eSantéMentale.ca

Behavioural Activation for Depression: Information for Primary Care

Image credit: Adobe Stock

Sommaire : A common recommended therapy for depression is CBT (cognitive behavioural therapy.) It is often difficult to find professionals offering this type of approach or the cost of such a treatment is unaffordable. Fortunately, a brief behavioural treatment, behavioural activation (BA), has been shown just as effective for treating depression, and can be easily used in a primary care setting.

Case

You are seeing a 35-yr female with symptoms of depression. Your locum saw the patient last month and has made a diagnosis of depression already, and started the patient on an SSRI, and she is on the 3-6 month wait list to see a counselor/therapist. You learn that she was previously an active person but now spends most of her time at home and has withdrawn from friends and family.

Your patient asks you: “So I’m depressed and I’m on medications. Is there anything else you can recommend?”

You only have 20-minutes for your visit… What are you going to recommend?

Introduction

During the brief time that is available during a typical primary care encounter, it can seem challenging supporting a patient with depression.

Fortunately, recent clinical trials studies show that a brief behavioural treatment, behavioural activation (BA), is effective for treating depression when delivered in a primary care setting (Richards et al., 2008.)

What is Behavioural Activation?

BA was developed in the 1970’s. It is based on the theory that depression occurs when people lack positive reinforcement in their lives. When people become depressed, they tend to withdraw activities which bring them a sense of enjoyment or sense of accomplishment. The more a person withdraws, the worse their mood and the more they are likely to withdraw. This is the “vicious cycle” of depression. For mental wellness, people need a connection to people, things and activities that give them a sense of purpose, belonging, hope and meaning (First Nations Mental Wellness Continuum Framework, 2014).

Behavioural activation is the “B” from CBT (cognitive behaviour therapy). It is a stand alone treatment that predates the development of CBT and is also a component of CBT for depression. Cognitive strategies (“C”) may

not be necessary and have no added benefit for many patients (Jacobson et al, 2001).

In other words, for most patients (but not necessarily all patients), it is not necessary to focus on identifying and changing unhelpful thoughts.

Not only is providing behavioural activation more efficient and cost effective than providing full CBT, behavioural activation strategies can also be more easily used within the 15-20 minute primary care encounter.

Principles of Behavioural Activation

As mood lowers, patients engage in a range of activities in an effort to cope with being overwhelmed:

- Neglecting basic self care
- Avoiding housework, paying bills
- Spending more time in bed
- Withdrawing from friends and family
- Missing work
- Stopping exercise or usual hobbies
- Spending less time outdoors in nature
- Ruminating about problems or deficiencies in themselves
- Engaging in numbing activities, e.g watching TV, playing video games, surfing the net
- Consuming more alcohol than usual, using illicit drugs, using more benzodiazepines

Unfortunately, these short-term coping strategies are not helpful, and may inadvertently worsen the depression.

BA aims to help patients understand that the stresses of life can cause anyone to slip into a vicious cycle of depression and to help them gradually re-engage with activities that bring them a sense of purpose, hope, belonging and meaning, or enjoyment and pleasure. This is done in a gradual systematic way guided by key BA principles.

- Help people understand that changing what they do will help them feel better.
- Recognize the short-term coping strategies that may be keeping them stuck
- Change is easier when starting small
- Emphasize a problem-solving approach
- Act according to a plan and not a feeling

Steps to Behavioural Activation in Primary Care

Initial visit

1. Establish a safe therapeutic setting with sensitivity to the shame and self-recrimination that often comes with depression

2. Elicit the history of depression

- Life stresses that led to the depression
- Behaviour changes since the drop in mood.

3. Explain link between stress, withdrawal from usual activities and depression.

4. Provide rationale for behavior activation

- Clinician: “A drop in mood is an understandable reaction to life stresses. The human brain is “wired” to retreat or avoid when in pain or feeling low and this can inadvertently maintain the depression. We often stop doing activities that bring us a sense of accomplishment or enjoyment, or activities that make life meaningful to us. The less we do these things, the worse we feel and we get caught in a vicious cycle of depression. Does this fit with your experience?
- Patient: “It does, it makes sense.”

- Clinician: There is good evidence now that by gradually resuming some of the activities you have stopped can be as powerful as medication or an essential add-on to medication for treating depression. What do you think of that?
- Patient: “Sounds easier said than done..”
- Clinician: “You are right. It is easier said than done. While getting starting it can help have some coaching. I could make myself available to meet you for 4-6 appointments to help you begin to break this vicious cycle of depression.
- Patient: ”Yes but I do not think it will help”
- Clinician: “ Good. I look forward to working together on this. I am not surprised to hear that you have your doubts. Part of depression is feeling quite hopeless. Your openness to trying it out is a key attitude for behavioural activation”.
- Patient: “I will try.”
- Clinician: “We covered a lot today so could we end today with two things: 1) could we right out together the key points from today so can add to them at home and 2) If there was one small step to tackling this depression what would it be? Would you like to test it out?”

5. Develop therapeutic alliance by first agreeing on goals

- Behavioural activation will not work if the patient does not agree with the clinician’s goals, nor if the patient feels pressured or coerced

Example I.

- Clinician: “Based on what I am hearing, the stress of work and the holiday time has led to a drop in mood and you have stopped doing some of the things you used to do that helped keep your mood better. Does that fit with what your are experiencing?. , it sounds like you have symptoms of depression. The good news, is that I can work with you and find a way to help your mood get better. How does that sound to you?”
- Patient: “Yes, that’s what I want.”
- Clinician: “What would your goal be, in your words?”
- Patient: “I just want to feel better again.”
- Clinician: “So if you were feeling better, what’s one activity or thing that you’d be doing differently?”
- Patient: “Well, I guess I’d be going to bed earlier rather than binge watching videos…”
- Clinician: “Okay, how’s this then… Let’s work together to help get your sleep better, for example by getting to bed earlier.”

Example II - Sleep

- Patient: “I know I need to get better sleep.”
- Clinician: “Sounds good. Let’s work on a plan to help you get better sleep. What time do you need to wake up the next morning? ”
- Patient: “7 AM would be good.”
- Clinician: “Okay, so in order to get the average 9-10 hrs that people need, you’d need to be in bed by 9-10 PM… How does that sound?”
- Patient: “Yeah, sounds about right.”
- Clinician: “So what do we need to do so that you can get to sleep by 9-10 PM?”
- Patient: “By 9 PM, I should probably brush my teeth, take a shower put on my pajamas, and then get into bed …”
- Clinician: “Any other key things we should cover?”
- Patient: “No, if I can just start my bedtime routine by 9 PM rather than keep watching TV, I know it should make a difference.”
- Clinician: “Okay, sounds good. Let’s write all these key steps down then and we’ll see how it goes.”

Example III - Outdoor physical activity

- Patient: “I know I should probably get outside more.”
- Clinician: “That sounds excellent. Studies show that nature is therapeutic. In fact, just getting outside also gets us more physically active, which is healthy as well. What type of outdoor activity would you like to do more regularly?”

- Patient: “Probably if I just walked the dog outside every day I know that’d be better for me and the dog… Right now, I’m lucky if every few days I walk the dog.”
- Clinician: “Okay, so I hear that you’d like to get outside everyday and walk the dog. What would be a reasonable goal for us to set every day that?”
- Patient: “Maybe if I walked after dinner for 15 minutes?”
- Clinician: “At the moment, you’re walking maybe every few days. And so you’d like to set a goal for a daily walk of 15 minutes after dinner?”
- Patient: “Yeah, I think I should be able to do that.”
- Clinician: “Okay, let’s write that down, and try that out then.”

Follow-up visits

1. Review progress on goals

- Review progress on goals
    - Clinician: “When we last met you decided to try out an earlier bedtime routine to see if that would help your sleep. How did that go?
    - Clinician: “You had set a goal for yourself for walking the dog 15 minutes after dinner to begin to get more active again, what did you learn from that experiment?

2. Collaborate with the patient to identify lists of routine, pleasurable and necessary activities.

- Asking about activities that have been stopped because of the depression
- Find out if there are any particular therapeutic lifestyle changes that the patient would like to start with (see list below)
- If the patient is unable to come up with some healthy activities, then offer suggestions for developing the three lists.
- Clinician:
    - “Let’s run through your typical day before the depression began what would you typically do in the morning, afternoons and evenings?”
    - “What were some of the routine activities (washing up, eating, cleaning house)
    - “What were some activities that brought you pleasure, a sense of meaning (going out with friends, helping out an elderly neighbour)”
    - “What were some of the necessary activities (paying bills, confronting a difficult situation at work)”
- Sample lists:
    - List of routine activities
        - Eat breakfast
        - Get dressed
        - Tidy house
        - Buy groceries
        - Walk dog
    - List of pleasurable/meaningful activities
        - Call best friend,
        - Colour pictures with children
        - Volunteer at community center
        - Do yoga video
    - List necessary activities
        - Pay bills
        - Call for specialist appointment
        - Call insurance company to get form
        - Gather papers for taxes
        - Prepare resume

3. Structure the three lists (routine, pleasure and necessary) into a hierarchy.

- Work with patient to identify the most difficult routine activity first and put it at the top of the hierarchy. Then the easiest is placed at the bottom. A third activity is then placed roughly halfway between the two in terms of difficulty. Repeat this process for the pleasurable and necessary activities.
- Sample hierarchy:
    - Most difficult
    - Prepare resume
    - Tidy house
    - Do volunteer work
- Medium difficulty
    - Buy groceries
    - Get dressed
    - Call best friend
    - Do yoga video
    - Call specialist for appointment
    - Gather papers for taxes
- Easiest
    - Eat breakfast
    - Colour pictures with children
    - Call insurance company to get form
    - Pay bills
    - Walk dog

4. Plan some routine, pleasurable and necessary activities.

- Patients schedule some activities from near the bottom of the hierarchy.
- Ensure planned activities are reasonable and small initially
- Rather than “try some activities this week”, encourage patient to write down specific activities and specify exactly when they will do them.
- Activities should be a mixture of routine, pleasurable, and necessary.
- Remind patient that they may not accomplish all of their goals and that this is normal and will provide you both with important information for future planning next time you meet.

5. Reinforce positive behavior change

- If the patient has been successful for meeting goals, then provide positive feedback and reinforce the change, for example:
- Example
    - Clinician: “How do you feel about being able to accomplish the activities you set out for yourself last time we met?”
    - Patient: “My mood is not really better but I guess I am glad to have those things done.
    - Clinician:”We would not expect your mood to improve so quickly, however, how do you imagine you would have felt today if you had not managed to get those two activities you planned done?”
    - Patient: “Probably worse.
    - Clinician: “So thanks to your efforts since we last met, you have learnt something really important about tackling depression - that is by planning specific reasonable activities that have been important to you in the past you begin to gain a sense of accomplishment again. That is wonderful! I am so happy for you!”

6. If goals have not been attained, then re-adjust as necessary

- Adopt a curious, problem solving attitude if the patient has not been able to complete the goals they set out for themselves.
- Consider reducing the number of activities or breaking the task down into smaller steps
- Trying to do too much too soon is a common problem in BA
- Sometimes enlisting the help of a trusted friend or family member to get some of the activities done can

help also.
- Use empathy and validation that it can be challenging; avoid using blame or guilt, as that leads to people feeling more stressed, which usually makes it less likely they will succeed with their goals
- For example:
    - Clinician: “I’m so sorry to hear that it was hard meeting that goal you had set. What obstacles got in the way of that goal?”
    - Patient: “I know we had talked about getting to bed every night by 9 PM, but I’d be watching movies on my cellphone, and before you’d know it, it’d be 10 PM!”
    - Clinician: “So I’m hearing from you that it's really hard to put down that cellphone!”
    - Patient: “Yeah -- I know I’m probably addicted to my cell phone, like everyone else is these days!”
    - Clinician: “Anything that you could do to make sure you put your cellphone down by 9 PM?”
    - Patient: “Well, I guess I could set an alert for 9 PM for me to put the devices away…”
    - Clinician: “Okay, then let’s try that. Any other things we might try?”
    - Patient: “No that sounds fine to me!”

Therapeutic Lifestyle Changes

What are some of the healthy behaviours that might try to encourage your patients to do?

The positive mental health and resiliency literature supports eight main therapeutic activities for mental (and physical) health (Walsh, 2011):

1. Relationships

    - Spend quality time with loved ones, for example:
    - Let them know that most of the time, what you need for emotional support is simply someone to listen and validate your feelings (as opposed to someone giving you advice and judgement).
    - Family dinners
    - Walks with family/friends
    - Sharing a meal or a (non-alcoholic) drink with family/friends

2. Sleep

    - Ensure that you sleep at least 9-11 hrs a day

3. Exercise

    - At least 30-minutes a day of aerobic exercise (e.g. walking)

4. Nutrition and diet:

    - Ensure a well balanced diet consistent with Canada’s Food Guide recommendations, and that:
    - Mostly consists of multicolored fruits and vegetables (“rainbow diet”)
    - Get enough omega 3 fatty acids, e.g. consume fish, or vegetable sources such as flax seeds
    - Reduces excessive calories
    - Reducing processed foods
    - Reducing soft drinks
    - Reducing animal fats

5. Nature

    - Spend more time in nature. The exact time is uncertain, but studies on eye health suggests that humans need at least 10 hrs / week (i.e. at least 1-hr daily outside).

4. Reduce overuse of technology

    - Do not let devices replace human contact or contact with nature

- Limit recreational screen time, e.g. watching movies / TV

5. Recreation

   - Ensure that there are enjoyable and pleasurable activities that may be:
   - Fun and humour, e.g. watching or listening comedy
   - Creative, e.g. art, music, dance, reading
   - Games and sports

6. Relaxation and stress management

   - Ensure that you have ways to relax and manage stress levels. Modern society is stressful, and it is thus important to have practices such as relaxation, meditation, deep breathing or mindfulness to help cope with stress

7. Religious and spiritual involvement

   - Find a way to feel deep connection and meaning to other people, the world and the universe. This might involve religious practices such as belonging to a Church, or it might be contemplative practices such as meditation, or spending time in nature.

8. Contribution and service to others.

   - Be helpful and contribute to others. This can range from simply doing good deeds for others (e.g. helping someone with their household chores such as cooking, groceries or laundry), or volunteer work, or other work.

Case, Part 2

You are seeing your 35-yo patient with symptoms of depression. She is a bit disappointed that the locum only focused on medications. She asks you, “Is there anything else you can recommend other than just medications?”

You validate her goal of wanting to feel better, and that she wants more than simply take medication. You ask her what other things she might want to try for her depression… She reports that low energy and feeling tired is her biggest complaint, and with your support, she agrees that it would be helpful to get more sleep. She acknowledges that she has trouble putting away her electronics and that this is what keeps her up at night. She comes up with the idea whereby at 9 PM, she will put her device in a bowl in the bathroom, away from her bed. She will also go to the library and get some library books and relaxation CDs, as other strategies to relax her brain at night.

She leaves your office, feeling good that her regular family physician is a “holistic” doctor…

References

Bilsker, B., Patterson R. (2009).Antidepressant Skills Workbook. Retrieved from http://www.comh.ca/antidepressant-skills/adult/

Dimidjian, S., Hollon, S. D., Dobson, K. S., et al. (2006) Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. Journal of Consulting and Clinical Psychology, 74, 658–670.

Health Canada and Assembly of First Nations (2014). First Nations Mental Wellness Continuum Framework.

Jacobson N et al. (2001): Behavioural Activation Treatment for Depression: Returning To Contextual Roots, Clin. Psychol. Science and Practice, 8(3): 255-270.

Walsh, R. (2011) Lifestyle and Mental Health. American Psychologist, 66(7): 579-592.

About this Document

Written by Dr’s Michael Cheng, Psychiatrist, uOttawa; Douglas Green, Psychiatrist, uOttawa; Jeanne Talbot, Psychiatrist, uOttawa, Royal Ottawa Mental Health Centre.

Reviewed by members of the eMentalHealth.ca Primary Care Team, which includes Drs. Mireille St-Jean (Family Physician, Ottawa Hospital), Eric Wooltorton (Family Physician, Ottawa Hospital), Farhad Motamedi (Family Physician, Ottawa Hospital) and Dr. Michael Cheng (Psychiatrist, Children’s Hospital of Eastern Ontario).

Disclaimer

Information in this pamphlet is offered ‘as is' and is meant only to provide general information that supplements, but does not replace the information from your health provider. Always contact a qualified health professional for further information in your specific situation or circumstance.

Creative Commons License