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Depression

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A grief without a pang, void, dark, and drear,
A stifled, drowsy, unimpassioned grief,
Which finds no natural outlet, no relief,
In a word, or sigh, or tear.

Samuel Taylor Coleridge, Dejection: An Ode

Matt, a 47-year-old stock broker and runner, reluctantly sought treatment with a sport psychologist, on the recommendation of his sports medicine physician and physical therapist. During a race three months previously, he had been side-lined with a hamstring tear; recovery was both slower and more painful than he anticipated. He told the sport psychologist, “I don’t know if this is going to help, but I can’t think what else to do. I’m feeling empty, like a shell of myself. I’m tired all the time – I think that’s because I sleep for about three hours and then spend the rest of the night going over all the things I have to do or didn’t do. When I get to work, I can’t focus. When I’m at home, my kids just irritate me. I know I should be enjoying my son’s soccer prowess but right now I just don’t care. I don’t even care if I run ever again – and that was always my great passion in life.”

The poem by Coleridge, and Matt’s presentation, illustrate the essence of the emotional, cognitive, and behavioral manifestations of major depressive disorder (MDD) or unipolar depression. An acute depressive episode involves changes – in thoughts, feelings, and behaviors – from previous functioning. A person is diagnosed with MDD under the following conditions: for at least a two-week period, the person has had either depressed mood or loss of interest or pleasure in most activities. Additionally, during that same time the person has experienced at least four of the following: significant changes in weight or appetite; changes in sleep patterns (especially early morning awakening, without being able to return to sleep); psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or unreasonable guilt; problems with concentration, indecisiveness; recurrent thoughts regarding death or suicide.

More generally classified under the rubric of mood disorders, MDD is differentiated from a number of other mood disorders: mania, at the other end of the mood spectrum; swings between mania and depression, formerly known as manic-depressive disorder but currently
described as bipolar disorder; or dysthymic disorder, involving chronic or persistent depressed mood but fewer of the cognitive, affective, and vegetative symptoms mentioned above. Other manifestations of depression include seasonal affective disorder, post-partum depression, and further variants that reflect the frequency, intensity, and/or duration of episodes.

**Differential diagnosis**

Grief is depression in proportion to circumstance; depression is grief out of proportion to circumstance. … Grief is a humble angel who leaves you with strong, clear thoughts and a sense of your own depth. Depression is a demon who leaves you appalled.

Andrew Solomon, *The Noonday Demon*

At different times, everyone experiences difficulties. Losses are an aspect of being alive; to be human is to suffer at least some of the time. In the quote above, though, Andrew Solomon highlighted some of the differences between “ordinary” sadness, loss, or grief as compared to depression. Depression is disproportionate to the precipitating circumstance; to the extent that depressed people feel “depth,” they also feel unable to haul themselves out of those depths. Loss, bereavement, or grief involves tangible deprivation. Although loss may precipitate or co-occur with depression, ultimately, depression can be differentiated from sadness by the number, extent, and/or duration of the symptoms.

For athletes, or those who work with athletes, it is important to distinguish between depression and overtraining or burnout. Symptoms of overtraining include such mental characteristics as depressed mood, irritability, and decreased sleep. Overtraining can be differentiated from MDD in that there is both evidence of a specific precipitant (intensive training over a prolonged period of time) and a direct method of assessment: if a marked decrease in training results in a reduction of the depressive symptom cluster, most likely the issue was overtraining (see Chapter 31 in this book).

**Co-morbidities and depression**

Depression is not necessarily a stand-alone disorder. Anxiety disorders and substance abuse may be present along with depressive disorders (Kessler, Berglund, Demler, Jin, & Walters, 2005). Some people “self-medicate” for their depressive feelings, typically with alcohol or other substances. Because alcohol is itself a depressant, however, this attempt at a solution may further compound the problem. Also, a complex interaction exists between eating disorders and depression (see Chapter 24 in this book).

Depression can also be one characteristic or symptom of other diagnostic issues, such as traumatic brain injury or post-traumatic stress disorder (PTSD). Among chronically ill patients or those recovering from acute medical illnesses, depression may play an integral role in the course of illness and recovery (Ebmeier, Donaghey, & Steele, 2006).

**Incidence, prevalence, and risk factors**

Depression has always been for me, and remains, a self-punishing language, a prolonged sensation of filthiness and worthlessness, of embarrassment at being alive;
a sickening deadness I enviously compare to the liveliness other people seem to enjoy.

John Bentley Mays, *In the Jaws of the Black Dogs: A Memoir of Depression*

MDD affects approximately 16% of U.S. adults at least once in their lifetimes (Gartlehner *et al.*, 2007). Major depression is increasingly diagnosed: During 1991–92 in the USA, 3.3% of the adult population was diagnosed with MDD; in 2001–02, the percentage was 7.1%, more than double that of ten years earlier. These increases were consistent across almost all socio-demographic population sub-groups (Compton, Conway, Stinson, & Grant, 2006).

MDD affects the ways in which people feel, think, and behave. It is thus not surprising that well over 50% of MDD patients experience role impairment (Ebmeier *et al.*, 2006). The financial as well as emotional costs are enormous: major depressive disorder is the leading cause of disability among people ages 15–44 in the USA (World Health Organization, 2004).

Women are twice as likely as men to experience depression (Ebmeier *et al.*, 2006), probably due to an interaction of social, economic, biological, and emotional factors (McGrath, Keita, Strickland, & Russo, 1990). Rates of depression also vary in relation to age, cultural and ethnic differences, and various other demographic characteristics.

Depression is a high-risk factor for suicide. Although many people with major depression do not contemplate, attempt, or commit suicide, more than half of the people who commit suicide were experiencing a mood disorder. Women attempt suicide at least twice as often as men, but four times as many men as women die as a result of suicide (Weissman *et al.*, 1999).

For both men and women, the primary risk factors for an episode of depression include: certain personality traits, drug and alcohol abuse, acute and chronic stress, traumatic experiences (including childhood traumas), a family history of depression, and a previous depressive episode.

**Athletes and depression**

Although athletes tend in general to be healthy, they are not immune from depression. Because of its frequency and ubiquity, depression has been described as the “common cold” of mental disorders (Andersen, 2002). Elite and sub-elite athletes often experience substantial stress both within sport (e.g., performance pressures, coach–athlete conflicts) and in their everyday lives (e.g., work, school, family expectations). Managing all these demands may be taxing. Because of their sport involvement, ironically, athletes may in some ways be at risk for depression (e.g., the risk of injury, the stress of handling injury recovery and rehabilitation). Psychological adjustment to injuries and rehabilitation management can be strongly influenced by athletes’ appraisals of their abilities to cope with their injuries, their attributions of the injuries’ causes, and their levels of confidence in full recovery. Further, the interaction of injury and depression can have a direct effect on the process of injury rehabilitation (for a case example of treatment of an athlete with injury-related depression, see Brewer & Petitpas, 2005).

**Diagnosis and treatment**

Depression was a very active state really. Even if you appeared to an observer to be immobilized, your mind was in a frenzy of paralysis. You were unable to function, but were actively despising yourself for it.

Lisa Alther, *Kinflicks*
Depression is generally diagnosed by subjective account or others’ reports or observations, because no laboratory tests have been developed to measure its presence. Beginning in the 1960s, a number of rating and self-rating scales were developed, designed to assess both the presence and the severity of symptoms. Among those scales most frequently used are the Hamilton Depression Rating Scale, the Beck Depression Inventory (BDI), the Symptom Checklist–90, and the Zung Self-Rating Depression Scale. Although self-rating scales are rife with a number of potential errors and inaccuracies, as general screening devices these measures operate somewhat like a thermometer: They indicate the presence and intensity of various somatic, behavioral, affective, and cognitive symptoms.

A number of types and kinds of treatment are available in the management of depression. Medication and/or psychotherapy are the most common.

**Psychotropic medication**

Medication designed specifically to treat depression was initially developed in the 1950s. Now described as first-generation antidepressants, tricyclic antidepressants (TCAs) are still prescribed. So-called second generation drugs include selective serotonin reuptake inhibitors (SSRIs) and serotonin and nor-epinephrine reuptake inhibitors (SNRIs). Currently, SSRIs and SNRIs are more typically prescribed for the treatment of depression; they may have fewer negative side effects and carry fewer risks than TCAs. In general, research has shown that these second-generation antidepressants have similar rates of effectiveness (Gartlehner et al., 2007).

**Psychotherapy for depression**

**Psychoanalytic and psychodynamic treatment**

Sigmund Freud developed psychoanalysis at the turn of the twentieth century: It is both a theory and a method of therapy. As currently practised, psychodynamic psychotherapy is a verbal, intensive, long-term treatment that addresses the underlying sources of a person’s problems: understanding or insight is considered central to behavior change. One shorthand version of the psychodynamic understanding of depression is that it is “anger turned inward.” For a case example of a depressed athlete, illustrating the use of psychodynamic therapy (in conjunction with other psychotherapy methods), see Cogan (2000).

**Cognitive-behavioral therapy (CBT)**

CBT came of age with the original 1979 publication of psychiatrist Aaron Beck’s (and colleagues’) *Cognitive Therapy of Depression* (see Beck, Rush, Shaw, & Emery, 1987). In contrast to earlier theories and therapies, CBT posits that depressive symptoms and behaviors are the result of dysfunctional beliefs and thoughts. By examining and challenging those negative assumptions and engaging in cognitive restructuring, positive changes in thought and behavior can result.

**Mindful attention without judgment**

Whereas psychodynamic treatment focuses on affect and CBT on faulty cognitions, researchers and practitioners have noted that attention to cognitions and affect, without judgment,
can have profound therapeutic effects. This perspective of nonjudgmental attention is central to acceptance therapy, dialectical behavior therapy, and most recently, mindfulness treatment specifically in regard to depression. Mindfulness-based cognitive therapy (MBCT), developed as a synthesis of mindfulness-based stress reduction (MBSR) and principles and practices of cognitive therapy, is characterized as a “combination of Western cognitive science and Eastern practices” (Williams, Teasdale, Segal, & Kabat-Zinn, 2007, p. 5). MBCT has been found especially effective in the prevention of further relapse for patients with three or more episodes of depression.

**Physical activity**

Depression is an inter-related function of negative mood and negative thought, described as mood congruence (Thayer, 2001). When people are depressed (mood), they tend to remember and focus on the negative things that have happened to them (negative cognitions). This interaction may be directional. If low energy produces negative cognitions (rather than negative cognitions resulting in low energy), increased energy associated with physical activity can serve, at least, a moderating function with regard to negative thoughts (Thayer, 2001).

Beginning in the 1920s, researchers began studying exercise as a low-cost, effective alternative to medication or psychotherapy for the treatment of depression – and one that does not have negative side effects. A number of analyses and meta-analyses (e.g., Landers & Arent, 2001) consistently report at least moderate effect sizes for exercise in reducing depression. Although seemingly too simple a treatment for a syndrome as serious and complex as depression, the prescription of exercise has increasingly gained legitimacy. Recent research suggests that there may even be a dose-response relationship (i.e., more exercise may result in more improvement). Dunn and colleagues (2005) conducted a randomized study of four aerobic exercise treatment groups, varying the frequency and intensity of exercise among a group of 80 adults diagnosed with mild to moderate MDD. After 12 weeks, those exercising at higher levels of intensity showed more significant recovery than those on a lower dose.

Physical activity is a particularly valuable treatment method for certain vulnerable populations. Depressed older adults, for example, have become significantly less depressed when treated with aerobic exercise (Penninx et al., 2002). Because of the ways in which exercise is related to increased self-esteem and empowerment, exercise appears to be a useful treatment option for depressed women. Vasquez (2002) found support for this relationship in work with Latinas.

**Comparisons of therapies**

Because a number of treatment options exist, research has been conducted comparing different forms or methods of treatment. Medications have been compared with each other; different methods of psychotherapy, likewise, have been compared with each other; and comparisons have been made between types of treatments.

Within a medical model, psychotherapy is typically relegated to the treatment of milder depression or, for more severe depression, as an adjunct to antidepressant medication (Ebmeier et al., 2006). Other models point to the usefulness of, for example, MBCT compared with anti-depressant medication in terms of relapse prevention, even in the face of discontinuation of medication (Kuyken et al., 2008).

As Cuijpers, van Straten, Andersson, and van Oppen (2008) noted, “[M]ost effects of psychological treatments are caused by common, nonspecific factors and not by particular techniques. These common factors include: the therapeutic alliance between therapist and
client, belief in the treatment, and a clear rationale explaining why the client has developed the problem” (p. 909).

Various studies of exercise, as compared with psychotherapy, have consistently found exercise to be a robust intervention for the treatment of depression (Hays, 1999; Johnsgard, 2004). Recently, comparisons of exercise with the use of SSRIs in depressed elderly patients has, again, suggested that exercise is an important and legitimate method of treatment for a wide range of depression (Babyak et al., 2000).

A model of evidence-based practice suggests that the best treatment for any one individual will take into account the research that informs practice, the clinician’s various sources of knowledge, and the attitudes, beliefs, and culture of the client (Goodheart, Kazdin, & Sternberg, 2006). This third element, often overlooked, is critical to successful treatment, particularly when changes both to that client’s thoughts and moods are involved.

**Treatment of depression: the case of Matt**

Depression sits on my chest like a sumo wrestler.

Sandra Scoppettone, *I’ll Be Leaving You Always*

In the short vignette about the runner Matt, which opened this chapter, I was his sport psychologist. A tall, lanky man, Matt exuded an air of somber hopelessness. As if an invisible cloak cut him off from human connection, he sat dejected, responsive to questions but initiating little. Dutifully, he completed a screening tool, the BDI. He admitted that at times, thoughts of being dead were appealing; nonetheless, though he felt that he was dragging himself through life, he had not considered suicide.

Matt was the eldest of three children in an intact family. The children were acutely aware that they should not disturb their mother on the days when she sat utterly still in a darkened room. Matt recalled that his mother had undergone three unexplained hospitalizations. Now as an adult, he surmised that those hospitalizations were for depression.

In high school, and then at university, Matt focused heavily on studying, broken only by his intense involvement and success in track and field. Following graduation, he worked successively at two brokerage firms and was considered a reliable and productive employee. Marrying in his late thirties, he had a stable, if unexciting, relationship with his wife. He surprised himself by the level of his involvement in his children’s lives, especially that of his eldest son. During his university years, Matt had felt overwhelmed at times, but he had never experienced this current level of emptiness and despair.

We reviewed his history of running. Taking up running again shortly after his marriage, he enjoyed long solitary runs that prepared him for three marathons a year. He recognized that in addition to the physical benefits, running was critically important to his self-definition; it also might have been important in staving off depression. During this period of injury and recovery, Matt had not explored any other form of exercise.

I focused on three primary tasks in our initial interview: understanding his current symptoms and obtaining relevant history, to form an initial diagnosis and treatment plan; establishing rapport; and initiating some treatment recommendations and suggestions. During this first interview, I asked specific questions and took notes. I responded to Matt's bewilderment and discomfort with careful reflection and explanation of my understanding of his experience.

I concluded the interview by discussing with Matt my diagnostic impression. Based on his symptoms, history, self-presentation, and the BDI results, he appeared to be
clinically depressed. I outlined for him what I saw as a likely course of treatment and anticipated outcomes.

Pointing out that the root of his depression might include some genetic factors, I noted that he had a choice of two biochemical-altering treatment options: medication or exercise. Matt was adamant that he did not want to take psychotropic medication. He had been cleared to begin running again, although initially at many fewer miles per week than prior to his injury. He said that he hadn’t started running. The task felt too effortful, and he felt too tired. Looking back at other times when he had sustained minor injuries and returned to running, he recalled that once he got started, the process wasn’t as arduous as it now felt. He committed to two runs, at the recommended distance, over the next week. I also suggested that he notice his mood both before and after the run (Hays, 1999). Using a 10-point scale, he recorded those two numbers in his BlackBerry. Although Matt was not enthusiastic about swimming, he agreed to check out his local pool and swim once, at least, and use the mood-rating scale for the swim as well.

Matt’s problem with sleep was also pivotal in relation to his recovery. We reviewed some elements of sleep hygiene. Additionally, he was intrigued by an initial explanation and demonstration of diaphragmatic breathing for deep relaxation as well as methods for mind-clearing.

Matt was not hopeful at this point, but he left the session with a clearer understanding, less distrust about the process, some specific plans, and a sense of direction. We scheduled a follow-up session for a week later.

At that session, Matt reported two nights of improved sleep: even when awake during the night, diaphragmatic breathing allowed him to drift peacefully. He had complied with the exercise plan. He was surprised that the run was less painful than he had anticipated. He had known intellectually that running improved his mood, but was startled to note that even with a short run, his sense of well-being had shifted 3 points each time. In contrast, even though swimming was of cardiovascular use, it had less effect on his mood.

During this session, we began working much more directly on some of Matt’s thoughts and beliefs about himself – his self-statements, capacity to catastrophize and to anticipate dire consequences. We framed out a simple thought record that he could use to record his cognitions. He also was willing to begin making use of “worry time” (30 minutes per day designated specifically for worrying) to contain negative thoughts and anticipations. With plans for a business trip the following week, we scheduled the next appointment for two weeks thence.

Over the next three months, Matt returned for five subsequent appointments. He saw our work together as a collaborative project. His negative bias about psychotherapy decreased; he even encouraged a friend to seek help. He returned to running on the schedule suggested by the physical therapist and supplemented the running with swimming and light weights. Although never enthusiastic about these latter forms of exercise, he recognized that they were helpful physiological adjuncts to his training. Additionally, he appreciated their psychophysiological benefit. Both improved his mood and served as place-markers that kept him from overtraining with running.

Sleep returned fairly rapidly, aided no doubt by the increase in energy expenditure through exercise. Matt developed an ongoing plan for worry time – and built it into his daily schedule of activities. Through the regular use of the thought record, he came to recognize his tendency to anticipate the most dire of consequences. Over time, he learned a number of methods to deal with his thoughts. He could dismiss irrelevant thoughts, challenge and counter them, or use his worry time to explore and resolve troubling issues.
Re-engaging with his family, Matt again took interest in his son’s soccer prowess. His daughter and he developed a special weekly time during which he would run while she biked beside him. He incorporated these sessions into his schedule to return to racing. His score on the BDI at this time indicated minimal levels of depression.

Matt recognized the probable genetic component to his depression and the need to actively monitor his tendency toward depression. He contacted me about 18 months later, at a point when his sleep was again becoming disrupted due to new pressures at work. Within a few sessions, Matt was able to re-stabilize his thoughts and emotions and remind himself of the methods that had previously served him well. For future reference, he wrote out a letter to himself of lessons he had learned and made a list of the mental tools he could use, on a continual basis through his life, to retain his equilibrium.

Conclusion

Depression is a complex interaction of thoughts, feelings, and behavior, one of the most frequently diagnosed disorders of mental health. Although all of us feel depressed at times, MDD is characterized by specific symptoms occurring over a period of time and with a certain depth. MDD is diagnosed through a combination of self-report and observation. Because of their general health, physical activity, and sense of purpose, athletes may be somewhat less vulnerable to depression but are by no means immune. Ironically, a number of the symptoms of athletic overtraining are also those characteristic of depression. Various treatment options for MDD include: psychotropic medication, psychotherapy, and physical activity, alone or in combination. In general, people experiencing MDD can be treated effectively; as well, treatment often decreases the likelihood of relapse. See Box 27.1 for take-home messages from this chapter.

Box 27.1

Take-home messages on depression

- Major depressive disorder (MDD) may be caused by any one or a combination of genetic, biochemical, intrapsychic, or situational factors.
- Depression can be differentiated from loss or grief by characteristic symptoms and the number, extent, or duration of these symptoms.
- Depression affects approximately 1/6 of the population at some time in their lives; during any one year, 7% of the population may experience depression.
- A person may experience a number of mental health issues at any one time; depression may also be a symptom of other problems.
- Although exercise is an important component in the prevention of depression as well as its treatment, overtraining can produce symptoms of depression.
- Athletes may be less likely to become depressed, but they are not immune to depression. Various stressors, including performance expectations, the management of weight or injury, and intense interpersonal relationships may increase the risk.
A number of treatments for depression exist, including psychotropic medication, psychotherapy, and exercise. The best treatment for a particular person should be based on a combination of relevant research, clinical knowledge, and the client's attitudes, beliefs, and culture.

References


