990, 58:499-511; Wierzbicki M, Rexford LJ. Cognitive and behavioral correlates of depression in clinical and nonclinical populations. *Clin Psychol*, 1989, 45: 872-877.
 8. Shulberg HC, Katon WJ, Simon GE et al. Best clinical practice: guidelines for managing Major Depression in primary medical care. *J Clin Psychiatry*, 1999, 60 (suppl 7): 19 – 26; Shulberg H, Block M, Madonia M et al. Treating major depression in primary care practice: eight-month clinical outcomes. *Arch Gen Psychiatry*, 1996, 53: 913-919; Mynor-Wallis LM, Gath DH, Day A. Randomized controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *BMJ*, 2000, 320:26-30; Gloaguen v, Cottraux J, Cucherat M et al. A meta-analysis of the effects of cognitive therapy in depressed patients. *J Affect Dis*, 1998, 45: 59-72.
 9. Thase M, Greenhouse J, Frank E et al. treatment of major depression with psychotherapy or psychotherapy – pharmacotherapy combination. *Arch Gen Psych*, 1997, 54; 1009-1015; Keller MB, McCullough JP, Klein DN et al. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression *N Engl J Med* 2000 May 18;342(20):1462-70.
 10. Simons AD, Murphy GE, Levine JL, Wetzel RD. Cognitive therapy and pharmacotherapy for depression. Sustained improvement over one year. *Arch Gen Psychiatry*. 1986 Jan;43(1):43-8.
 11. Zajecka J, Mitchell S, Fawcett J. Treatment B emergent changes in sexual function with selective serotonin reuptake inhibitors as measured with the Rush Sexual Inventory. *Psychopharm Bull*, 1997, 33:755-760; Modell JG, Katholi CR, Modell JD et al. Comparative sexual side effects of bupropion, fluoxetine, paroxetine and sertraline. *Clinical Pharmacology and Therapeutics*, 61:476-487
 12. Coupland NJ, Bell CJ, Potokar JP Serotonin reuptake inhibitor withdrawal. *J Clin Psychopharmacol* 1996, Oct;16(5):356-62; Black K, Shea C, Dursun S, Kutcher S. Selective serotonin reuptake inhibitor discontinuation syndrome: proposed diagnostic criteria. *J Psychiatry Neurosci*, 2000,25(3):255-61.
 13. A study in the UK found that “most of the British public thinks that depression is due to adverse life events and that counseling should be offered. Few think that it should be treated with drugs” [Priest RG, Vize C, Roberts A et al. Lay people’s attitude to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. *BMJ*, 1996, 313: 858-859]. It would be interesting to discover whether this attitude were as prevalent in North America.
 14. “Approximately 40% to 50% of patients prescribed an antidepressant medication will not take it for the minimum period needed to achieve therapeutic gains or will fail to improve even when adhering to prescribed dosages.” Schulberg, HC, Katon W.J., Simon GE, & Rush, AJ (1999). Best clinical practice: Guidelines for managing major depression in primary medical care. *J Clin Psychiatry*, 60(Suppl 7), 19-26. P.21. Johnson DAW. Depression: treatment compliance in general practice. *Acta Psychiatr Scand*, 1981, 63 (Suppl): 447-453.
 15. Churchill R, Dewey M, Gretton V et al. Should general practitioners refer patients with major depression to counsellors? A review of current published evidence. *Br J Gen Pract*, 1999, 49: 737-743; Shulberg HC, Katon WJ, Simon GE et al. Best clinical practice: guidelines for managing Major Depression in primary medical care. *J Clin Psychiatry*, 1999, 60 (suppl 7): 19 – 26; Friedli K, King MB, Lloyd M, Horder J. randomized controlled assessment of nondirective psychotherapy vs. routine general practitioner care. *Lancet*, 1995, 350: 1662-1665; Centre for Evidence Based Mental Health Website, *A systematic guide for the management of depression in primary care*, 2000.

APPENDIX:
LIFESTYLE INFORMATION

Diet

Food is the most obvious source of our energy. When we are depressed, however, our diet often suffers. Some people overeat. A more common problem is lack of appetite. If this occurs, it is important to remember that although you may not *feel* particularly hungry, your body's need for fuel continues. Here are some tips on keeping up adequate nutrition during difficult times.

Eat regular meals. It is usually easiest to eat (and to control what you eat) if you keep to a routine. Try to have three set mealtimes per day. Ensure that you have enough food at home for all three.

Eat by the clock, not by your stomach. If you have lost your appetite, push yourself to eat at mealtimes anyway. If you have been overeating, try to eat only at mealtimes while sitting at the table.

Make it easy. The important thing is to eat, not to cook. Buy foods that are easier to prepare (but keep an eye on their nutritional value).

Make extra. You can cut your preparation time by making larger amounts and refrigerating or freezing certain dishes for reheating later.

Make it healthy. Stock up on nutritious food and snacks using the Canada Food Guide (see the box).

Watch your sugar intake. Avoid eating too much refined sugar. Complex carbohydrates are generally preferable (particularly whole grain products, brown rice, and potatoes).

Avoid dieting. Avoid strict diets, even if you wish to lose weight. It is much better to adopt healthy (rather than restrictive) eating habits and increase your activity level. Ask your physician for advice before attempting to lose weight.

The Canada Food Guide

Guidelines are per day for adults. The actual amount of food needed depends on your age, body size, and activity level. The guide recommends choosing low-fat alternatives where practical.

Grain products: 5-12 servings. Examples of a serving: one slice of bread, 30g of cold cereal, 3/4 cup of hot cereal, half a bagel, half a cup of pasta or rice.

Vegetables and fruit: 5-10 servings. One medium size vegetable or piece of fruit, one cup of salad, half a cup of juice.

Milk products: 2-4 servings (more if pregnant or breast-feeding). One cup of milk, 3/4 cup yogurt, 50g cheese.

Meat and alternatives: 2-3 servings. 50-100g meat, poultry, or fish, 1-2 eggs, 2/3 cup beans, 1/3 cup tofu, 2 tbsp peanut butter.

Physical Activity

Regular physical activity is related to improved mental and physical well-being. Recent research indicates that physically fit people are less vulnerable to depression, and that regular exercise can markedly reduce symptoms of depression for many people.

Exercise affects mood in four ways. First, it can produce a brief “runner’s high” just after exercising in some people (during depression this effect may not occur). Second, after a few weeks of regular exercise (three to four times a week, at least 20 minutes at a time), a general improvement in mood tends to begin. Third, improvements in physical fitness are associated with improved energy, which can enable you to do more. Finally, exercise can be a good way of “burning off” stress when you are feeling tense.

Here are some tips for developing an exercise program:

- ❖ **Get a physical.** Before starting, ask your physician about any limitations on your activity.
- ❖ **Pick the right activities.** The biggest challenge is keeping at it. Pick activities that you really enjoy. Both aerobic (cardiovascular) exercise (in which your heart rate accelerates into a target range for 20 minutes or more) and anaerobic exercise (such as weight training or yoga) have shown positive effects on mood. Select the type that suits you best. Variety also helps: pick more than one activity and alternate them.
- ❖ **Stretch and warm up first.** Learn how to do stretching exercises properly, then make sure to do them before each exercise session. This can help reduce the likelihood of exercise-related pain or injury.
- ❖ **Frequency is more important than duration.** Regular short periods of exercise (three to four times a week) are better than irregular long periods.
- ❖ **Focus on enjoyment.** People who exercise for enjoyment and challenge seem to show bigger mood improvements than people who exercise mainly to look better. Try to put an emphasis on how you will *feel* rather than how you want to look.
- ❖ **Monitor if bipolar.** The effect of exercise on bipolar (manic-depressive) mood problems is less clear than for other forms of depression. Strenuous exercise during a manic episode or upswing in mood may aggravate the problem in some cases. Gentler exercise at these times may be preferable.
- ❖ **Nothing changes overnight.** Use goal-setting when developing a fitness program, and be sure to pick something achievable. For example, aim to swim once for five minutes rather than starting off by committing yourself to a daily 70 laps.

Sleep

Stress, anxiety, and depression often disrupt sleep, but this sleep disruption can lead to even more anxiety and depression. In other words, sleep difficulties are **a cause and an effect** of mood problems. Regardless of which came first, it can be worth the effort to work on getting a good night's sleep. Here are some tips:

- ❖ **Avoid over-the-counter sleeping medication.** Although it may help you to fall asleep, the type of sleep you get will usually not be as helpful as normal sleep. Instead, take sleeping medication only as directed by your physician. If you do take sleep medication, remember that the mark of its success is how you feel during the day, not whether it actually puts you to sleep. Report the results to your physician.
- ❖ **Set a standard bed-time and rising time.** Your body operates on a 24-hour cycle that can be disrupted by going to bed and getting up at different times. This is what causes jet lag: not the air travel, but the change in sleeping hours. Having regular hours for going to bed and getting up can help to set your internal clock.
- ❖ **Don't go to bed too early.** If you never get to sleep before 1 a.m., don't go to bed before 12. Want to get to sleep earlier? Start by setting your bed-time between 30 minutes and an hour before the time you have normally been getting to sleep. Then gradually begin going to bed earlier (by, say, a half-hour a week).
- ❖ **Save your bedroom for sleep.** Avoid associating this area with activities that are inconsistent with sleep – like working, eating, arguing, exercising, using the telephone, watching television, and so on. Sex, though, is fine.
- ❖ **Create a good sleep environment.** The best bedroom temperature for most people is 18° to 21° (65°F to 70°F). If noise is a problem, some options include earplugs, soundproofing the room (cloth hangings can help a bit), and devices that emit white noise (e.g., fans or special noise machines). Eliminate hourly watch beepers or clocks that gong. If a restless bed partner is a problem, consider a larger bed, special mattress, or even twin beds for a time.
- ❖ **Avoid napping during the day.** Unless, that is, you are a great 20-minute napper. Longer daytime naps can disrupt your ability to get to sleep at night.
- ❖ **Prepare for sleep.** Avoid strenuous activity, exercise, heavy meals, and bright light for at least one hour before going to bed.
- ❖ **Practice breathing or distraction strategies when attempting to get to sleep.** Focusing on your worries or on how much you need to get to sleep will only keep you awake. Practice any mental exercise that takes your mind away from these topics.

Caffeine

Caffeine stimulates the sympathetic nervous system, which governs the stress response. If your depression comes with a lot of anxiety, the last thing you need is a chemical that makes the stress response system more active. Caffeine can also aggravate tension headache, irritable bowel syndrome, chronic pain, and other physical problems.

Caffeine is an addictive drug. Heavy users can become psychologically dependent on it, develop tolerance (meaning that more caffeine is needed to get the same effects), and undergo withdrawal if they don't get it. Withdrawal symptoms include headache, drowsiness, irritability, and difficulty concentrating. Many people discover that they are dependent on caffeine when they go for a day or two without coffee and develop splitting headaches.

How much caffeine does it take to become dependent on it? Estimates vary, but 450 milligrams per day is about average. Some people are more sensitive, others less. Use the table below to calculate your average daily consumption. Notice the small serving sizes. Your coffee cup may hold three or four of these!

Substance	Amt in mg	# per day	Total
Coffee			
Drip (5 oz.)	130	× _____	= _____
Instant freeze-dried (5 oz.)	70	× _____	= _____
Decaffeinated (5 oz.)	3	× _____	= _____
Espresso drinks (1 shot)	90	× _____	= _____
Tea			
5-minute steep (5 oz.)	60	× _____	= _____
3-minute steep (5 oz.)	35	× _____	= _____
Other			
Hot cocoa (5 oz.)	10	× _____	= _____
Regular or diet cola (12 oz.)	45	× _____	= _____
Most other soft drinks (12 oz.)	0	× _____	= _____
Small chocolate bar	25	× _____	= _____
Total			= _____

If you decide to try reducing your caffeine intake, do so slowly to avoid the withdrawal symptoms. Drop your intake by about half for 4-6 days, then half of the remainder, then half again until you are drinking only ½ cup per day. Then stop.

DRUGS AND ALCOHOL

One of the reasons that people take street drugs and drink alcohol is that these substances sometimes make them feel better – temporarily. In the long run they can make problems worse:

- ❖ Problems are avoided rather than being dealt with.
- ❖ Performance at work, at home, and in social situations is impaired.
- ❖ Psychological and/or physical dependence can develop.
- ❖ Physical health can be impaired.

During periods of depression, alcohol and drug use may seem particularly tempting. But at these times using such substances can be a particularly bad idea. Your tolerance for their effects and your ability to control your use may both be lower than usual. The situation usually requires concrete, constructive action rather than a retreat into substance use. As well, drugs and alcohol interact with many prescription medications, including most of the medications prescribed for anxiety and depression. In general, then, it is best to follow these guidelines for a sustaining and sustainable lifestyle:

- ❖ Avoid recreational drug use.
- ❖ Avoid using alcohol at all during periods of depression or severe stress.
- ❖ Avoid using alcohol if you have a personal or family history of alcohol abuse.
- ❖ Even if you are feeling fine and have no history of abuse, adopt a personal policy to drink only in moderation.

The prospect of eliminating alcohol and drug use from your life can be a daunting one. Remember that while using none is best (particularly in the case of recreational drugs), reducing your intake is better than becoming overwhelmed and giving up. Use the principles of goal-setting to help you examine the problem and overcome it a bit at a time.

If your use of drugs or alcohol is altogether out of your control, you are in good company: Many people have had this problem. A number of organizations exist that can help you to regain control. Ask your physician for more information.