

Depression Toolkit

Information and Resources for Effective Self-Management of Depression

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**Depression Toolkit: Information and Resources for Effective Self-Management of Depression
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The BC Partners for Mental Health and Addictions Information brings together seven leading provincial mental health and addictions non-profit agencies. The agencies are working together because they recognize that people need to have access to quality information on mental health and substance use issues. The BC Partners want to promote information and tools backed by high-quality research that can help people and families living with mental health and addictions issues live productive, fulfilling lives. The seven agencies making up the BC Partners include the Anxiety Disorders Association of BC, Awareness and Networking Around Disordered Eating, BC Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, and Mood Disorders Association of BC. These organizations are well respected in the field and have regional networks throughout the province. Funding is provided by the Provincial Health Services Authority.

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Why do we need a toolkit for depression?

If you or someone you know suffers from depression, you are not alone, and there *is* hope. Depression affects approximately 4% of the population at any one time and 10% over the course of a lifetime. That means that at any given time 160,000 British Columbians suffer from depression. In most cases, depression is an illness that can be successfully treated and managed. This toolkit is designed to help people with depression find the help they need and learn to live successfully with their health condition.

What is in the toolkit?

This toolkit contains resources and strategies important for the “self-management” of depression. Self-management means having basic understanding about your illness and then being able to apply it in your own situation. It’s about working with your mental health professional to find the treatment that works best for you and then sticking with it. It’s also about developing strategies for dealing with depression and its impact on your day-to-day life.

In order to help you on your path to self-management, the toolkit provides a number of things:

- Information about depression, and the different types of this disorder
- Information about evidence-based psychosocial and medication treatments
- An overview of strategies for working with your health professional to find the treatment that works best for you, known as “shared decision-making”
- An overview of resources and strategies for managing depression on a day-to-day basis, including the *Depression Self-Care Program* and *Changeways*
- Information about other key resources for depression self-management



How do I use this toolkit?

Read through the material in this toolkit at your own pace, and review it whenever you need to. You may find you are familiar with the basic information provided in the earlier sections of the toolkit. In that case, follow up on the recommended resources, or feel free to skip ahead to the later sections.

This toolkit can be used by itself, or in combination with other resources. If you suffer from depression and also have symptoms of anxiety, you can use this toolkit along with the *Anxiety Disorders Toolkit* at www.heretohelp.bc.ca. If you suffer from depression as well as another mental disorder, or if you suffer from bipolar illness, you can also use the *Mental Disorders Toolkit* on our website. Readers may also want to access other resources being produced by the BC Partners, including *Wellness Modules*, *Family Toolkit* and *Problem Substance Use Workbook*.

If you or someone close to you is currently in dire distress, or is suicidal, see “How Do I Know If I or Someone Close to Me Needs Help?” “Suicide Risk” and “How Do I Find the Help I Need?” on pages 11 and 12 of this toolkit.

Disclaimer

The BC Partners for Mental Health and Addictions Information seeks to provide people with reliable and practical information. Facts and findings from well-conducted studies have been summarized to present the best available material and evidence on topics of interest. Special attention has been given to ensure that the sources are credible, accurate, current and relevant.

While the material is comprehensive, it is not exhaustive, and may not apply to all situations. Decisions regarding specific interventions remain the responsibility of the individual who has the illness in collaboration with their health care professional and support network. The information provided through the BC Partners toolkits is intended for educational use only and is not intended to provide or substitute for professional medical advice or services.

bibliography

- ★ For major references that informed this toolkit, see www.heretohelp.bc.ca/helpmewith/dtoolkit.shtml

Most people have felt depressed or down at some time in their life. Feelings of discouragement, frustration, and even despair are normal reactions to loss or disappointment. These feelings usually only last for a few days or weeks before they gradually disappear on their own. When feelings like these last for two weeks or longer and begin to interfere with work, family, and other aspects of life, the low mood may be a sign of major depressive disorder, also known as clinical depression.

Sometimes depression does not show itself as sadness, but instead as a sense of emotional numbness or emptiness. Other signs and symptoms of depression include:

- Loss of interest in previously enjoyable activities
- Disrupted sleep (either trouble falling asleep, staying asleep, or sleeping too much)
- Significant changes in appetite or weight (eating more or less than usual, losing or gaining weight)
- Feeling tired or having little energy
- Feelings of guilt or worthlessness
- Difficulty concentrating or making decisions
- Moving or speaking more slowly than usual, or being so fidgety or restless that others notice
- Thoughts that life is not worth living, or that you are no good to anyone

How does depression affect us?

Depression impacts many areas of a person's life including our emotions, thoughts, body responses (physiology), and our behaviours. These various areas can also influence each other.

Stressful situations

Depression is often triggered by stressful situations, or difficult situations that we don't know how to manage successfully. If attempts to cope with the situation are not successful, we may begin to feel overwhelmed and hopeless.

Emotions

Depression affects how we feel. When people are depressed they feel down, tearful, uninterested in people and activities, discouraged and even despairing. These feelings make it hard for us to cope with the stressful situations that may have led to the depression in the first place. They may also make it difficult for us to seek the assistance of others in order to feel and cope better with our situation.

Thoughts

When we are depressed, it is easy to have a distorted view of situations. We may be unrealistically negative about our current situation, unfairly critical of ourselves, and overly pessimistic about the future. The way that depression affects our thinking tends to increase the negative impact of difficult life situations and to interfere with our normal coping and problem-solving abilities.

Body responses

Depression is often accompanied by a number of physical symptoms such as altered sleep, low energy, and changes in brain chemistry. These physical changes make it harder to cope with our problems. For example, a lack of sleep can make it harder to concentrate properly and deal with stressful situations.

Behaviours

Depressed people often withdraw from others, reduce or limit their activities, and may find it harder to take care of themselves. They may decline social invitations, stop eating well or exercising, or give up hobbies. These changes, while often an inevitable part of the depression, can make the other symptoms of depression worse.

key messages in this module

- ★ Depression appears in approximately 4% of the population at any one time and in the majority of cases can be successfully overcome.
- ★ It is often brought out by stressful situations and can affect several areas of our life, including our emotions, thoughts, behaviours, and bodily responses (physiology).
- ★ There are many things that can cause or contribute to depression including stress or difficult circumstances, genetics or family history of depression, and gender (women are two times as likely to have depression).
- ★ Depression can appear slightly differently in different groups of people, and the symptoms can vary depending on things such as age, gender and ethnic background.
- ★ If you have experienced at least five of the symptoms of depression over the past several weeks listed on this page, then you should make an appointment with a mental health professional for a thorough assessment.
- ★ If you or someone you know is experiencing thoughts of suicide or harming someone else, then you should seek help immediately.

What causes depression?

The exact cause of depression is unknown. However, both environmental and bodily (neurobiological) factors play an important role. Many studies show biological changes in the brains of people with clinical depression. Genetics also plays a role, as depression can run in families. Another significant risk factor for depression is gender (women are two times as likely as men to present with clinical depression). Depression is often triggered by loss, conflict, or isolation. As well, stressful life situations, like having a low income or a chronic physical illness, and personality factors such as one's way of looking at the world and at situations (known as cognitive style), can increase the likelihood of becoming depressed.

Depression can occur in individuals of all ages, but is most prevalent in people of middle age, and in certain portions of the elderly population. The prevalence of depression in young people has grown in recent years. There is increasing recognition that depression can occur in childhood and adolescence, despite our past tendency to think that moodiness in young people is just "part of growing up."

What are the types of depression?

In the next section, we'll discuss the common types of depression. The most prevalent type is major depressive disorder, or MDD (sometimes also referred to as "clinical depression"). Subtypes of MDD include seasonal affective disorder (SAD), postpartum depression, and psychotic depression. The other main type of depression is known as dysthymia. Depression is also a feature of bipolar disorder, either bipolar I (manic depression) or bipolar II (hypomanic depression).

Major depressive disorder

To be diagnosed with major depressive disorder, a person must have at least five of the symptoms listed on the previous page, for most of the day, for at least two weeks. The symptoms of major depression typically cause significant distress, and can lead to impairment in functioning at work or with relationships, especially if left untreated for a length of time. Major depression may occur in episodes lasting weeks or months, or may be chronic, lasting longer periods of time. For some individuals, the depression will go completely away after the end of an episode. Others may continue to experience ongoing low levels of symptoms after the major depression has gone away. Clinically, this is referred to as dysthymia (see page 9). Having one episode of depression puts a person at risk of having another.

example *Maria is a 28 year-old single woman who felt she just couldn't cope because she was so tired and fatigued. When she got home at night from her job, she tried to read a book, but found that she couldn't focus. On the weekends, she was watching TV and eating junk food for hours at a time. She didn't do much socially, as she didn't find going out very rewarding, and worried that her friends thought she was no fun, and that they didn't want to be around her. For several weeks, she had been feeling that she couldn't cope. One night, while she was preparing supper, she was overwhelmed with a feeling of "how pointless it was to be peeling those carrots." After being diagnosed and treated for depression with an antidepressant, she is now starting to feel like socializing, and doing some of the hobbies she used to enjoy. One of her friends — who also suffers from depression — suggested that she should find a therapist to help her deal with her stress at work.*

example *Sharon is a 40-year old lawyer who had been working hard on a case for several months. She put in many late nights, and didn't see her family much during that time. During that period, things were tense with her husband, who resented her absence from the home. Just as her trial was finishing up, she came home one night to hear the news that her mother had died. After that, Sharon wasn't the same for quite a while. She couldn't get over her guilty feelings about not being there for her mother when she was sick. She was feeling edgy and having trouble getting along with her colleagues at work. When her husband first encouraged her to get some help, she was very reluctant. But after finding a therapist she trusted, she's been able to reexamine her relationships and her lifestyle, and has started to gain some perspective on her life. She is starting to feel more comfortable with herself and the others around her, at home and at work.*

Seasonal affective disorder

Seasonal affective disorder or SAD is a type of clinical depression that appears at certain times of the year. It usually starts with the shortening days of late autumn and lasts through winter. SAD is more common in northern countries, where winter days are shorter. In Canada, about 2 to 3% of the population will experience SAD in their lifetime. Another 15% of Canadians will experience a milder form of low mood during this time referred to as the “winter blues.” The term “winter blues,” however, can be misleading: some people have a rarer form of SAD that is a “summer depression.” This condition usually begins in late spring or early summer.

One of the most distinctive signs of SAD is a change in appetite. Often, the person gets cravings for sweet, starchy, or other carbohydrate-rich foods. This can result in overeating and weight gain. People with SAD are often tired all the time, tend to oversleep, and can sometimes feel anxious and desolate as well. SAD can be confused with manic depression, which often features moderately severe depression in the winter and hypomania (less extreme symptoms of mania including bursts of activity, excitement, etc.) in the summer. Research shows, however, that most people with SAD simply have unipolar depression (depression without periods of elevated mood) in the winter, and feel substantially better in the spring.

Scott, 45, was an RCMP Constable stationed in Prince Rupert, in northwestern BC, when he first began experiencing problems functioning effectively throughout fall and winter. “I became tired and constantly feeling like I was moving in slow motion, wanting to just put my head down and hibernate,” he says. Scott also felt more than just physical symptoms during these episodes. “The deep depressions were complete with sensations of deep and utter hopelessness,” he states. “I contemplated suicide more than once.” Scott was initially very hesitant to talk to his doctor about his symptoms, but five years ago, sought professional help and was diagnosed with thyroid problems and SAD.

When first diagnosed in 1998, Scott’s doctor recommended phototherapy and he has used it ever since. “Since starting a regular routine of using the lamp, I’ve found that the lamp tends to energize me for the day ahead,” Scott says. Beginning in October and running daily until April, he sits in front of his SAD device each morning and spends 30 minutes in front of the bright light working on creative writing projects. Lifestyle changes have also helped. Scott, who has since been diagnosed with bipolar disorder, knows too well that leaving his SAD symptoms unchecked can spell disaster for his other conditions and that the light device is only part of a larger wellness plan. “I no longer ignore stress, and have learned to work with it. Healthy lifestyle changes like exercise, relaxation, healthful diet, social supports, medical supports, using my SAD lamp and compliance to my medications. All of those have made a difference for me.”

example

Postpartum depression

Postpartum depression is a form of MDD that occurs most commonly in the early weeks after giving birth. It affects approximately 15% of mothers, but it is especially likely to occur in women with a history of depression. It lasts weeks, months, or even years after birth, and is different from the fleeting “baby blues”: a feeling of distress and tearfulness that usually disappears within the newborn’s first weeks of life.

Postpartum depression is not restricted to women who are giving birth for the first time. It is just as likely to affect women who are adopting, and those who have had children before. It can occur anytime from right after childbirth, to a few months after. Ten per cent of women will begin to have symptoms during pregnancy.

The symptoms of the illness include feelings of helplessness, numbness, and depressed mood. Women with the condition often feel a lack of control over their emotions, sometimes crying for no reasons, or having a panic attack (intense feelings of anxiety, often accompanied by pounding heartbeat, sweating, and usually reaching their peak after a few minutes.) Also, it is common for women with this condition to feel inadequate or unable to cope with their new responsibilities. For instance, they might be overly concerned about the baby, feel anxious, irritable, worry excessively, have difficulty sleeping, or feel resentment towards the baby or other family members. This in turn, can make the individual feel guilty for having these emotions.

Sometimes women experience frightening or upsetting thoughts about harm coming to their infants, or of harming their babies, even though this is not something they would ever do. These thoughts are quite common with postpartum depression, but rarely does a mother act

on them. In the very rare cases where this does happen, she is usually experiencing a condition known as postpartum psychosis, which affects one to three women out of 1000. It is important to remember that even women with postpartum psychosis very seldom harm their children.

example

Linda experienced severe postpartum depression with all her three sons. Although she didn't think to seek help the first time, the births of her second and third sons presented with anxiety and propelled her to seek help. "There was a lot of fear," she says. "I would have images of something bad happening to my children or husband. For example, I would be overly afraid of falling down the stairs with my baby. I felt really vulnerable as well. With my first son, my self-esteem was in really bad shape, yet on the outside, I appeared to have it all together." When the birth of Linda's third son brought about the same depressive symptoms, this time she knew about organizations such as Pacific Post Partum Society and decided to seek help from them. "I received gentle, nurturing support, and was reminded that I was important too," she says. "I didn't receive any messages that I should be so happy with childbirth. Rather I received more understanding from people who knew exactly how I felt and believed in me."

Other reproductive mental health issues

Beyond the postpartum period, there are other times in a woman's reproductive cycle that may impact on mood to the point where some intervention is needed. These include:

- **Premenstrual period.** 30 to 70 % of women may experience symptoms of depression before their menstrual period. Approximately 5 to 10 % of women have a condition known as Pre-Menstrual Dysphoric Disorder that results in mood and behavioural distress.
- **Before, during, and after menopause.** Women who experience postpartum depression may be at greater risk of experiencing a depression in menopause.
- **Pregnancy.** About 10 % of women with postpartum depression will experience symptoms during pregnancy, especially during the first and third trimesters.
- **Miscarriage or stillbirth.** Grief reactions are common and for some individuals may lead to depression. Women who experience multiple miscarriages, late pregnancy loss, or women over 35 years with two miscarriages may be at higher risk.
- **Infertility.** Recent research points to a relationship between infertility and onset of depressive symptoms. One study found that women who are infertile over 12 months are twice as likely to report depressive symptoms than women who conceive prior to the 12 month period.

For more information about reproductive mental health issues and related treatment options, see www.bcrmh.com and www.wellmother.com

Psychotic depression

About one in 10 people with major depression will have psychotic symptoms, such as hallucinations (hearing voices) or delusions (ideas with no basis in reality). A person with psychotic depression normally won't experience psychosis every time they have an episode of depression. These may occur in as few as 15 % of episodes. In psychotic depression, the symptoms are "mood congruent," that is they are consistent with the individual's mood. This distinguishes them from psychotic symptoms that occur in other illnesses, especially schizophrenia.

example

Mark had experienced a number of bouts of depression, but his most recent episode was the worst. He had lost most of the pleasure he normally took from doing things, and withdrew from seeing anyone. He decided he would go back on his antidepressant medication, but it was slow to work. After about a month on his medication, he was still feeling depressed, and he became increasingly focused on a recurrent thought that the world was going to end and it was all going to be his fault. This made him alarmed, as he knew this kind of thinking "just wasn't right," so he made an appointment with his doctor. She prescribed a dose of an antipsychotic medication to go along with his regular medication. She was also able to help Mark discuss ways of countering this thought, such as using a diary to chart when the thought seemed to come on, and developing relaxation exercises when his thoughts seemed to start heading in that direction. Gradually, Mark is starting to feel more comfortable with his thinking, and he's also starting to feel better.

Dysthymia

Dysthymia is a chronic, low-grade depression that affects about 3% of the population. To be diagnosed with dysthymia, an individual needs to have experienced chronic low mood, as well as at least two of the other symptoms of depression, for at least two years. In children and adolescents, irritability is usually more common than low mood, and the condition can be diagnosed after one year. In some cases, dysthymia occurs in episodes, although it can last almost all of the time. Some people with dysthymia develop major depression later on, sometimes called “double depression.” Some individuals may experience dysthymia after a major depressive disorder.

George is a divorced middle-aged man who talks about feeling “empty” and also feels he drinks more than he should. George had a troubled upbringing, and was raised by a single mother who also suffered from depression. His father left the family when he was ten years old. Before that, he was abusive to George, his mother, and his siblings. Looking back on his life, George comments that he never realized he had depression, because “I was always kind of depressed, and just assumed that was the way I was supposed to feel.” After two months of psychotherapy, however, he has started to realize that there is a different way to feel.

example

Bipolar disorder

Bipolar disorder, formerly known as manic depression, is a form of mood disorder that affects 1 to 2% of the population or about one in every five persons with mood disorders. The two main subtypes of bipolar disorder are bipolar I (or manic depression) and bipolar II (or hypomanic depression). Recent research, however, suggests that the proportion of people with mood disorders who have some form of bipolar disorder is actually significantly higher than previously recognized. Bipolar disorder appears in men and women at the same frequency.

A person with bipolar disorder will experience cycles of moods, including periods of depression, normal mood, and elevated or agitated states referred to as the “manic” phase of the illness. Individuals with bipolar II will experience hypomania, which is a less severe form of the “high” phase of the disorder. Depressive symptoms are similar to those experienced by people undergoing a major depression. In contrast, a person in a manic phase of the illness may suddenly experience an excessively high or elated mood. They may begin to talk rapidly, have little need for sleep, make grandiose plans, and start to carry them out. Such uncharacteristically risky or ambitious behaviour can sometimes land the person in trouble. For example, someone may spend money very freely and get into debt, or show disregard for the law. They may also show an uncharacteristic lack of judgment in their sexual behaviour. Some people have symptoms of psychosis (also “mood congruent”) during this time.

From time to time, James experienced bouts of depression for which he had received treatment. Generally, though, his life was going well, and he considered himself to be “an extremely productive person” at his job and in other areas of his life. As he became older, however, his moods became increasingly troubling to him, and they started to get in his way. During one particularly bleak period, he took a leave from his job because he just couldn’t function. Shortly after that, he asked his doctor for a referral to a psychiatrist, so he could see what was going on, and figure out why his present treatment didn’t seem to be working. After doing a thorough assessment, he was surprised when the doctor told him he actually had a form of bipolar disorder known as bipolar II or hypomania. James challenged the doctor about this diagnosis, because as he said “I never went on spending binges, or bought a whole bunch of hats that I didn’t need.” By helping him reconsider his past medical history, however, the doctor helped James remember that there had been a number of times in his life where he had gone without much sleep, and “worked himself into a frenzy.” The doctor pointed out how these times also tended to lead him into a depression. By adding a mood stabilizer to his antidepressant medication, and by reconsidering his lifestyle, James feels he is now “turning the corner,” and “really getting a handle on his life, and his moods.”

example

How does depression appear in different populations?

Depression has similar features regardless of who it affects, but it may appear slightly different depending on a number of factors, including gender, age, and ethnocultural background.

Gender

In **women**, depression is often expressed as sadness or tearfulness, whereas **men** more often show signs of low mood such as a “flatness” or “numbness” of feeling.



Age

In **adolescent** depression, irritability may often be a more of a telltale symptom than low mood. Boredom, apathy, or feelings of despair and helplessness may also be common. Unlike adults, sleeping problems for teens with depression generally involve oversleeping, rather than insomnia.

In **children**, depression can be difficult to recognize as the symptoms often appear similar to other behavioural syndromes such as attention deficit disorder, hyperactivity, or “problem behaviour.” Depression in children can be also confused and expressed as physical symptoms, such as stomach aches and headaches.

In the **elderly**, symptoms of depression such as early waking and reduced eating are also typical signs of aging. Memory problems associated with depression can also be confused with the normal process of aging, or with onset of dementia, making the condition difficult to recognize. Other symptoms, such as slowed speech or movement, may be mistaken for a stroke. Like children, older people may also become preoccupied with physical complaints.

Ethnicity and culture

The phenomenon of presenting with physical complaints, common in children and elderly people, is known as “somatization.” This is also common in people of certain ethnocultural backgrounds. It is important to recognize that people from different ethnic or cultural backgrounds will express low mood differently. For instance, in people of Chinese background, sadness and despair may be expressed as “heartache” and “fatigue” or “tiredness,” unless clarified by a mental health professional.

What other conditions appear with depression?

Depression commonly appears in combination with other mental disorders. This is referred to as having “co-morbid” or “concurrent disorders.” For instance, a significant proportion of people with depression also have some form of substance use problem. Depression and anxiety disorders are commonly found together. Over 30% of people diagnosed with a mood or anxiety disorder have both existing at the same time.

Depression is also found with eating disorders and schizophrenia, and many people with depression also suffer from physical health conditions, such as heart disease, diabetes, allergies, arthritis, or other conditions involving chronic pain. In some cases, depression may be secondary to the other existing condition, and may resolve when the other problem is dealt with or treated successfully.

How do I know if I or someone close to me needs help?

To get a better idea of whether you might need help, ask yourself two questions:

- Have I been bothered by a loss of interest or pleasure in doing things?
- Have I been feeling down, depressed or hopeless during the past month?

Alternatively, you can look at the signs of depression to the right. If you have experienced five or more of these in the past few weeks, or if you answered yes to one or both of the two questions immediately above, then you should see a mental health professional to investigate things more closely. In general, if you think that something “isn’t quite right” or you don’t feel like yourself, then you should see a mental health professional to get a thorough assessment.

What does a thorough assessment for depression involve?

Using a self-screening instrument like the one on this page or at www.heretohelp.bc.ca/self-tests is not enough to determine if someone meets criteria for a diagnosis of major depression. However, self-screening instruments can indicate when help from a mental health professional is needed. This person can then confirm whether in fact you do have depression or not. When you visit your doctor, he or she will perform a thorough assessment of your difficulties. The assessment should include:

- an assessment of your current symptoms and a thorough history of past symptoms
- an assessment of how well you are functioning in your social life and at work and the degree to which you are impaired by your condition in these settings or roles
- questions about social, educational, and work development
- questions about your personal relationships and employment history
- a medical history and examination to rule out a possible medical cause for your depression (e.g., an underactive thyroid gland), or to identify other existing physical illnesses along with depression
- an assessment to determine if you suffer from other mental disorders that might involve depression, such as bipolar disorder, psychosis or anxiety disorders
- assessment for suicidal feelings and your risk for suicide

Unfortunately, often a routine office visit with your family physician does not allow enough time for a thorough assessment. In Module Three, we include suggestions about what you can do to make sure your mental health professional has all the information that he or she needs to make an accurate assessment. We will also discuss how you can play an active role in deciding on a successful treatment strategy.

Suicide risk

Sometimes when people feel depressed they begin to think a lot about death or about taking their own life. In some cases, depressed people will actually attempt to take their own life, sometimes successfully. It’s estimated that three quarters of suicides involve untreated depression. Obviously, anyone experiencing an episode of clinically significant depression is in need of treatment. However, if that person is also thinking a lot about death and has expressed some plan or intention of acting on their thoughts, they need immediate assistance.

Common symptoms of depression

- ★ Loss of interest in previously enjoyable activities
- ★ Disrupted sleep (either trouble falling asleep, staying asleep, or sleeping too much)
- ★ Significant changes in appetite or weight (eating more or less than usual, losing or gaining weight)
- ★ Feeling tired or having little energy
- ★ Feelings of guilt or worthlessness
- ★ Difficulty concentrating or making decisions
- ★ Moving or speaking more slowly than usual, or being so fidgety or restless that others notice
- ★ Thoughts that life is not worth living, or that you are no good to anyone

How to help someone with thoughts of suicide

- ★ remind yourself that all talk of suicide must be taken seriously
- ★ say to the person:
 - ★ *“It’s reasonable to feel as you feel, but I can help you find other solutions”*
 - ★ *“You are really important to me”*
 - ★ *“I don’t want you to die”*
- ★ phone your local emergency number: confidentiality can be waived in life or death situations

Where do I start looking to find the help I need?



If you or someone you know feels desperate or suicidal and needs help immediately, you can phone or go to the emergency department of your local hospital.

Most communities, especially cities and large towns, have a number of different places where you can find help:

- You can call the local crisis hotline listed on the first page of your phone book. For information about the local crisis response or emergency mental health team in your area, or about other options, call the BC Mental Health Information Line at 604 669 7600 or 1 800 661 2121 or the BC Health Guide Nurse Line at 604 215 4700 / 1 866 215 4700
- The local mental health centre or emergency mental health service is listed under Health Authorities in the Blue Pages of your phone book
- Ask for your family doctor to help you find the professional help you need. First, he or she should start by giving you a thorough physical check-up to rule out an underlying medical cause to your symptoms. A referral to a psychiatrist or other mental health professional may be needed.

Who are the mental health professionals that can provide treatment and support?

As you look for help, you may encounter a number of different professionals who provide treatment of one kind or another. Each has different training and may be equipped to provide different kinds of services. The section below describes the various kinds of mental health professionals that may assist you.

- **Family doctor.** Your family physician (or general practitioner (GP)) has general training in medicine, and many may have specific experience in dealing with mental illness. Often your family doctor is the first step in accessing the mental health system and getting referred to more specialized or intensive resources. GPs usually work in private practice, although may also work within the formal mental health system. They can prescribe medication and may provide psychotherapy. Some GPs have training in evidence-based psychotherapies, such as cognitive-behavioural therapy or interpersonal therapy.
- **Psychiatrist.** A medical doctor with specialized training in psychiatry is able to prescribe medications and provide psychotherapy, and may be trained in evidence-based psychotherapies. A psychiatrist may work in private practice, within the hospital system, or as part of a mental health centre or team.
- **Registered Psychologist.** Registered psychologists have a PhD in Clinical Psychology, can provide diagnosis and evidence-based psychotherapy, but do not prescribe medication. Psychologists are not covered by the Medical Services Plan, but may be covered through private or workplace insurance plans.
- **Registered Clinical Counsellor.** Clinical counsellors provide clinical assessment, prevention, therapy and intervention to address mental health issues and have a Masters degree or equivalent in Counselling Psychology. They often provide services through workplace programs.
- **Social Worker.** A social worker with a Bachelor's (BSW) or Masters degree (MSW) is trained to assess, refer or provide counselling to people with mental disorders or difficulties with everyday living. They often provide a "case manager" function within the mental health centre or team setting, and provide counselling to people with serious, ongoing mental illnesses such as schizophrenia and bipolar illness to help with solving problems and linking with needed resources on a day-to-day basis. Some social workers also provide counselling to people with a range of mental health concerns on a fee-for-service basis, or to people covered by private insurance plans or workplace programs.
- **Employee Assistance Plan (EAP) Professional.** EAP professionals may have various forms of training; they provide counselling to employees with mental health concerns through workplace insurance plans.

- **Nurses.** Registered Nurses are medically trained caregivers employed throughout the mental health system, including on the hospital ward or within a mental health centre or team. They provide a wide variety of functions, including medication monitoring. Registered Psychiatric Nurses are educated specifically to take care of people with mental illnesses, and usually work within hospital and mental health centre settings.
- **Occupational Therapist.** This is a university-trained professional who often works within mental health team settings to provide rehabilitation and help people improve their functioning in various roles and settings.

For general information and advice about how to access the help you need, call one of the provincial mental health agencies listed near the end of Module Four of this toolkit.

Summary

In this module, we've described the various types of depression, and introduced the concept of self-management. In Module Two, we'll look in more detail at the various kinds of options that exist for the treatment of depression. This information will set the stage for Module Three, which is about how you can work with your mental health professional to find the options that are *right for you*.

key messages in this module

- ★ With effective treatment, the majority of people with depression will improve significantly.
- ★ The best treatment option will depend on a number of factors such as the type and severity of the illness, past responses to particular treatment approaches, availability of appropriate care and personal preference or values
- ★ The two main types of treatment options for depression are antidepressant medications and evidence-based psychotherapy such as cognitive-behavioural therapy or interpersonal therapy
- ★ Combined treatment of medication and psychotherapy should be considered for people with chronic or severe episodes of depression, who have concurrent mental or physical disorders, or for those who are not benefiting from psychotherapy by itself
- ★ Other treatments such as electroconvulsive therapy, repetitive transcranial magnetic stimulation or light therapy may be indicated for special populations
- ★ Alternative or complementary approaches may be considered as long as a person can learn the skills to weigh the pros and cons of the approach

With effective treatment, the majority of people with depression will improve significantly. When symptoms of depression are reduced or resolved, the impact of the illness in other areas of your life is usually lessened as well. Truly effective treatment should also reduce the likelihood of a relapse or recurrence of your illness. Different types of treatments may be more or less effective in helping you achieve these goals.

There are two main types of treatment options for depression: antidepressant medications and psychotherapy. This module concentrates on providing you with information about the various treatments within these two categories. For each, we'll provide some general information about what it is, how it works, how long it may take to work, and some considerations to keep in mind (that is, the pros and cons). We'll also talk about other evidence-based treatments that are used in certain circumstances such as light therapy and electroconvulsive therapy (ECT). As well, we'll discuss emerging therapies such as rTMS and other alternative or complementary therapies, and how you can weigh the pros and cons of those.

Every individual is unique, and the best treatment option will depend on a number of factors such as the type and severity of the illness, past responses to particular treatment approaches, availability of appropriate care and the individual's personal preference. In Module Three, we'll talk about how you can weigh these various factors, and in partnership with your mental health professional, play an active role in making decisions about your treatment.

Psychotherapy

For people with mild to moderately severe major depressive disorder (MDD), two forms of psychotherapy, in particular, have proven to be effective. These are cognitive-behavioural therapy (CBT) and interpersonal therapy (IPT). Because the effectiveness of these approaches has been supported by well-conducted research studies, they are referred to as "evidence-based" therapies for depression. Both CBT and IPT have proved to be as effective as antidepressant medication for people with mild to moderate MDD. In most cases, they can be given alone, and combining them with medication will give no added benefit.

Combined treatment of medication and psychotherapy should be considered for people with chronic or severe episodes of depression, who have concurrent mental or physical disorders, or for those who are not benefiting from psychotherapy by itself. In such cases, medication can act as "an enabler" by removing some of the symptoms (e.g. low motivation) that may be interfering with the success of the psychotherapy. CBT may also be beneficial for individuals who have symptoms that aren't completely resolved through the initial medication treatment.

Cognitive-behavioural therapy (CBT)

How it works

Once you become depressed, your thoughts and behaviours can often maintain the depression. With depression, people tend to view themselves, their relationships with others, and the world around them in a negative way. When negative events happen, they tend to blame themselves, and blow things out of proportion. CBT works on helping individuals identify patterns of negative thinking, and then learn to challenge these when they arise.

Depressed people also tend to withdraw from their relationships with others and their usual activities, sometimes even staying in bed all day. This tends to be self-reinforcing in that the less you do, the less you want to do.

The CBT therapist works together with the client on both of these areas: negative thought patterns and behaviours that maintain the depression. Eventually, the person is able to replace this style of thinking with one that is less negative. Viewing oneself and the world in a more positive way also helps to combat the inactivity that comes with depression.

The second area that CBT works on is inactivity. Many people with depression have lost pleasure in doing things they normally did, and may find these things overwhelming even to think about. In CBT, the therapist helps people to identify and prioritize some activity-related goals, and then helps them strategize about how they can accomplish the goals. Each session may involve "homework" where the person works on the goals set out, and then reports back on progress at the next session. Goals are reevaluated as needed. By gradually increasing activities, the individual can regain a sense of accomplishment and pleasure they had lost. Increasing activity in this way can help to gradually restore the person's mood to where it once was.

The third area that CBT typically works on is in dealing with challenging situations that ordinarily cause stress for the individual, and which may serve to reinforce the person's negative mood, or may cause people to avoid and isolate themselves. This approach — known as the structured problem-solving approach — helps people identify and prioritize problems. It then helps them identify, evaluate and try out potential solutions. The skills learned through this approach may be applied to a number of situations that cause difficulty and reinforce low mood, such as dealing with financial or relationship difficulties.

How long does CBT take to work?

A typical course of CBT lasts three to four months, or about 12 to 16 weekly sessions. Recent evidence has shown, however, that briefer CBT interventions can also be effective, and that benefits can be achieved in fewer than five sessions.

Considerations

The strength of the CBT approach is that it focuses on building skills and preventing recurrences of depression even after the formal therapy has ended. In other words, CBT tends to help people take an active role in dealing with their condition. In some cases, CBT may take longer to work initially, when compared to antidepressant medication. Unlike medications, however, CBT has no side effects. Keep in mind that it may take a degree of effort and motivation that some people with depression may not have, especially if severely affected.

CBT may also be difficult to access either because of cost or because of the limited number of therapists who are trained in this approach. The type of professional most likely to have this training is a clinical psychologist. Although clinical psychologists are sometimes covered through extended health plans, they are not normally covered by the Medical Services Plan (MSP). They may also not be covered by workplace Employee Assistance Plans. However, CBT may be available free of charge through outpatient clinics or day programs at some hospitals or mental health centres. A private psychologist with CBT training can be found through referral, such as from the BC Psychological Association Referral Service (604 730 0522 or 1 800 730 0522). CBT that *is* covered by MSP may be obtained by asking a family physician for a referral to a psychiatrist with CBT training. Or, your family physician may have special training so that he or she can provide this therapy. As we'll discuss in Module Four, another way of gaining the benefits of this therapy is through CBT-based group programs, such as *Changeways*, and CBT-based self-directed manuals, such as the *Depression Self-Care Program*, and *Feeling Good*, by David Burns.

Interpersonal therapy (IPT)

How it works

IPT focuses on different kinds of interpersonal problems that may cause problems for people with depression. These problems may have triggered the depression in the first place, or they might be a result of the depression. The first step in this approach is to identify what kinds of interpersonal difficulties the individual is experiencing. The therapist will look at four specific areas. These are:

- **Prolonged grief:** Grief of this type may be due to: (a) the loss or departure of an individual from the person's life (via separation or death) or (b) the loss of a function or role in a person's life (e.g., lost physical abilities because of an accident or illness).
- **Role transitions:** A parent whose children leave home may have to take on a different role within the family, or a person may experience role difficulties when a spouse or partner starts a new job or career.
- **Interpersonal disputes:** Examples include ongoing conflicts with family members, co-workers, or close friends.
- **Interpersonal deficits:** Interpersonal deficits (problems in how we think about and interact with others) can interfere with a person's ability to find and maintain employment and form and build a solid base of social support. We know that good social support offers strong protection from depression. Interpersonal problems or deficits can contribute to social withdrawal and isolation, and interpersonal conflict.

After the key areas of difficulty have been identified, therapy then focuses on resolving the difficulties. Goals of therapy often include building communication and dispute resolution skills, and helping the individual solve interpersonal problems in a structured way.

How long does IPT take to work?

IPT is similar in length to CBT, lasting between 3 to 4 months, or from 12 to 16 weekly sessions.

Considerations

The same considerations apply to IPT as for CBT. The approach is effective for people with mild to moderate major depressive disorder (MDD). It is not a first-line treatment for people with severe MDD, though it may be helpful for people whose depression hasn't responded well to antidepressant medication. A combined approach (both medication and IPT) may also be helpful for individuals who try IPT initially but don't respond well. Drawbacks or barriers to this approach include cost, availability of trained practitioners, and the response time (compared to medications which may often work more quickly than psychotherapy). Like CBT, IPT is an approach that is aimed at building skills that can be applied successfully after the formal therapy has ended.



Medication

For mild to moderate major depressive disorders, a person can choose between one of the psychotherapies described above, or antidepressant medication. Either type of approach is considered to be a “first-line” treatment. For people with severe MDD, antidepressant medications are generally considered to be the first treatment choice; however, many people with severe depression say they benefit from both medication and psychotherapy. There are about 20 different antidepressant medications currently available which fall into several different categories or “families” of medications. First-line medications include those in the SSRI family (Selective Serotonin Reuptake Inhibitor) such as Prozac or Paxil, as well as some of the more recent types of medications known as the “Novel Action” antidepressants. These are discussed in more detail below.

How they work

In general, antidepressant medications, like other psychiatric medications, work by affecting the transmission of electrical impulses between brain cells. Each family of medications has a slightly different way of affecting the chemical messengers — known as neurotransmitters — that transmit information from one nerve cell to another across a tiny gap between neighbouring cells known as the “synaptic cleft.” Different medications may affect different brain chemicals that play an important role in depression — for example, smaller amounts of the neurotransmitter, serotonin, have been shown to be present when people are depressed.

SSRIs are the most commonly prescribed medications for depression. The first SSRI, Prozac, became available in the late 1980s. Prozac acts by increasing the amount of serotonin that remains available in the synaptic cleft, so that more of it can be sent successfully between one cell and another. There are a number of different serotonin “receptor sites.” Each kind of the SSRI affects various combinations of these sites.

Other categories of antidepressants include the Tricyclics, and the MAO (Monoamine Oxidase) Inhibitors. Newer types of antidepressant medications include “Novel Action” antidepressants, including RIMAs (Reversible Inhibitor of Monoamine Oxidase A) and SNRIs (Serotonin and Noradrenaline Reuptake Inhibitor). While the initials and names can be confusing, the important thing to remember that each of these medication families acts on key neurotransmitters that are important in depression, and each has a slightly different way of doing so.

Which medication is most appropriate often depends on a person's individual response to the medication and the side effects experienced. While some medications typically have fewer side effects than others and are therefore tried first, it is not possible to accurately predict which medication may work best for any given individual, and which of the possible side effects may come about. The SSRIs are as effective as the older medications, and generally they are also safer and have fewer side effects. Some of the even newer categories of medications (Novel action, RIMAs and SNRIs), are also considered first-line medications, though they have been studied for a shorter period of time and may not be as widely available as other types.

How long do antidepressants take to work?

You should start to notice a difference in the first few weeks of treatment on medication. The full effects, however, might not be felt for four to eight weeks. In order to feel the full effects of the medication, you must take it as prescribed, and you must be taking an adequate dose (see dosage ranges in the table below). Mild side effects are common at the beginning of treatment, but usually go away once your body gets used to the medication. If the medication doesn't work or the side effects aren't tolerable, there are a number of different options. The doctor might suggest adjusting the dose, switching to another antidepressant in the same family, or to a different category of antidepressant altogether. Another option might be to combine the medication with another one from a different category of antidepressant. Finally, combining medication treatment with one of the two psychosocial approaches outlined above may be a further option.

Considerations

Generally speaking, antidepressant medications are effective whether a person suffers from mild, moderate or severe depression. In comparison with psychosocial treatment, they may be relatively quick to take effect. The lag time, even if only one or two weeks, may still be a dangerous period for someone who is suicidal, so additional care may be needed during this period to ensure the safety of the individual. Care must also be taken in the period immediately after the individual starts feeling better, particularly when the person has previously been suicidal, as this may be a time when previous suicide plans can be acted upon. Taking medications daily may be considered more convenient than attending weekly therapy appointments, though a daily medication regimen requires a reasonable amount of discipline that can be difficult for some people. A drawback of medication, when compared to cognitive-behavioural therapy, is the higher risk of relapse once the medication is discontinued, especially for people who haven't developed non-medical relapse prevention strategies. As compared to psychotherapy, medications are less likely to address difficulties that the person might have with their roles, relationships, and other situations in their life. Concern about side effects is an issue that can also make psychotherapy a more attractive option for some people.

side effects to watch for

SSRIs

- ★ Nausea/Diarrhea
- ★ Difficulty sleeping
- ★ Anxiety
- ★ Sexual dysfunction (e.g., lower desire for sex, problems becoming aroused, delayed or absent ejaculation or orgasm)
- ★ Toxicity: SSRIs are not as dangerous as Tricyclics when taken as an overdose. With SSRIs a condition known as "serotonin syndrome" can occur on high doses. Although very rare, the condition is usually fatal.

Tricyclic Drugs

- ★ Sleepiness
- ★ Dry mouth
- ★ Blurred vision
- ★ Constipation
- ★ Difficulty passing urine
- ★ Sweating
- ★ Toxicity: some tricyclics are more dangerous when taken as an overdose, and cause death.

Therapeutic doses of commonly prescribed antidepressants

Antidepressant	Trade Name	Usual daily dose (mg)
Novel Action		
<i>bupropion-SR</i>	<i>Wellbutrin</i>	150-300
<i>mirtazapine</i>	<i>Remeron</i>	30-60
<i>nefazodone</i>	<i>Serzone</i>	200-400
<i>trazodone</i>	<i>Desyrel</i>	200-400
RIMA		
<i>moclobemide</i>	<i>Manerix</i>	450-600
SNRI		
<i>venlafaxine-XR</i>	<i>Effexor</i>	75-225
SSRI		
<i>citalopram</i>	<i>Celexa</i>	20-40
<i>fluoxetine</i>	<i>Prozac</i>	20-40
<i>fluvoxamine</i>	<i>Luvox</i>	100-200
<i>paroxetine</i>	<i>Paxil</i>	20-40
<i>sertraline</i>	<i>Zoloft</i>	50-150
TCA		
<i>amitriptyline</i>	<i>Elavil, Endep</i>	100-250
<i>clomipramine</i>	<i>Anafranil</i>	100-250
<i>desipramine</i>	<i>Norpramin, Pertofrane</i>	100-250
<i>imipramine</i>	<i>Janimine, Toifranil</i>	100-250
<i>nortriptyline</i>	<i>Aventyl</i>	75-150
MAOI		
<i>phenelzine</i>	<i>Nardil</i>	30-75
<i>tranlycypromine</i>	<i>Parnate</i>	20-60

RIMA = Reversible inhibitor of monoamine oxidase A

SNRI = Serotonin and noradrenaline reuptake inhibitor

SSRI = Selective serotonin reuptake inhibitor

TCA = Tricyclic antidepressant

MAOI = Monoamine oxidase inhibitor

Adapted from the BC Drug Formulary and the Manufacturers' list (2001)

Considerations about use of medication in special populations

The risks and benefits of antidepressant medications depends to some extent on factors such as age, ethnocultural background, and on reproductive health issues, such as pregnancy and childbirth. This may increase the need for individuals to explore other treatment alternatives.

Medication and pregnancy and childbirth

Women who are trying to conceive, who are pregnant, who want to breastfeed, or are planning on breastfeeding need to be especially mindful of their choices about antidepressant medication. In these situations, both the mother's and the baby's health are involved, and there are difficult decisions to be made with respect to balancing both concerns. The first twelve weeks of pregnancy, in particular, are crucial. This is when the fetus is most likely to be affected by medications and when the health and well-being of the mother is especially important. For these reasons, it is important for the woman and her doctor to carefully discuss the treatment plan during this time. Psychosocial treatment may be an excellent option for women during pregnancy, as the evidence suggests that in most cases, psychosocial approaches will be as effective as medication and have no impact on the developing fetus. Lithium (a medication used in treating bipolar disorder and in some other forms of depression) should not be taken during pregnancy or while breastfeeding. Antidepressants are considered one of the safest kinds of drugs to take while pregnant or breastfeeding. Studies have shown they don't appear to cause fetal abnormalities. The newer classes of medications, in particular, are considered to be safe to use while pregnant or breastfeeding. Even so, this research is relatively recent, so it is important for the woman to talk this choice over with her doctor.

Medications and children and youth

Research on the use of medications in adolescents or younger people is relatively limited. There is some evidence for the benefits of the use of SSRIs in adolescents. The use of antidepressants alone, however, should not be an option in this population. In children, psychotherapy such as CBT, including support for the parents, should be the main approach, though medication may be considered in some situations. Recent evidence suggests the medication Paxil (paroxetine) should *not* be used in treating children and adolescents. Given the developmental issues of young people — establishing relationships, achieving educational and vocational milestones — it is important that non-medication approaches are always part of a treatment strategy for young people with depression.

Medication and the elderly

The effectiveness of antidepressants in the elderly may be hindered when other physical health conditions exist. It is not uncommon for elderly people to take a number of medications for different health conditions at the same time. In these situations, the use of antidepressants may not be an option, given the potential harmful interactions that can take place when different medications are combined. A doctor should always be consulted and be made aware of all medications currently being taken. If the depression is mild or moderate, then psychotherapy may be the preferred option. If the condition is severe, or potentially life-threatening, then electroconvulsive therapy (ECT) may be the preferred course.

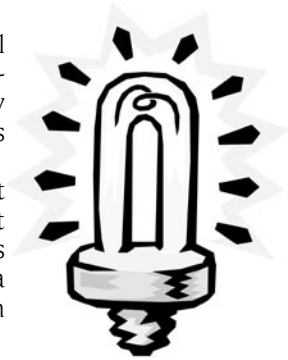
Medication and ethnicity

Research suggests that the effectiveness of antidepressants may be affected by an individual's ethnic makeup. This is because of variations in the way that medication is processed or metabolized by different body types. For people who have a faster metabolism, less medication may be necessary to achieve the same impact, and to avoid side effects.

Light therapy

Light therapy, also known as phototherapy, is an approach taken for people with seasonal affective disorder or SAD. Light therapy has become more increasingly used (compared to antidepressants) as research has shown its effectiveness. Research on *how* it works is in the early stages, but it is believed that the approach works by affecting the natural biological patterns of the body known as circadian rhythms, which are affected by daylight, or lack thereof.

Light therapy can be administered by either using a fluorescent light box that can be put on a table, or a light visor which can be worn while walking around. Treatment takes about 30 minutes a day, starting in late fall and continuing until the end of winter. About two thirds of people who use light therapy benefit from the treatment. Usually an effect is felt after a week, when the intensity of the light is increased gradually and then re-evaluated again in another two weeks.



Considerations

Research on light therapy is in its early stages, and it is not clear whether this approach is superior to antidepressant therapy or to other approaches. Nonetheless, the treatment may be more appealing for people who are reluctant to take medication. Side effects of light therapy, especially with the light visor, may include mild nausea, headaches, eye strains, or feelings of edginess or “being wired” that usually go away after using the light device for some time. People with medical conditions such as epilepsy should not undertake light therapy, nor should those with eye conditions such as glaucoma. The diagnosis of SAD should be confirmed by a doctor before starting light therapy, and only a reliable light box recommended by the doctor should be used. For more information about SAD, light therapy, and a list of stores and companies that sell reputable light boxes throughout BC and Canada, see www.psychiatry.ubc.ca/mood/sad.

Difficult-to-treat depression

Some people do not respond well to antidepressants or to psychotherapy. In this case, the diagnosis must be carefully evaluated. The dosage and choice of medication must be re-evaluated, as well as the possibility of combining psychotherapy or, in life-threatening situations, other alternatives, such as electroconvulsive therapy (ECT).

There are a number of factors that can prevent a full response to treatment. Achieving the best possible response is most possible when the mental health professional is aware of evidence-based treatment recommendations, has high expectations for treatment results, and when the consumer is actively involved in monitoring the success of his or her treatment and can communicate effectively when making treatment decisions. The value of “shared decision-making” is discussed in the next module.

What to do if nothing seems to work

If after trying both psychological treatment and medication, you still haven't found an effective approach, you and your caregiver need to reassess what's going on. It may be that your initial diagnosis was incorrect or incomplete. For instance, some people who experience depression may in fact suffer from an undetected mild form of bipolar disorder. Others may have depression and also another unrecognized disorder, such as an anxiety disorder, or may be also experiencing some form of psychosis. There may be an unrecognized physical health condition (e.g. diabetes, heart problems, etc.) that is complicating the picture. Once you and your caregiver have ruled out any of these factors, it might be that you have a form of depression that is difficult to treat, known as “treatment-resistant depression” (where symptoms won't go away), or “recurrent depression” (a form which goes away but returns frequently). Strategies for dealing with this include combining medications, combining medications with psychotherapy, modifying lifestyle, and in serious life-threatening cases, undergoing electroconvulsive therapy or a newer approach known as repetitive transcranial magnetic stimulation.

Electroconvulsive therapy (ECT)

People with severe depression or life-threatening depression that hasn't responded to other forms of treatment may benefit from electroconvulsive therapy (ECT). Contrary to public stereotype, ECT as it is administered today, is a safe, effective treatment for clinical depression.

In addition to being an option for people with severe depression, it may also be an option for people for whom medication is not recommended. For instance, elderly people with severe depression with multiple health conditions may have their health put at risk by the interactions between antidepressants and their other medications. Pregnant women with severe depression may also consider ECT, which may have less risks involved than antidepressant medication. Another group of people for whom ECT is recommended are those with psychotic depression. After trying a combination of a tricyclic antidepressant with antipsychotic medication or a mood stabilizer, ECT is the next recommended option in situations where the depression is severe and hasn't responded to these other strategies.

How ECT works

During ECT, an electrical current is administered through either one or two electrodes, placed on one or both sides of the head, which produces a seizure in the brain lasting about a minute. During this time, a general anaesthetic and muscle relaxant is given so the individual is not awake when ECT is performed, and there is no actual muscle seizure experienced during the procedure. The person is carefully monitored during this time. It is not clear how ECT works, but it is believed that the electrical current delivered may affect some of the same neurotransmitters that are targeted by antidepressant therapy.

How long does it take to work?

It usually requires about eight treatments over the course of three or four weeks before the full effect is felt. To retain the effects of ECT, less frequent maintenance therapy may be required.

Considerations

ECT is only considered for people with severe life-threatening depression that hasn't responded to first-line or any other treatment, for those whose depression has psychotic features that haven't responded to treatment, and for those who cannot take antidepressant medication. There is some debate in the research literature about whether "unilateral" or "bilateral" placement of the electrodes is more effective and safe (that is, whether the electrode should be placed on the left side of the head, the right side, or both). This issue should be discussed with the doctor before hand. Those for whom ECT is usually not recommended include people with physical health conditions, which may increase the risk of adverse effects.

One of the side effects of ECT that has received a lot of attention is memory loss. Research shows that memory for events prior to the ECT treatment can be affected, but these memories usually return within the first few months after treatment. Studies also show that an individual's ability to store memories after the treatment is not affected, though some people may have trouble retrieving certain memories. This means that they may need help finding "cues" for accessing these memories. One difficulty with evaluating the effects of memory loss is that mood disorders, themselves, may make it harder to remember. As mood improves over time, the ability to remember things usually gets better.

Given the fear surrounding this treatment, it is important people for whom ECT is being considered be thoroughly educated by their doctor about potential benefits and risks. If you feel you don't have enough information to make an informed decision, ask questions of your doctor, and follow up on suggestions for further reading.

Repetitive transcranial magnetic stimulation (rTMS)

A new treatment that shows evidence of effectiveness — particularly for severe depression — is called repetitive transcranial magnetic stimulation (rTMS). This approach works by passing a magnetic field briefly over the left prefrontal lobe (around the top of the forehead) an area of the brain that has been implicated in depression. Unlike ECT, no anesthesia is needed, and there are no obvious major side effects from the treatment. Usually several treatments are needed before the approach can work. Research on the effectiveness of this approach for various forms of depression — including severe treatment-resistant depression and other forms of depression — is in its early stages. At this point, the evidence is strongest for the use of rTMS with severe treatment-resistant depression. The value of the technique for people with other forms or types of depression may become clearer as more research is completed. Currently the treatment is available in private clinics in certain locations (Vancouver), and may also be made available as part of a research study at a university.

Alternative or complementary treatments

People with depression may wish to explore alternative or complementary treatments for their condition. Alternative treatments are those for which clear evidence of effectiveness does not exist; or those that seem to work, but where there is little understanding by Western medicine of *how* they might work. It has been suggested that one possible reason that they can be beneficial is that they involve an active choice on the part of the person with depression, and that active choice itself is therapeutic. Complementary therapies are alternative therapies that are taken together with a Western treatment approach. Alternative treatments approaches range from promising interventions with incomplete research, to those that may have no benefit at all. Examples of alternative or complementary approaches include homeopathy, aromatherapy, acupuncture, meditation, relaxation therapy, yoga, Tai Chi, herbal supplements and others. It is important to be able to sort out which ones may have some value from those that may be potentially harmful. It is also important to be aware of potentially harmful interactions between antidepressant medications and complementary therapies (such as herbal supplements).

Part of the problem in assessing the value of these approaches is that little research exists. Examples of alternative therapies where research does exist and there is evidence for effectiveness, include:

- **Exercise** for mild to moderate major depression, and including any alternative therapy, such as yoga, Tai Chi, etc., which includes exercise
- **Herbal treatment** with St. John's Wort for mild to moderate depression. This is the only herbal treatment that has been proven to be as effective as antidepressants, at least in the shorter term. It has fewer side effects, but may lead to sleeping problems, or result in light sensitivity for fair-haired people and it cannot be taken with antidepressants or medications for other health conditions (talk to a pharmacist about possible interactions.) These supplements are not regulated, so the amount of active ingredient is not controlled, meaning dosages vary; because of this, it should be purchased from a reliable manufacturer or supplier and the same brand should be used over time to keep the amount of active ingredient consistent
- **Acupuncture** is a traditional Chinese medicine that is thought to work by releasing the body's natural endorphins — pleasure-producing hormones — and thereby counteracting depressed mood. Some family physicians will refer people to a private acupuncture clinic, staffed by personnel who are qualified to practice the approach.
- **Relaxation** therapies including relaxation classes, breathing exercises, and meditation.

Staying with the approach that works for you

Once you've found an approach that works for you, it is important to stay with the approach long enough for it to be maximally effective. In the case of psychosocial therapy, this means sticking with the treatment for the full 12 to 16 sessions. Sometimes psychological treatment will be spaced at the end with sessions becoming further and further apart. It may also be a good idea to schedule a follow-up session for two to three months after treatment has ended so that your caregiver can assess how well you have maintained your progress from treatment. Ideally, you will also continue to use the skills and techniques that you learned during treatment to help protect you from depression recurring in the future.

If you have succeeded in finding a medication that works for you, you should stick with it for at least six months. At that point, if you are feeling better, you can work with your caregiver to gradually taper off the dosage. Going off suddenly, without the supervision of your doctor is not a good idea. Ideally, you will also have learned some of the key skills for managing your depression such as challenging negative thinking, dealing with stressful situations, when discontinuing your medication. This will lower the chances of having a recurrence of your depression. See Module Four for a discussion of some of the ways you can learn some of these self-management skills.

Addressing reasons for non-compliance

For various reasons, some people are “non-compliant”; in other words, they find it difficult to stay with their treatment. Concern about medication side effects is one reason. Remember though: some side effects will go away after an initial period, and if they don’t, you can always talk to your doctor about adjusting the medication or dosage. Become familiar with common side effects, and discuss these with your doctor if they occur.

Being worried about becoming addicted or overly reliant on the treatment is another worry for some people. It is important to know that antidepressants aren’t in fact addictive. It is also important to see treatment — whether medication or psychotherapy — as one option, among others, to *take control* of your situation.

Feeling better, and seeing no need to continue is another reason why people may discontinue their treatments. It is important to keep in mind, though, even if you might be feeling better, that you may need to follow through on taking the treatment for a longer period of time if you are to obtain its full benefits and if you want to lower the chances of having a relapse. If a person has had two or more episodes of major depressive disorder, he or she may need to stay on medication for a longer period of time, even for the rest of his or her life. It is also important for individuals in this situation to develop ongoing coping strategies to minimize the risk of relapse.

Thinking about how long to take medications (or about having to learn to manage an illness for long periods of time) can be difficult subject, which needs to be discussed openly and carefully with your mental health professional, as well as with significant others.

Self-management approaches

Module Four of this toolkit discusses some other resources that are often valuable in helping you manage your depression on a day-to-day basis. The focus of that module will be on self-management approaches, such as CBT-based self-help manuals, such as the Self-Care Depression Program, CBT-based groups such as Changeways, the Chronic Disease Self-Management Program, and other resources. Each of these offers a way to help you develop skills for coping with depression outside of the mental health professional’s office, on a day-to-day basis. They generally involve learning techniques for monitoring and addressing negative thought patterns, dealing effectively with stress, and other ways of avoiding a relapse of your illness.

Other resources that may be helpful for people with depression include self-help groups, and personal stories from others who have experienced and learned to live successfully with depression — either in written or video formats.

Summary

In this module, we’ve outlined information about the various approaches that have been found to be effective for dealing with depression. We’ve also talked about how each approach works, and discussed some general considerations that should be kept in mind when considering which approach, or combination of approaches to try. The next module details how to work with your mental health professional to decide which approach is right for you, given your unique situation and personal preferences.

What is shared decision making? Why is it important?

In the last two modules, we talked about the various kinds of depression and the different treatments that exist. We also discussed how to assess which options might be appropriate or helpful in certain situations. The knowledge you have gained is the foundation for playing an active role in making decisions about what kinds of specific treatments will work for you.

Shared decision-making means that you are an equal partner in the decisions that affect your health. This is an integral part of self-management, and is important in ensuring that you find the treatment approach that works best for you. Your ability to participate in this way may be different from other people — who may prefer less direct involvement in their care. The extent to which you take an active role may vary depending on what stage of the illness you are currently at: whether you have been recently diagnosed or you have a fair amount of experience with your illness. Regardless of your preferred level of involvement, you *do* need to be involved to some degree.

Taking an active role in your treatment requires a number of different skills. First of all it means that you need to be able to communicate clearly to your doctor or other health professional — in an informed way — about what you think the problem is, about how it affects your daily life, and about what you expect to get out of the treatment. Good communication with your doctor enables you to share in the key decisions about your treatment plan or strategy.

Once you have developed an initial strategy, your next role is to help monitor whether it is successful. For example, if you make an initial decision to try a particular medication, you then need to be able to monitor whether in fact the medication is working as well as it should.

To take on this responsibility, you need some benchmarks to measure success. For example, you need to know what to expect about how long the medication or other psychotherapy will take before it works, and about what level of recovery it should bring. You also need a clear idea about what impact you hope the treatment will have on your day-to-day life, so you can measure success against these expectations.

Once you have an idea about what you hope to achieve, you then need to be able to report to your doctor what has been happening between visits. If necessary, you may have to negotiate some adjustments in the medication dose, or even a different medication or treatment approach altogether. It may take a while to find the approach — or combination of approaches — that works best for you.

What's involved in shared decision-making?

In the section above, we discussed the process of shared decision-making in broad terms. It can also be looked at as a series of steps that you will take that will eventually result in an effective individualized treatment plan. The steps are:

- **Problem definition.** Also known as assessment, where your role is to explain the problem in your own terms
- **Goal-setting.** Deciding what the goals of treatment will be, or deciding what you want to happen as a result of treatment
- **Decision making.** Developing and deciding on treatment strategies to balance the advice of your mental health professional with your own expectations and priorities for treatment
- **Monitoring.** Evaluating whether the strategies are working properly, and if necessary, reassessing the treatment plan.

In the rest of this module, we'll talk about how to work through each of the stages.

key messages in this module

- ★ Playing an active role in your treatment can make you more satisfied with the results of the strategies you and your mental health professional choose to adopt
- ★ Being active means being able to communicate and negotiate with your health professional about your expectations
- ★ When you make a decision about your treatment plan, you need to reflect on a number of things: reliable information about the risks and benefits of potential treatment options, your own values and attitudes, and the experiences of others similar to you who have tried the options you are considering
- ★ Playing an active role also means being able to monitor whether your treatment plan is working on a day-to-day basis, and being able to negotiate an adjustment to the strategy if necessary
- ★ Once you've found an approach that works, you should follow through on your plan

Stage One: Problem definition

When you first go to see a mental health professional, he or she will sit down with you to assess your problem. Your job at this stage is to provide as much information as you can to make sure that the doctor has the full picture of what's going on. You need to be able to describe in your own words just what has happened to you, the kinds of problems you've experienced, and what has happened with any other treatment approaches you've tried in the past. As you do this, you need to describe the different kinds of changes you have experienced in terms of your:

- **thoughts:** for example, thoughts of worthlessness, hopelessness and self-blame
- **behaviours:** for example, if you are withdrawing from social events, or you are becoming more irritable or argumentative than normal
- **emotions:** for example, feelings of sadness, but also of numbness, emptiness, distress.

You should also talk about the impact your mental health is having on different areas of your life, such as your job, your home life, your other relationships, etc. It is also important to talk not only about the recent past, but other times in your life when you might have been experiencing depression, including when you might have experienced some form of mania (feelings of elation, being very active, not needing much sleep, for example). You should also reflect on whether you have experienced symptoms of other mental disorders that sometimes go along with depression, such as anxiety, or psychosis. See the *Anxiety Disorders Toolkit*, and the *Mental Disorders Toolkit* for more information, available free online at www.heretohelp.bc.ca.

It is often useful to reflect on these issues in advance of your appointment, and to write some of the key things down on paper. Some people find it helpful to bring a family member or other close person to help describe what's going on. Another suggestion is to bring any self-tests you've taken with you, as this might allow the mental health professional to gain a clearer picture of what is going on as he or she performs a formal assessment.

tips for talking with your doctor or mental health professional

- ★ **P**lan — Think about what you want to tell your doctor or learn from your mental health professional today. Once you have a list, number the most important things.
- ★ **R**eport — When you see the doctor, tell him or her what you want to talk about during your visit.
- ★ **E**xchange Information — Make sure you tell the doctor about what's wrong. Printing out an online screening tool, or bringing a diary you may have been keeping can help. Make sure to describe the impact your symptoms or side effects are have on your day-to-day life. Sometimes it can help to bring a friend or relative along for support and to help describe your behaviour and symptoms if you're unable to.
- ★ **P**articipate — Discuss with your doctor the different ways of handling your health problems. Make sure you understand the positive and negative features about each choice. Ask lots of questions.
- ★ **A**gree — Be sure you and your doctor agree on a treatment plan you can live with.
- ★ **R**Epeat — Tell you doctor what you think you will need to take care of the problem.

Source: Institute for Healthcare Communication P.R.E.P.A.R.E. Patient Education Program.
www.healthcarecomm.org/index.php?sec=courses&sub=special&course=1

Related Resource:

- ★ Reclaiming Your Power During Medication Appointments with Your Psychiatrist by Patricia Deegan, PhD.
www.power2u.org/selfhelp/reclaim.html

Stage Two: Goal-setting

Before you and your health professional can decide upon a treatment strategy, you need to think carefully about what you want to change. As we've just discussed, an essential part of explaining your problem to a health professional is not just talking about your symptoms or moods, but describing what impact your condition is having in your living or working environment, and on your day-to-day life. Your eventual satisfaction with your treatment strategy will depend on whether it helps you deal with these kinds of impacts. The goals you decide on should involve making change in these areas.

At this point, you need to think carefully not just about what goals you have, but also about which goals are presently most important for you. When you consider which issues *are* priorities, you need to consider which issues you are currently ready or able to deal with. This will depend on your own personal skills and resources, and it will also depend on the resources that are available in your social support network, and from the health care system in your community. The key is to decide to deal with problems or issues that you *can* deal with presently, so that you get off on the right foot, and develop a sense of confidence and success.

Your sense of priorities may be different from those of your health professional, so in this case you need to be able to explain what *your* priorities are, and why they are important.

When you're working these issues out, you need to be open to listening to advice from your health professional or others in your support network, and to considering new information and perspectives that may lead you to change your ideas. For example, your doctor might be most concerned with dealing with your depressed mood. You might be more preoccupied at the moment with dealing with an important relationship that has suffered as a result of your mood. The ideal situation is one where you can communicate your own concerns, listen to new information and perspectives, and then come together and agree on a strategy of what goals to address first. In the example above, this might mean that you and your doctor agree to a trial of antidepressant medications, so that once your mood improves somewhat, you can start to deal with the relationship issue.

Once you've decided on some issues that you feel you can realistically address, you then need to decide on some *specific* goals that you plan to achieve. For example, if you are depressed and have become socially isolated, a goal for you may be to become more socially active. At this point, it will be helpful to define for yourself in concrete terms what you'd like this to look like. For example, "In the next week, I'd like to make contact with one friend whom I haven't talked to lately."

Be "SMART"

Ideally a "change goal" should be described in SMART terms. That is, it should be **s**pecific, **m**easurable, **a**chievable, **r**ealistic and **t**imely. That means you need a "goal statement" that says *what* you want to achieve and who's responsible; *how much* you are going to change, *by when* you're going to achieve it, and a way of measuring whether you *have* achieved it.

A good way of formalizing your agreement about your preferred goals is to write a goal statement that you and your mental health professional can then agree to work towards. The goal statement then becomes the basis of your joint decisions about which treatment approach to try and a clear basis for evaluating the success of your strategy.

Decision-making

The next step, after you've decided what you want to change, is to figure out *how* you're going to change it. In some cases, this will involve choosing a medication that is right for you. In other cases it will involve non-medical approaches such as cognitive-behavioural therapy, interpersonal therapy, or a combination of medication and psychotherapy. You may also benefit from information or referral to community resources such as case management, supported housing, supported employment, and/or income support programs. Finally, you will need to decide on a self-management plan for dealing with your illness outside the doctor's office.



Deciding to start a particular treatment involves a number of components. These include: a) considering evidence about its effectiveness, b) considering your own preferences and values and, if possible, c) talking to others who have chosen the treatment you're considering. As we discussed earlier, it also involves finding an approach that is consistent with your own goals for treatment. Below, we'll talk in more detail about each of these issues, so that you can be as sure as possible that the treatment strategy you decide on is the right one for you.

A) Considering evidence

When you consider an option for treatment, you need to know some basic facts about the treatment. When considering a particular medication or therapy, you need to find out how the approach works, how long it will take to work, its potential risks and benefits, and whether it is an appropriate choice for you. In the last chapter, we talked in general terms about the evidence about the various approaches. The next step is consider how this information applies to *your* situation. This is a matter of knowing how to apply that information and clarifying with your health professional what it means in your specific situation.

In general, there are four questions you need to keep in mind when you consider evidence — whether this is from your mental health professional, or material you've come across on your own — when you make an informed choice about a particular treatment. These are:

What are the intervention options?

Consider the assessments and treatment interventions for the condition, or suspected condition. What are the benefits and harms of the intervention options?

Consider which benefits and harms might occur, and what they would look like in your life such as reduction of symptoms, improved functioning vs. side effects, costs of treatment, etc. Also consider the chances that these costs or benefits might occur, when they might occur, and how long they would last.

What would happen if I do nothing?

Consider what negative outcomes would occur in this event, and how likely are they to occur such as having a worsening or reoccurrence of a depression, suicidal thoughts or behaviour, and so on.

How do the benefits and harms weigh up for me?

Consider what you want to get out of the intervention, what you want to avoid, and what risks you are willing to take. Also consider risks and benefits associated with being in a certain population, such as child or youth, postpartum, elderly or ethnocultural minority.

Do I have enough information to make a choice?

Consider whether you're satisfied with the information you've looked at, whether there are other treatment options you haven't considered.

For more information about these issues, please see Chapter 5 of *Smart Health Choices*, Irwig, L. www.health.usyd.edu.au/smarthealthchoices/contents.html

Making a decision involves more than weighing information. It also involves considering your own attitudes — including your values and fears — and considering the experiences of others in your situation. It may also involve considering the perspectives of your family members or friends.

B) Considering attitudes, values and fears about treatment

As you make a treatment decision, you need to consider all the things that influence your thinking, including your personal values, emotions and attitudes about your illness and potential treatments. For instance, in the last module, we discussed a number of common fears and attitudes about medication or other therapies, such as concern about being overly reliant or addicted to medication or fear about side effects. Before making a decision one way or the other, you should reflect carefully on which of these issues apply to you, and have an open discussion with your mental health professional so that you can address your own particular concerns.

C) Considering experiences of others

One final step you may want to take before you decide on a particular option is to consider the experiences of others who have tried a similar approach. This is helpful for many people, as it can provide valuable information about what to expect, and it can often provide reassurance. It is recommended that you talk to several people, not just one or two, in order to get a variety of perspectives. Remember everyone's situation is unique but there are often commonalities. There are many sources for learning about the experiences of others. Support groups are a good place to meet others and hear about their stories. The Internet also provides a number of avenues for reading about other people's experiences. There are also various books that have been published (see Module Four).

Summary: Making the decision

Once you've had a chance to sit down and consider the information you've gathered from all the various possible sources — from your health professional, from material you've found yourself, from talking to others, and by reflecting on your own attitudes — you'll be in a much better position to make an informed decision. You will also be much more comfortable with that decision. In part, this will be because it is *your* decision, and you will have played a significant role in making it. The next challenge for you is to make sure that your decision works.

Stage Three: Monitoring

Once you start a particular treatment approach, it is important to monitor whether it works, in relation to the goals you and your mental health professional have agreed to. The first step is evaluating the success that the medication or other strategy is having in eliminating or minimizing your symptoms. As we've said, the success of your treatment should not be judged simply on the basis of symptoms and side effects. Ultimately, you need to evaluate the treatment in terms of its success in minimizing the impact your illness has on your quality of life, and your ability to function in the settings or roles that are important to you.

To play an active role in monitoring your treatment — including symptoms, side effects, and day-to-day functioning — you need to have a sound knowledge of your own illness, and about potential side effects to watch for. To aid in this task, there are various tools that can help you systematically evaluate the success of your treatment strategy, including diaries, self-report charts, and side effect charts. Generally, these tools list symptoms and side effects to watch for, as well as day-to-day functioning. They also provide a place to record or chart whether these are increasing or decreasing, improving or worsening, as you follow through on your treatment plan. Some tools include sample goal statements that you can use as benchmarks. Some useful examples that you can download and use on a daily basis include:

- depression, bipolar disorder and anxiety disorders personal diaries, which include symptom and side effect charts, as well as treatment goal charts, from Okanagan Clinical Trials in Kelowna at 250 862 8141 or www.okanaganclinicaltrials.com/public/store.htm
- symptom and side effect reporting charts for depression, bipolar illness, and schizophrenia from the Texas Medication Algorithm Program, available at www.dshs.state.tx.us/mhprograms/PtEd.shtm
- Harvard Bipolar Research Program self-report and mood chart for bipolar disorder at www.manicdepressive.org/selfreport.html and www.manicdepressive.org/moodchart.html

In the short term, the purpose of using these monitoring tools and approaches is to get a general sense of whether your treatment strategies are working as well as you think they should. You can then communicate this back to your doctor, so that if need be, you can reassess the treatment strategies and attempt to figure out a better one. In the early stages of developing a treatment strategy, you should meet fairly frequently with your mental health professional, to monitor your progress and come up with a different strategy if necessary.



Just as you did for the initial assessment phase, you need to communicate with your mental health professional whether your overall treatment goals — including quality of life and symptom relief — are being achieved. For instance, Patricia Deegan of the National Empowerment Center, describes a concise, effective way of describing the success of a treatment strategy as follows:

example *“Well, doctor, before I began this medication trial I was so depressed that I missed 7 days of work, spent 14 days in bed and lost 3 pounds. But during the last two months, since starting the drug and using the new coping strategies, I have only missed 2 days of work, have regained the weight I lost and I have only spent 4 days cooped up in my apartment.”*

In this scenario, you and your mental health professional might decide to “stay the course.” If the approach you tried was less successful, you and your therapist can jointly decide on the new approach you’re going to take.

In some cases, it can take a number of different tries before arriving at an approach that works. If nothing seems to work, it is important to make sure that your diagnosis is correct, or that you don’t have other undetected issues that are making your mental health condition harder to manage. For some people, the barrier to finding an approach that works is not misdiagnosis, but low expectations on the part of the mental health professional. If you feel you should be feeling better, but your mental health professional is unwilling to try different options, then you should consider asking for a second opinion, or looking for someone else who may be able to help you better.

It is important to maintain hope in situations where nothing seems to work. If you and your mental health professional take a systematic approach to exploring different options, then the chances of you finding the right approach are quite high. In the meantime, you need to keep experimenting until you find an answer that helps you live successfully with your illness.

Summary

In this module, we’ve discussed how you can work with your mental health professional to develop a treatment strategy that is as effective as possible. This involves knowing how to communicate your problems in your own terms, and then working with your doctor to decide what you want to get out of treatment, and what strategies you want to try. The final aspect of shared decision-making is being able to monitor whether the approach works as well as it should, and being able to work with your mental health professional to come up with a new approach, if need be.

The final module discusses the importance of self-management; that is, how to cope with your depression on an ongoing basis, outside of the doctor’s office. We also discuss various resources that can help you build the necessary skills for doing so.

Core self-management skills vs. illness-specific skills

In the previous modules, we've discussed the development of core self-management knowledge and skills. In other words, these self-management skills are useful for all mental disorders, regardless of your diagnosis. These skills include: learning about the illness and the various treatment options (Modules One and Two); working effectively with your mental health professional to find the approach that works best for you (Module Three); and sticking with that approach over time (Module Three).

Self-management also involves developing the skills to cope with your illness on a day-to-day basis, in between appointments with your mental health professional. Other core self-management skills include such things such as:

- dealing effectively with stressful or challenging situations so you can avoid a recurrence of your symptoms — including your emotions, thoughts and behaviours
- developing coping strategies for dealing with symptoms that do arise
- knowing when to seek outside help before things get out of hand.

Self-management skills specific for depression

For a discussion of core mental illness-related self-management skills, you may want to read through the *Mental Disorders Toolkit*, which contains descriptions of these general self-management skills, as well as a number of resources that you can follow up on. The self-management of *depression* however, also involves a number of specific skills that apply particularly to this condition. These will be the focus of Module Four.

In fact, these particular skills have been identified earlier in this toolkit, since they relate closely to the skills that evidence-based psychosocial approaches seek to impart. Depression self-management approaches take these skills outside of the clinical setting and allow you to learn them in different ways.

The approaches that this module will describe are:

- the Self-Care Depression Program which uses a self-directed manual based on cognitive-behavioural therapy (CBT) principles
- the Changeways Program which uses a group approach based on CBT
- the Chronic Disease Management Group (CDSM) approach which is not explicitly based on CBT, but works on similar principles

The self-care depression program

The Self-Care Depression Program (SCDP) is a manual designed to help people develop depression self-management skills. It is useful for people with moderate or mild depression whether or not they are taking medication. The self-directed manual can be used independently, or as part of a treatment plan with a mental health professional.

Based on the principles of cognitive-behavioural therapy (CBT), the manual focuses on three key areas that serve to trigger or maintain episodes of depression. These are: inactivity, negatively distorted thinking, and becoming overwhelmed by difficult or stressful situations. The manual is divided into three major sections that address each of these.

Overcoming inactivity

Part One. “Reactivating Your Life,” starts from the premise that during a depression, most individuals stop performing the activities that they normally find rewarding. Avoiding activities may initially feel comfortable or offer relief. In the longer term, however, inactivity serves to reinforce and worsen feelings of depression. The first step of Part One asks the reader to identify activities that could be increased. Activities could be in any one of four areas, including involvement with family and friends (i.e. social life); self-care (e.g. eating regularly, personal hygiene); personally-rewarding activities (like hiking, hobbies, reading, that the person has found rewarding in the past); and small duties (such as paying bills, shopping).

Step Two invites the individual to choose two of these activities that he or she would like to pursue, each from a different activity area. After these are chosen, Step Three asks

key messages in this module

- ★ There are several self-management skills specific to issues related to depression
- ★ Overcoming inactivity and isolation begins by identifying activities that could be increased, pursuing goals related to these activities and monitoring goals over time to increase social connectedness
- ★ Challenging negative thinking begins by identifying different patterns of negative thinking, recognizing them when they occur, understanding how they can trigger or worsen a depressed mood, and learning new coping mechanisms to practice more realistic thinking habits
- ★ Identifying and managing challenging situations through effective strategies such as structured problem-solving can help prevent warning signs of relapse from occurring, or can help you deal with them if they do occur
- ★ By evaluating your past coping strategies and by considering the successful strategies adopted by others, you can enhance your own abilities for coping with distressing symptoms or situations that otherwise might lead to relapse



the reader to set a realistic goal that he or she feels that they can accomplish in the short term. The manual helps the reader frame goals that are specific, realistic, and scheduled: for example, in the next two weeks, to walk three times a week at 7:00 pm, on Mondays, Wednesdays and Saturdays. The reader is then encouraged to think of the activity as an appointment with themselves, and to write them down on their calendar.

Step Four is to carry out the goals, and then to check them off as accomplished. If the goal wasn't accomplished, the individual is helped to think through what got in the way, and to re-set the goals in a more realistic fashion. If the goal was achieved, the individual is encouraged to congratulate themselves, and to think about setting a somewhat larger set of goals for the following two weeks.

As one gradually increases their activity level, motivation and enjoyment typically return, even though accomplishing these goals may not *feel* that enjoyable in the early going.

Challenging negative thinking habits

Part Two of the SCDP is based on the premise that people with depression typically think in ways that are both unrealistic and unfair to themselves. That is, they tend to judge themselves negatively, they see the world in negative terms, and have negative expectations for the future. These are habits of thinking that may trigger depression, or they may maintain or worsen the depression that already exists.

The first step of Part Two focuses on identifying different types of negative thinking (cognitive distortions). Examples of distortions include “catastrophizing” (e.g., failing in a small project at work leads you to think that you can't do any part of your job); “labeling” (e.g. calling yourself a “loser” or “idiot”); and “mind reading” (believing you know what others think about you — usually something negative).

The reader is then helped to recognize his or her own negative thoughts and how they trigger a depressive mood. The manual prompts the reader to imagine a situation they have experienced that triggered a depressed mood, and identify the specific negative biases that occurred in their own thinking. For example, a friend cancels a lunch date. The person with depression might think this means: “she doesn't like me,” “no one wants to be with me,” and furthermore that “the world is not an accepting place.”

The person is then helped to replace these patterns with a more balanced, realistic way of looking at the situation. Specific techniques for doing this include considering alternative evidence and explanations for the situation, thinking about how someone you know would evaluate the same event, and thinking about less extreme ways of looking at the situation.

The final step of Part Two includes an exercise for putting all these skills into place, called the “Three Column Technique.” The triggering situation itself (e.g. lunch date cancelled) is written down in the left column. In the middle column, the individual writes down any distortion that occurs (e.g. “she doesn't like me,” “the world is rejecting.”). In the third column, the person writes down a more fair and realistic thought to replace the negative thought: for example, “she cancelled because something came up.”

As with Part One, replacing thoughts with more positive ones might feel unnatural at the beginning, but over time the individual will start to become comfortable with this more balanced form of thinking.

Solving problems effectively

In **Part Three**, the individual is asked to identify and address problems that have been overwhelming for them, and which might have served to trigger or maintain their depression. Problem-solving can be particularly difficult for depressed individuals who may lack concentration and energy, or who may be preoccupied with the depression itself and the accompanying stress and anxiety.

The manual illustrates the “structured problem solving” approach to dealing with difficult situations. This includes:

- identifying some relevant problems (e.g. having to find a new housing arrangement; a work deadline, etc.) and making an inventory
- selecting a problem from this list that seems relatively solvable
- brainstorming potential strategies for solving the problem by thinking about past situations or obtaining the help of others
- deciding which of these options might work

- developing a plan of action which follows the MAST principle:
 - Manageable*: something you could do even if you don't feel any better than you do now
 - Action-oriented*: defined in terms the behaviours you'll be doing, not the emotions you'll feel while doing it
 - Specific*: detailed steps rather than broad statements (e.g. "go to community centre to find out if they teach yoga" versus "get in shape")
 - Time-limited*: states date or time that you will carry out the actions
- evaluating progress to decide if the strategy needs to be changed, concentrating on successes (even partial ones) rather than things gone according to plan.

The reader is then encouraged to apply the same approach to a bigger part of the goal, or to another goal he or she chooses to work on.

Reducing the risk of relapse

A final section of the manual asks the individual to think about which of the coping strategies outlined in the previous three sections have been working the best for them, and to continue applying them over time, even if they feel "good enough." Planning ahead for stressful situations is another topic, and includes both anticipated stresses like holidays or applying for a job and those that can't be predicted.

For those that can be predicted, the manual discusses strategies such as introducing stress gradually, lightening up existing responsibilities, and keeping up with self-care.

The manual also helps people create a "mood emergency action plan." This is an advance plan for what to do if you were to become depressed again. The plan may include such things as increasing rewarding activities by revisiting Part One of the manual; reducing obligations; getting professional help; asking for other kinds of support; and managing lifestyle patterns, such as sleep, exercise, and diet, that can significantly affect mood.

Appendices of the SCDP manual also contain further reading and strategies for changing some key lifestyle behaviours such as diet, sleep, physical activity, drugs and alcohol, and caffeine intake.

The SCDP can be accessed free of charge by downloading it from UBC's Mental Health and Community Consultation Unit website at www.mheccu.ubc.ca/publications. The manual may also be available from your mental health professional.

Changeways

The Changeways Depression Program is a group-based educational program designed to introduce clients to basic self-management concepts. The groups are led by a mental health professional who has undergone specific training in delivering the workshop. The program is applicable to a variety of people and is most often provided to clients experiencing major depression, as well as dysthymia, bipolar II disorder, and generalized anxiety disorder. It has also been offered to people experiencing major life stressors or transitions (such as retirement, immigration/acclimation, and dealing with chronic illness). In addition to the group component, the program also includes a workbook that describes the core concepts of the course in a module format. The workbook is available in both Mandarin and Cantonese as well.

Based on the principles of CBT, the program instructs individuals in a variety of problem-solving and lifestyle management skills. It is designed to run for six to ten weeks (one session per week), with an emphasis on providing specific, research-based strategies for dealing with life problems that relate to depression. The contents are similar to the SCDP and include:

- identifying problems and transforming them into goals for change
- breaking goals down into manageable steps
- learning about stress
- the signs, symptoms and causes of depression
- the effects of diet, exercise, sleep habits, caffeine, and drugs and alcohol
- the importance of building recreation into one's daily life
- strategies for developing a more satisfying social life
- an introduction to assertiveness skills

- identifying negative and self-defeating thought patterns
- learning to think in a more balanced and realistic manner
- preventing mood problems from becoming unmanageable

Graduates of the core program also have the option to continue with an eight-session assertiveness training group; a six-session relaxation skills group; a single evening lecture on recovery from depression; and a follow-up support group.

Originally offered in Vancouver, the program is now offered in a number of hospitals and community mental health centres across the province. See www.changeways.com for details about how to access a program in your community. Note: there may be some limited costs involved.

Chronic disease self-management program (CDSMP) groups

The CDSMP approach was developed at Stanford University for people with different types of chronic health conditions, with the recognition that people with ongoing health conditions face similar challenges, one of which may be depression. It is particularly appropriate for individuals with heart disease, arthritis, diabetes or chronic kidney disease or major depressive disorder. Like Changeways, it is a group-based approach that also includes an individual workbook.

The CDSMP is led by trained lay persons and is delivered to groups of 10 to 12 people once a week for two and a half hours over six consecutive weeks. The groups include both people with various chronic health conditions and their significant others. The leaders, who have chronic health conditions themselves, complete a four-day training workshop in leading the program. Through the course, individuals learn and practice a number of skills, including:

- ways of getting started with important behaviours such as exercise and healthy eating
- how to problem-solve (people with various chronic health problems are continually faced with problems)
- how to communicate effectively with family, friends and health care professionals
- how to effectively work with health care professionals
- how to deal with the anger, fear, and frustration that commonly accompany having a chronic health condition
- how to deal with depression
- how to deal with fatigue
- how to evaluate treatment options (media, friends and family members are constantly suggesting new medicines or treatments to try)

While skills are important, the concept of “self-efficacy” is fundamental to the CDSMP. Self-efficacy simply means that one has the confidence that they can actually apply their acquired skills in managing their a health condition on a daily basis. The group aspect of the program is central to acquiring self-efficacy, as research has shown that observing someone similar to yourself (a “peer”) performing successfully has a powerful influence on your own perceived ability to do the same.

For more information, or to check for availability in your area, see web.uvic.ca/~pmcgowan/research/cdsmp/ Note: The CDSMP will soon be available across BC.

Other self-management resources

Other resources are available that offer effective guidance in self-management skills for depression. These include self-management books (also known as bibliotherapy), self-management related websites, self-help groups, anthologies featuring stories about people with depression, resources for depression in special populations, and other community resources.

Self-management books

Other books that work on evidence-based CBT or other self-management principles include:

- *The Feeling Good Handbook*, David Burns (1999). Plume Books.
- *Mind Over Mood*, Dennis Greenberger & Christine Padesky (1995). Guilford Press.
- *Your Depression Map*, Randy Paterson (2002). New Harbinger Press.
- *Learned Optimism*, Martin Seligman (1992). Simon & Schuster.
- *Managing Depression*, David Westbrook (2002). Ordering information for this and other cognitive behavioural self-help resources at www.octc.co.uk/html/self-help.html
- *Living Without Depression & Manic Depression: A workbook for maintaining mood stability*, Mary Ellen Copeland (1994). New Harbinger Press.

Self-management websites

- *National Electronic Library for Mental Health* (UK). Information and resources relating to self-management of depression and other mental disorders. Go to libraries.nelh.nhs.uk/mentalhealth/
- *Beyondblue*, the website of the Australian National Depression Initiative. Includes information, resources and personal experiences. Go to www.beyondblue.org.au
- *Beating the Blues*. An evidence-based eight-session computerized cognitive-behavioural therapy program for people with mild to moderate depression. For information, see www.ultrasis.com/pdf/btb_overview.pdf
- *Moodgym Training Program*, a computer-based cognitive therapy program for depression, developed at Australian National University. For information, see moodgym.anu.edu.au
- *BC Healthguide Online*, Bipolar Illness “Health Tool,” go to www.bchealthguide.org/kbase/as/ty6584/actionset.htm



Self-help groups

Self-help or support groups have a long-standing role in helping people cope with mental health problems, mental illness and substance use problems. Many people find comfort in knowing they are not alone and benefit from the emotional support and practical tips that are often provided. It is important to keep in mind that some support groups are better than others. Problematic support groups are those that do not empower people and instead keep people trapped in old unhealthy coping patterns that do not help make things better. Some support groups only allow a place for members to “vent” without attempting to solve any ongoing problems. Although it is very important to feel heard and understood by others, a group should provide more than a venue for members to voice their concerns. The best support groups are those that provide members with reliable and accurate information that helps them better understand their mental health problem. A critical component is also the passing of knowledge about helpful resources and coping strategies that actually help a person make progress (e.g., places to get treatment, effective self-management strategies, high quality books and websites, etc).

To find out about a support group in your area, look in your local community services directory, contact the BC Mental Health Information Line at 604 669 7600 or 1 800 661 2121, or contact one of the BC Partners agencies listed on page 35.

Resources for special populations

- information about seasonal affective disorder and on light therapy. See www.psychiatry.ubc.ca/mood/sad
- *Post Partum Depression and Anxiety: A Self-Help Guide for Mothers*. For ordering information for this book, and for other resources on postpartum depression, see the website of the Pacific Post Partum Support Society, at www.postpartum.org. The Society is at 104-1416 Commercial Drive, Vancouver BC V5L 3X9. Telephone: 604 255 7999 Fax: 604 255 7588

- www.wellmother.com: the website of Dr. Shaila Misri, author of *Shouldn't I Be Happy?: Emotional problems of pregnant and postpartum women*.
- For information and resources on depression, including depression in women, children, adolescents and elderly populations, see PsychDirect at www.psychdirect.com
- Multicultural Mental Health Australia. Translated brochures on depression and other mental disorders and mental health topics at www.mmha.org.au/ResourceDatabase/
- *Preventing Relapse, and the Preventing Relapse Workbook*, a self-management workbook for people with co-occurring substance use and mental illness, including depression, by the Dual Diagnosis Recovery Network. To order, see www.dualdiagnosis.org

Anthologies on depression

Another option when building self-management skills is to learn from the experiences of others with depression through written or audiovisual accounts. Examples include:

- *On the Edge of Darkness*, Kathy Cronkite (1994). First person accounts of well-known people who have been through serious depression.
- *Living Meaningfully with Recurring Depression*, Nan Dickie (2002). Features vignettes of people learning to cope with various aspects of depression. You may purchase her book by emailing her at nan-dickie@shaw.ca
- *The Last Taboo*, Scott Simmie and Julie Nunes (2000)
- *Beyond Crazy*, Julia Nunes and Scott Simmie (2002). McLelland & Stewart. Both books by these authors feature personal stories of people with depression and other major mental illnesses, as well as information about how to access effective help.
- *Depths of Despair*. An excellent radio series by CBC Radio. To order tapes, send cheque or money order only to: The Sunday Edition, P.O. Box 500, Station A, Toronto, ON, M5W 1E6

Community-based mental health services

For more information about the self-management-related resources in your area, contact your local health authority. For additional information about self-management, housing, employment and income-related supports, you can also contact any of the BC Partners agencies listed to the right, or see the *Visions* journal issues produced on these and other related topics, by contacting Canadian Mental Health Association, BC Division.

Vancouver Coastal Health Authority
www.vch.ca
 1 866 884 0888 or 604 736 2033

Fraser Health Authority
www.fraserhealth.ca
 1877 935 5669 or 604 587 4600

Interior Health Authority
www.interiorhealth.ca
 250 862 4200

Northern Health Authority
www.northernhealth.ca
 1 866 565 2999 or 250 565 2649

Vancouver Island Health Authority
www.viha.ca
 1 877 370 8699 or 250 370 8699

Further resources from the BC Partners

Each of the BC Partner agencies may provide valuable information about depression, or about illnesses that may go along with depression. They may also run self-help groups. For further information, contact:

Awareness and Networking Around Disordered Eating
11739 223rd Street, Maple Ridge, BC V2X 5X8
604 466 4877 or 1 877 288 0877
www.anad.bc.ca

Anxiety Disorders Association of BC
105-129 East Columbia Street, New Westminister, BC V3L 3V7
604 681 3400
www.anxietybc.com

BC Schizophrenia Society (BCSS)
201-6011 Westminister Hwy, Richmond, BC V7C 4V4
604 270 7841 or 1 888 888 0029
www.bcscs.org

Canadian Mental Health Association BC Division
1200-1111 Melville Street, Vancouver, BC V6E 3V6
604 688 3234 or 1 800 555 8222
www.cmha.bc.ca

Centre for Addictions Research of BC
2210-1177 West Hastings Street, Vancouver, BC V6E 2K3
604 408 7753
www.silink.ca

FORCE Society for Kids' Mental Health Care
c/o 1433 McNair Drive, North Vancouver, BC V7K 1X4
604 878 3400
www.bckidsmentalhealth.org

Mood Disorders Association of BC
202-2250 Commercial Drive, Vancouver, BC V5N 5P9
604 873 0103
www.mdabc.ca

CONCLUSION

We've covered a lot of ground in this toolkit and hopefully supplied some useful ideas and resources that can help you move further down the road to self-management of depression. Just to review where we've been, we started by discussing how to understand your illness, and the various treatment approaches. Then, we moved on the topic of how to find a treatment approach that works best for you. Finally, we talked about some approaches and resources for coping with depression and avoiding relapse on a day-to-day basis.

We hope you've found the material useful, and that it will help you make your way down the path to self-management of depression. Please take a few minutes to give us your thoughts on this resource, and how we could improve it. By doing this, you can help us assist others down the path to recovery.

★ As you follow up on some of the resources we've suggested, either in the Resource Catalogue, or earlier in the toolkit, you may find that some of the contact information — websites, phone numbers, etc. — is out of date. If that is the case, or if you are having trouble tracking down any of the resources listed in the toolkit, please phone one of the BC Partners Agencies listed in this module. You can also check the BC Partners website for information updates at www.heretohelp.bc.ca

NOTES:

We are strongly committed to matching this toolkit to the needs of the individuals and families who will be using the information and resources. To help us improve this toolkit we welcome your comments, suggestions and feedback.

Did you find the Depression Toolkit useful? Please describe.

Did you find the information accurate? Please identify any errors.

Did you find the information clear in terms of writing style, size and appearance of text, general presentation and content?

Were there sections in this toolkit that were perhaps not as comprehensive as they could be?

Did you find the suggested exercises contained in this toolkit useful and effective?

Please mail or fax this document back to us or fill out our online version of this form at www.heretohelp.bc.ca, where you will find the rest of our series of toolkits and other information regarding mental health and substance use.

**BC Partners for
Mental Health and
Addictions Information**

- * c/o 1200 - 1111 Melville Street
Vancouver, BC Canada V6E 3V6
- * bcpartners@heretohelp.bc.ca
- * www.heretohelp.bc.ca
- * tel: 1 800 661 2121
- * fax: 604 688 3236



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