PSYCHOTHERAPY

Regime in CBT of major depression: Theory and practice

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Submitted: 2022-03-17 Accepted: 2022-04-12 Published online: 2022-04-12

Key words: **Depression; Cognitive-behavioral therapy; Regime; Activity scheduling**

Act Nerv Super Rediviva 2022; **64**(1): 33–45 ANSR64122A08

Abstract

Major depression is a common mental disorder that impacts debilitating impacts a patient's quality of life and functioning. While reaching and maintaining a complete remission is the primary goal of the treatment, some patients with major depression achieve only partial remission with standard therapy and continue experiencing one or more depressive symptoms. Furthermore, approximately half of the patients will experience another episode of depression during their lifetime. Therefore, it is essential to improve the implementation of the established treatment approaches and find new effective therapeutic methods, significantly improving the quality of remission and the prognosis of the patient's condition. This article focuses on the former and describes the options of working with a regime within cognitive-behavioural therapy. It also outlines approaches for dealing with common regime-related problems.

Introduction

Depression is a potentially chronic mental disorder with a significant impact on an individual's life functioning (Greden 2001). It burdens the individual, surroundings, and society (Lecrubier 2001). The treatment of depression is complex and depends, among other things, on the severity of the depressive disorder (Praško *et al.* 2007) – from a mild, non-comorbid episode, for which psychotherapy alone is usually sufficient (preferably CBT, interpersonal therapy, or short psychodynamic therapy); through moderate, when additional pharmacotherapy should be added, to a severe major depressive episode, where pharmacotherapy or electroconvulsive therapy plays a significant role, and psychosocial interventions become adjunctive, or - more often - implemented only after partial improvement (Praško *et al.* 2007). Therapeutic work with regime permeates the treatment of the whole spectrum of depressive disorders and all spheres of professional care – psychotherapy, psychoeducation in pharmacotherapeutic management, outpatient and inpatient care.

Although the work with the regime may be perceived as trivial, it is the basis for effective therapy of various psychopathological conditions - depression or anxiety disorders (Hughes *et al.* 2014) as well as bipolar disorder (Frank *et al.* 2007) and psychosis (Perivoliotis & Cather 2009). It forms the basis for other therapeutic methods,

such as schema work. The reason is that the regime one chooses and adheres to increases one's self-confidence, sense of control over one's life, and hope that things will eventually get better. Maintaining a particular regime reflects one's core beliefs that may be adaptive ("I am a worthy person, so I take care of myself, although I don´t feel well.") or maladaptive ("Why should I try? I will fail anyway. I´ve always been a failure.") in their nature. The work with the regime is systematically intertwined with cognitive approaches and remains a potential therapeutic topic throughout the therapy and after its termination in relapse prevention and management. The following case description illustrates the significance of the regime.

Veronika is a young woman suffering from recurrent depression with a seasonal pattern. She has been suffering from winter depression for three years in a row. She always felt well in the summer, but the depressive symptoms returned in the late autumn. When the depressive episode developed for the third time, she decided to seek professional care. She sought a cognitive-behavioural (CBT) therapist, received an antidepressant from a psychiatrist and, on recommendation, bought a lightbox and started bright light therapy. Despite minor fluctuations, her condition gradually improved as she adhered to the combined treatment. After several weeks, she achieved a fragile remission. She felt quite well but still experienced short depressive slumps after minor failures or frustrations.

Among other things, she was told by a doctor and a psychotherapist about the need to adhere to a stable regime, especially to get up regularly, even on weekends (with one hour margin), so that she would not shift her circadian rhythms. She was told that maintaining regular rhythms decreases stress because the body is prepared for activities. She understood the regime measures' importance and mostly adhered to them. In particular, she tried to maintain a regular sleep pattern and a diet. It was harder for her to exercise and find a steady rhythm on weekdays, but she gradually felt better.

Within a month of treatment, her condition had significantly improved. Until it was Saturday… As always, Veronika's alarm clock rang at 6:00. She was supposed to get up and turn on the phototherapy lamp. However, Veronika thought: "Oh, I'm fine now, I don't want to get up ... It's a weekend ... Who gets up so early on Saturday? I will sleep some more. I won't be a slave to something as mundane as the regime! I've worked hard enough. Normal people sleep when they want to."

When Veronika woke up three hours later, she felt something was wrong. She felt tired, without energy, in a worse mood, and craving carbohydrates. It scared her and confused her. It was as if she were at the beginning of her treatment again. All her previous effort felt useless. The treatment seemed not to work... She mailed her therapist, who wrote her back that she understood her concerns and that it was likely that she had reset her circadian rhythms. She suggested that Veronika restore the regime to which the body was used - to get up around six o'clock, go to bed at ten o'clock in the evening, and turn on the lamp in the morning. When they see each other in a regular session, they will explore the setback in more detail. Veronika tried not to fall asleep, though she was exhausted when she disrupted the regime. She managed to do so, and within a few days, her condition improved again. However, she felt a little disappointed that she would have to be stick to a regime like that.

During the next therapeutic session, the therapist and Veronika talked about what had happened. The first goal was to explore what was going through her mind. The moment she woke up and was about to switch on the light, and then three hours after her sleep when her mood worsened after waking up. At first, they focused on the first situation when she did not stick with the regime. She did not like the regime. She wanted to be spontaneous and creative from childhood, like her mother, who was a little chaotic and emotionally unstable – sometimes overly nice, sometimes snappy and reproachful. During her school years, Veronika´s father was kind and kept some order in the family. However, Veronika´s mother thought that he was boring and eventually left him to a man who was as spontaneous as she was. Veronika liked both of her parents and felt sad when they divorced. The family became even more chaotic, but Veronika thought it was normal. However, she missed her father, who was interested in her, praised her and encouraged her to persist when some difficulties arose. Mom was bright, original, but unstable in her rearing style and her own life - sometimes overjoyed, sometimes anxious about every day.

The therapist began investigating with Veronika how it worked for her. They discussed its ups and downs. It was nice for Veronika to have had many interests all her life. She was just as enthusiastic about relationships, especially in the beginning. Others were excited about her sometimes, too, because she was fun. However, when she was not in the mood, she also disappointed them, and when she was told that she was not very reliable, she felt hurt. She did well at school, but preparations for exams were complicated because she could not motivate herself on a long-term regularity. She excelled at the university because she was interested in the field. It only irritated her that professors preferred hard-working and systematic, albeit uncreative, students. She envied the students a little, and when she managed to work systematically and regularly, she was proud of it. Veronika graduated and got employed. She has gained much freedom, and sometimes she works enthusiastically. Sometimes it has been harder for her to work in a group, and she has preferred to do it herself.

T: *"You think about it very well, Veronika. You seem to understand a lot. Can I try to summarise how I understood it? It may be a bit simplistic or inaccurate, so adjust it if you´d like to. It seems that you behave similarly to your mother in some ways. It is essential for you to be free, creative, and not be bound by rules. This often works, and then you charm others. As I know from the past, you are also willing to help others, and you like to do it. You need to get praised too, or you're upset, and then you get angry. You also perceive the order that others want of you as a lack of freedom, and then you rebel. At the same time, you want others to accept it when you are unsystematic and rebellious. Moreover, it appeared on Saturday when you did not keep the regime. Because you didn´t want to get up so early, you fell asleep again and felt discomfort. It scared you, so you started to stick to the regime again, which helped you, but it still annoys you a bit. I think I understand both of your needs – freedom and feeling well. I just don't know how you would like to meet both yet."*

V: *"I will probably have to accept some regularity in my life. I just can't imagine how it could work yet. I've told myself many times to do it; I decided to stick with it, I tried hard, but then I didn´t do it.*

I then get mad at myself because I feel miserable. I also think that I´m incompetent. I'm tired and getting depressed again. It would be much easier if I could just take my medicine and sort it out that way."

T: *"It seems that you sometimes accept that you need some regularity in your life, such as the regime, but as you say, you try hard, feel pressured and stop doing it. It seems like a pattern - I try too hard - I get exhausted - I get overwhelmed - I resign – and then blame myself and think it´s meaningless because I feel miserable. Is it something like that?"*

V: *"It is probably a bit more complicated. Depression sometimes comes right from exhaustion. Then I don't want to do anything, and I think others are exhausting me with their demands… At the same time, maybe I am the one who exhausts myself with excessive effort. And then I want others to stop pressuring me, which they sometimes do, but sometimes they get angry," she contemplates. Then she adds helplessly, "I don't know what to do with it. If I knew, I would do it. What can I do about it, doctor?"*

T: *"We can think about it; first, you are thoughtful, I also believe that you already understand the problem very well, and that seems like a solid basis to us."*

V: *"Yeah, but what should I do?"*

T: *"Maybe we can try to describe it on paper first if you´d like. This is called problem formulation. We can start writing down what has been essential to this problem since childhood, which experiences, which schemas and rules, then how it has consolidated at school, among peers, and what triggers it today. Once you're happy with the mapping, we can start thinking about ways to change it. We probably won't be able to do that in one session, but when we consider the pros and cons of every possibility of changing it, we have a chance to find fitting solutions. For today, however, we could do something short-term and practical to find out if you want to keep the regime and in what way, what are the advantages and disadvantages, and if you decide not to keep it now, what are the advantages and disadvantages for you. I would like you to choose freely for yourself. Otherwise, you may sooner or later discontinue, as you experienced during the weekend."*

Veronika decided to follow the basic regime after using the four-square method (advantages and disadvantages of having or not having a stable regime). The therapist suggested not planning a regime that was too strict and instead of making it as pleasant and varied as possible so that there was a chance to follow and enjoy it.

Veronika decided to follow the regime and regularly took antidepressants that helped her stabilise her condition. During the treatment, Veronika took the medication as prescribed; she evaluated thoughts that evoked feelings of helplessness and hopelessness or sadness and anxiety; she planned her daily activities and made functional changes in her environment to reduce the likelihood of future depressive episodes gradually. After stabilising and working on her schemas, she could relax her daily regime without triggering depressive slumps.

Regime in the treatment of depression

Regime procedures (e.g., activity scheduling) can be defined as techniques and procedures that establish and maintain a regular daily rhythm. Such rhythm offers a room for sufficiently long and refreshing sleep, quality diet, reasonably demanding activities, and pleasant activities, including sports, relaxation, and social gatherings. These components of daily functioning are typically impaired in depression and maintain psychopathology if not addressed in treatment (Lopresti *et al.* 2013). Establishing a healthy regime grows in severe depression, where this part of treatment typically comes first (together with pharmacotherapy, bright light treatment, or other biological treatment). Through improving the regime, the patient experiences:

(a) An increase in the feeling of control over one's life, which is accompanied by a renewed sense of hope (i.e., a decrease in helplessness and hopelessness through behavioural experiments that facilitate the subsequent acquisition of cognitive restructuring);
(b) A relief from commonly occurring ruminations and feelings of being accepted by a supportive social environment (which can also help with cognitive work - close people can provide cognitive restructuring in a way);
(c) Alternatively, improving the mood through serotonin and dopamine release, e.g. during physical activities;
(d) Adjusting eating habits improves depression through biological ways, such as intaking food with tryptophan, a serotonin precursor (Rao *et al.* 2008);
(e) Similarly, adequate hydration enhances mood, and
(f) Regular sleep time is also essential, especially stable getting up time that regulates disturbed circadian rhythms (Tsuno *et al.* 2005).

Another example shows the importance of the regime for patients with major depression.

Alena was a married middle-aged woman who had experienced several depressive episodes with increasing severity during her life. After discovering her husband's affair and meeting his mistress, whom she perceived as more beautiful and successful than herself, Alena started having thoughts of being inferior and felt miserable and soon became depressed. During the day, she usually lay in her bed. She had to make a great effort to get to a job where her performance was declining because she poorly concentrated, got soon tired, and was entangled in worrisome thoughts of the marriage. She evaluated the decline in her performance as further evidence of her inferiority. This led her to "nothing is worth it" thoughts, driving her back to the bed. She did not sleep at night and worried about their future, which she thought was bleak. Alena also stopped seeing her friends because she did not want to talk about what had happened and did not want them to know because she felt ashamed. She resigned from the activities she had enjoyed before - she was no longer running or going to yoga classes. In addition, she stopped taking care of herself because she could not find the energy or why. This further reinforced her belief in her inferiority. Her husband and children criticised her for stopping cleaning, shopping, and cooking, for spending most of her time in bed. The husband felt guilty for believing that his affair had caused his wife's condition, but at the same time, he thought she was "doing it on purpose" to "emotionally blackmail him," so he was

angry at her. He was trying not to feel guilty, and it was easier for him to be upset with his wife.

In this example, we see changes in the behaviour and thinking of a patient who developed a depressive episode after an escalated marital crisis.

Alena changed her normal daily functioning in the following ways:

- She stopped sleeping regularly.
- She stopped eating regularly.
- She reduced her general activity and lay in bed for many hours during the day.
- Her days lost their regularity and rhythm.
- She avoided activities that she perceived as unnecessary (work activities, housekeeping, hygiene).
- She stopped performing sports, relaxation activities, and other previously pleasurable activities.
- She reduced social contacts and isolated herself.

Parts of the regime and methods for their establishment and maintenance

The following text focuses on the essential components of the regime and outlines therapeutic techniques that can influence them.

Sleep

Sleep disturbances present one of the core symptoms of depression (Riemann *et al.* 2001). Patients with depression typically awake early and experience terminal insomnia. However, some individuals may experience intermittent sleep or difficulty falling asleep, especially patients with comorbid anxiety (Riemann *et al.* 2001). Sleep in patients with depression shows a decreased duration of deep sleep and REM sleep disinhibition, which generally leads to a decrease in the sleep duration before the first REM episode. This is due to a lack of slow-wave sleep, with the first REM elongation of the first REM episode and generally increased intensity of REM sleep (Riemann *et al.* 2001; Nutt 2008). In patients with major depression, REM sleep lasts a shorter time but is more intense than in non-depressed individuals. At the same time, the sleep is not sufficiently refreshing because of the shorter NREM sleep in which stages III and IV may almost disappear. Thus, the patients experience many vivid dreams. Their brains work hard during sleep, but their cells show a decreased anabolic activity. The patients then feel exhausted the next day.

Another potential issue is hypersomnia, excessive sleepiness, or time spent sleeping. This sleep is insufficient for anabolic processes because REM sleep occurs more often, and the individual gets even more tired. Hypersomnia is more common in bipolar depression, but younger individuals with unipolar depression (especially women) also sometimes experience this sleep disorder (Nutt 2008).

Zdenek is a 62-year-old man suffering from a depressive disorder and intense anxiety. He complains that he has very vivid and strange dreams at the psychiatrist's check-up. The dream content is often scary or induces helplessness - someone chases him or watches his loved ones dying. During the night, he wakes up sweating, and then he falls asleep but wakes up in the morning and feels shattered. Sleep is "hard work" for him.

One of the explanatory theories of these sleep disturbances comes from the finding that sleep is regulated by the serotonergic system, where REM sleep, in particular, depends on a decrease in serotonergic activity in the brainstem (Adrien 2002). Because major depression is associated with a functional reduction of the serotonergic neurotransmission, it creates a ground for more intense REM sleep and prevents the implementation of adequate NREM sleep (Adrien 2002). Such sleep is energy-intensive, and at the same time, it does not supply much energy to the organism. The patients, therefore, wake up two, three, sometimes more hours before the usual waking time and no longer fall asleep, even when they are tired.

The pharmacotherapy or biological treatment, which often solves sleep problems with greater or lesser success, will not be discussed (see Riemann *et al.* 2001, Adrien 2002). Still, we will focus on working with the regime and cognitive strategies according to the type of sleep disturbance.

Initial insomnia

Some patients who experience depression and anxiety tend to have difficulty falling asleep. They lie in their bed for an hour, two or more and are still awake. The reason for that is the general arousal of the organism, which may have the following causes:

- Not being tired enough to get asleep due to a low physical activity during the day;
- Excessive intake of caffeine and other stimulants in the afternoon and evening before going to bed or significant physical exertion one or two hours before bedtime;
- Using a bed for activities other than sleep and making love;
- Playing videogames or watching TV (usually horror or action films) late in the evening;
- Being exposed to the blue light late in the evening;
- Going to bed and getting up at considerably different hours (sometimes associated with shift work);
- Anxious contemplation, ruminations, or problem-solving attempts while lying in bed.

The following methods can be used while working with patients who struggle with initial insomnia:

1. Identification of behaviour or thoughts that result in staying awake

2. Education about sleep hygiene, with an increased focus on problematic areas and the creation of a plan to tackle them:

When working with a patient who is physically hypoactive, we plan to increase physical activity during the day, especially in the morning, to reinforce the circadian rhythms:

P: *I can't sleep at night. I'm lying in bed, and I'm useless the following day.*

T: *I see, and that must be not very easy. Could you tell me what do you usually do during the day?*

P: *These days... Well, I admit I'm not doing much. I get up in the morning, then sit down at the computer and translate one project for a client. I'm not very good at it. I'm having difficulty concentrating, and I´m making many mistakes. However, I still try to do a good job. Then I make some coffee, then lunch. I work a little more again in the afternoon. Then I watch the news, work again, and go to bed. Furthermore, it takes around an hour and a half or two to get asleep.*

T: *Uhm. You work hard to get the project done and do good work. It seems that you may be quite mentally tired in the evening, but the body is probably not too tired because it doesn't have many exercises during the day.*

P: *I guess so. I feel better with that medication, but I can't fall asleep. I used to go jogging at least three times a week before, but now I don´t.*

T: *And how did you sleep then?*

P: *Like a baby.*

T: *I see, that´s interesting. What would you say about putting a bit of running back into the daily routine? Or possibly another physical activity? Sometime during the day, so that you wouldn´t feel too energetic in the evening, making falling asleep difficult.*

P: *Well, it could work, even if my physical form is not what it used to be. I can imagine running at a slower pace for half an hour or so.*

T: *That´s ok. It´s good to enjoy sports, release the endorphins, and make the body feel a bit tired. It would be great to have some aerobic exercise most days a week, and thirty minutes would be excellent. The body gets tired, and the mind relaxes.*

P: *Yes. A half an hour of jogging sounds about right. I feel nervous that I´d not work during that time, but I can´t concentrate when I don´t sleep well anyway, so I will give it a shot.*

T: *Sounds great to me. Bad sleep can hinder our productivity. How often do you want to go running?*

P: *So, three times a week, maybe? And on the other days... On Sunday, I can go swimming with my friend, that's nice too. Moreover, I can do Nordic walking the rest of the day, and I could always do that in the morning.*

T: *Awesome, I like that. There are various activities, and you could do some sports with a friend. When you consider exercising, what do you think is the probability that you will devote half an hour a day to some of these activities – let´s say – four times a week?*

P: *80 %, I guess.*

T: *I like that. Well, what if we agreed to try to include one physical activity until our next meeting for four days, and we'll see how it went the next week? It's about getting tired to make you sleep better. You have to get a bit sweaty to release the endorphins, and you don't have to worry about the performance.*

P: *Ok, it will work.*

T: *Would you like to write it down in advance and reward yourself?*

P: *Yeah, that sounds good.*

In the evening, caffeine intake in the afternoon, smoking, sports, or artificial blue light (from electric devices without a filter) disrupt sleep. The therapist explains the stimulating effect of substances or activities and explores the possibility of moving these activities to earlier hours so that the patient would not get energised for the evening. If the patient is motivated, the therapist discusses the change of stimulants for more suitable alternatives – such as chicory coffee or decaffeinated tea, reading a book in the evening in a pleasant warm light instead of watching a horror film, etc.

If the client usually eats, reads, surfs the net or works in the bed, the therapist can explain the connection with the classical conditioning and help the patient find pleasant places to carry out these activities instead of the bed.

If the patient goes to bed and gets up at different hours (typically students), the therapist can educate him about conditioning and circadian rhythms. Subsequently, they try to optimise the time of going to bed and getting up as regular as possible. This issue is not very correctable for people working shifts. For this reason, shift work is not suitable for people with bipolar disorder or recurrent unipolar depression.

Suppose the reason for initial insomnia lies in anxious thinking and stressful attempts at problem-solving. In that case, the therapist focuses directly on working with thoughts - cognitive restructuring - or chooses relaxation techniques.

P: *I can't sleep at night. I'm just lying in bed. I go to bed, and I won´t ever fall asleep.*

T: *What makes you think you won't be able to sleep?*

P: *I feel tense, here in the chest. My stomach tightens too.*

T: *I see. That sounds like anxiety.*

P: *Yes, it is. It´s very unpleasant.*

T: *Uhm. I wonder what do you do when you start feeling like that?*

P: *I'm lying in bed thinking how awful it will be when I am sleepy tomorrow. I look at the clock and see that I only have four hours ahead of me before I must get up.*

T: *I´m sorry to hear that. That must be stressful for you. Feeling that pressure… Anxiety is a good thing when you're running from a tiger. Because anxiety stirs up the energy reserves that the body has, your heart rate speeds up, you breathe faster, and the blood moves to your muscles, giving you a better chance of running away from that tiger.*

P: *Ha-ha.*

T: *It works great when there´s a tiger around. Or a wolf. But I guess there are not many of those in your bedroom.*

P: *Ha-ha, there are none – yet, ha-ha.*

T: *I´m glad. I´d be more worried about you. Well, if you happen to come across one when you´re lying in bed, your body is already prepared for the action. But when you're not running from any tiger, the energy that anxiety mobilises stays in your body. You are awake, and you can't fall asleep, you're not calm enough to fall asleep. In addition, when you think about nights like these, your body can get used to the fact that "lying in bed" means "worrying" and "not sleeping".*

P: *What does that mean? That I´ll never sleep again?! Now I´m really stressed!*

T: *Um-um, thankfully not. It's just a learned reaction, and learning can be unlearned.*

P: *Ok. But how?*

T: *We have several options. One option is to work with those thoughts. So, for example, have you ever failed in doing something when you only slept for a few hours? Or are you anxiously awaiting your premiere?*

P: *Ha-ha, very funny. No, I haven´t failed at anything yet. But I could.*

T: *Uhm. I get it. It's better to get stressed every night. What if a catastrophe happened the next day...?*

P: *Well, when you say that, it sounds stupid.*

T: *On the contrary. I understand that you worry, and it just doesn't sound like a very useful way to relax and fall asleep, and I would like to help you with that. How many nights have you had thoughts like this?*

P: *About two weeks...*

T: *Ok. That´s unpleasant, but you managed to work without making mistakes the next day.*

P: *That's true. Nothing happened. So, I'm afraid of something that may not even occur. Moreover, even though I'm not asleep, I've always managed it somehow at work. However, I didn't feel well.*

T: *So, if you sleep only a few hours, you don't feel well, but it doesn't lead to any disaster. What if you wrote it down on a piece of paper here and – let´s say – put it on the bed to look at it if you get anxious?*

P: *Yeah, that could help.*

T: *There is also a question of what you should do, if not worry.*

P: *Maybe sleep?*

T: *Ha-ha. Let´s work on that. What would you say about the muscle relaxation we learned together? When you relax, the body calms down, the mind relaxes, and you can fall asleep easier.*

P: (smile) *I could try it. When I relax in the morning, it helps me be calmer. I could do it tonight.*

T: *Great, I like that! So, what if you looked at that piece of paper in the evening if you got anxious and did muscle relaxation every day before going to bed?*

P: *Ok. I'll tell you next week how it went.*

Patients often lie in bed even when they cannot sleep. Sooner or later, they start creating anxious scenarios. A good strategy is to get out of bed if one does not fall asleep within twenty minutes, engage in some calm activity in another room (reading, listening to calm music or pleasant podcasts), and return to bed when drowsiness sets it. They should then imagine pleasant things or apply relaxation in the bed.

Sleep restriction

Sleep restriction can present an effective strategy that systematically reduces bedtime to increase the efficiency and duration of sleep (Praško *et al.* 2007). The time of getting up remains intact, and the patient's bedtime shifts. First, the patients observe and calculate the average duration of their sleep (e.g., 5 hours a day). The patient then gets to bed five hours before getting up for one week and writes down how many hours they were lying in bed and how many hours (preferably in minutes) they were sleeping. As soon as the sleep period lasts more than 90 % of the time spent in bed, the patient goes to bed 15-20 minutes earlier. They continue to progress this way until the sleep time meets the patient's healthy optimum. The sleep diary and the gradual increase in sleep time play critical roles in this technique (Praško *et al.* 2007).

During the cognitive restructuring of the sleep concerns, the therapist works with the patient's formulation, which will most effectively reduce anxiety while remaining realistic.

For more severe insomnia, for which psychotherapeutic interventions do not help enough, consider referring the patient to a psychiatrist for medication, such as mirtazapine or trazodone, and continue to establish sleep hygiene.

Intermittent sleep

Disturbed sleep is also often associated with anxiety. The patient usually wakes up during the night and becomes anxious that they will not function the next day or develop other catastrophic scenarios. The therapeutic options are similar to those applied in initial insomnia. Another recommendation is not to turn on the light due to a possible decrease in melatonin secretion (Brown 1994). Developing an accepting and non-evaluative stance also helps.

P: *I woke up again shortly after 2 a.m. and then stared at the ceiling for an hour.*

T: *That sounds burdensome. Do you remember what were you thinking?*

P: *That the next day I will be exhausted again.*

T: *Exhausted?*

P: *Like I'm not going to function as I should.*

T: *I see. Understandably, you had stressful thoughts. Looking back now, do you think that not functioning as you should is the same as being exhausted?*

P: *Well, it's not the same.*

T: *It seems that such a thought is making you uneasy… And how anxious do you feel at night – on a scale of 0 to 10?*

P: *I´d say seven out of ten.*

T: *That's also pretty high. Moreover, what about now, when you realise that it does not mean that you won´t function properly, but rather that you won't feel good?*

P: *So, at five.*

T: *So it´s a bit lower. Great. Could you tell yourself something like that when you wake up again at night?*

P: *Yes. That might help.*

T: *Uhm. How about trying not to think about it too much at night when you wake up and trying to take it more as the fact that you woke up?*

P: *What do you mean?*

T: *Like, if you wake up, you'd register it, of course, but you would try not to ponder about it too much. You would say to yourself something like, "ok, I woke up". Moreover, you wouldn't look at the clock and think about what it means. When you think at night, your brain gets aroused, and so is the body, preventing you from falling asleep again.*

P: *Ok, that sounds interesting. So when I wake up, I'd lie in bed, do not look at the clock so it doesn't stress me out, and take it as the fact that I'm just awake.*

T: *Yes, that's exactly what I mean. I like the way you summarised it. Alternatively, you could start imagining something nice to calm the body and fall asleep.*

P: *I'll try, and it won't be a problem. I'll try not to overthink about being awake. I'll try to imagine something like lying on the sand at the beach by the sea.*

T: *That sounds nice. What if you tried to wake up at night? Next time we will talk about how you did and sleeping.*

P: *Ok.*

Terminal insomnia

Premature awakening is a common problem, especially in moderate and severe depression (Besiroglu *et al.* 2005). This issue generally disappears with appropriate pharmacotherapy but is not always the case (Franzen & Buysse 2008). As with previous types of insomnia, we apply sleep hygiene with the main emphasis on the problematic parts of the daily routine that the individual is struggling with. It also helps the patient accept and not negatively evaluate the early awakening. It is an unpleasant state because the patient is tired during the day, but it is not life-threatening, and it does not say anything about the value of a person who wakes up prematurely, as patients sometimes think. So, it may help work with cognitions - decatastrophicization and reconstructing stressful thoughts such as "I'm up again at four in the morning. It´s still night. I will be exhausted all day. I can´t make it. I'm useless." In general, it's best for an individual to just get out of bed and engage in some not demanding and pleasant activity do something rather than succumb to depressing ruminations. The sleep will often gradually improve in this way.

Food

Major depression usually brings dietary issues, usually a loss of appetite and a consequent weight loss (WHO 1992). Alternatively, the appetite may increase toward high-calorie carbohydrate foods (Ouwens *et al.* 2009). Both dietary changes are unfavourable in the long run. Limited calorie intake leads to fatigue and irritability because the organism does not draw energy. An increased intake of high-calorie foods temporarily improves energy and (theoretically) mood. Still, it happens at the cost of fluctuations in blood sugar levels, consequent drops in energy levels, and long-term weight gain (Christensen & Pettijohn 2001). A similar problem presents eating readily available food (such as fast food or pastries). This usually happens when an individual lacks the energy to prepare more complex meals, leading to an unhealthy and unbalanced diet. It is often associated with mild depression (Murphy *et al.* 2009).

On the other hand, some foods can improve depressive symptoms and present a basis for a healthy and balanced diet. Foods with tryptophan, a precursor of serotonin, have been widely discussed (National Institute of Mental Health 2000). This group of foods includes oatmeal, legumes, eggs, sunflower seeds, seaweed, salmon, red meat or chicken, and soy or tofu (Nutrition data 2017). Foods containing tyrosine or phenylalanine, converted to dopamine in the organism, have a similar beneficial effect on depressive symptoms (Montgomery *et al.* 2003). Curiously, foods rich in tyrosine include the already mentioned seaweed, soy, eggs, cheese, tuna, chicken, and beef (Nutrition Data 2017). These foods are also rich in B-complex vitamins, and some contain significant amounts of omega-3 fatty acids, which also act as essential adjuvants in treating depression or maintaining remission (Rao *et al.* 2008).

Eating disturbances are generally not one of the first topics that an individual with depression opens in their therapy. However, it commonly arises sooner or later as a problem that needs to be addressed, often while working on the topic of fatigue. We outline three ways of working with diets in major depression - when a patient eats less than before, when one craves high-calorie meals and when an individual excessively seeks an easily accessible but not nutritiously rich diet.

Eating not enough nutritious food

The patient usually does not think about eating or does not see a reason to eat because the food lacks taste. A patient with such an issue does not have to present their eating struggles as a problem to solve - at least until, for example, a close person is concerned about their weight loss. The patient may talk about fatigue and mention the current eating habits by the way or only when asked. When this topic, a therapist may follow this procedure:

1. Education about the significance of a nutritious diet - food as "a fuel", the quality diet as an essential part of the treatment
2. Identification of obstacles associated with eating
3. Joint development of a plan to gradually and realistically change eating habits

If the patient is not motivated to change their eating behaviour, the therapist can focus on related cognitions, such as guided discovery. The patient may benefit from finding that eating serves other purposes besides enjoyment, that decreased appetite is common in depression, and that it is necessary to increase the intake of quality food to reduce the depressive symptoms (and thus increase appetite). The cognitive approach is also helpful in the cases where starvation emerges from beliefs of inferiority ("I don´t deserve to eat.") or hopelessness ("It won´t be better anyway.").

T: *You said that you don't eat much now, Paula.*

P: *Yes, I don´t eat much lately. The food is so bland (crying). I used to like salads, cook porridge for breakfast and such... But everything tastes the same to me now... It doesn´t have any flavour. So, I eat only occasionally and just a little... I take a bite of a croissant and leave the rest for the children.*

T: *I see. It´s not enjoyable anymore. You eat a little, and the children eat the rest of the meal. Then you do some house chores and do your best, though you don´t feel much energy.*

P: *Yeah... (crying)*

T: *I understand that it's a painful topic for you. Could you say what goes on your mind now?*

P: *I'm useless, and it will never get better. I'm such a loser when I can't even eat normally.*

T: *Uhm, uhm… I see… What would you say… Do you think that eating less and having a lesser appetite that you´ve been experiencing recently means that you´re useless and that it is hopeless?*

P: *Yes. The children go to school, my husband leaves for work, and I stay home alone before going to the hospital. I have a problem getting out of bed. When I get up and go to the kitchen, I know I should eat, but I know in advance that I can barely find the east half of a croissant. I can't even eat normally (crying). Then I try to eat something, but I wouldn't say I like it. I feel miserable, so I go back to bed. And then I have to force myself to do anything.*

T: *I understand that it's hard for you to eat when you don't like food very much now, and you feel so tired. You try to eat something, which is very good because you are not completely hungry. This is important because it gives you some energy. When you have trouble eating like before, you experience painful thoughts, such as uselessness, and feel bad. What do you think, could there be some other explanation for why you stopped eating, other than proof that you are useless?*

P: *I talked to Tonda at the hospital. He told me it didn't mean I was useless; I didn´t eat much because of the depression. He had it the same way and forced himself into food when depressed. There are more of us who have the same problem.*

T: *Uhm, great. I like that you spoke with Tonda about that, and he supported you. What do you think about what Tonda said?*

P: *Well... I don´t know…*

T: *Do you think Tonda was useless when he didn't like the food before?*

P: *No, Tonda is fine.*

T: *Uhm... So, do you think there could be another explanation for why he didn't like it and used to eat less than before?*

P: *He had a difficult time. His wife has left him, and he has debts; he still pays them.*

T: *Uhm, that makes sense, right? When we are stressed or feel unwell, we often feel less appetite. Some people lose weight, and when they feel better, they start eating more regularly. Tonda has recently experienced some stressful and painful events, and he was depressed. However, that doesn't mean he's useless, do you agree?*

P: *Yeah, I agree.*

T: *What do you think? Could your appetite loss also mean something other than proof that you are useless?*

P: *Well, I've known that I eat less when I don´t feel well for a long time. When I get stressed or have a difficult time, I generally avoid the food and eat much. When I feel better, I usually eat more again. Moreover, that seems to be what some other people do as well. Maybe it doesn't mean I'm useless, although I often get these thoughts. It could mean that I just don't feel well.*

T: *You worked out the idea very nicely. That´s great. How are you feeling now?*

P: *I'm a bit relieved.*

T: *I´m glad. I agree with you, and you also know that the body needs strength to cope with depression. What do you say if you focused a bit on how to plan your diet to eat a little more during the day, even if you don't like it very much now?*

P: *Ok, I´d like that.*

The therapist and the patient can continue with a gradual change in the diet. It is advisable to proceed in smaller steps, including healthy foods that the patient liked in the past and are available to them. For example, the patient may prepare a simple meal for the next day or prepare a light breakfast on the table in the evening. It proceeds in a matter of weeks. The therapist appreciates every progress and encourages the patient to adjust their diet.

If the individual does not eat because they do not have sufficient access to food, the therapist can modify the behaviour and the client's environment.

P: *I haven't eaten much recently. There was almost nothing to eat at home, and I couldn´t have gotten up to go to the store. I´ve just gone to the corner shop for some pastries, and that´s been it. My roommate left for two weeks, so she's not there to buy some food either.*

T: *So, you stay more at home now?*

P: *Yes. I mostly lie in bed, and it's challenging to make myself do anything.*

T: *It seems that it has been recently tricky for you to get up and buy some fruits, vegetables, or yoghurts, for example, to have something to eat besides the pastries.*

P: *Uhm, getting out of the house is hard for me.*

T: *I see that it´s difficult for you at the moment. It is also likely not very enjoyable to eat the pastries for days.*

P: *Yeah, it sucks…*

T: *I´d say that it would be good for you to get something more nutritious than the pastries, to have a more variable and balanced diet, what do you think?*

P: *Yes, I agree. I don´t enjoy the pastries one bit.*

T: *Ok. What if we tried to find a way for you to access the general store?*

P: *I´d like that. I can´t even look at the pastries anymore. I´m fed up with them, though I still have about ten rolls at home…*

T: *I can imagine that you are fed up with it. The good thing is that you managed to come to me today, and it´s not very close to your home. Do you think it could be possible to connect the travelling here for a session with some shopping?*

P: *Hmm…. There is a supermarket nearby that I could visit when our session ends. I'll be tired, but I could try to go there.*

T: *Yeah, that´s true. I like shopping there; there is good quality food, especially vegetables and fruits. What would you like to buy there?*

P: *Not much, just what I can bring home by the commute. I want to buy some "liquid" things like yoghurts or milk, then some vegetables, maybe cheese...*

T: *Great, I like the list. These are nutritious and tasty foods. Would you like to write it down, so you don't forget it when you go there?*

P: *Sure, I can´t rely on memory much now.*

T: *We could also think about a reward you could give yourself for going to the store. It would be best if you made an effort to go there, and it´s been difficult for you to go shopping recently.*

P: *Could I buy some chocolate? This usually works well as a reward (a slight smile).*

T: *Definitely (smile).*

T: *That sounds very good. I also wonder, do you have any errands until our next session?*

P: *No, but my friend would like to visit me.*

T: *Nice. Could it be an opportunity to buy something to eat together?*

P: *Yes, I could buy something in advance, but we could also go shopping together. At least he'll pull me out of the house (smile).*

4. Monitoring the plan's implementation and homework and problem solving: Some patients struggle with self-blame when not meeting their eating habits. The progress is usually not linear. On the contrary, the patients may experience better and worse days and feel demoralised when things do not go according to plan. They can subsequently resign by pursuing a healthier and more balanced diet. In such cases, the therapist can normalise the presence of these fluctuations and help the patient gain a more balanced perspective on the process. Individuals can also benefit from learning to reward themselves for small achievements. The goal is to eat reasonably healthy and regularly.

Craving for high-calorie meals

Some patients with depression experience an increased appetite for a high-calorie diet which is usually a subconscious effort to gain enough energy (Ouwens *et al.* 2009). They seek foods with a high content of simple sugars or fat. Individuals with this diet usually present it as a problem they would like to solve because of the related weight gain. Again, some education is typically appropriate, accompanied by the guided discovery to explore what purpose this diet serves and help the patient change their perspective on their eating behaviour, which they might fear being unmanageable.

Since this eating behaviour usually presents an effort to supply energy, the therapist aims to change the diet and daily activities gradually - moderate activities provide energy more reliably and for a more extended period than e. g. sweets. The goals should be proportionate and realistic to the patient's capabilities. As a rule, excluding all junk food from the diet is unnecessary. It is usually more sustainable to gradually replace them with healthier alternatives and activities, where some sweets may occasionally remain a bit of reward. This approach usually calms the patient and increases their cooperation.

Suppose the intake of high-calorie foods improves the mood (it tends to do it in the short term). In that case, education should re-emerge about the positive but short-term effects of these foods and the fluctuations in the blood sugar levels, which are associated with energy fluctuations and mood swings. Apart from the gradual replacement of these foods with healthier alternatives, the therapist and the patient also work with thoughts and physical activity (or relaxation).

Seeking easily accessible food

Due to the decrease in energy, some individuals with major depression eat almost exclusively readily available foods, which may or may not be a portion of junk food. In that case, the therapist work in a similar way as in the previous issues. If the patient initially struggles to shop or cook independently, they may begin to do this accompanied by a relative or friend. Gradually, with the acquisition of energy, they should shop and cook on their own to increase their self-confidence and autonomy. However, most individuals find that preparing food in advance works suffice. They may prepare some easy-to-make foods when they have more energy (for example, in the afternoons) and eat them the next day. The general aim is to re-establish a regular and nutritious diet, and self-rewarding should be a part of it when needed.

Physical activity

One of the main symptoms of the major depression diet is increased fatiguability. Patients often perceive fatigue as something unwanted that they would like to get rid of. The fatiguability increases in more severe depression, negatively affecting functioning in life and hindering the enjoyment of previously pleasant activities.

The most beneficial and available non-pharmacological approach to increasing the perceived energy level is regular exercise (Young 2007). The recommended "dosing" of the sport presents an aerobic exercise three to five times a week (Dunn *et al.* 2005) for half an hour. This leads to favourable changes in serotonin synthesis and metabolism (Dey *et al.* 1992) and, at least in elderly individuals, also to the synthesis of the brain neurotrophic factor (BDNF) (Erickson *et al.* 2012). The effect of exercise on serotonin can be observed one week after the last training (Babyak *et al.* 2000). In the case of chronic depression, regular exercise can have the same effect as antidepressants and significantly reduce the likelihood of relapse (Babyak *et al.* 2000; Dunn *et al.* 2005).

Therefore, it is recommended that the patient starts or returns to physical activity. The therapeutic work can be summarised, for example, in the following points:

1. Education about the relationship between physical activity, fatigue, and depression
2. Mapping the patient's relationship and a previous experience with sports exploring the options of engaging in sports activities for the patient's health condition, preferences, age, time, and financial opportunities
3. Formulating the goals and the plans related to the physical activity:
   - Patients with mild depression or an incipient relapse usually do not have much difficulty resuming or exercising more regularly. It is helpful to determine which activities the patient prefers, whether they can engage in them, and, if they cannot, which other sports they would like to do. They may do various exercises but preferably aim for an aerobic exercise that lasts at least thirty minutes and can

be implemented 3-5 times a week. Combinations of several aerobic exercises are possible and welcome. The patient can approach this goal gradually. For example, if an individual experiences hypobulia, they can benefit from exercising with a close person. This may increase the motivation to exercise. Sports such as tennis or squash can be used for this purpose. Patients who are overweight may benefit from Nordic walking or fast walking.

- Patients with a more severe depressive episode may considerably struggle with their usual daily functioning, let alone sports. It is necessary to help them with setting realistic goals. Pronounced hypobulia and fatiguability are significant obstacles to regular and sufficiently long exercise. Therefore, one would benefit from having "a sports partner". Such support is easier to arrange if the patient is hospitalised or goes to a daily sanatorium. If a support person is absent and the individual visits an outpatient non-sanatorium facility, it is possible to go to the sessions on foot initially. If the individual lives in a place farther from the therapist´s office, they can get off the public transport a few stops earlier and reach the therapist by a quicker walk. With the brightening of mood and increasing energy, they can perform more complex activities, including sports.

4. Monitoring the establishing and maintaining the sports regime: The therapist needs to notice and praise even a minor step forward. They also help correct any excessive expectations from patients' performance that lead to disappointment. The goal is to reduce fatigue and improve the mood, not break records.
   - It is advisable to monitor the degree of fatigue or a decrease/elevation of the mood before and after exercise. The patient can choose a simple analogous scale of 0-10. The technique is especially suitable for people who doubt the effectiveness of the sport, who feel helpless and hopeless or demoralised. The scale will show them that they can achieve a positive change.

Reasonable workload

A phenomenon related to the abandonment of physical activities is the individual's withdrawal and the overall reduction in the activity – especially in those tasks that the patient perceives as strenuous. An individual, who is depressed, may stop performing daily activities, thinking that they cannot handle them. On the contrary, the gradual involvement in more demanding activities and the renewal of a regular daily routine weaken the learned helplessness (Seligman 1975) and reinforce one's own perceived fitness and self-confidence.

The process by which a patient is exposed to activities and situations that they do not think they can handle is essentially a behavioural experiment. If planned and implemented correctly, it makes working with maladaptive beliefs easier. Let us describe one common scenario:

P: *The postman rang me on Tuesday. I lay in bed that day; I didn't even shower, eat, and don´t do anything. I felt ashamed to answer the door, and I felt weak. She put a ticket in my inbox to pick up the letter at the post office. I need to pick it up. However, I looked at the delivery note, and I couldn't do it...*

T: *I see. It was difficult for you to get up and answer the door, but you needed to pick up the letter from the post office. What did you think when you looked at that ticket?*

P: *(anxious with tears in her eyes) That I could not do it. I would come there and forget my ID, then the clerk at the counter would be upset, and I would cry. People would tell me I was utterly useless. Then would I run away, and I wouldn't go back there. The letter would then go back to the sender – the insurance company that sent it to me, and I'd have big problems. My husband would find out, and when he realised how incompetent I was, he would leave me and take the children with him. Every court would rule the custody of the children to him when they would see how I was doing. I would end up alone and homeless (crying).*

T: *I see. It seems that when you looked at the delivery note, you thought that you couldn't pick up the letter, and then your thoughts started moving into a catastrophic scenario. Do I understand that correctly?*

P: *Yes, it was terrible...*

T: *That sounds like a harrowing scenario. I understand that when you wondered how bad it could turn out, it was hard for you to go to the post office. It's also a letter that you need to pick up because you may have problems if you don't.*

P: *Yes, I couldn't do it, but I have to do it. But I can't ...*

T: *I understand that when you are depressed, you have a hard time concentrating, and you have to overcome things that used to be easier. It is difficult for you to pick up the letter, and you're afraid of the consequences if you would not do it. At the same time, you have thoughts that can be pretty burdensome. It also occurs to me that those thoughts may perhaps be too black. What do you think?*

P: *Maybe… Maybe it´s the depression. I don´t know… It´s scary…*

T: *Yeah, it seems that the depression is trying to cloud your view. Do you remember how we talked in the session that now you often think you're incompetent, and then you saw that you have many strengths and, despite your depression, you manage to accomplish a lot? How do you manage to go to the store and buy vegetables, fruits, and other food according to the list, even though you thought you couldn't do it before? Is it possible that now that you thought you couldn't go to the post office, it could also be similar?*

P: *I see. I completely forgot. That's the way it is now. I don't believe myself.*

T: *How did you feel the last time you came out of the store?*

P: *I was in a better mood. I felt better that I managed it. I thought maybe I wasn't so incompetent. However, I went to bed and woke up again in the morning, miserable.*

T: *The mood can change. Sometimes it´s better, sometimes it´s worse, but it gradually improves, step by step. You showed that when you went to the store. When you returned, how much did you believe you were incompetent?*

P: *About fifty per cent and that is progress. It used to be ninety, and that is true.*

T: *Uhm, I remember that. You looked uplifted when you talked about it in our last session. What about now? How much do you believe you can't go to the post office and pick up the letter?*

P: *Eighty per cent.*

T: *That's quite a lot. Still, you believed something wouldn't work, and then you managed to do it in the past. What do you say if we´d think together about how to go about picking up the letter and then doing it?*

P: *(sigh) Okay ...*

T: *Perfect. You said that you were afraid you would forget your ID. I wonder… Where do you keep it?*

P: *In the wallet. I'm afraid that I'll forget that wallet at home. I have a terrible memory now, and I don´t concentrate very well.*

T: *Uhm, I see. Do you have an idea what could you do to ensure you don't forget your wallet?*

P: *Well ... I could put my wallet next to the keys - I'll never forget those, so when I leave, I'll notice the wallet.*

T: *Perfect. You worked that very nicely. I like that. Can we agree to put your wallet next to the keys?*

P: *Uhm, I´ll put it in the same pocket in the jacket I always wear in the spring. This one.*

T: *Yeah, I like the jacket, and I think that its colour suits you very well and that it compliments your figure. So, you have your keys and the wallet, and then you come to the post office… What follows?*

P: *I'll take the ticket and wait until it's my turn.*

T: *Then you go to the counter and hand over the ID with the delivery note, ok?*

P: *Yes ...*

T: *And what will happen then?*

P: *The lady will find the letter, give it to me, and then I will go home.*

T: *How does that sound to you?*

P: *I could handle that. We won´t need to talk much, and it´s just about showing the ID.*

T: *Perfect, now you're encouraged. I have no doubt you can pick it up. How much do you think you can handle it now?*

P: *Forty per cent.*

T: *That sounds better than a while ago. Did you notice that? A moment ago, you only believed it for twenty per cent.*

P: *Well, that's true.*

T: *Can we arrange for you to go to the post office and pick up the letter?*

P: *Yes.*

T: *Great. When would you like to go there?*

P: *What about tomorrow morning?*

T: *Sounds good. I just want to ask why tomorrow morning?*

P: *I thought I would be tired today.*

T: *Uhm. What do you think would be better for you – to do it today or postpone it for tomorrow?*

P: *I would feel better leaving it for tomorrow, but I´d probably be still nervous in the morning.*

T: *I can imagine that you would feel relieved for now but a bit nervous in the morning. What do you think would be better for you?*

P: *Going there today, I guess…*

T: *Awesome! I imagine you will feel relieved when you do—and encouraged – similarly to when you went to the store. Would it be possible to do something that would help you go there today?*

P: *For example, as we said... Write now on a piece of paper what to take - mainly an ID, then eat something, and then I could go to the post office…*

T: *I like that plan. Moreover, you made it yourself.*

P: *Yeah, that's right.*

T: *And what could you get as a reward? You could use one.*

P: *I could watch my favourite TV series, one episode of the Black Dogs and Brown Otters: Why Friendship Matters.*

T: *That sounds perfect. Next time we'll talk about how you made it.*

Social activities

Patients with major depression often avoid social contact and thus remain isolated and on their own. At the same time, close people can present an essential source of support, motivation, and a different perspective to help patients manage their depression. Therefore, it is recommendable that the patient gradually restores their social contacts. If they would like to increase the decreased social activities, then:

1. We find out what prevents the patient from contact with others.
   - If it is fatigue, we work to reduce it according to the cause, for example, by establishing appropriate sleep hygiene or a diet, increasing physical activity, or considering the effect of medication and recommending its reassessment.
   - When the patients have negative beliefs about themselves ("I´m not socially attractive.") or others ("Others are rejecting."), we can choose cognitive restructuring or schema work.
   - We can plan social skills training if the patient feels unsure about social contact.
2. We set a reasonable goal together ("I will talk to a girl", "I will a good friend at least once a week") and the ways to achieve it (activity planning, behavioural experiments, exposures, social skills training, assertiveness training).
3. We implement the plan, monitor its success, and identify and address possible disruptive influences.

Self-reward

Rewarding oneself is a cornerstone of behavioural techniques. Leaving aside punishments, which have only a limited effect and usually worsen an individual's mental state, rewards are the fuel that draws a person to expose themselves to situations they fear, which they perceive as difficult or which they do not feel sure about. The chance of doing something uncomfortable increases when a patient rewards. They look forward to and associate unpleasant with pleasant things, thus alleviating the adverse effect through conditioning (especially for anxiety) over time. That is why rewards are essential (Table 1).

Planning pleasant activities

Major depression often brings fatigue, making a previously colourful life dull and uncomfortably grey.

Individuals with depression, therefore, tend to drop activities they enjoyed before and do not see any reason to continue implementing them when they no longer please them. However, enjoyable and relaxing activities are an essential part of the regime, and they help gain strength and living, not just survive. Therefore, the patient should reintroduce them into their daily routine. The approach can proceed as follows:

1. Educating about the need for pleasant activities in life
2. If the patient says, they can no longer experience pleasurable feelings, fill in the daily plan schedule. The patient writes down what they want to do and then what they did and evaluates on an analogous scale how successful the activity was and how much pleasure it brought them. Patients with depression often think that nothing improves their mood, and however, this simple technique can show them that they still experience at least slightly uplifting moments in some activities.
3. The patient then identifies these uplifting activities and plans to do them more often or for a more extended time.
4. Putting the plan into practice and monitoring the effect of previously pleasant (or new, potentially pleasant) activities on the patient's mood and activity.
5. Praising the progress and addressing possible maladaptive thoughts ("I don't deserve to be happy.")

Regime in remission

Achieving remission represents a significant milestone in the treatment. However, it is not the end of the therapeutic work. The patient needs to be informed about possible transient mood swings, that these are expected and not per se harmful but should be taken into account and handled accordingly (Lin *et al.* 1998). Maintaining a balanced daily routine is also a part of relapse prevention. This means that the patient should sleep at least somewhat regularly and adequately, eat relatively healthily, play sports several times a week, maintain fulfilling interpersonal relationships, rest satisfactorily, and avoid having excessive demands from oneself. This may occasionally be challenging because it represents a significant lifestyle change for many patients. However, a healthy lifestyle is a motto that most people accept and try to follow.

Regime in relapse management

Relapse is common in major depression (Lin *et al.* 1998). The most favourable scenario is when the relapse is halted at the beginning. It is needed to follow the principles of the balanced regime. It is common for the patient to back away from the regime and "get on the same train" as before. At the beginning of the relapse, they learn to follow the basic regime principles again. At the same time, it is appropriate to educate the patient that the slips are common and understandable so that they do not feel guilty and demoralised. Changing the daily rhythm alone may be enough to manage the relapse if we catch it initially.

The same work with the regime mentioned in the previous pages works with the developed relapse. Introducing medication may be appropriate – its adjustment if the patient is on a stabilising dose or start using it again if it has already been discontinued.

Conclusions

The establishment and maintenance of a balanced regime play an essential role in treating major depression. The health-promoting regime includes regularity, sufficient space for refreshing sleep, quality food, and activities that a) reinforce the will and self-confidence, b) allow to relax, or c) to enjoy, and d) lead to rewarding social contact. Adherence to a regime is often challenging for a person who is depressed, and it is a similarly difficult task for individuals who try to maintain remission or actively manage relapse. While setting up and maintaining a regime, slips are common and understandable; learning to handle these slips flexibly may help maintain remission. On this journey, the CBT therapist plays the role of a guide who helps patients find ways to reach a quality life without "the black dog".

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Tab. 1. Main principles of self-rewarding

- The individual creates a list of possible rewards. Some may be large (spending holidays abroad), but most should be regular – the ones they can use regularly. The list may include food and beverages (a piece of chocolate, favourite food, coffee, tea) or activities (sports, meeting a loved one, listening to a favourite song, attending a concert, reading, watching a favourite show, going for a walk in a favourite place, having a pleasant shower, etc.).
- The reward should be planned ("I'm afraid of the dentist, but I'll go there, and when I return, my wife and I will watch the film Hopeful Tomorrows we were looking forward to.").
- The reward is to follow an activity that the patient overcomes at least a little bit.
- Rewards should be specific and alternate.
- The individual should gradually start applying them irregularly. Irregular rewards reinforce the desired behaviour the most.

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