Chapter 12

Depression

Understanding depression

Depression is common. Between 5 and 10% of people seen in primary care suffer from major depression, and as many as 2–3 times more people experience depressive symptoms but do not meet diagnostic criteria (see *Box 12.1*) for major depressive disorder (Katon & Schulberg, 1992).

Box 12.1

Diagnosis of major depression (DSM-IV Criteria: APA, 1994)

Five of the following criteria (including at least one of the first two criteria) must have been present *almost every day for more than two weeks*, and must cause significant impairment in social, occupational or other areas of functioning.

- Depressed mood for most of the day
- Reduced pleasure or interest in usual activities for most of the day
- Fatigue or loss of energy
- Substantial change in appetite or unintentional weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Diminished ability to think or concentrate, or indecisiveness
- Feelings of excessive guilt or worthlessness
- Recurrent thoughts of death or suicide

Cognitive-behavioural therapy for depression

CBT is the psychological treatment of choice for depression (NICE, 2009a). It is as effective as antidepressant drug therapy for major depression in primary care (Scott *et al.*, 1997). It also has a lower rate of long-term relapse than antidepressants (Paykel *et al.*, 1999), because patients develop lasting skills to help them cope with difficulties in life. In severe depression, a combination of CBT and antidepressants is more effective than either treatment alone.

A combined approach to depression for primary care

NICE advocates a stepped care approach to depression management, which includes psychological approaches and medication as potential treatment options in the primary care setting (*Box 12.2*).

Brief CBT approaches by primary care health professionals are particularly useful for patients with mild depression, for whom there is little evidence that antidepressant medication is effective. This can be carried out alongside self-help strategies, graded exercise programmes or medication if appropriate.

Box 12.2

Stepped care model (NICE, 2009a)

Focus of the intervention	Nature of the intervention
Step 1 All known and suspected presentations of depression	Assessment, support, psycho-education, active monitoring and referral for further assessment and interventions
Step 2 Persistent sub-threshold depressive symptoms; mild to moderate depression	Low-intensity psychological and psychosocial interventions, medication and referral for further assessment and interventions
Step 3 Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
Step 4 Severe and complex depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care

Understanding depression

Typical thoughts and thinking styles in depression

Depressed people characteristically develop *negative* thinking patterns, which are often examples of *unhelpful thinking styles* (*Box 12.3*).

Box 12.3 **Common unhelpful thinking styles in depression**

- Black and white thinking (*"I am completely useless"*)
- Negative, self-critical view of self (*"I am such an idiot"*)
- Ignoring positives (*"Nothing went well this week"*)
- Mind-reading (*"He thought I was boring"*)
- Negative view of the future (*"Nothing will ever get any better"*) and predicting catastrophes
- Taking excessive personal responsibility/self-blame (*"I ruined the party for everyone"*)

Depressed people tend to have self-critical and self-blaming thoughts, which lower confidence, self-esteem and cause problems in relationships with others:

"I'm a terrible parent; I'm a burden to others; I'm useless"

These thoughts are usually *self-fulfilling* because thinking so negatively tends to prevent people from behaving in constructive or positive ways.

Depressed people also take a negative and pessimistic view of the world. They jump to the worst conclusions and perceive others as critical, uncaring or hurtful. For example, they may focus on one minor criticism whilst ignoring a barrage of compliments.

"The world is so full of terrible events; Nothing ever goes right for me"

Negative thinking or hopelessness about the future is common in depression, and at its most severe, can be linked with suicidal thoughts and behaviour.

"I'll never get a job – what's the point in trying?"

"I will never get over this depression. Nothing will get any better"

From *theory* to *practice*...

Notice the negative thoughts displayed by depressed people. Look for negative thoughts about the self, world and future. Which unhelpful thinking styles are most common?

At this stage, do not attempt to *challenge* these thoughts. When you notice a negative thought, try pointing it out to the patient and empathise with the distress that the thought might cause (*"It must be very difficult to think that way..."*) Then discuss the impact of thinking so negatively (*"I wonder how it affects your mood to think that way...?"*).

Case Example 12.1: Negative thoughts in depression

Cathy is a 26 year old bank clerk who suffers from mild depression. Here, she describes a barbecue that she attended at the weekend.

"I went to Alison's barbecue at the weekend. I didn't want to go, because I knew that I wouldn't enjoy it. I never have anything interesting to say. While I was there I made a terrible mistake – I forgot the name of Alison's sister, Joanne. I've only met her once before and my mind went blank. I looked like a complete fool. I tried to make it up to her by apologising and asking about her children, but I don't think that was enough. Alison will never invite me to another party."

Read through the text and identify Cathy's negative or unhelpful thoughts.

Negative, unhelpful thoughts:
"I won't enjoy the barbecue"
"I never have anything interesting to say"
"I made a terrible mistake by forgetting Joanne's name"
"I looked like a complete fool"
"It wasn't enough to apologise and ask about her children"
"Alison won't invite me to any more parties"

Which unhelpful thinking styles are represented by these thoughts? (*See Box 12.3* for a reminder.)

Feelings and emotions in depression

Depressed people experience a wide variety of negative emotions, including:
- persistent depressed mood – feeling sad, low, bleak, numb and empty
- loss of enjoyment or pleasure in usual activities
- anxiety, worry and panic
- anger and irritability: with self and others
- guilt and shame.

Biological factors and physical symptoms in depression

Depression is associated with a wide range of unpleasant physical feelings and symptoms. Many depressed people present to health professionals with physical or somatic rather than psychological symptoms (NICE, 2009a). Common physical reactions include the following.
- *Low energy and lethargy*: feeling tired all the time is one of the most common physical aspects of depression. It often results in a marked reduction of activity which worsens mood and fatigue as a vicious cycle.

- *Disturbed sleep:* includes difficulty getting off to sleep, early morning wakening or excessive sleeping.
- *Difficulty concentrating and problems with short-term memory:* people may find it difficult to read or follow a TV programme or conversation.
- *Changes in appetite and weight:* may be weight loss or weight gain due to 'comfort eating'.
- *Reduced libido:* loss of interest in sex.
- *Becoming 'slowed up'* (*psycho-motor retardation*): people often think and move more slowly than usual. This may include other bodily functions such as becoming constipated.
- *Physical agitation:* muscular tension and restlessness.
- *Increased pain:* people often feel pain more intensely when depressed.
- *Associated physical conditions:* depression is more common in people with physical health conditions.

From *theory* to *practice...*

Remember to ask depressed people about any physical symptoms, including low energy and fatigue. Explain that these are caused by the patient's depression and that they are likely to improve with treatment for depression.

Altered behaviour in depression

Unhelpful behaviour plays a key role in exacerbating or maintaining feelings of depression. This includes reduced activity and increasing unhelpful activities.

Reduced activity

Depressed people withdraw from social activity and reduce participation in enjoyable activities, such as hobbies and interests. They may also reduce activities that give life a sense of meaning or achievement, such as taking exercise, going to work, or daily activities like household chores. In more severe depression, people stop caring for themselves adequately.

These changes in behaviour may be due to:

- lethargy and tiredness (*"I'm too tired to do it"*)
- depressed mood and lack of enjoyment in usual activities (*"There's no point in going because I won't enjoy myself"*)
- negative thinking and low motivation (*"I can't be bothered to try"*).

Reducing activity only worsens depression as a vicious cycle. Becoming withdrawn and reducing enjoyable activities makes life increasingly mundane and isolated. Avoiding routine tasks and chores, such as ironing or washing up, can make people feel ashamed and guilty, and increases their sense of failure and lack of worth (*"I can't even manage to keep the house tidy – I'm completely useless"*).

Increasing unhelpful activities

Depressed patients may also develop new, unhelpful behaviours, which make their problems worse, including:

- misuse of alcohol or drugs
- self-harm
- making excessive demands or seeking reassurance from others
- sabotaging their own attempts to achieve positive goals ('setting themselves up to fail')
- behaving in ways which increase the likelihood of being let down or rejected by others.

From theory to practice...

Ask depressed patients whether they are behaving differently:

"What do you do differently, now that you feel so depressed? How did you behave before you felt depressed?"

Is this behaviour helpful or unhelpful? How does it affect their depressed feelings?

The role of environmental and social factors in depression

Life events, social difficulties and environmental problems, both past and present, all contribute to the development of depression (*Box 12.4*).

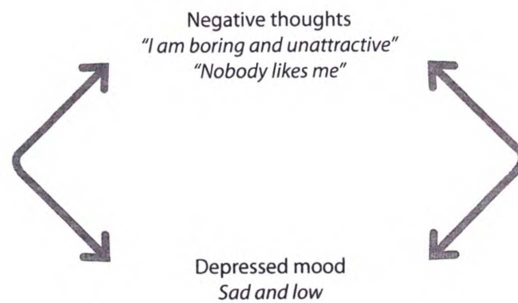
Box 12.4

Risk factors for depression

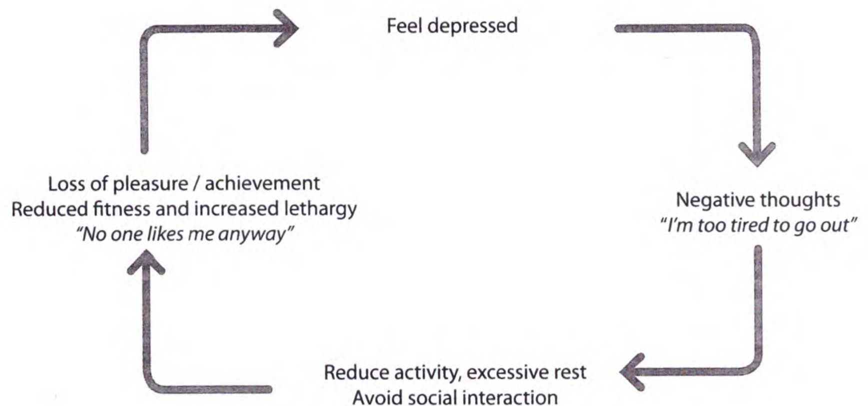
- Female sex: women are twice as likely to develop depression, particularly if caring for young children and lacking social support
- Socioeconomic factors such as financial problems, poor housing or unemployment
- Family history of depression
- Loss of a parent before adolescence
- Lack of social support network (e.g. close friends or family)
- Negative or stressful life events
- Experiencing chronic physical illness or being a carer

Vicious cycles in depression

Negative thoughts and low mood in depression tend to reinforce one another as a vicious cycle.



Similarly, reducing activity and withdrawing from other people also tends to make depression worse. This makes the person feel even more isolated and confirms any negative beliefs about their own lack of self-worth.



From *theory* to *practice*…

Remember to gather information about all five areas of the CBM when assessing depressed patients. Make particular note of any unhelpful behaviour such as reducing activity.

Can you identify any vicious cycles? What behavioural changes might enable the patient to break these cycles and make small steps forwards?

Case Example 12.2: Using the CBM to understand depressed patients

Roger is a 40 year old teacher who became more depressed 6 months ago when he was having problems with a colleague at work. He started antidepressant medication, which did improve his mood and had few side-effects. However, he still periodically feels low and depressed. He does not want to change his medication.

Roger's GP asked Roger to identify a specific situation that illustrated his difficulties and together they created the following CBM chart:

<table>
<tr><td colspan="2">Problem list:
1. Anxiety and lack of confidence to speak up during staff meetings
2. Not managing to get jobs such as marking or lesson planning done on time
3. Feeling tired and lethargic
4. Irritable and snappy with wife and children
Roger chose to focus on not managing to get jobs such as marking or lesson planning done on time</td></tr>
<tr><td colspan="2">Specific situation that illustrates the problem: Tuesday evening, coming home from school and realising there is huge amount of marking to do.</td></tr>
<tr><td>Thoughts
"I won't ever be able to cope with this workload – there's too much to do"
"I will just make a mess of it"
"I haven't achieved anything this evening"
"I'm a terrible teacher"</td><td>Feelings
Depressed
Down
Fed up</td></tr>
<tr><td>Behaviour
Puts off starting the work
Dozes in front of the TV all evening</td><td>Physical symptoms
Tired and sluggish
Sleepy and exhausted</td></tr>
<tr><td colspan="2">Environment / situation / other problems
Works as English teacher in a secondary school
Married to Valerie, two children, good relationship, but he feels increasingly irritable with small problems that arise in the family
Problems last year with a difficult head of department – little confidence in own work</td></tr>
</table>

Reflection

What vicious cycles can you identify for Roger? What 'handover' questions could the GP ask that might highlight these to Roger?

Using 10 Minute CBT with depressed patients

Depressed people often welcome a psychological approach to their problems. Nevertheless, symptoms such as tiredness, lethargy, difficulty concentrating and a continual barrage of negative thoughts make it difficult for depressed people to actively engage in the approach. Some key consultation skills that can help patients overcome these difficulties are shown in *Box 12.5*.

Box 12.5

Key consultation skills to use with depression

- *Written information*: providing written self-help leaflets and a summary of any discussion is especially important in depression where patients have poor concentration and memory.
- *Focus on specific, concrete examples*: ask the patient to choose the most important issue to discuss. Often the discussion can be generalised to other areas of the patient's life.
- *Guided discovery*: encourage patients to take the lead in discussions and discover new perspectives for situations themselves. Remember that depressed people may think slowly and have difficulty concentrating. Keep questions simple and allow them time to come up with answers.
- *Homework*: encourage the patient to make real changes in their life based on your discussion. Focus on increasing activity levels. Remember to review homework when you next see the patient.

Empowering explanations in depression

An important aim for GPs is to help patients understand depression better. Try to use the five areas of the CBM to map out and explain the vicious cycles that typically maintain depression. Always ask a handover question to encourage the patient to reflect on your discussion:

> *"What do you make of all this information that we have gathered? How could you use this approach to help you improve things?"*

The most important empowering explanation for depression involves discussing *depression tiredness*. Depressed people commonly feel tired and lethargic, and consequently rest and reduce activity even more. However, the tiredness associated with depression is *made worse* by rest and the most helpful and effective way to increase energy and reduce tiredness in depression is to *increase activity*, which energises people and improves mood.

From *theory* to *practice*...

Ask patients whether tiredness is preventing them from increasing their activity levels. If so, does rest seems to make them feel less tired? Explain that 'depression tiredness' is made worse by rest but can be improved by gradually increasing activity levels to build fitness and muscle strength.

Then try to collaboratively agree some goals to increase activity levels in bite-sized steps. If the patient is unsure, you could plan a behavioural experiment to test out the impact of increasing activity by rating their feelings of lethargy before and after various activities.

Making behavioural changes in depression

Depressed patients benefit from increasing activity levels *despite* their negative thoughts or feelings, including lethargy or tiredness. Regular aerobic exercise may be as effective as antidepressants in improving mood in depressed patients (Babyak *et al.*, 2000).

Increasing activity has several useful effects:

- enjoyable activities make life more pleasurable and interesting
- participating in activities distracts people from continually mulling over negative thoughts that worsen mood
- success at even small tasks like tidying the house or washing the car gives patients a sense of achievement and increased control over their life
- increasing exercise may directly alter brain biochemistry, promote positive feelings and improve mood.

Encourage the patient to ***behave 'as if'*** they are no longer depressed. This involves making positive behavioural changes *despite* feeling tired or lethargic. Choosing small, achievable goals will help build patients' self-confidence and self-esteem.

Initially, the patient may not enjoy activities as much as before being depressed. The first step is to restart the activities anyway. Participating in events can still increase patients' sense of achievement. Over time, the increase in activity will help the depression to lift and allow the enjoyment to slowly return.

Case Example 12.3: Changing behaviour in depression

George has been depressed for over 2 years. He feels tired and lethargic and tends to take naps during the day. *"I'm too tired to do anything right now. I need to rest for a while."* George's GP suggests that he could try a behavioural experiment to test out whether these thoughts are accurate.

They decide to compare two different ways of coping when he feels tired. On one day, he will go to bed and sleep as soon as he feels tired. On the next day, he will go for a 10 minute walk instead. He will do this on alternate days until he next sees his GP. George agrees to rate his feelings of sadness and lethargy before and after each strategy.

On the next appointment, George reported that he had been surprised to find that resting usually made him feel worse rather than better – his mood dropped lower and he usually felt even more tired. However, doing activity had actually lifted his mood on several occasions. He had also achieved several jobs that he had been putting off for some weeks, and felt a sense of positive achievement from this.

After the experiment, George reframed his original thought: "Resting when I am tired usually makes me feel worse, it is usually better to try to do something more active" and agreed to continue to gradually increase his activity levels further.

Behavioural activation in depression

Behavioural activation is an extremely effective strategy for overcoming depression (see *Chapter 7*). The first step is for the patient to keep track of their current behaviour using a behaviour monitoring form (*Figure 12.1*). They should keep track of what they do throughout the day and rate each activity according to its importance and enjoyment. Daily completion of the monitoring form is an essential part of this approach.

Monitoring behaviour can highlight unhelpful behaviour patterns where patients are spending a lot of time on activities that are neither enjoyable nor important. It may also help to identify any positive or helpful activities and encourage the patient to continue these.

After monitoring for several weeks, the next step is to begin to plan new activities. It is useful to set goals according to the individual patient's values and important life areas (*Chapter 8*). Encourage patients to aim for small, realistic increases in meaningful and enjoyable activities, keeping in mind the principles of pacing and avoiding boom-bust activity patterns that worsen fitness over time.

The patient can write their goals onto a daily monitoring form using a different colour. Then, they complete the daily monitoring form as usual, and compare what they planned with what they actually achieved. If the patient did not achieve their planned goal then consider setting a more achievable goal or helping the patient to find ways to overcome the obstacle next time.

Time	Activities (give details)	Importance (rate 1–10)	Enjoyment (rate 1–10)
06:00–07:00 am			
07:00–08:00 am			
08:00–09:00 am			
09:00–10:00 am			
10:00–11:00 am			
11:00–12:00 am			
12:00–1:00 pm			
1:00–2:00 pm			
2:00–3:00 pm			
3:00–4:00 pm			
4:00–5:00 pm			
5:00–6:00 pm			
6:00–7:00 pm			
7:00–8:00 pm			
8:00–9:00 pm			
9:00–10:00 pm			
10:00–11:00 pm			
11:00–12:00 pm			
12:00–02:00 am			
02:00–04:00 am			
04:00–06:00 am			

Figure 12.1: Behavioural monitoring form

Case Example 12.4: Using an activity chart in depression

Penny has been depressed for 9 months. She feels low, tired and has very little motivation to carry out her usual tasks. Penny's GP suggested that she could use a behavioural monitoring form to keep track of her activities throughout each day. They spent a few minutes during the appointment filling in the chart for that day, to give Penny some practice at using the chart. She also agreed to continue filling in a daily chart at home for the next 2 weeks.

Time	Activities (give details)	Importance (rate 1–10)	Enjoyment (rate 1–10)
07:00–08:00 am	Got up and got kids ready for school. Felt irritable and shouted at kids.	8	4
08:00–09:00 am	Had breakfast and did school run.	9	6
09:00–10:00 am	Came home feeling tired. Watched TV.	5	5
10:00–11:00 am	I wanted to do some housework but still tired. Carried on watching TV.	2	3
11:00–12:00	Got up and did the washing up. Did a few household jobs.	5	3
12:00–1:00 pm	Had lunch. Still hungry after so had a bar of chocolate.	5	4
1:00–2:00 pm	Went to supermarket and bumped into a friend. Bought myself a magazine.	7	7
2:00–3:00 pm	Came to visit GP to talk about how I'm feeling.	8	5

Two weeks later, Penny and her GP talked through some of her completed charts. Penny was surprised that she often achieved more than she had expected through the day. But it was also clear that she was spending more time on activities such as watching TV even though this was not rated as important or particularly enjoyable.

Penny's GP pointed out that there seemed to be very few enjoyable or social activities in her week. Penny agreed that she had cut down on many activities which she had previously found enjoyable – such as physical exercise and seeing friends.

The next step was to plan some important life areas and set some activity goals. Penny decided that her important life areas were relationships with friends and hobbies. She planned to make time to meet a friend for lunch and to start swimming again.

Physical exercise

Physical exercise has a direct effect on mood to alleviate depression, and is therefore a particularly important activity for the patient to carry out. This could include walks with friends, gardening, swimming or playing with children. Walking is a particularly accessible option, which is cheap and does not necessarily involve a great deal of time. Even a very short walk (5–10 minutes) can be very beneficial to alleviate depressed feelings.

Coping with negative thoughts in depression

The process of *identifying* and *labelling* negative thoughts helps to strengthen the view that such thoughts are simply *opinions* rather than absolute facts and helps to promote a more balanced and realistic perspective.

Distraction

Distraction is a simple but effective short-term strategy to reduce the number and impact of negative thoughts by focusing the mind elsewhere. Concentrating on a practical activity or exercise can distract a depressed person from their negative thoughts and lift their mood.

Exploring and reframing negative thoughts

As always, the first stage is to identify any negative thoughts that arise during a specific situation. Ask the patient to choose one negative thought to look at in more depth. The next step is to try to identify evidence both for and against this thought and finish by asking the patient to try to find an alternative, balanced perspective.

Mindfulness

Mindfulness-based cognitive therapy has been shown to reduce relapses in patients with recurrent depression (NICE, 2009a). Practising mindfulness can help people to see more clearly the patterns of thoughts in the mind and to recognise when their mood is beginning to go down, enabling them to take action at an early stage to prevent further decline. It also helps the person to focus on the present moment, rather than getting caught up in negative thoughts about the past or the future which serve to lower mood.

Key learning points

Summary of the cognitive behavioural model for depression:

Thoughts / thinking styles	**Feelings**
• Negative thoughts: self-criticism, negative view of world, hopelessness about future • Low motivation and apathy • *"I'm useless. I'm a failure"* • *"I'm a terrible parent. It's all my fault"* • *"Nothing will get any better"*	• Sadness, low mood, loss of enjoyment • Anxiety and worry • Guilt, shame, anger
Behaviour	**Physical symptoms**
• Reduce meaningful and enjoyable activities, excessive rest • Withdrawal and loss of social interaction • Other unhelpful activities, e.g. misuse of alcohol, self-harm, reassurance-seeking	• Low energy and tiredness, poor sleep • Poor concentration and memory • Changes in appetite and weight • Loss of libido; ill-health
Environment / social factors • Lack of social support, unemployment, financial problems, stressful life events • Loss of a parent before adolescence, family history of depression	

- 10 minute CBT strategies are particularly useful for GPs to help patients with mild to moderate depression. The approach can be combined with self-help, graded exercise and antidepressant medication.
- Increasing meaningful and enjoyable activity is one of the most important methods of breaking the vicious cycles that maintain depression.
- Use principles of behavioural activation to encourage your patients to be more active *despite* negative thoughts or feelings of lethargy. By behaving 'as if' they are less depressed, they are likely to feel better.
- Encourage patients to set their own behavioural goals based on their personal values and important life directions. To build confidence, make sure these goals are bite-sized and easily achievable. Where possible, encourage social interaction and social support for maintaining the goals.