✓Treatments *That Work*™

Coping With Chronic Illness

A Cognitive-Behavioral Therapy Approach for Adherence and Depression

Therapist Guide

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About Treatments *That Work*™

Stunning developments in health care have taken place over the past several years, but many of our widely accepted interventions and strategies in mental health and behavioral medicine have been brought into question by research evidence as not only lacking benefit but perhaps inducing harm. Other strategies have been proven effective using the best current standards of evidence, resulting in broad-based recommendations to make these practices more available to the public. Several recent developments are behind this revolution. First, we have arrived at a much deeper understanding of pathology, both psychological and physical, which has led to the development of new, more precisely targeted interventions. Second, our research methodologies have improved substantially, such that we have reduced threats to internal and external validity, making the outcomes more directly applicable to clinical situations. Third, governments around the world and health care systems and policy makers have decided that the quality of care should improve, that it should be evidence based, and that it is in the public's interest to ensure that this happens (Barlow, 2004; Institute of Medicine, 2001).

Of course, the major stumbling block for clinicians everywhere is the accessibility of newly developed evidence-based psychological interventions. Workshops and books can go only so far in acquainting responsible and conscientious practitioners with the latest behavioral health care practices and their applicability to individual patients. This new series, Treatments *That Work*™, is devoted to communicating these exciting new interventions to clinicians on the frontlines of practice.

The manuals and workbooks in this series contain step-by-step detailed procedures for assessing and treating specific problems and diagnoses. But this series also goes beyond the books and manuals by providing ancillary

materials that will approximate the supervisory process in assisting practitioners in the implementation of these procedures in their practice.

In our emerging health care system, the growing consensus is that evidence-based practice offers the most responsible course of action for the mental health professional. All behavioral health care clinicians deeply desire to provide the best possible care for their patients. In this series, our aim is to close the dissemination and information gap and make that possible.

This therapist guide and the companion workbook for clients describe a cognitive-behavioral treatment (CBT) that targets both depression and adherence in individuals living with chronic illnesses who are also depressed. Depression is common among individuals with chronic medical conditions and can significantly impair their ability to manage their illnesses. Depressed individuals tend to practice poor self-care behaviors, which may include forgetting to take their medication as directed (or not taking it all), missing medical appointments, and neglecting to exercise and eat healthfully. Increasing engagement in these sorts of behaviors is the focus of this modular program. The treatment is based on standard interventions used in CBT for depression but chosen and adapted for persons with chronic illness, with the specific emphasis on self-care behaviors and medical adherence. Clients will learn core skills such as problem solving and cognitive restructuring in order to help them take better care of themselves. They will also learn relaxation and breathing techniques to help them cope with symptoms and side effects. Complete with step-by-step instructions for delivering this unique intervention, this book is sure to become an invaluable resource for mental health professionals and their chronically ill clients.

David H. Barlow, Editor-in-Chief,
Treatments *That Work*™
Boston, Massachusetts

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Chapter 1 *Introductory Information for Therapists*

Background Information and Purpose of This Program

This treatment manual and the accompanying client workbook describe a cognitive-behavioral treatment that targets both depression and adherence in individuals living with both a chronic illness and depression. For the purposes of this guide, we will refer to the treatment program as CBT-AD (cognitive-behavioral therapy for adherence and depression).

Depression is prevalent among individuals with chronic medical conditions and can significantly impair their ability to manage their illness. Patients with both a chronic medical condition and depression experience greater distress and worse medical outcomes (including mortality) than do those with a medical condition who do not have depression. Although there is some emerging evidence that depression can impact illness directly through associated biochemical changes, one of the reasons for worse medical outcomes in individuals with depression is that depression may contribute to poor self-care behaviors, including medical nonadherence.

Individuals with chronic illness and depression represent a complex population with heterogeneous individual needs. To address those needs, this manual is designed in a modular format. Each module of treatment is based on standard interventions used in cognitive-behavioral therapy (CBT) for depression but chosen and adapted for persons with chronic illness, with an emphasis on self-care behaviors and medical adherence. Because of the complexity of managing a medical illness comorbid with depression and simultaneously increasing adherence, therapist flexibility is key. For example, therapist flexibility may be necessary in regard to the delivery of specific modules based on individual need, as well as the sequencing of the modules (though we recommend that the psychoedu-

cation module come first). It is also likely that the number of sessions per module will vary according to the clinical presentation and needs of the client. Additionally, individuals with a chronic illness and depression frequently experience multiple significant life stressors. Therapist flexibility is necessary to balance the need to set and adhere to an agenda in order to teach the coping skills described in this manual with the need to provide necessary psychosocial support to clients when stressful life events occur.

Problem Focus: Depression and Adherence in Chronic Illness

Mental health professionals who treat depression are likely to encounter clients who have comorbid chronic medical conditions. Some data suggest that up to 30% of individuals with a medical condition experience depression and that depression is the most common condition that co-occurs with a medical illness. Research in various illnesses, including HIV (e.g., Dew et al., 1997; Rabkin, 1996), diabetes (e.g., Anderson, Freedland, Clouse, & Lustman, 2001; Egede, Zheng, & Simpson, 2002), heart disease (e.g., Januzzi, Stern, Pasternak, & DeSantis, 2000; Frasure-Smith, Lesperance, & Talajic, 1995b), cancer (e.g., Spiegel & Giese-Davis, 2003; Pirl & Roth, 1999), stroke (e.g., Morris, Robinson, Andrzejewski, Samuels, & Price, 1993), and life-threatening illness in general (Silverstone, 1990), shows higher prevalence rates of depression. Rates of depression in patients with comorbid medical illnesses increase 2–5% in community settings, 5–10% in primary care, and 6–14% or greater in patients with comorbid medical illness (Katon & Ciechanowski, 2002; Wells et al., 1991; Katon & Sullivan, 1990).

Why Do Depression and Chronic Medical Illness Overlap?

There are many potential reasons for the overlap between depression and chronic illness. Living with a chronic illness can be stressful and can limit one's involvement in pleasurable activities. Physical symptoms such as fatigue can impair one's ability to maintain one's usual activities and can cause losses in functioning. Adjusting to an illness that has waxing and waning symptoms can also be upsetting. Finally, cognitive as-

pects may include perceptions of loss of control or altered goals in life. These factors together can result in distress and/or depression.

In some cases, the relationship between depression and chronic illness may even be cyclical. In diabetes, for example, depressive symptoms such as reduced energy, lower motivation, and difficulties with problem solving negatively impact self-treatment and can lead to hyperglycemia or high blood sugar. In turn, hyperglycemia and the threat of complications can lead to hopelessness, self-blame, and helplessness. In HIV, depression can lead to worse immune functioning, both through worse treatment adherence and possibly through reduced levels of the hormone cortisol. This hormone is produced by the adrenal glands and helps regulate blood pressure and cardiovascular function, as well as the body's use of proteins, carbohydrates, and fats (Antoni et al., 2005). Having worse immune functioning leaves one at risk for various infections, causing symptoms and impairment, and consequently leading back to increased depression. Thus clients with chronic illness and depression may experience a vicious cycle of increasing depression and worsening illness and may require interventions aimed at both decreasing depression *and* improving self-care.

Depression Comorbid With a Chronic Illness Is Costly and Impairing

Depression is quite costly in the context of chronic medical conditions. In diabetes, for example, patients with depression fill nearly twice as many prescriptions, make twice as many ambulatory care visits, and have total health care expenditures 4.5 times greater than patients with diabetes and no depression (Egede et al., 2002). Rates of functional disability are considerably higher in individuals with comorbid depression and diabetes (77.8%) when compared with individuals with depression without diabetes (51.3%), with diabetes without depression (58.1%), or with neither depression nor diabetes (24.5%; Egede, 2004). In diabetes, depression results in significant functional impairments, reductions in quality of life, and increased disabilities (Bruce, Davis, & Davis, 2005; Goldney, Phillips, Fisher, & Wilson, 2004) and more than doubles the risk for mortality (Katon et al., 2005).

Depression is associated with increased mortality rates, both in the context of chronic illness and in community samples (e.g., Cuijpers & Schoevers, 2004). Decreased adherence to treatment has been proposed as one of the likely mechanisms through which depression confers an impact on mortality outcomes in the context of chronic illness.

Depression Affects Adherence to Medical and Self-Care Behaviors

Individuals with depression are three times more likely than nondepressed individuals to be nonadherent with medical treatment recommendations (DiMatteo, Lepper, & Croghan, 2000). A strong body of evidence supports the association between depression and treatment nonadherence in chronic illness populations, including individuals who are post-myocardial infarction (Ziegelstein et al., 2000) and in cancer patients in chemotherapy (Valente, Saunders, & Cohen, 1994). Studies from our group (Gonzalez et al., 2004; Safren et al., 2001) and others (e.g., Singh et al., 1996; Simoni, Frick, Lockhart, & Liebovitz, 2002) demonstrate that, in HIV, higher levels of depression are associated with worse adherence to HIV medications. These findings suggest a robust relationship between depression and poor adherence and point to the need for interventions to enhance adherence in individuals with depression and physical illness.

Depression May Be Hidden in Individuals With Chronic Illness

Depression goes undetected and likely untreated by the health care system in nearly half of comorbid patients. For example, among diabetic patients correctly recognized as depressed, 43% received one or more antidepressant prescriptions and less than 7% received four or more psychotherapy sessions during a 12-month period (Katon et al., 2004). Rodin, Nolan, and Katz (2005) suggest several possible reasons for the underdiagnosis and undertreatment of depression in the medical system, including the overlap of symptoms of depression and medical symptoms and the difficulty of differentiating sadness as a natural response to a serious diagnosis from clinical depression. However, depression in the context of medical illness is treatable—both with medi-

cations and with CBT. The present manual describes a CBT approach that involves treating depression *and* teaching skills to improve medical adherence.

Different Types of Depression: Diagnostic Criteria

In the following tables we list the criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR;* American Psychiatric Association, 2000) for the most common types of depression, including major depression, dysthymia, and bipolar disorder, which has features of mania and depression. This treatment manual is mainly designed for individuals with unipolar depression. However, in our studies we included individuals with bipolar disorder who were currently depressed and who had not recently experienced a manic or hypomanic episode. We believe that this manual would be appropriate for those with bipolar depression if they were currently depressed. The presence of mania would necessitate other interventions to stabilize mood, which are not focused on in this manual. Also, although we have designed this treatment manual for use with clients who have symptoms of depression that are severe enough to warrant a clinical diagnosis, there is evidence that lower levels of depressive symptoms also negatively impact self-care and medication adherence (e.g., Gonzalez et al., in press), and it is likely that the strategies that we present in this manual could be modified for use with patients who have some symptoms of depression, even if they do not meet criteria for a formal diagnosis.

Major Depressive Disorder

Major depressive disorder is characterized by single or recurrent depressive episodes in the absence of manic or hypomanic symptoms. The specific criteria from the *DSM-IV-TR* (APA, 2000, p. 356) follow.

A. The person experiences a single major depressive episode:
    1. For a major depressive episode a person must have experienced at least five of the following nine symptoms during the same 2-week period or longer, for most of the time almost

every day, and this must represent a change from his or her prior level of functioning. One of the symptoms must be either (a) depressed mood or (b) loss of interest.

   a. Depressed mood. For children and adolescents, this may be irritable mood.
   b. A significantly reduced level of interest or pleasure in most or all activities.
   c. A considerable loss or gain of weight (e.g., 5% or more change in weight in a month when not dieting). This may include an increase or decrease in appetite. Children may fail to show expected gains in weight.
   d. Difficulty falling or staying asleep (insomnia) or sleeping more than usual (hypersomnia).
   e. Behavior that is agitated or slowed down, which is observable by others.
   f. Feeling fatigued or having diminished energy.
   g. Thoughts of worthlessness or extreme guilt (though not about being ill).
   h. Reduced ability to think, concentrate, or make decisions.
   i. Frequent thoughts of death or suicide (with or without a specific plan), or attempt at suicide.

2. The person's symptoms do not indicate a mixed episode.
3. The person's symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.
4. The person's symptoms are not caused by substance use (e.g., alcohol, drugs, medication) or a medical disorder.
5. The person's symptoms are not due to normal grief or bereavement over the death of a loved one, they continue for more than 2 months, or they include great difficulty in functioning, frequent thoughts of worthlessness, thoughts of suicide, symptoms that are psychotic, or behavior that is slowed down (psychomotor retardation).

B. Another disorder does not better explain the major depressive episode.

C. The person has never had a manic, mixed, or a hypomanic episode (unless an episode was due to a medical disorder or use of a substance).