

	<p>V. Study Unit: Basic Techniques of the psychotherapeutic treatment of the depressive episode</p> <p>Dr. Zsolt Unoka</p>
Purpose	<p>The purpose of this chapter is to acquaint the user with the basic techniques of the psychotherapeutic treatment of depressive symptoms.</p>
Introduction	<p>Introduction</p> <p>In this chapter you will become acquainted with those more simple psychotherapeutic techniques, by the help of which one may be of assistance in alleviating the various symptoms of the depressive episode more effectively.</p>
Tasks	<p>Target group: General practitioners and medical students</p> <p>Suggested study methods</p> <p>Read the texts and watch the video sections belonging to each text. Following this, answer the comprehension questions. If you were not able to answer all the questions, survey the problematic parts in the texts again. After that, do the exercises belonging to the video sections, and finally do the self-check tests. We suggest that each course of lectures should be surveyed in one go.</p> <p>Total amount of study-time necessary: 3 hours</p>
Readings	<p>Recommended Reading</p> <p>Beck, A. T., & Rush, A. J. Shaw, BF, & Emery, G.(1979). Cognitive therapy of depression. Guilford, New York.(Paper back edition: 1987).</p> <p>Gabbard, G. O., Beck, J. S., & Holmes, J. (Eds.). (2007). Oxford textbook of psychotherapy. Oxford University Press.</p> <p>Key words: symptoms of depression, cognitive model, behaviour activation, problem solving, increasing positive experiences</p>
Summary	<p>Content of Chapter</p> <p>V. Psychotherapeutic treatment of depressive state V./1. Symptoms of depressive episode and their assessment V./1.1. Depressed mood, sadness V./1.2. Loss of interest or joy: anhedonia V./1.3. Decrease or increase of body weight with the change of appetite V./1.4. Sleep disorder</p>

- V./1.5. Psychomotor retardation or agitation
- V./1.6. Decreased vigour and/or increased fatigue
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 - V./4.2. 7. Employing the questioning of negative automatic thoughts
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 - V./4.3.2.1. The 6-step method of problem-solving
 - V./4.4. Increasing positive experiences
 - V./4.4.1. Identifying the everyday routine activities and the enjoyable activities
 - V./4.4.2. Creating a weekly action plan
 - V./4.4.3. Executing actions
 - V./4.3.4. Discussing results
 - V./4.5. Developing new attention distracting skills
 - V./4.5.1. Discussing the positive aspects of life
 - V./4.5.2. Diary of positive events

V./1. Symptoms of a depressive episode and their assessment

Introduction

In this chapter we present a few basic techniques of the psychotherapeutic treatment of depression, which may be efficient in the case of a mild or moderate form of depression. Prior to presenting the psychotherapeutic techniques, we

<p>Task</p> <p>List the psychotherapeutic effects of the assessment of symptoms.</p>	<p>briefly outline the symptoms, forms and disease-process of depression. By this we aim to facilitate the identification of depression, and to call attention to forms of depression in which psychotherapeutic treatment in itself is not sufficient, or in which hospitalization is needed for the sake of the safety of the patient.</p> <p>The word “depression” has become part of our everyday language, where it refers to a bad mood. In psychiatric diagnostics, however, depression is a syndrome that is the joint existence of several symptoms for a specific amount of time.</p> <p>The assessment of the symptoms of depression, and informing the patient of the symptoms and nature of depression are in themselves of psychotherapeutic value.</p> <ul style="list-style-type: none"> • One: It gives reassurance to the patient that he has found an expert for whom his symptoms are familiar. • Two: The symptoms of depression are in many cases experienced by the patient as a fundamental decline of his mode of functioning. Often they are not considered by him as symptoms of depression but rather as the fading away of love, as a sexual disorder, as dementia, as moral decline, as laziness, or as some severe physical illness. Putting the several divergent symptoms back to their proper places often gives relief to the patient. • Three: Since the symptoms of depression affect the patient’s whole personality and his view of the world, he often has the notion that he himself, the people around him and his place in the world has once and for all changed. Communicating knowledge available about the natural course of depression (according to which depression does not last forever) may give hope to him. • Four: In many cases depression can be treated. Knowing that the patient himself can do something for this condition to be changed, that there is remedy for his affliction, may reduce hopelessness and the feeling of helplessness. <p>In the following we present the characteristic symptoms of depression one by one, and we also present the questions with which the therapist can inquire about symptoms.</p>
<p>Important</p>	<p>V./1.1. Depressed mood, sadness</p> <p>One of the major symptoms of the depressive episode is the dispiritedness, which may occur in the form of a prolonged sadness or a bad mood. With some people this occurs in the form of frequent crying. With some others the feeling of emptiness is determinant. The gravity of the depressive state may fluctuate according to the part of the day or as a result of pleasant or unpleasant events, but subsists permanently. The state of mood is not in proportion with the stress or the unpleasant life-events of the person. The person may seem sad, gloomy or void of expression, and may speak with a deep and melancholic voice. Nevertheless the perceptible suffering is not always expressed explicitly, and is not an essential criterion in ascertaining the existence of the symptom.</p> <p><i>Question pertaining to symptom:</i> Has there been such a period of time during the last month when you were feeling depressed or in a bad mood? Have you felt permanent sadness without any particular reason?</p>

Important	<p>V./1.2. Loss of interest or joy: anhedonia</p> <p>The other important area is the loss of interest or joy, also known as anhedonia. This is the considerable decrease of joy in all or almost all of the activities for the most part of the day and almost every day (hinted at either by a subjective report or by an observation of others). The patient experiences considerable lack of motivation concerning his job, his hobbies and his leisure time activities, which are otherwise sources of satisfaction for him.</p> <p>For this reason the amount of time spent on these activities or the efficiency of these activities decreases. In milder forms this is experienced as if he needed to make greater efforts do his job or the housework, or to engage in regular social activities, amusement or hobbies.</p> <p>There is no such change in his circumstance of life which would account for the lack of motivation – e.g. somatic illness, the season, the weather, etc., or stress connected to work and/or the social network, shortage of money, lack of time, change of permanent residence, change of partner.</p> <p><i>Question pertaining to symptom:</i> Has there been such a period of time during the last month when you lost your interest towards the things you previously had enjoyed?</p>
Important	<p>V./1.3. Decrease or increase of body weight with the change of appetite</p> <p>One's appetite may frequently change when in depression. Either there is a lack of appetite, which results in considerable weight loss, or there is an increase of appetite which may result in weight gain. We consider it pathological if the weight loss – or weight gain – reaches 5% of body weight monthly (without any particular diet) or there is a considerable decrease or increase of appetite almost every day. It is important to separate this from a volitional slimming diet.</p> <p><i>Question pertaining to symptom:</i> What was your appetite like in the past month? What was it like compared to your usual appetite? Did you need to force yourself to eat? Did you eat less/more than usual? Was this typical of almost every day? Have you lost/gained some weight? How much? Did you actually want to lose weight?</p>
Important	<p>V./1.4. Sleep disorder</p> <p>In the case of depression sleeping habits often change; one sleeps either less or more. Some complain about difficulty in falling asleep. With others the major symptom is oversleeping or early rising. Less sleep gives rise to the feeling of lack of sleep and results in fatigability. With others it is the opposite: they are sleepy most of the day, and they are indeed able to fall asleep any time. They need to sleep much more than 8 hours a day.</p> <p><i>Question pertaining to symptom:</i> How was your sleep in the past month? Did you happen to have problems with falling asleep; did you wake up often and/or easily; did you rise very early <i>in the morning</i> OR just the opposite: you slept too much? How much did you sleep a</p>

<p>Important</p> <p>Task</p> <p>List the catatonic symptoms of depression, and the treatments to be chosen.</p>	<p>night compared to usual? Did it happen almost every night?</p> <p>V./1.5. Psychomotor retardation or agitation</p> <p>In the case of depression the patient's movement, speech and thinking noticeably slackens. This can be felt subjectively by the patient himself, but according to the definition of the symptom, this should be conspicuous for the external observer as well. The symptom's major forms of manifestation are a slackened thinking and a decreased concentration, which leads to memory problems and the aggravatedness of everyday decisions. The patient may experience a general slackening in all of his movements. This is manifested in his speech too, for example in the late answers given to questions.</p> <p>In severe cases the person is totally unable to answer, and cannot execute even the basic self-care functions, such as eating, washing, and dressing. The patient with this catatonic type of depression may have strange gestures, mannerisms, aimlessly repeated movements or sentences. He may repeat other people's speech and gestures like a parrot; he may put up resistance when asked to move or to an attempt to be moved, and to answering questions. In the case of such a severe form of depression psychotherapy is not the treatment to be chosen first. The safest option is hospitalizing and biological treatment (ECT, medicinal treatment).</p> <p><i>Question pertaining to symptom:</i></p> <p>Have you spoken or moved more slowly than it had been usual for you? Was it so conspicuous that others noticed it as well? What struck them? Has it been like that almost every day? Do you need more time for doing things? Has your thoughts slackened?</p> <p>There are patients who, on the other hand, are characterized more by motor agitation, restlessness, excitement. They are not able to sit still. Increased agitation can also be an obstacle of psychotherapeutic treatment. In the case of intense agitation medicinal treatment is recommended.</p> <p><i>Question pertaining to symptom:</i></p> <p>Has it frequently happened that you were so agitated and restless that you could not sit still? Was it so conspicuous that others noticed it as well? What struck them? Has it been so almost every day?</p>
<p>Important</p>	<p>V./1.6. Decreased vigour and/or increased fatigue</p> <p>Patients feel fatigued and feeble almost every day, for the most part of the day. This fatigue exists in spite of the fact that they do not perform exhausting mental or physical activities. They feel their limbs to be weak, tired and feeble.</p> <p><i>Question pertaining to symptom:</i></p> <p>How healthy and strong have you been feeling in the past month? Did you feel constant fatigue during the day in spite of the fact that you hadn't done much physical work? Do you regularly feel your movements to be slackened, your arms and legs heavy? How often do you feel this?</p> <p>V./1.7. Feeling of worthlessness, self-reproach, consciousness of guilt</p>

<p>Important</p>	<p>A frequent symptom of depression is the lack of self-confidence and self-esteem. Patients feel themselves worthless. They are tormented by an exaggerated (because the degree of it does not follow from their life-story) self-reproach and consciousness of guilt almost every day – and we are not talking about the remorse or consciousness of guilt felt on account of the illness.</p> <p>In a psychotic depression these may even mount up to delusions. There is a constant worrying because of his imperfection – e.g. he blames himself for problems of personal, domestic or communal nature. He is convinced that he is unworthy of the attention and care of family members and friends. These thoughts may be based on real problems but either they exaggerate the consequences of those problems or they occupy the person's mind too much and they preoccupy him for most of the day.</p> <p>In the case of psychotic depression these thoughts can be delusions, like e.g. an unshakeable belief that with some minor fault he had caused a natural disaster – an earthquake or a flood –, or belief in a crime – robbery, murder –, and often confesses to that.</p> <p>In the case of psychotic depression he may hear voices, which declare him guilty or frail.</p> <p>In the case of psychotic depression psychotherapeutic treatment in itself is not sufficient. Medicinal treatment is needed and in most cases hospitalization is the safest option.</p> <p><i>Question pertaining to symptom:</i> How satisfied you have been with yourself in the past month? Do you feel that you are as good as others? Do you generally feel worthless? Are you in the habit of blaming yourself when something fails? Do you have a consciousness of guilt when you commit a minor mistake? Do you sometimes feel as if you have done something very evil for which you deserve to be punished?</p>
<p>Important</p>	<p>V./1.8. Cognitive symptoms</p> <p>It belongs to the symptoms of depression that during the time of depression the ability to think, to concentrate or to make a decision is often reduced. When reading, patients find it increasingly difficult to concentrate. At the bottom of the page they cannot remember what they read at the top of it. They cannot pay attention to movies, radio broadcasts, and conversations. They also experience memory disorder; it is more difficult for them to memorize things, and they easily forget about tasks to be done. These symptoms occur in other pathologies too. In the case of depression, however, with the passing of depression these symptoms also disappear. If we inform the patient of this, it may in itself bring about great relief.</p> <p><i>Question pertaining to symptom:</i> Has it been difficult for you to think or to concentrate on something? What were the things you were hindered in? almost every day? Do you have difficulties in making everyday decisions? Do you tend to forget about things more often?</p> <p>A cognitive phenomenon preserving the state of depression is the constant brooding over negative thoughts, also known as rumination.</p>

Important	<p>V./1.11. Somatic complaints in depression, assessment of pains</p> <p>Frequent symptoms of depression are somatic complaints, feelings of pain, in the background of which there is no organic lesion. There are many depressive patients taken to medical wards, in the foreground of whose complaints there are somatic complaints. In their cases organic diseases can be precluded after a prolonged examination process.</p>
Important	<p>V./1.12. Assessment of functioning</p> <p>Besides other reasons, depression is a significant problem on account of the fact that it causes subjectively very unpleasant and, in many cases excruciating symptoms. In its more severe forms, however, it leads to the disorder of everyday functioning or a total inability to function. Prior to the commencement of the psychotherapeutic treatment, the level of the incapability of functioning has to be assessed.</p> <p><i>Assessment of the incapability of functioning:</i> Have the symptoms of depression hindered you in performing your usual activities? How many days have you spent in bed for the purpose of resting?</p>

Important	<p>V./2. Types of depression, and their course</p> <p>The depressive syndrome is also classified on the basis of its severity and nature.</p> <p><i>According to its severity</i> it can be mild, moderate, severe without psychotic symptoms and severe with psychotic symptoms.</p> <p><i>According to its nature</i> it can be catatonic, melancholic, atypical, beginning post partum and seasonal.</p>
Task: Memorize the subtypes of depression.	<p>The depressive episode in terms of the process of illness can be part of more <i>diagnostic categories</i>: it can be one phase of a unipolar depression, or a newer episode of a repeatedly occurring unipolar depression, or it can be the depressive phase of a bipolar affective disorder. Depression may occur also in the post-psychotic phase of schizophrenia, or in the depressive episode of a schizoaffective disorder, along with the psychotic symptoms.</p> <p>The depressive syndrome can develop as a result of drug consumption or as a concomitant of somatic illnesses.</p> <p>Milder forms of the depressive syndrome may occur in dysthymia, in cyclothymia, and in a stress-induced reaction.</p> <p>The depressive disorder frequently occurs in the medical practise. Doctors, however, do not always recognise it, and it remains untreated. Despite its being a frequent occurrence, it has severe negative consequences, but what is most important, it can be treated. There are many factors influencing the fact that</p>

	<p>depression remains undiagnosed. On the one hand, there is a considerable overlap between the symptoms of depression and those of the diseases of internal organs. On the other hand, it is hard to separate the normal reaction given to the stress caused by some severe somatic illness from the pathological depressive state. At the same time a mistakenly positive diagnosis of depression should also be avoided, for if we are not careful numerous severe somatic illnesses might escape our attention.</p>
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Important	<p>V./4. General principles of the treatment of depression</p> <p>In the course of the treatment of depression one has to proceed according to the professional protocol. Treatment methods for depression should be chosen subsequent to the thorough assessment of the exciting causes.</p> <p>If the symptoms are caused by somatic illnesses, drug use or the side effect of medications, then those problems have to be solved first, and supporting psychotherapy is brought up as a complementary treatment.</p> <p>In the case of a severe or psychotic depression or in the depressive phase of a bipolar pathography or schizoaffective pathography biological treatment must be employed, for in these cases psychotherapeutic treatment in itself is not sufficient. safe enough.</p> <p>The patient has to be informed of the efficient treatment methods of depression, acquainting him also with the advantages and drawbacks of them. The patient has to be involved into the selection of the appropriate treatment. In the decision making process, however, professional rationality has to be represented without exception. In the case of a patient who is not able to decide, it must be considered, whether the patient may be burdened by the making of the decision.</p> <p>We recommend outpatient psychotherapeutic treatment if the gravity of depression is mild or moderate, there is no immediate threat, and we have precluded somatic causes, bipolar disorder or other severe disorder in need of medicinal treatment.</p> <p>In the more severe forms of depression psychotherapeutic treatment has to be commenced under hospitalized circumstances and combined with biological treatments.</p> <p>In the more severe forms of depression one has to be careful on account of the increased attention and memory disorder, the fatigability and self-belittlement, and is allowed to employ only those forms of psychotherapeutic treatment which do not overburden the actual capacity of the patient. If the patient is given tasks that considerably surpass his abilities, this may further increase his feeling of failure and self-belittlement.</p> <p>In the case of a severe, psychotic depression, suicidal intention and planning or other endangering conditions we have to take the initiative and determine what treatments to choose, and we, with due respect for the adequate legal regulations, are allowed to come to a decision that may be in discord with the patient's will. When necessary, we may initiate hospitalization contrary to the patient's will.</p> <p>In the course of the psychotherapeutic treatment the state of depression may</p>
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<p>Important</p>	<p>change for the worse, and complementation of the treatment with biological forms of treatment may become necessary. The patient may continue the treatment in a hospital. The aggravation of the patient's condition may revise the treatment protocol of the actual psychotherapeutic method, and either the treatment has to be complemented or the form of the treatment has to be changed.</p> <p>In the following we present such WHO-recommended simple treatment techniques that, with mild and moderate forms of depression, may improve the patient's condition, or can be employed in addition to medicinal treatment.</p> <p>V./4.1. Psychoeducation</p> <p>Providing information concerning his depression promotes the patient's coping with his illness. The purpose of psychoeducation is to give information concerning the symptoms and natural course of the illness, and the advantages, side effects, temporal and financial concomitants of the possible treatments.</p> <p>In the course of revealing the causes of the illness the patient has the opportunity to learn what biological and social phenomena may improve or impair the symptoms of depression. This knowledge may increase the feeling of control and efficiency, and improve his cooperation with the treatment. If, prior to the introduction of the medicinal treatment, we give the patient adequate information concerning the side effects and the possible outset of the effect of the medications, there is a greater chance of cooperation.</p> <p>It is likewise appropriate, in the course of psychotherapy, to introduce the individual psychotherapeutic interventions with psychoeducation, which must contain the following:</p> <ul style="list-style-type: none"> ▪ Information concerning the nature of depression. Why, do we think, the depression has developed, or what preserves it, or what aggravates it. ▪ The effect of the intervention on the factors influencing the depression. ▪ What precisely are we going to do, and what we expect from the patient. <p>V./4.2. Amending negative thoughts with cognitive therapeutic techniques</p> <p><i>V./4.2.1. First interview and cognitive case conceptualisation</i></p> <p>The initiation of a psychotherapeutic treatment is preceded by a diagnosis established according to the previously presented aspects. If the patient is diagnostically suitable for psychotherapy, then in the course of the first interview we assess, employing the techniques of our psychotherapeutic method, how well the patient is able to utilize the method we use.</p> <p><i>V./4.2. 2. Presentation of the cognitive model</i></p> <p>It is of great help for depressive patients if they understand that some of their symptoms are caused by negative evaluation of themselves, their</p>
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Task:
Fill in the three-column table for a sad feeling or bad mood experienced by you some time in the past.

world/environment and their future. We attempt to place the situations related by the patient into the cognitive model. When, for example, he complains about having frequent bad moods lately, we ask him to tell us about a situation, when he noticed that his mood had changed for the worse. Then we ask him to recall how he assessed that situation. What were the thoughts crossing his mind? Then we discuss with him the inferences among the situation, the assessment of the situation and the negative feeling. We structure the experiences of the patient with the help of the three-column method.

The therapist attempts to summarize for the patient the connection between the development of the bad mood and the negative assessment of the situation in accordance with the cognitive model. This has two functions: 1. summary for the sake of asking for feedback; 2. demonstrating the cognitive model.

V./4.2.3. The three-column method

Depressive patients tend to assess numerous situations negatively, and these situations thus bring about negative feelings in them. The negative assessment of situations occurs automatically. Because of the cognitive distortions characteristic of depression, they assess situations gratuitously or exaggeratedly negatively. An initial step of the therapy is to make the patient's automatic, unconscious assessment of the situation conscious. We prompt the patient to observe his inner processes, to break up his bad experiences into parts, and to separate the events inducing bad feelings from the assessment of the events, and the reactions given to the events (emotion, somatic feeling, behavioural response). This technique is called three-column method.

Disqualification of success: the person has a gratuitous conviction that positive experiences, actions or values do not count. *For example*: "I've got an excellent for this exam, but it doesn't mean that I'm competent, it only means that I was lucky". (**disqualification of success**)

The therapist constantly works on the *development of the therapeutic alliance*. It improves the alliance if the patient understands how the activity done in therapy leads to the ceasing of his complaints. The purpose of the education about the cognitive model of depression is to make the patient understand what the connection is between the activity suggested by the psychotherapist (revealing the negative assessment of situations) and the patient's complaints. (**education, negative thoughts, depression**)

Important

Core belief: I am bound to be rejected.			
Intermediate beliefs: People who make mistakes are rejected. I make more mistakes than other people. I will be rejected.			
Compensatory strategies: Avoiding intimacy	Compensatory strategies:	Compensatory strategies:	Compensatory strategies:
Situations/Events: Casual social interactions	Situations/Events:	Situations/Events:	Situations/Events:
Automatic thoughts: They will think I'm an idiot.	Automatic thoughts:	Automatic thoughts:	Automatic thoughts:
Emotions: Anxiety	Emotions:	Emotions:	Emotions:
Behavior: Avoidance	Behavior:	Behavior:	Behavior:

V./4.2. 4. Redirection of attention to positive memories

Through his cognitive distortions, the patient concentrates on failure. One of the aims of the therapy is that the patient should, even in difficult situations, be able to recall the objective successes from his memory, and in this way the image created about himself and his abilities should be more balanced. (**direction of attention to positive memories**)

V./4.2.5. Giving home assignments: The three-column method

In cognitive therapy great emphasis is put on the patient's acquiring new skills and his ability to employ them on his own as soon as possible. The development of new skills comes about through much practise. The giving of home assignments aims at the acceleration of the learning process. It is worth filling out a three-column worksheet together, for in this way we can check whether the patient understands the task or not.

The three-column home assignment

EVENT	NEGATIVE AUTOMATIC THOUGHT	REACTION
I go out with my friends.	I am a burden for them.	
		EMOTION
		Sadness
		PHYSIOLOGICAL SYMPTOMS
		weakness
		BEHAVIOR
		I go home.

V./4.3. Problem solving

With certain persons we can find relational, workplace and financial problems in the background of the evolvement of depression. Revealing the problems and supporting the solving of problems may considerably improve the condition of the depressive person, and in certain cases it leads to the considerable alleviation of depression.

V./4.3.1. Assessment of problems in the background of depressive episodes

It is worth assessing the problems together with the patient, either in the course of the conversation or with the help of the enclosed problem assessment sheet, which may be handed over to the patient prior to the interview. Typical problems activating depressive symptoms:

Relational disorders:

- cohabitative and marriage conflicts
- divorce or separation
- loneliness
- child birth
- children leaving the family
- death of spouse or partner

Workplace disorders:

- workplace conflicts
- questioning the quality of workplace
- losing workplace

Financial problems:

- poverty
- unemployment
- debts
- residence problems

Traumatic experiences

- victim of accident
- victim of abuse
- development of severe somatic illness

Changes

- moving
- being in a new cultural environment

Organic causes

- alcohol and/or drug consumption
- taking depression inducing medication
- somatic illnesses inducing depression

V./4.3.2. Treatment of problems in the background of depressive episodes, with the help of problem-solving strategies

In the course of their lives everyone encounters problems, and these problems may cause a bad mood, moreover, they may sometimes induce depression or exacerbate an already existing depressive state. In the previous chapter we have

Task:
Read the problem-solving sheet.

listed a few typical problems, the prolonged existence or unsolvedness of which may cause a bad mood. In many cases, solving the problem may result in the improvement of the mood.

The revealing of problems is an important element of the treatment of depressive patients. Solving of the revealed problems may considerably reduce the stress in people's lives. One of the consequences of the reduction of stress may be the alleviation or even the ceasing of the symptoms of depression. Through the technique of problem-solving we may be of considerable assistance to such depressive patients, in whose cases the development or the continuation of the depressive episode can be connected to certain problems.

The technique of the problem-solving consultation is an easily acquirable method. The patient can be easily taught this technique, by solving a problem together. If there is a way, let us initiate a relative, chosen by the patient, into the practising of the method. With depressive patients, in the case of more severe conditions, outside help counts a lot.

The using of the problem-solving worksheet has to be made a daily routine. We recommend that the patient, with the assistance of a relative, and using the 6-step problem-solving sheet, should regularly discuss his difficulties in his home.

V./4.3.2.1. The 6-step method of problem-solving

This method teaches the patient how to make a simple and efficient problem-solving plan or how to arrange a discussion to eliminate some difficulty or to reach some goal. We have to teach the patient (and also his relative) to be able to identify his problems and make a well-grounded and feasible plan for preventing them. If the patient solves his problems, and, for the sake of reaching his goals, makes easily realizable plans, then, breaking them up into manageable steps, realizes them day by day, step by step, he may considerably improve his general condition.

The efficiency of the problem-solving activity may be considerably improved, if the patient asks people who are important for him to take part in this activity.

The problem-solving activity may reduce several symptoms of depression: the feeling of hopelessness, helplessness, anxiety, guilt, and decreased self-esteem. For this very reason it is important to help depressive persons to acquire the efficient method of problem-solving.

The enclosed problem-solving sheet is used in the course of the discussion of problems.

Legend: *Supplement 3: PROBLEM-SOLVING Sheet empty*

SOLVING PROBLEMS AND ACHIEVING GOALS

Step 1. What exactly is the problem or goal?

Talk about the problem or goal until we can write down exactly what it is. Ask questions to make the issue clearer. Break a big problem or goal into smaller parts.

Step 2. List all possible solutions -- brain storming

Make a list of all ideas, even "bad" or "silly" suggestions. Get everyone to suggest something. Do NOT talk about whether ideas are good or bad at this stage.

1. _____

2. _____

<p>Task:</p> <p>List the factors that in depression impede the experiencing of positive experiences.</p>	<div data-bbox="438 91 1497 237"> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> </div> <div data-bbox="438 275 1509 421"> <p>Step 3. Briefly highlight the main advantages & disadvantages</p> <p>Get our group to say quickly what we think are the main advantages and disadvantages of each suggestion. Do NOT write anything. Do NOT compare the possible solutions at this point.</p> </div> <div data-bbox="438 459 1509 568"> <p>Step 4. Choose the most practical suggestion</p> <p>Choose the solution that can be carried out most easily with the resources (time, skills, materials, money) that we have at present.</p> <p>_____</p> <p>_____</p> </div> <div data-bbox="438 678 1509 788"> <p>Step 5. Plan exactly how to carry out the solution</p> <p>Organise the resources we need. Consider how to cope with likely hitches. Practice all difficult steps -- rehearse or role play.</p> <p>_____</p> <p>_____</p> </div> <div data-bbox="438 862 1316 898"> <p>Date and time to review progress with plan _____</p> </div> <div data-bbox="438 936 1509 1081"> <p>Step 6. Review progress in carrying out plan</p> <p>Praise all the efforts we have made. Review progress on each step. Change the plan. Try another solution. Continue problem solving until our problem is resolved or our goal is achieved.</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> <div data-bbox="438 1229 1509 2078"> <p>The six-step method of problem-solving is comprised of the following steps:</p> <ul style="list-style-type: none"> • <i>As a first step</i>, the patient is asked to chose a problem, the solving of which would bring about a considerable improvement of disposition, or to set a goal, the reaching of which would bring about considerable improvement. It is important to teach the patient to choose a well-defined problem, and that the goal to be reached should be realisable in the near future. If the patient wishes to realize a bigger goal, then we should break up that goal into parts, and develop the six-step method for the first part. It is very important, so the patient should constantly experience success, and sense the feeling of success at each small step. • <i>The second step</i> is the enumeration of the possible solutions. This phase is also called brainstorming. Here it is important to emphasise that the patient should stoke his imagination and come up with any idea that crosses his mind. The thinking of depressive patients is often inhibited and they have difficulties in coming up with ideas – in such cases it is worth helping them with the brainstorming. Many times, however, it is not inhibition but self-critical thinking is which prevents them giving vent to their imagination and voicing their ideas freely. In the case of the latter it may be of help if we encourage the patient to engage in an unimpeded and criticism-free brainstorming. The patient should write down every idea that occurs to him. </div>
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- In *the third step* we ask the patient to consider the advantages and drawbacks of each an every idea. This task is of help in altering the exaggerative, all-or-nothing way of thinking so characteristic of depressive persons, for we are prompting the patient to consider not only the drawbacks of the individual ideas but also the advantages of them.

The recognition and re-evaluation of the negative cognitive schemata activated during the reconsidering of the advantages and drawbacks of ideas is also of assistance in the making of adequate decisions. An effective technique is the changing of the perspective: we ask the patient to consider a similar problem from the perspective of another person. In numerous cases, people, when imagining themselves in the place of another person, are able to conceive an answer much more adaptive than their own.

- In *the fourth step* the patient selects the solution most suitable for his situation and goals.

In *the fifth step* we plan the realization of the chosen solution in detail. We ask the patient to plan every step accurately. It is worth making the patient consider in advance what the probability is of him being able to make that step. We should only accept the plan that the patient believes to be realisable. Let us set an appointment for the revision of progress.

- The sixth step occurs during the realization of the plan. The sixth step is the continuous evaluation of the results of the efforts undertaken for the sake of the successful realization of the plan.

This six steps we have summarized on worksheets which can be used as guiding principles during the solving of problems, and for note-taking as well.

A_P_4_Supplement_V_4_3_2_1

Legend: *Supplement 4: Problem-solving sheet filled out*

SOLVING PROBLEMS AND ACHIEVING GOALS

Step 1. What exactly is the problem or goal?

Talk about the problem or goal until we can write down exactly what it is. Ask questions to make the issue clearer. Break a big problem or goal into smaller parts.
 __Sandy is always late. It makes me angry. I would like to discuss it with her. _____

Step 2. List all possible solutions -- brain storming

Make a list of all ideas, even “bad” or “silly” suggestions. Get everyone to suggest something. Do NOT talk about whether ideas are good or bad at this stage.

1._I will avoid discussion. I do not care. _____

2._Next time I will discuss it with her. I am afraid that I will lose control, and will be too angry. ____

3._I will write an email, to avoid potential angry outburst. _____

4. _____

5. _____

6. _____

Step 3. Briefly highlight the main advantages & disadvantages

Get our group to say quickly what we think are the main advantages and disadvantages of each suggestion. Do NOT write anything. Do NOT compare the possible solutions at this point.

Step 4. Choose the most practical suggestion

Choose the solution that can be carried out most easily with the resources (time, skills, materials, money) that we have at present.

_____ Writing an email

Step 5. Plan exactly how to carry out the solution

Organise the resources we need. Consider how to cope with likely hitches.

Practice all difficult steps -- rehearse or role play.

_____ Writing an email, discuss it with a friend, then send it.

Date and time to review progress with plan__2011.12.08. _____

Step 6. Review progress in carrying out plan

Praise all the efforts we have made. Review progress on each step. Change the plan. Try another solution. Continue problem solving until our problem is resolved or our goal is achieved.

(see in “**PROBLEM-SOLVING IN SIX STEPS**”). The worksheet gives guidance regarding the process of the discussion and provides assistance for writing down the important things. Let us read over the worksheet entitled “**PROBLEM-SOLVING IN SIX STEPS**”.

The technique of problem-solving should be regularly practised, so that it becomes a routine in the life of the patient.

V./4.4. Increasing positive experiences

Depressive patients find it difficult to process positive experiences, that is why they need assistance in regularly obtaining positive experiences. Phenomena belonging to the symptomatology of depression strongly inhibit this process.

- Firstly, on account of *anhedonia* they have difficulties in finding pleasure in activities and experiences they previously had found pleasure in.
- Secondly, on account of their *negative cognitive style* they question and negatively re-evaluate numerous relational situations and successes of achievement.
- Thirdly, on account of their negative self-image they avoid company and challenges, thus having no opportunity to share in new and joyful experiences.

In this chapter we present a very simple and easily acquirable technique, the aim of which is to make patients increase the frequency of joyful activities. This

technique comprises of four steps:

1. identifying routine and joyful activities,
2. fashioning a weekly action-plan,
3. performing the activities,
4. discussing results.

V./4.4.1. Identifying the everyday routine activities and the enjoyable activities

In the course of a depressive episode, patients abandon many such activities as household maintenance (washing up, tidying up, cleaning, laundering, etc.), washing (bathing, tooth-brushing, washing one's hair, combing, shaving, epilation, clean clothes, etc.), shopping, working. The omission of these impairs the patient's disposition and reacts upon the depression, further aggravating it. A great part of the above listed routine activities can also be performed in a depressive state. If patients perform these activities, that may improve their self-esteem and general condition.

In the course of the depressive episode patients generally abandon pleasant activities as well. From a subjective point of view they do, of course, have a good reason for that. Because of their bad mood they are not able to take part in social life events so cheerfully, and they are afraid to spoil the good mood of the others. They find it difficult to concentrate thus they cannot sit through a movie, a play or a concert, and reading exhausts them. They underrate themselves very much, and for this reason they are ashamed to mix in with people, they avoid meeting their friends. They are afraid of failure, so they avoid their favourite, but at the same time challenging, activities, such as cooking, sports, hiking, dancing, and arts. Experience has shown, however, that if they, nevertheless, force these activities on themselves, their bad mood may temporarily cease.

Prior to starting to assess these activities, it is important to keep it in mind that depression is an illness, and it is not because they are lazy that patients do not perform these activities. It is important to emphasise throughout the assessment that we understand that from a subjective point of view how burdensome and tormenting it is for them to enter into these activities. We should avoid using a moralizing tone! We should not, for example, say such things as: "You should really pull yourself together!"

Let us collect into a chart those routine and joyful activities that the patient has abandoned since the beginning of his depression. Then it is worth collecting such joyful activities which he had previously desired, but has not yet mustered up enough courage to realize them. Then choosing from this list, let us fashion a weekly action-plan.

V./4.4.2. Creating a weekly action plan

The fashioning of the weekly action-plan should be entrusted to the patient, since he knows best what he will be able to perform in his condition. If patients suffering from depression are confronted with a gamut of difficult tasks, which they cannot fulfil, the result is counterproductive and may further impair their self-esteem.

Since their self-esteem is very low and they feel enfeebled and dispirited they tend to take upon themselves too little and in this case we have to motivate them to take something on. The optimal balance should be found between these two. It is felicitous to involve a relative chosen by the patients themselves in this work, and discuss these aspects with him.

V./4.4.3. Executing actions

The patient executes in his home the tasks written down in his schedule. We ask him to keep a diary about the execution of the tasks. We ask him to write down how he felt prior to the execution of the task. He should make a three-column assessment before the commencement of the task, then assess the task and his mood again, subsequent to the execution.

V./4.3.4. Discussing results

In the course of the discussion of the results of the past week, we review the diary. We affirm the successes and discuss the fiascos. When discussing the fiascos we have to make clear whether the patient indeed was unsuccessful in the completion of the task, or it is just his cognitive schemata that distort the reality. In the former case we prompt the patient through a problem-solving conversation to work out a better strategy; in the latter case we help in questioning the negative thoughts, and work out a more balanced assessment of the situation together with him. If he failed to complete the set tasks because he did not feel like it, then first we have to admit sympathetically that it really must be very hard to set out to do the tasks half-heartedly, then we have to discuss it again why there still is sense in doing it, even if he feels insufficient inclination for it.

V./4.5. Developing new attention distracting skills

One of the characteristics of the cognitive functioning of people suffering from depression is that they usually direct their attention to the negative aspects of their lives, and they ignore those things that are valuable in their lives. This kind of cognitive style preserves and intensifies their bad mood. If, however, they make an effort, they are able to recall positive things from the past, and even to recognise them in the present. With regular practise this new skill of directing their attention may become automatic and improve their moods.

V./4.5.1. Discussing the positive aspects of life

Discuss with the patient what positive things happened to him and what valuable things he did the past week. In the course of the discussion it is worth revising the list of previously discussed logical fallacies, because due to the “all-or-nothing way of thinking” or the “disqualification of positive things” the value of the already occurring positive things may become questioned again. With a regular discussion of the positive events we provide a model for the patient, how to value even minor successes.

V./4.5.2. Diary of positive events

Keeping a regular diary can also be of assistance for the patient in making a daily effort to direct his attention to the good things that have happened that day. The regular recording of these things and browsing through them from time to time

	creates a more balanced image of the world and of himself. The activities that have been completed each day are recorded in the activity-diary, and each activity is evaluated in terms of the achievement and the joy caused by the activity.
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