

Inside Depression Strategies by Claudia Black

Preface

For twenty-five years, I have been offering educational and clinical trainings to a variety of service providers. These range from family service agencies, to mental health centers, private psychotherapy practices, correctional facilities and addiction treatment programs. A common denominator for all providers has been the need to recognize and treat depression. Depression itself is a debilitating and sometimes, life-costing illness. Yet it is immanently treatable.

What is depression?

A psychological reaction to early life experiences

A learned behavioral style

A biochemical disorder

A genetic behavioral trait

The answer is all of the above. No one point of view represents a complete understanding of this complex condition.

My bias is that depression is a complex disease that is a combination of 1) disordered neurochemistry; 2) cognitive distortions; and 3) unresolved loss and pain (unresolved situational grief or having been subject to a loss condition, i.e. growing up with a raging, verbally abusive parent).

Typically, working with a client purely from a physiological, cognitive or affective orientation will not result in long-term recovery from depression. Frequently, it is only once a client receives appropriate medication that he or she can respond to a therapeutic process. Then, a combination of cognitive/behavioral and affective interventions can be effective. I have also found it important to acknowledge that what is missing in some clients' lives is a lack of spiritual meaning.

Depression is very common among spouses/partners of addicts and adult children raised in addicted families. In my many years of working with addicted clients and their family members, I have observed how relapse is fueled and recovery is impeded by depression that is unrecognized and untreated. I have treated clients with various types of depression. For some, the depression was a primary disorder; for others, it was a co-occurring disorder. Depression is often a co-occurring or subsequent disorder in the addicted client. Because of what I've learned

from my experiences, I have included material that will assist health care professionals in bridging a long time gap between the mental health and addiction fields.

This workbook is composed of six sections,

- Depression
- Depression History Strategies
- Cognitive Strategies
- Affective Strategies
- Behavioral Strategies
- Conceptive Spiritual Strategies

In each of the six sections I offer modules to give you ideas for structured interventions derived from the use of handouts. There is a variety of written exercises; graphs, checklists, sentence stems and art activities. When completed, these handouts provide your clients with a tangible picture of their disease and a roadmap for the recovery process.

These reproducible handouts and a compact disc, *Imageries*, are included in this workbook. The disc contains four imageries: Relaxation Exercise, Inner Child Affirmation, Inner Source of Wisdom and Letting Go and Receiving.

This is *not* a how-to-treat depression book. It is meant for use by the clinician already skilled in identifying and treating depression; one who is vigilant to recognizing co-occurring disorders, both psychiatric and addictive. This book was written trusting that the clinician has resources available to address the issue of indicated medications, the ability to assess and intervene if there is a possibility of suicide, and will incorporate sound clinical judgment in the use and timing of these exercises.

It is my hope this book will be a valuable aid to the mental health addiction practitioner or health care provider who is working with clients experiencing depression. With the foundation of good client assessment and intervention, this workbook, *Depression*, will be of great assistance.

Table of Contents

Preface

1 Depression: An Overview

2 Depression History Strategies

Session — *Depression History*

Depression History Discussion

Handout — Depression Index

Handout — Portrayal of Depression History (A)

Handout — Portrayal of Depression History (B)

Handout — Identification of Depression-Related Behaviors

Handout — Depression Graph

Handout — Triggers

Handout — Portrait of Depression

Session — *Loss*

Handout — Loss Events

Handout — Identifying Losses

Session — *Addiction History*

Handout — Portrayal of Addiction History (A)

Handout — Portrayal of Addiction History (B)

Handout — Addiction History Exercise

Handout — Addiction/Depression History Graph

Handout — Family Tree

3 Cognitive Strategies

Session — *Distorted Thinking Styles*

Handout — Distorted Thinking Styles

Session — *Cognitive Distortions*

Handout — Cognitive Distortions

Session — *Interrupting Faulty Thinking*

Session — *Inner Critic*

Handout — Inner Critic

Session — *Liking Yourself*

Handout — Liking Yourself

Handout — Self-Value

Session — *Stilted Success*

Handout — Stilted Success

Session — *Depression Self-Talk*

Session — *Affirmations*

Session — *Carried Beliefs and Feelings*

Handout — The Baggage Cart

Handout — Your Cart

4 Affective Strategies

Session — *Feelings*

Handout — Formative Years

Session — *Picture of Feelings*

Session — *Defenses and Feelings*

Handout — Masks

Handout — Defenses as a Mask

Session — *My House*

Handout — My House

Handout — Safe Places

Session — *Expression of Anger*

Handout — Scale of Anger

Handout — Anger Sentence Stem

Session — *Anger Patterns*

Handout — Anger Line

Session — *Beliefs That Deny Anger*

Handout — Beliefs That Deny Anger

Session — *Beliefs That Fuel Anger*

Handout — Beliefs That Fuel Anger

Session — *Recipient of Unjust Anger/or Inappropriate Behavior*

Handout — Inappropriate Behavior

Session — *Expression of Fear*

Handout — Scale of Fear

Handout — Fear Sentence Stem

Handout — Fear Line

Session — *Expression of Sadness*

Handout — Scale of Sadness

Handout — Sadness Sentence Stem

Handout — Sadness Line

Session — *Secrets*

5 Behavioral Strategies

Session — *Redirecting Depression Behaviors*

Handout — Identification of Depression-Related Behaviors

Session — *Accepting the Positive*

Session — *Stress Reduction*

Handout — Progressive Muscle Relaxation

Session — *Nutrition*

Handout — Basic Food Pyramid

Session — *Physical Activity*

Handout — How Active Are You?

Session — *Personal Choices*

Handout — Personal Choices

Session — *Triggers*

Handout — Assess Potential Depression Triggers

Session — *Healing and Recovery Tools*

Handout — Recovery Tools

Session — *Relapse Indicators*

Handout — Relapse Indicators

Session — *Warning Signs*

Handout — Warning Signs Checklist

Session — *Taking Risks*

Handout — Taking Risks

Session — *Portrait of Action Against Depression*

Handout — Portrait of Action Against Depression

Session — *Timeline of Accomplishments*

Handout — Timeline of Accomplishments

6 Conceptive Spiritual Strategies

Session — *Powerlessness*

Session — *Reinforcing the First Step*

Session — *Description of a Higher Power*

Spiritual History Discussion

Handout — Description of My Higher Power

Handout — Creating a Vision of My Higher Power

Session — *Spirituality and Religious History*

Session — *Practicing Spirituality*

Handout — Gratitude List

Session — *Faith Inspirations*

Handout — Desiderata

Handout — Faith Inspirations

Handout — Footprints

Handout — Praise to the Eternal Light

Handout — Native American Prayer

Excerpts

DEPRESSION HISTORY STRATEGIES HANDOUT

IDENTIFICATION OF DEPRESSION-RELATED BEHAVIORS

Check (✓) any of the following behaviors that you engage in while depressed.

drawing shades or keeping lights low

unplugging the phone or not answering it

not answering the door

staying in bed past normal rising time

- long periods of time (other than appropriate amount of sleep) spent in room or away from others
- avoidance of social events
- avoidance of family events
- avoidance of physical activity
- avoidance of work, reading, or other activity that requires concentration
- restricting your food intake
- bingeing on “comfort” foods or on whatever food is available
- listening to music or watching movies that cause you to be tearful, sad or agitated
- completing detailed tasks regarding your death (such as letter writing, distribution of valuables, writing will)
- spending impulsively, especially in amounts that you do not have readily available
- beginning several consecutive projects or tasks without finishing previous projects or tasks
- staying up for excessive number of hours or even days
- ignoring personal appearance and hygiene
- talking excessively
- behaving self-destructively i.e., cutting, burning, slapping self, etc.

Describe: _____

Other

Describe: _____

DEPRESSION HISTORY STRATEGIES HANDOUT

LOSS EVENTS

The following list of events that are often traumatic frequently fuel depression. Note whether or not you experienced any of them and indicate your approximate age or age range.

- Living with addiction (alcohol, drugs, work, gambling, sex) Age _____ Age Range _____
- Living with mental illness Age _____ Age Range _____
 - depression schizophrenia other

- | | | |
|---|-----------|-----------------|
| <input type="checkbox"/> Physical abuse
(hitting, slapping, pushing, shoving) | Age _____ | Age Range _____ |
| <input type="checkbox"/> Sexual abuse | Age _____ | Age Range _____ |
| <input type="checkbox"/> Emotional abuse
(being raged at, called names, left alone, being
covertly sexually abused – not being touched – but inappropriate nonetheless) | Age _____ | Age Range _____ |
| <input type="checkbox"/> Witnessing abuse of others in the family
(physical, sexual, emotional) | Age _____ | Age Range _____ |
| <input type="checkbox"/> Accidents
(auto, falls, fire, tornados, floods, etc.) | Age _____ | Age Range _____ |
| <input type="checkbox"/> Death of a pet
Your relationship to pet | Age _____ | Age Range _____ |
| <input type="checkbox"/> Death of a loved one
Your relationship to this person | Age _____ | Age Range _____ |
| <input type="checkbox"/> Important separations (Describe) | Age _____ | Age Range _____ |
| <input type="checkbox"/> Significant moves (Describe) | Age _____ | Age Range _____ |
| <input type="checkbox"/> Home | | |
| <input type="checkbox"/> School | | |
| <input type="checkbox"/> Work | | |

DEPRESSION HISTORY STRATEGIES HANDOUT

IDENTIFYING LOSSES

1) Identify three losses you experienced prior to the age of 10.

2) What did you do to cope with those losses? Be specific.

3) Identify three losses you experienced between the ages of 11 and 18.

4) What did you do to cope with those losses? Be specific.

5. Identify three losses you experienced in your adult life.

6) What did you do or have you done to cope with those losses? Be specific.

COGNITIVE STRATEGIES

Distorted Thinking Styles

Client Objectives

To identify distorted thinking styles

To develop a rational response to replace the distorted thinking

The handout, Distorted Thinking Styles, describes eleven types of distorted thinking. Ask the clients to identify two examples of each style, and with the use of a board, note the examples.

When the clients have shared, ask each of them to identify the three types of distorted thinking they most utilize. Then, with the examples they just gave, ask them to respond to the following questions. (It is helpful to write these questions on a board so that the client can refer to them.)

How did it feel when you used that distorted thinking?

How has it caused conflict between you and others?

What would be a rational comeback to replace that distorted thinking?

What might the result be?

If you are working with a group, ask each person to identify an example of distorted thinking and walk through the above questions with each example given. If certain distorted thinking styles are not identified, the clinician will need to assist in offering examples.

You may also find it more time-expedient for the group participants to work in pairs, each pair selecting one style of distorted thinking that is frequently used and work through the points together. When the full group is resumed, the group and clinician can offer additional feedback.

COGNITIVE STRATEGIES HANDOUT

DISTORTED THINKING STYLES

Depression is often fueled by distorted styles of thinking. The following are common thought patterns that create problems and generate negativity.

Filtering:	Looking at only one part of a situation to the exclusion of everything else.
Polarized Thinking:	Perceiving everything at the extremes, all-or-nothing thinking with no middle ground.
Overgeneralization:	Reaching a broad generalized conclusion based on just one piece of evidence.
Mind-Reading:	Making assumptions and reaching conclusions based on what you believe others are thinking.
Catastrophizing:	Always expecting the worst-case scenario.
Personalization:	Interpreting everything around you in a way that reflects on you and your self-worth.
Change Fallacy:	Assuming that other people will change to suit you if you pressure them enough.
Fairness Fallacy:	Falling into the trap of judging people's actions by rules that you have concocted about what is and what isn't fair.
Global Labeling:	Making a broad judgment based on very little evidence.
Blaming:	Believing that bad hurtful things that happen are someone else's fault.
Shoulds:	Operating from a rigid set of indisputable rules about how everyone, including yourself, should act.

Think of an example of a time you have used one of the distorted thinking styles listed above.

Identify the distortion.

How did it feel when you used that distorted thinking?

How has it caused conflict between you and others?

What would be a rational comeback to replace that distorted thinking?

What might the result be?

COGNITIVE STRATEGIES HANDOUT

COGNITIVE DISTORTIONS

FILTERING

Negative Thought: Every time I talk to my husband about my problems he tells me what to do. He's a bad husband.

***Counterthought:* At times my husband isn't the best listener, but he has other good qualities.**

POLARIZED THINKING

Negative Thought: It's 8:30 a.m. and I am late for work. I've spilled coffee on my new suit and put a run in my hosiery. This day is shot.

***Counterthought:* Good things may happen today. I can start my day over at any time.**

OVER GENERALIZATION

Negative Thought: Every time I drive on the freeway, someone gets in my way and cuts me off.

***Counterthought:* There are lots of drivers who give me enough room to drive. I'll focus on them instead of focusing on the one who cut me off.**

MIND READING

Negative Thought: She's late for dinner again and the food is getting cold. She's probably mad at me for being late to the movie last night. I'll bet she thinks I was late on purpose.

***Counterthought:* She's late for dinner again. I'm going to ask her when she gets here why she was late.**

CATASTROPHIZING

Negative Thought: The repairman didn't come on time and that means I'll be late to pick up the kids. Then dinner will be late, my husband will be mad at me and the kids will miss soccer practice. Then the kids will be mad at me, too. Sometimes I don't know why I bother. Life is so complicated and things don't work out the way they're supposed to.

***Counterthought:* ___ This isn't the end of the world. If the repairman is more than fifteen minutes late, I'll call to reschedule. If the repair work takes too long, I'll ask a neighbor to pick up the kids. I can manage.**

PERSONALIZATION

Negative Thought: My co-workers were laughing when they looked at me. I thought they were making fun of me.

***Counterthought:* I don't know why my co-workers were laughing; maybe they just heard a joke.**

CHANGE FALLACY

Negative Thought: If my mother would just work less, I know we would be closer to each other.

***Counterthought:* Whether my mother works less or more, only I can impact how I relate to my mother.**

FAIRNESS FALLACY

Negative Thought: It's only fair that Mark pays this bill since I offered to pay and paid for our last two lunches.

***Counterthought:* I will not expect Mark to pay without talking to him about it first.**

GLOBAL LABELING

Negative Thought: The people in that business are only interested in making money. They have no regard for ethics.

***Counterthought:* I don't know all of those people (I only know a few), therefore I can't possibly be aware of everyone's motives.**

BLAMING

Negative Thought: I wouldn't have lost my temper with you had you come home in time for dinner.

***Counterthought:* I have the right to be angry, but not to rage. I am responsible, not others, for my behavior.**

SHOULD

Negative Thought: I should not ever have to be angry if I just handle things right.

***Counterthought:* Everyone gets angry at times. I can learn to tolerate and express anger in a way that feels okay.**

COGNITIVE STRATEGIES

Interrupting Faulty Thinking

Client Objective

To interrupt faulty thinking

There are a variety of ways to begin to change or eliminate thinking processes that are distorted, negative, or faulty. Identifying the distorted thinking pattern is the first step. When the client is aware that he or she is mired in a pattern, taking control and applying the STOP technique is a simple yet effective process of eliminating faulty thinking. After providing the two examples below, supply cognitive distortions the client can identify. Strategize the thought-stopping techniques to the examples.

Example

First Step: **Identify the negative or faulty thinking.**

“It's never going to get any better.”

Call STOP: **Identify whether or not the thought is helpful.**

Does it reinforce helplessness? If it is not helpful or it reinforces helplessness, call STOP again.

Describe the situation that fueled this thinking.

“When my husband said hurtful things to me, I spoke up, but he didn’t listen or apologize, he just left the house.”

Refute the situation.

“I stood up for myself and that is good.”

One *cannot* change another person’s behavior. In this situation the goal begins with asserting oneself and beginning to practice self-care.

Example

First Step: **Identify the negative or faulty thinking.**

“My son isn’t home on time, he is probably in a car wreck and dead.”

Call STOP: **Identify whether or not the thought is helpful.**

“Not helpful.”

Describe the situation that fueled this thinking.

“My son did not come home when he should have and lots of kids die on the road when they are out late at night.”

Refute the situation.

“I have no information to indicate there has been an accident or that my son is involved in anything hurtful. I only know he is not home on time. There could be many reasons why he isn’t home yet. He could have had a flat tire, or maybe he’s having fun and hasn’t noticed the time.”

To identify other possibilities moves the person out of the catastrophizing mentality. Once out of that pattern, a healthier response and/or healthier problem-solving can take place.

This process of interrupting faulty thinking only works if it is practiced repeatedly. Have the client begin to utilize this STOP technique with a situation that is easy for the client to identify. With practice, the process will become automatic during those more subtle occasions when his or her thinking is faulty.