REVIEW ARTICLE

Self-Management of Depression: Beyond the Medical Model

Harpreet S Duggal, MD, FAPA[1]

Perm J 2019;23:18-295

E-pub: 05/31/2019

https://doi.org/10.7812/TPP/18-295

ABSTRACT

Self-management is increasingly becoming the standard of care among people with chronic medical conditions. Its application to depression is mostly extrapolated from the paradigms used for nonpsychiatric medical illnesses. Such an approach falls short in addressing strength-based interventions that foster recovery in individuals with depression. This article describes a new paradigm of self-management, which is in line with the recovery model, is patient-centered, and goes beyond amelioration of clinical symptoms.

INTRODUCTION

During the last 2 decades, as chronic diseases have increased owing to an aging population, health care delivery systems have developed evidence-based self-management programs to cater to these needs. Most of these programs have involved patients with medical conditions such as hypertension, congestive heart failure, diabetes, arthritis, and asthma. Self-management programs for these medical illnesses have been extensively studied and transformed into best practices, but self-management for depression has still lagged behind. Most self-management strategies currently being used in depression are an extrapolation of the Chronic Disease Self-Management Program (CDSMP).[1] Although 25% of individuals with chronic illnesses may have concurrent depression,[2] most self-management medical programs give mental health only a superficial treatment under the rubric of "dealing with psychological issues." However, depression, with its myriad presentations, cannot be treated by such one-size-fits-all programs, which, although moving away from a paternalistic health care model, are still mostly prescriptive in nature.

When I see patients seeking help for depression, more often than not, their primary reason for seeing me is, "Doc, I want to be happy," or "I want to be able to enjoy life." Being trained as a physician, I practice the medical model, which emphasizes finding what is not working and fixing it. Thus, when my patients ask me how they can feel happy again, I find myself redirecting the conversation to why they are feeling *depressed*. Regrettably, the focus of traditional psychotherapies and self-management programs has been on mitigating deficits, disorders, symptoms, syndromes, weaknesses, and vulnerabilities. This is not surprising given the fact that negatives are more pervasive and potent than positives and for 1 positive emotional term, there are 10 negatives.[3] However, this deficit-based medical model has 3 major shortcomings[3,4]:

1. It incorrectly assumes that only "symptoms" must be treated, and any positives are byproducts of treating the negatives
2. It fosters labeling of psychological distress into discrete disorders, which is not undesirable but robs an individual of his/her rich complexity
3. It does not necessarily enhance well-being or happiness. Research has shown that absence of psychological distress is not equivalent to presence of well-being.[5]

I have faced these shortcomings of the medical model when helping individuals with depression. I use medications and evidence-based psychotherapies such as cognitive behavioral therapy (CBT) to treat depression. These treatments are successful in ameliorating depression in most of my patients. However, I still grapple with the question, "Are these individuals happy or, as one would say in the positive psychology lingo, flourishing?" Put in real-life terms, not having clinical depression does not automatically guarantee that one is having a meaningful life along with the ability to enjoy things and have positive relationships. This is where evidence-based self-management strategies based on a person's preferences and values provide a useful adjunct to traditional treatments. Self-management of mental illnesses in the context of recovery is a recent paradigm shift, which differentiates this approach from the traditional medicalized self-management paradigm. This approach is the focus of this article.

WHAT IS SELF-MANAGEMENT?

Before we delve into what self-management in the context of recovery looks like, it is prudent to first review what self-management actually means. *Self-management* refers to the use of self-regulation skills to manage chronic conditions or risk factors for these conditions. The *processes* involved in self-management generally include tasks such as goal setting, self-monitoring, decision making, problem solving, planning for and engaging in specific behaviors, self-evaluation, and management of physical, emotional, and cognitive responses associated with health behavior change.[6] The *goals* of self-management are to have individuals with chronic illnesses recognize the signs of deteriorating health status, plan actions to take when they see signs of relapse, and know what resources are available and how to access them.[7]

When it comes to self-management of depression, the grim reality is that most of the evidence-based treatments still focus on treating acute episodes of depression, either with medications or with individual and/or group psychotherapy. This "self-help" approach runs contrary to the current conceptualization of depression being a chronic illness, with up to 35% of people with depression having a chronic long-term course.[8] According to a study that followed individuals with depression over 25 years, more than 80% of individuals experienced recurrent depression.[9] The high rates of relapse and/or chronicity in many individuals with depression has led to recommendations for maintenance treatment of 2 or more years for chronic depression.[10]

Author Affiliations

[1] Department of Psychiatry, Walnut Creek Medical Center, CA

Corresponding Author

Harpreet S Duggal, MD, FAPA (harpreet.s.duggal@kp.org)

Keywords: behavioral health, depression, lifestyle medicine, mental illness management

A distinction must be drawn between self-help and self-management. Most of the self-help approaches for treating depression are repackaging of techniques based on CBT and are geared toward treating *acute* symptoms of depression. In contrast, self-management involves learning new ways to *manage* an illness during a longer period. Lorig and colleagues[11] further elaborate on self-management: It is a "management style" wherein one is a positive self-manager who not only uses the best treatments provided by health care professionals but also approaches one's illness in a proactive manner on a daily basis, leading to a healthier life. Self-management teaches skills that continue to work above and beyond the short-term relief that may be gained from self-help strategies. To illustrate this, let us consider diabetes as an example. Good self-managers of diabetes, besides taking medications, educate themselves about diabetes, learn to recognize symptoms of low or high blood glucose (sugar), monitor their blood sugar levels regularly, eat healthy and avoid foods that may destabilize their diabetes, exercise to maintain their weight, and seek professional help if their blood sugar levels are staying above or below the normal range. People with diabetes, heart disease, emphysema, asthma, and other long-standing medical conditions have successfully used self-management to live a healthy life. Unfortunately, the treatment of depression is still catching up with incorporating the concept of self-management, even though approximately 1 in 3 people with depression have a chronic course.

Key components of self-management are highlighted in Table 1, although the list is not exhaustive.[12,13] As can be gleaned from this list, most of the prevalent paradigms of treating depression are devoid of a majority of these components of self-management. Being able to self-manage depression, a disease that can make one feel powerless, fosters a sense of empowerment, enhances confidence, and gives one a sense of control in dealing with one's illness. Enhancing *self-efficacy,* that is, the ability to successfully perform a task or specific behavior or change one's state of mind, is the driving force behind the self-management construct.[14]

NEED FOR SELF-MANAGEMENT IN DEPRESSION

Our current understanding of depression is that it results from a complex interplay of biological and environmental risk factors. Unfortunately, the modern conceptualization of depression has been skewed by popular media into making people believe that it is purely a "chemical imbalance" that must be fixed by taking medications that "restore the imbalance." This has led to a misperception that antidepressants are the be-all and end-all of depression treatment. Here is a fact check. The response rate of antidepressants (eg, 50% decrease in depressive symptoms compared with baseline) is approximately 54%, and that for a placebo is around 37%.[15] The remission rate, which is now considered the goal for antidepressants, also presents a sobering picture, with only 37% individuals with depression remitting after the first trial of an antidepressant and subsequent rates of remission being lower with later treatment steps.[16] Evidence-based psychotherapies for depression such as CBT are as efficacious as medications for treating depression, but this efficacy also depends on the adequacy of therapy implementation and the competence of the therapist.[17] This is not to suggest that antidepressant medication or CBT is not an effective way to treat depression and that people quit taking antidepressants or stop seeing their therapist. It does, however, indicate that antidepressants and existing depression-focused psychotherapies are far from being the optimal treatment of depression. This is where self-management strategies complement the existing approaches to treat depression by boosting an individual's sense of well-being.

Table 1. Components of self-management of depression[a]

Component	Tasks
Information	Educating self and family members/friends about depression
Medication management	Taking medications as recommended by one's health care provider
	Overcoming barriers to adherence to medications
Symptom management	Using various strategies to manage symptoms of depression
	Self-monitoring of symptoms
	Managing concurrent symptoms of anxiety and/or substance use
	Using techniques to deal with frustration, fatigue, and isolation
	Managing sleep
	Managing symptoms of medical conditions associated with depression
	Relaxation
	Using strategies for preventing relapse of depression
Lifestyle	Exercise
	Overcoming barriers to exercise adherence
	Vacations
	Leisure activities
	Healthy nutrition and diet
Social support	Family support
	Relationships with peers and friends
Communication	Assertiveness
	Communication strategies (eg, with mental health professionals)
Others	Accessing support services
	Creating action plans
	Decision making
	Goal setting
	Problem solving
	Career planning
	Spirituality

[a] Adapted from: Barlow et al[12] and Duggal.[13]

Depression differs from other chronic illnesses because of the associated social stigma and its effect on one's self-esteem and identity. Core symptoms in depression include loss of interest, low motivation, and low energy levels, which are more pronounced compared with other medical conditions. Thus, whether general interventions of self-management like those used in the CDSMP are applicable to depression, is questionable.[7] Evidence also shows that given a choice between antidepressants and psychotherapy, people with depression prefer psychotherapy because they assume that it provides them with an opportunity for personal exchange and to solve the problem underlying the depression.[18] Self-management also assumes importance in the context of recovery. The concept of recovery in mental health has expanded beyond the narrow definition of absence of clinical symptoms to include the following[19,20]:

- hope for the future
- reestablishment of a positive identity
- establishment of personal meaningful goals
- taking responsibility for one's life
- feeling included and connected to others
- feeling empowered
- contributing to community life.

Established treatments of depression may help an individual meet the clinical cutoff for remission from depression on rating scales, but recovery still remains a person-centered paradigm. This is where self-management techniques complement the traditional medical model of treating depression. Finally, self-management could be used as a prophylactic strategy in individuals with a high risk of developing depression or those who have had previous episodes of depression to prevent onset, recurrence, or relapse of depression.[21]

EFFECTIVENESS OF SELF-MANAGEMENT IN DEPRESSION

Depression has been a late entrant in the field of self-management. Most of the initial studies on self-management focused on medical illnesses and, interestingly, studied depression as an outcome measure under the general rubric of psychological well-being. A landmark study on the CDSMP showed that although the program was successful in increasing healthful behaviors, maintaining or improving health status, and decreasing rates of hospitalization, a noteworthy negative finding was that there was no change in psychological well-being compared with the control group.[22] A later study with a pre-post longitudinal design and lacking a control group documented the CDSMP being effective in decreasing depression when individuals were reassessed after 6 months.[23] A review of the literature on self-management for people with chronic conditions reported that it is effective in managing depression, but the review included only 1 study on depression.[12] A meta-analysis of "disease management programs" for depression demonstrated decrease in severity of depression, better adherence with treatment, and greater provider and patient satisfaction compared with usual primary care.[24]

Self-management is one of the core components of the collaborative Chronic Care Model (CCM), and CCM has been studied in people with depression. Several meta-analyses have shown CCM to be an effective intervention in improving depression outcomes across a wide variety of settings, with an effect size ranging from 0.25 to 0.31.[25-27] The benefit of this intervention, in some studies, lasted up to 5 years. To put this in perspective, the effect size of antidepressants in reducing depressive symptoms compared with placebo is 0.32.[28] A notable finding that emerged from 1 of the meta-analyses was that CCM may benefit people with moderate to severe depression more compared with those with mild depression.[27] When it comes to individuals with depression with comorbid chronic physical conditions, CCM is as effective in these individuals as in those without comorbid physical conditions.[29] This has put an end to the speculation that self-management strategies based on the CCM model are more effective when used for treating depression in the context of chronic medical illnesses in a primary care setting.

Besides programs that are facilitated by mental health professionals, there is an increasing impetus on trained peer specialists co-leading self-management programs. Compared with a professionally led group, a peer-led group is more likely to enhance an individual's sense of self-efficacy.[30] A randomized controlled trial studying individuals with chronic depression demonstrated that a self-management program co-led by peer specialists resulted in decreased depression and higher recovery scores.[31] Contemporary research shows that peer support increases an individual's engagement in nonacute and less costly care; activates them for self-care; decreases substance use, unmet needs, and demoralization; and increases hope, empowerment, social functioning, quality of life, and satisfaction with life.[32]

Although research has historically focused on self-management of depression from a chronic medical disease perspective, there are self-management programs that address depression per se outside a medical context. One such program is the Depression Self-Management Workshop, a community-based group program with 10 weekly sessions that are nonprescriptive in nature and emphasize participants' own strengths in their own recovery. In a pre-post design study without a control group, the Depression Self-Management Workshop significantly decreased depressive symptoms and improved self-efficacy and self-management behaviors in individuals with depression.[33] An important finding from this study was that most participants in this study were already being treated with antidepressants and had a history of having more than 1 episode of depression. This finding makes this intervention a viable option as an adjunct to antidepressants in individuals with recurrent depression.

Whereas most evidence points toward the effectiveness of self-management in improving outcomes in depression, some studies have not shown such positive results.[34,35] These, however, were pilot studies with small sample sizes.

FACTORS INFLUENCING SELF-MANAGEMENT

On the basis of structured models of self-management such as the CDSMP, it is tempting to think that such programs are homogenous and would benefit anyone with depression. Research shows otherwise. Self-management is not a

one-size-fits-all intervention, and its effectiveness depends of several variables. Some of the key variables are listed in Table 2.[36,37] Implicit in these factors are also the potential barriers to self-management, including at the patient, provider, and organizational levels. Also, it would be prudent to list factors that do *not* influence outcomes of a self-management program. The prominent ones in this category include system and clinic setting, disorder/diagnosis (depression vs other chronic medical illnesses), age, sex, minority status, and country where self-management is practiced.[27] This suggests that self-management is not only an evidence-based but also a population-based intervention with broader public health implications.

SELF-MANAGEMENT IN CONTEXT OF RECOVERY

What is Recovery?

Now more than ever, a multifaceted humanistic approach to recovery is front and center of patient-centered treatment in mental health. Recovery is not an elusive feel-good concept, as some skeptics might claim. Researchers have broken down recovery into 5 broad dimensions[38]:

1. *Clinical* recovery: This includes symptom management, medical care, medication management, and psychotherapy
2. *Existential* recovery: This includes religion and spirituality, self-efficacy, personal goals and hope, and personal empowerment
3. *Functional* recovery: The 3 main components of functional recovery are employment, housing, and education
4. *Physical* recovery: Physical recovery refers to positive improvement in physical health and well-being. It is known that depression is associated with an increased risk of metabolic syndrome, which in part, may be related to unhealthy diet and lack of physical activity.[39] In addition, physical recovery also involves recovering from the physical ill effects of any comorbid substance use disorders
5. *Social* recovery: Recovery from depression is incomplete without recovery in the interpersonal and community arena. Social recovery involves establishing and maintaining rewarding relationships with family, friends, peers, and significant others. It also involves engaging in rewarding social activities (eg, sports), actual and felt community integration, and active citizenship.

Clearly, recovery is more than just swallowing pills and changing one's biochemistry. It is changing one's life and requires hard work, strong will, vision, hope, courage, imagination, commitment, and resilience.

Self-Management and Dimensions of Recovery

In their quest to align self-management strategies to the currently prevailing concept of recovery, some investigators have identified individual strategies that target each of the 5 dimensions of recovery.[40] Although listing all these techniques would be beyond the scope of this article, some key interventions are highlighted in Table 3. A review of various self-management strategies used by people with depression identified that the most helpful strategies included those that fostered an increase in physical activity and engagement in mental health treatment.[41]

Table 2. Factors influencing self-management

Domain	Factors
Personal/lifestyle characteristics	Individual's level of knowledge about his/her health condition, symptom management, medication management, and alternative therapy
	Health and cultural beliefs
	Perception of stigma related to mental health issues
	Level of self-efficacy and hope to self-manage
	Availability of time to use self-management skills
	Prior experience with self-management
	Ability to integrate lifestyle and treatment-related behaviors into everyday life
Health status	Comorbid conditions (eg, anxiety, substance use, personality disorders, chronic medical conditions)
	Severity of depression
	History of prior good or poor response or adverse effects with interventions
	Cognitive ability to problem-solve
Resources	Financial (eg, funding for self-management programs, insurance coverage for self-management programs)
	Psychosocial (eg, perceived support or lack thereof from family, friends, or peers and access to support or peer groups)
	Internet-based resources (eg, online peer support groups)
Environmental characteristics	Conditions at home (eg, perception of family members about an individual's mental illness, health problems of other family members)
	Conditions at work (eg, support of employers and coworkers, time and schedule constraints imposed by work)
	Community (eg, transportation, social stigma, access to places that facilitate self-management such as a gym)
Health care system	Access to a health care system that promotes self-management
	Time constraints for providers to use self-management tools
	Availability of trained staff to run the self-management programs
	Ease of navigating the health care system (eg, long wait times, confusing communication with staff)
	Relationship with providers (eg, collaborative approach with shared decision making)

Table 3. Self-management strategies in recovery

Domain	Goals	Strategies
Social	Surround yourself with people who make you feel better	Get support from friends, family, and people with a similar illness
		Engage in activities with others
		Choose the people with whom you can discuss problems
		Avoid negative people or unhealthy relationships
	Take care of others	Serve as a role model for friends and family
		Recognize the support received
		Serve others
Existential	Have a positive outlook	Take inspiration from someone who has recovered
		Take stock of your own progress with recovery
		Use downward social comparison
		Reminisce about times of wellness
		Use humor
		Have spiritual beliefs
		See the illness as an opportunity to make some changes
		Read or post inspiring thoughts/images
		Appreciate positive aspects of your life
	Develop a balanced sense of self	Recognize and value strengths/achievements
		Accept the illness
		See mental illness as equivalent to a physical illness
		Accept your limitations/weaknesses
	Empower oneself	Realize the efforts required to recover
		Find the motivation needed to recover
		Be more assertive about your needs and expectations
	Find meaning	Have realistic expectations about recovery
		Pursue goals that promote autonomy, competence, and relatedness
		Find meaning in life by clarifying your values
		Find meaning even in adversity and suffering
Functional	Create a routine	Follow a schedule or a daily maintenance plan
		Perform daily personal care tasks
	Take action	Engage in activities that increase pleasure or sense of mastery
		Create an action plan on the basis of realistic, relevant, and measurable goals
		Adopt an important role in society
		Respect your own rhythm as you take action
Physical	Maintain a healthy lifestyle	Be physically active/exercise
		Adopt a good sleep pattern
		Eat well
		Reduce consumption of alcohol
		Stop smoking
	Manage one's energy levels	Avoid stimulating or stressful situations
		Engage in relaxation/breathing exercises
		Reduce hours of work
Clinical	Seek formal professional help	Take your medication and/or continue psychotherapy
		Receive help from a mental health organization
		Seek prompt help in times of crisis
		Receive an alternative treatment
	Develop a better understanding of your illness	Investigate the causes of your illness
		Attend conferences/workshops
		Find information on mental illness
		Learn about available resources
	Manage daily symptoms	Analyze and change your thoughts/emotions/behavior
		Challenge your fears
		Gain some perspective on situations
		Problem-solve
	Prevent relapse	Remain vigilant to signs of a relapse/monitor your moods
		Develop a relapse prevention plan

PROVIDER STRATEGIES TO ENHANCE SELF-MANAGEMENT

What can busy health care providers do to foster self-management in individuals with depression? Before we answer this question, it would be helpful to discuss the analogy cited by Wagner and colleagues[42] that the experience of living with chronic disease is akin to flying a small plane.

> If it [small plane] is flown well, one gets where one wants to go with the exhilaration of mastering a complicated set of challenges. If it is flown badly, one either crashes or lands shakily in the wrong airport, reluctant to ever leave the ground again. The patient must be the pilot, because the other possible pilot, the health care professional, is only in the plane a few hours every year, and this plane rarely touches ground. If chronically ill patients must pilot their planes, then the role of health care is to ensure skilled pilots, safe planes, flight plans that safely get the pilots to their destinations, and air traffic control surveillance to prevent mishaps and keep them on course.[42]

Borrowing from this pilot analogy, as a transient guide, a health care professional has roles, including to

- ensure that a person with depression has the confidence and skills to manage their condition
- offer the most appropriate evidence-based treatments based on an individual's values
- arrive at a mutually understood care plan
- have a plan to carefully follow-up.

The concept of recovery shifts a clinician's attention away from the disease processes and onto the whole person in the life context. Although a provider still pays attention to the pathologic processes, it is hoped that a recovery-driven intervention will foster a mindset that goes beyond the traditional "fix-what's-wrong" approach to "build-what's-strong" approach.[13] The first and foremost strategy to encourage self-management is for the clinicians to change their practice and accept advantages of transferring control to people with depression—a patient-centered approach that incorporates their preferences.

Ask Appropriate Questions

A simple yet effective way by which providers can facilitate self-management in people with depression is to ask appropriate questions.[13,37,43]

Activation Questions

Inherent in depression are fatigue, low energy, loss of interest, and lack of motivation that lead to avoidance and procrastination. This avoidance and procrastination fuels a sense of guilt, which then exacerbates depression. Behavioral activation is an evidence-based strategy that works to break this vicious cycle in depression.[44] This entails having people with depression engage in activities that increase either their sense of pleasure or their feeling of mastery. The following are several questions that will help an individual with depression explore some of these activities:

- "What will you be doing instead when you are no longer feeling so depressed?"
- "What will you be doing differently when you are happy?"
- "Supposing you wake up on a Saturday morning and look back at your week and say, 'Wow, that was a great week.' During a great week, what do you suppose you would be doing?"

These questions help direct a depressed person to switch from negatively stated goals and activities (eg, "I don't want to feel depressed") to positively stated and action-oriented goals.

The Miracle Question

The miracle question goes like this: "Suppose one night, while you are asleep, there is a miracle, and the problem that you are facing is solved. However, because you are asleep, you don't know that the miracle has already happened. When you wake up in the morning, what will be different that will tell you that the miracle has taken place?"

The miracle question helps the patient hone in on the solutions of a problem rather than getting stuck with the assumption that the solution is somehow connected with understanding and eliminating the problem. After the patient responds to the miracle question, you can ask, "What part of the miracle is already happening?"

Scaling Questions

"On a scale of 0 to 10, with 0 being no progress and 10 being that you have met your goal, how would you rate your progress in accomplishing your goal?" If the patient scores more than 0, ask, "How did you get up to this number from 0?" or "How is your score different from 0?" or "What makes your score not lower?" or "How will you know when you move just 1 number higher on this scale?"

The purpose of scaling questions is to amplify strengths, positive differences, and successes, which people with depression tend to disqualify. Doing scaling questions with a patient on an erasable whiteboard in your office and having that person circle the number s/he thinks s/he is at puts the patient in the driver's seat for self-management.

Coping Questions

When bogged down with a problem, people tend to ignore their strengths and the coping skills that they may have used to deal with a similar problem in the past. Ask the patient, "What would your loved ones see you doing now that would tell them that you are being strong and successfully handling this situation?" "What has worked well for you before?"

The Motivation Question

"Are you willing to do whatever it takes to make things better for you/solve this problem/achieve your goals?" You can also have the patient rate his/her motivation using the aforementioned scaling questions.

Exception Questions

When facing a problem or a difficult situation, it is not uncommon for people to make global statements, and depression makes this worse because of irrational thought patterns, such as all-or-none thinking. For example, an individual may say, "I am angry all the time," "I am totally stressed," or "He is never at home." These global statements reflect an inner state of feeling hopeless and out of control. However, no one stays angry 100% of the time, for they would surely be exhausted! In other words, every problem or difficult situation has some exceptions, but one has to look for those exceptions. Ask the patient, "Have there been occasions in the past when you didn't face this problem/felt angry (or any other emotion)?" "What did you do differently at that time?" "Why were you not feeling angry (or any other emotion)?"

The purpose of finding exceptions is to help an individual do more of what has worked well for that person in the past when s/he was not facing a particular

problem. This strategy allows patients to build on their strengths rather than inventing new strategies and also gives them a sense that they are in control more often than they think. Often, counting the minutes, hours, or days when a problem is not happening, makes the problem seem more solvable and less intrusive in life. For example, if a person feels depressed 3 days in a week and for 4 hours each day, it means that only 12 of 168 hours are "depression hours." This gives patients more sense of control over their depression.

Problem Solving

Problem solving is one of the core components of self-management and is also an effective treatment of depression, especially in older adults.[45] The problem-solving steps for the patient are described next.[46,47]

1. Define the problem in clear and specific behavioral terms, that is, what specific behavior needs to be addressed or changed. One is able to generate better solutions for a specific problem such as, "I have been postponing paying my bills for last 2 weeks and feel overwhelmed whenever I try to do that" vs the vague problem, "I cannot get anything done." To get the specifics of a problem, describe it in terms of Who? What? When? Where? Why? and How?
2. Define your goals in addressing the problem. "What is your desired outcome?" Goals are often stated beginning with the phrase, "How can I … ?"
3. Brainstorm possible solutions to the problem. When brainstorming solutions, generate as many solutions as possible, do not analyze or judge the possible solutions at this stage, and think in terms of both broad strategies and focused tactics. However, be aware that when one is feeling depressed, it is a challenge not to prematurely judge a solution negatively because of underlying negative irrational thoughts (eg, "This is never going to work," or "Yes, but …" rejection of a solution). Also, a judgmental stance engendered by depression curbs creative thinking. If the patient is drawing a blank, use the following strategies to stimulate the brain into thinking about more solutions:
   - "Think about an individual you know personally whom you admire and respect or someone from the world of movies, books, or current events. Next, ask yourself, 'How would he or she approach this problem? What actions would this person take if faced with the same problem?'"
   - "Close your eyes and imagine yourself in the problematic situation. Imagine yourself successfully coping with the problem. Think of what you would say and do to deal effectively with the situation."
4. Weigh pros and cons for each solution: "How likely is it that this solution would help you reach your goal?"
   - "What bad things could happen if you pick this solution?"
   - "What is the likelihood that you can implement this solution in its optimal form?"
5. Pick 1 solution and implement it. Sometimes, however, a combination of solutions may work better because they complement each other.
6. Evaluate the effectiveness of your approach and make changes if needed.
7. If the problem is not resolved, use 1 of the following troubleshooting strategies:
   - Reset your goals because they may not be realistic
   - Break the problem down into smaller chunks
   - Think of more possible solutions
   - Seek help from someone who is more knowledgeable or trained to deal with your situation.

Creating an Action Plan

A well-written action plan is key to the success of any self-management program and will help an individual to move from planning to action phase. A template for an action plan is illustrated as follows:

- *Goal:* "SMART" goal: Specific, Measurable, Attainable, Relevant, and Timebound.
- *Action steps:* What steps must be taken to implement the goal?
- *Resources:* What specific supports are needed to implement the action steps?
- *Potential barriers:* What problems would one run into with the action steps (time, cost, scope)?
- *Measures of implementation:* How would a person know that s/he has succeeded in his/her action steps?
- *Deadline:* By when will an individual complete the action steps?

Gratitude Journal

For 1 or 2 nights a week, write down 3 things that went well that day and their causes. Gratitude is one of the most commonly used evidence-based positive psychology practices for treating depression.[48] Interestingly, individuals with chronic medical conditions who are more likely to express gratitude show lower levels of depressive symptoms compared with those who are less likely to express gratitude.[49]

Exploring Your Core Values

Psychologist Russ Harris[50] describes values as our heart's deepest desires for the way we want to interact with the world, other people, and ourselves. They are what we want to stand for in life, how we want to behave, what sort of person we want to be, and what sort of strengths and qualities we want to develop. Values are subjective; what one may consider as a value (eg, being famous) may be considered as being cocky by another person. Below are some questions that you may ask a patient to evaluate his/her values[51]:

- "What do you care most about in life?"
- "What matters most to you?"
- "How do you hope your life will be different a few years from now?"
- "What are the rules you live by?"
- "If you were to write a *mission statement* for your life, describing your goals or purpose in life, what would you write?"
- "If you were to ask your closest friends to tell you what you would live for, what matters most to you, what do you think they would say?"
- "Imagine that you can write anything on your tombstone that says what you stood for in your life. What would you like your tombstone to say if it could be absolutely anything?"

Value-focused questions make an individual aware of the discrepancies between what they are pursuing in their life at present and what they really want their life to stand for. This discrepancy generates the drive and motivation to pursue

goals that are more in line with one's values. Research suggests that goals that are *self-concordant*, that is, representing one's values, lead to the largest degree of enhanced well-being.[52]

CONCLUSION

Self-management empowers people with depression to not only take more responsibility for their own recovery but also to take credit for it. Evidence-based self-management strategies offer an effective tool as an adjunct to traditional treatments of depression, particularly in people with chronic depression. Individuals using self-management have reduced depressive symptoms, lower relapse rates of depression, improved quality of life and psychosocial well-being, better adherence with medications, and a greater sense of self-efficacy (self-confidence in one's abilities).[7]

More research is needed on depression-specific self-management programs, which are recovery-oriented and in line with person-centered goals. In this context, the role of peer specialists—trained and certified peers in recovery—deserves more attention. One such program that is led by peer specialists is Wellness Recovery Action Planning (WRAP). This intervention embodies the recovery principles of participation, personal responsibility, empowerment, self-management, autonomy, and person-centered service and is proved to decrease depressive symptoms compared with treatment as usual.[53] Although this intervention has been widely used in people with severe mental illness across community mental health centers, its use in primary care settings for depression needs more research. ❖

Disclosure Statement

The author receives royalties from Archway Publishing from Simon & Schuster, New York, NY. The author has no other conflicts of interest to disclose.

Acknowledgments

Kathleen Louden, ELS, of Louden Health Communications performed a primary copy edit.

How to Cite this Article

Duggal HS. Self-management of depression: Beyond the medical model. Perm J 2019;23:18-295. DOI: https://doi.org/10.7812/TPP/18-295

References

1. Sobel DS, Lorig KR, Hobbs M. Vohs Award winner-multiple region category: Chronic disease self-management program: From development to dissemination. Perm J 2002 Spring;6(2):15-22. DOI: https://doi.org/10.7812/TPP/02-003.
2. Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: Results from the World Health Surveys. Lancet 2007 Sept 8;370:851-8. DOI: https://doi.org/10.1016/S0140-6736(07)61415-9.
3. Rashid T. Strength-based assessment. In: Joseph S, ed. Positive psychology in practice. 3rd ed. Hoboken, NJ: John Wiley & Sons Inc; 2015:519-42.
4. Rashid T. Positive interventions in clinical practice. J Clin Psychol 2009 May;65(5):461-6. DOI: https://doi.org/10.1002/jclp.20588.
5. Keyes CL. Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. Am Psychol 2007 Feb-Mar;62(2):95-108. DOI: https://doi.org/10.1037/0003-066X.62.2.95.
6. Ryan P, Sawin KJ. The individual and family self-management theory: Background and perspectives on context, process, and outcomes. Nurs Outlook 2009 Jul-Aug;57(4):217-25.e6. DOI: https://doi.org/10.1016/j.outlook.2008.10.004.
7. Houle J, Gascon-Depatie M, Bélanger-Dumontier G, Cardinal C. Depression self-management support: A systematic review. Patient Educ Couns 2013 Jun;91(3):271-9. DOI: https://doi.org/10.1016/j.pec.2013.01.012.
8. Nierenberg AA. Long-term management of chronic depression. J Clin Psychiatry 2001;62(Suppl 6):17-21.
9. Brodaty H, Luscombe G, Peisah C, Anstey K, Andrews G. A 25-year longitudinal, comparison study of the outcome of depression. Psychol Med 2001 Nov;31(8):1347-59.
10. Katon W, Rutter C, Ludman EJ, et al. A randomized trial of relapse prevention of depression in primary care. Arch Gen Psychiatry 2001 Mar;58(3):241-7.
11. Lorig K, Halsted H, Sobel D, Laurent D, Gonzalez V, Minor M. Living a healthy life with chronic conditions: Self-management of heart disease, arthritis, diabetes, asthma, bronchitis, emphysema and others. 3rd ed. Boulder, CO: Bull Publishing Co; 2006.
12. Barlow J, Wright C, Sheasby J, Turner A, Hainsworth J. Self-management approaches for people with chronic conditions: A review. Patient Educ Couns 2002 Oct-Nov;48(2):177-87.
13. Duggal HS. The happiness guide to self-management of depression: Practical and proven positive psychology methods for overcoming depression. Bloomington, IN: Archway Publishing; 2018.
14. Marks R, Allegrante JP, Lorig K. A review and synthesis of research evidence for self-efficacy-enhancing interventions for reducing chronic disability: Implications for health education practice (part II). Health Promot Pract 2005 Apr;6(2):148-56. DOI: https://doi.org/10.1177/1524839904266792.
15. Papakostas GI, Fava M. Does the probability of receiving placebo influence clinical trial outcome? A meta-regression of double-blind, randomized clinical trials in MDD. Eur Neuropsychopharmacol 2009 Jan;19(1):34-40. DOI: https://doi.org/10.1016/j.euroneuro.2008.08.009.
16. Rush AJ. STAR*D: What have we learned? Am J Psychiatry 2007 Feb;164(2):201-4. DOI: https://doi.org/10.1176/ajp.2007.164.2.201.
17. Hollon SD. Cognitive and behavior therapy in the treatment and prevention of depression. Depress Anxiety 2011 Apr;28(4):263-6. DOI: https://doi.org/10.1002/da.20797.
18. van Schaik DJ, Klijn AF, van Hout HP, et al. Patients' preferences in the treatment of depressive disorder in primary care. Gen Hosp Psychiatry 2004 May-Jun;26(3):184-9. DOI: https://doi.org/10.1016/j.genhosppsych.2003.12.001.
19. Andresen R, Oades L, Caputi P. The experience of recovery from schizophrenia: Towards an empirically validated stage model. Aust N Z J Psychiatry 2003 Oct;37(5):586-94. DOI: https://doi.org/10.1046/j.1440-1614.2003.01234.x.
20. Jorge-Monteiro MF, Ornelas JH. Recovery assessment scale: Testing validity with Portuguese community-based mental health organization users. Psychol Assess 2016 Mar;28(3):e1-11. DOI: https://doi.org/10.1037/pas0000176.
21. Yeung A, Feldman G, Fava M. Self-management of depression: A manual for mental health and primary care professionals. Cambridge, UK: Cambridge University Press; 2010.
22. Lorig KR, Sobel DS, Stewart AL, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: A randomized trial. Med Care 1999 Jan;37(1):5-14.
23. Ory MG, Ahn SN, Jiang L, et al. National study of chronic disease self-management: Six-month outcome findings. J Aging Health 2013 Oct;25(7):1258-74. DOI: https://doi.org/10.1177/0898264313502531.
24. Neumeyer-Gromen A, Lampert T, Stark K, Kallischnigg G. Disease management programs for depression: A systematic review and meta-analysis of randomized controlled trials. Med Care 2004 Dec;42(12):1211-21.
25. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med 2006 Nov 27;166(21):2314-21. DOI: https://doi.org/10.1001/archinte.166.21.2314.
26. Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic review and meta-analysis. Am J Psychiatry 2012 Aug;169(8):790-804. DOI: https://doi.org/10.1176/appi.ajp.2012.11111616.
27. Miller CJ, Grogan-Kaylor A, Perron BE, Kilbourne AM, Woltmann E, Bauer MS. Collaborative chronic care models for mental health conditions: Cumulative meta-analysis and meta-regression to guide future research and implementation. Med Care 2013 Oct;51(10):922-30. DOI: https://doi.org/10.1097/MLR.0b013e3182a3e4c4.
28. Kirsch I, Deacon BJ, Huedo-Medina TB, Scoboria A, Moore TJ, Johnson BT. Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. PLoS Med 2008 Feb 26;5(2):e45. DOI: https://doi.org/10.1371/journal.pmed.0050045.
29. Panagioti M, Bower P, Kontopantelis E, et al. Association between chronic physical conditions and the effectiveness of collaborative care for depression: An individual participant data meta-analysis. JAMA Psychiatry 2016 Sep;73(9):978-88. DOI: https://doi.org/10.1001/jamapsychiatry.2016.1794.
30. Bandura A. Self-efficacy: The exercise of control. New York, NY: WH Freeman; 1997.
31. Ludman EJ, Simon GE, Grothaus LC, Richards JE, Whiteside U, Stewart C. Organized self-management support services for chronic depressive symptoms: A randomized controlled trial. Psychiatr Serv 2016 Jan;67(1):29-36. DOI: https://doi.org/10.1176/appi.ps.201400295.
32. Davidson L, Bellamy C, Chinman M, et al. Revisiting the rationale and evidence for peer support. Psychiatr Times 2018 Jun 29;35(6).

33. Houle J, Gauvin G, Collard B, et al. Empowering adults in recovery from depression: A community-based self-management group program. Can J Commun Ment Health 2016;35(2):55-68. DOI: https://doi.org/10.7870/cjcmh-2016-033.
34. Ludman EJ, Simon GE, Grothaus LC, Luce C, Markley DK, Schaefer J. A pilot study of telephone care management and structured disease self-management groups for chronic depression. Psychiatr Serv 2007 Aug;58(8):1065-72. DOI: https://doi.org/10.1176/ps.2007.58.8.1065.
35. Howell CA, Turnbull DA, Beilby JJ, Marshall CA, Briggs N, Newbury WL. Preventing relapse of depression in primary care: A pilot study of the 'Keeping the blues away' program. Med J Aust 2008 Jun 16;188(12 Suppl):S138-41.
36. Schulman-Green D, Jaser SS, Park C, Whittemore R. A metasynthesis of factors affecting self-management of chronic illness. J Adv Nurs 2016 Jul;72(7):1469-89. DOI: https://doi.org/10.1111/jan.12902.
37. Duggal HS. The complete guide to self-management of depression: Practical and proven methods. Bloomington, IN: Archway Publishing; 2016.
38. Whitley R, Drake RE. Recovery: A dimensional approach. Psychiatr Serv 2010 Dec;61(12):1248-50. DOI: https://doi.org/10.1176/ps.2010.61.12.1248.
39. Matta J, Hoertel N, Kesse-Guyot E, et al. Diet and physical activity in the association between depression and metabolic syndrome: Constances study. J Affect Disord 2019 Feb 1;244:25-32. DOI: https://doi.org/10.1016/j.jad.2018.09.072.
40. Villagi B, Provencher H, Coulombe S, et al. Self-management strategies in recovery from mood and anxiety disorders. Glob Qual Nurs Res 2015 Sep 21;2:2333393615606092. DOI: https://doi.org/10.1177/2333393615606092.
41. van Grieken RA, van Tricht MJ, Koeter MWJ, van den Brink W, Schene A. The use and helpfulness of self-management strategies for depression: The experiences of patients. PLoS One 2018 Oct 28;13(10):e0206262. DOI: https://doi.org/10.1371/journal.pone.0206262.
42. Wagner EH, Austin BT, Davis M, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: Translating evidence into action. Health Aff Millwood 2001 Nov-Dec;20(6):64-78. DOI: https://doi.org/10.1377/hlthaff.20.6.64.
43. Lutz AB. Learning solution-focused therapy: An illustrated guide. Washington, DC: American Psychiatric Publishing; 2014.
44. Dimidjian S, Hollon SD, Dobson KS, et al. Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. J Consult Clin Psychol 2006 Aug;74(4):658-70. DOI: https://doi.org/10.1037/0022-006X.74.4.658.
45. Kirkham JG, Choi N, Seitz DP. Meta-analysis of problem solving therapy for the treatment of major depressive disorder in older adults. Int J Geriatr Psychiatry 2016 May;31(5):526-35. DOI: https://doi.org/10.1002/gps.4358.
46. Nezu AM, Nezu C, Perri MG. Problem-solving in depression: Theory, research, and clinical guidelines. New York, NY: John Wiley & Sons Inc; 1989.
47. Martell CR, Dimidjian S, Herman-Dunn R. Behavioral activation for depression: A clinician's guide. New York, NY: Guilford Press: 2010.
48. Gander F, Proyer RT, Ruch W, Wyss T. Strength-based positive interventions: Further evidence for their potential in enhancing well-being and alleviating depression. J Happiness Stud 2013 Aug;14(4):1241-59. DOI: https://doi.org/10.1007/s10902-012-9380-0.
49 Sirois FM, Wood AM. Gratitude uniquely predicts lower depression in chronic illness populations: A longitudinal study of inflammatory bowel disease and arthritis. Health Psychol 2017 Feb;36(2):122-32. DOI: https://doi.org/10.1037/hea0000436.
50. Harris R. ACT made simple. Oakland, CA: New Harbinger Publications Inc; 2009.
51. Miller WR, Rollnick S. Motivational interviewing: Helping people change. 3rd ed. New York, NY: Guilford Press; 2013.
52. Sheldon KM, Elliot A. Goal striving, need satisfaction, and longitudinal well-being: The self-concordance model. J Pers Soc Psychol 1999 Mar;76(3):482-97.
53. Cook JA, Copeland ME, Floyd CB, et al. A randomized controlled trial of effects of Wellness Recovery Action Planning on depression, anxiety, and recovery. Psychiatr Serv 2012 Jun 6;63(6):541-7. DOI: https://doi.org/10.1176/appi.ps.201100125.