jack hirose & ASSOCIATES INC.
Quality workshops & community resources

THE EVIDENCE-BASED AND INDIVIDUALIZED TREATMENT OF DEPRESSION

TUESDAYS: OCTOBER 2 - NOVEMBER 6, 2018 | 11:00AM - 1:00PM PST

WORKSHOP AGENDA

Week 1: Assessment, risk factors, and model
Which clients are these materials for?
Review of diagnostic criteria
Non-diagnostic symptoms associated with depression
Assessment strategy and goals
Risk factors and their relationship to treatment components
The floating diamond and nine-factor models of depression

Week 2: Behavioural activation strategies
Getting the client on board with life change
The $10 million question
The kidnapping question
Defining ultimate goals
Defining and setting effective immediate goals
Self-compassion in behavioural activation
Coping with success and failure

Week 3: The antidepressant lifestyle
Exercise: The most potent antidepressant
Dietary guidelines and supplementation
Sleep hygiene training
Caffeine: Friend or foe?
Media buffering
Work and finances
The usefulness of routine, and 3-periods scheduling

Week 4: Depression in the social context
The social census
Social contact assessment
Initiating, deepening, and reviving connections
The partner and family during depression
Assertiveness and boundaries
The personal support team

Week 5: Overcoming negative thinking
Introducing cognitive work
Cognitive challenging using column forms
Depressogenic beliefs, biases, and attributions
The outcome of cognitive work: Revolution or detachment?
Secondary appraisals: Overcoming the rejection of painful emotion
The river metaphor
Cognitive traps associated with mood fluctuations

Week 6: Meaning and relapse prevention
The role of meaning in recovery
Helping clients identify values and sources of meaning
Contribution-focused strategies
Mindfulness in recovery and relapse prevention
Preparing for the worst: Stress and relapse plans
Course wrap up

LEARNING OBJECTIVES

By the end of this course, you will:

- Have an organizing principle for your assessment.
- Be able to present two related models for depression symptoms, causes, and treatment.
- Be able to structure behavioural activation for maximum effect.
- Be able to identify lifestyle factors for targeted treatment focus.
- Know how to introduce cognitive therapy concepts with depressed clients.
- Understand the role of depressogenic primary and secondary appraisals.
- Be able to integrate meaning-focused work within standard CBT.
- Have the basics for relapse prevention and planning.
- Own a set of 40+ client handouts for use with your own clients.

Randy Paterson, Ph.D, R.Psych. is the founder and owner of Changeways Clinic, one of Vancouver's largest psychological practices. He is the lead author of The Core Program, Canada's most widely-used group therapy protocol for depression, and coauthor (with Dan Bilsker) of the online Antidepressant Skills Workbook. His books include How to be Miserable: 40 Strategies You Already Use, Your Depression Map, The Assertiveness Workbook, and Private Practice Made Simple. He has conducted over 250 workshops and training programs for mental health practitioners on topics ranging from diversity awareness to depression treatment to psychotherapy process. Materials based on his work have been translated into 10 languages.

1

Treating Depression

An Individualized And Evidence-Based Approach

Randy Paterson PhD
Changeways Clinic

2

The Course

1. Assessment, risk factors, & model
2. Behavioural activation
3. The antidepressant lifestyle
4. Overcoming negative thinking
5. Emotion and social support
6. Meaning & relapse prevention

3

Modularity

For each client:

Assess and collaboratively create treatment plan.

Generally, do behavioural activation early.

Then, select and order elements based on individual priorities.

Material late in the course may be introduced early for your client.

4

Limitations

We won't discuss all the treatment options for comorbid conditions.

We won't focus on historical issues - though these may be valuable in your therapy.

We will not focus on suicide risk assessment and prevention, which merits a course of its own.

5

Let's make it interactional!

Email me your questions & comments!

paterson@changeways.com

I will reply, and create a weekly email digest sent to all students.

6

The Course

1. Assessment, risk factors, & model
2. Behavioural activation
3. The antidepressant lifestyle
4. Overcoming negative thinking
5. Emotion and social support
6. Meaning & relapse prevention

7

Session One: Assessment, Risk Factors, & Model

8

Today

Introductions
Defining our population
Assessment strategy
The floating diamond
The depression map
Risk factors
Treatment planning

9

Defining our population

10

Major depressive disorder

Lifetime prevalence

- 5-12% of men
- 10-25% of women

11

Dysthymia

Generally milder intensity.

Present a majority of the time, at least 2 years.

Lifetime prevalence: About 2.5%.

12

Subclinical depression

Lifetime prevalence:

- Unknown.
- Likely a majority of the population.

Low mood and periods of difficulty are NORMAL human experiences.

- Though not disorders, people can often benefit from therapy.

13

Related presentations

Bipolar disorder

Various anxiety disorders

Adjustment disorder

Bereavement

Failure to launch

14

Assessment Phase

15

Why assess?

"So that I can diagnose the problem."

Some regard assessment and diagnosis as virtual synonyms.

My stance: These are opposites.

16

Assessment

The process of establishing a caring relationship with a client,

and learning about their life, thinking, and situation,

so that the problem becomes understandable,

and no longer sounds like a disorder.

17

Diagnosis

The process of taking all that complexity,

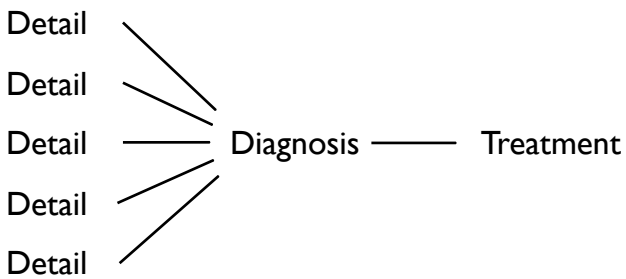
and reducing it to a concise label,

that trims away all the detail,

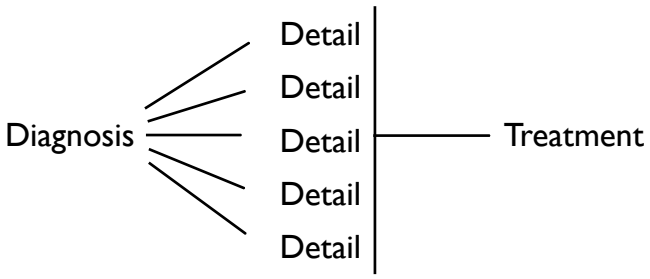
to the point that we don't know how to proceed,

other than to regard them as ill, and not like us.

18



19



20

So diagnosis is useless?

Often, depressive symptoms - and episodes - can be normative responses to extreme stresses, or to certain ways of living or thinking.

We would be depressed too, if we had similar lives.

We can label the response cluster as depression.

But this often gives us little additional insight.

21

So diagnosis is useless?

It can give useful hints.

It may reassure some clients.

"This is a thing, it even has a name, and other people have had it too."

It can also be damaging.

"Yes, you DO have problems A, B, C, and D. And you're mentally ill on top of it all!"

22

A Core Idea

Depression is not a disease.

It is a destination.

There are many paths to this place.

Understanding the client's path IN can point you to the path OUT.

23

3 kinds of risk factors

Vulnerability factors

- Present before the disorder appears.

Precipitating factors (or triggers)

- Turn a vulnerability into a disorder.

Maintaining factors

- Appear after the disorder starts, and helps perpetuate it. Often symptoms.

24

Assessment Strategy

25

What's Up?

What brings the client to see you?

Why now and not before?

What is their present life situation?

What reactions (symptoms) are they experiencing?

Consider the diagnostic criteria if relevant (to guide treatment, assess severity, communicate with other providers, for admin reasons).

26

Development of the problem

When did it start?

Sudden or gradual?

What makes it intensify or wane?

What does client think are causes / risk factors?

Do you have other possible risk factors to ask about?

27

A Core Idea

"Biochemical imbalance" explanations are usually unhelpful.

The science is poor, the tests are absent.

The intent is to alleviate guilt and shame.

The effect is iatrogenic helplessness.

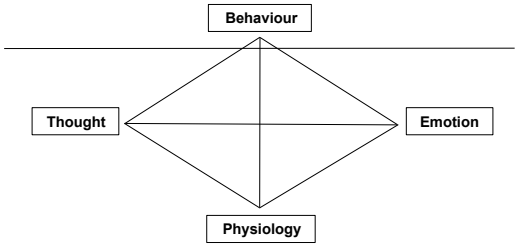
Helplessness is the problem, not the solution.

Avoid reinforcing OR disputing the idea.

28

The Floating Diamond

29



30

Behaviour

- Inactivity
- Changes in eating habits*
- Changes in sleep habits*
- Avoidance of others
- Poor self-care
- Lack of exercise
- Allowing chores to build up

* Diagnostic criterion

31

Emotion

Sadness or feeling 'down'*
Emptiness
Anhedonia* (a="not", "hedon"=enjoyment)
Despair
Anxiety
Guilt and shame*
Anger

* Diagnostic criterion

32

Thought

Neg. view of self, future, world
Biased perception and memory
Easily overwhelmed
Difficulties concentrating, making decisions*
Sense of worthlessness*
Poor memory
Thoughts of death or being better off dead*

* Diagnostic criterion

33

Physiology

Agitation or slowing*
Weight loss or gain*
Insomnia or hypersomnia*
Fatigue*
Reduced sex drive
Malaise

* Diagnostic criterion

34

Usefulness with clients: Point 1

Depressive symptoms feel like a big confusing tangle of problems.

Part of the function of therapy is to tease this apart and organize their experience.

Can use the diamond form to record the symptoms in each area.

35

Usefulness with clients: Point 2

Depression is said to be a MOOD disorder.

It isn't.

Depression affects EVERYTHING.

This can normalize part of their experience.

36

Usefulness with clients: Point 3

We can use the model to educate family members about

- How depression works.
- Why the person acts the way they do.

37

Usefulness with clients: Point 4

We can show how reverberations work within the system.

38

Virus Flu Symptoms

39

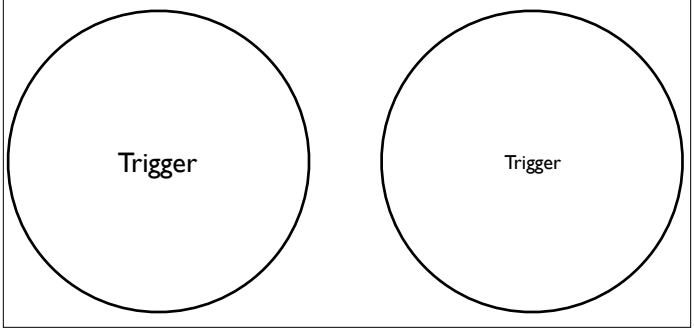
Depression Sleep Disruption

40

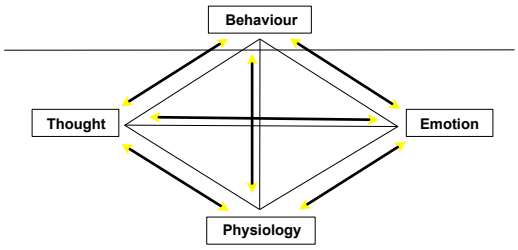
Common Snowballs

- Insomnia
- Light avoidance
- Social withdrawal
- Poor diet
- Lack of enjoyable activity
- Little exercise
- Little structure in the day
- Negative thinking
- Use of alcohol, drugs, or caffeine

41



42



43

The usual CBT model

Situation

↓

Thoughts, Behaviour

↓

Emotional State

44

But our model is lacking.

45

Social risk factors

Isolation.

Impoverished social network.

Relationship breakdowns.

Family issues.

Romantic/relationship problems.

Role conflict.

Difficult/abusive relationships.

Lack of assertiveness skills.

46

Situational risk factors

Major life events
Over/underpacked life.
Immigration / acculturation.
Housing / community issues.
Screen time.
Trying to live at 100% of capacity.
Work/life balance.
Career issues.
Personal finances.
No contact with nature.
… and, of course, too many more to name.

47

Biological risk factors

Genetics / family history.

But: We inherit vulnerability, not depression.

A risk, not a heritage.

Substance use (direct and indirect effects).

Medications (mood effects are common).

Poor nutrition.

Physical illness; pain.

Childbirth.

48

Historical risk factors

Poor attachment history.

Relationship disruption in childhood.

Parenting.

Trauma & abuse (distant and recent).

Past unresolved losses.

Unprocessed bereavement.

Meaning-based risk factors

49

Sense of meaninglessness.

Living contrary to one's values (eg in job).

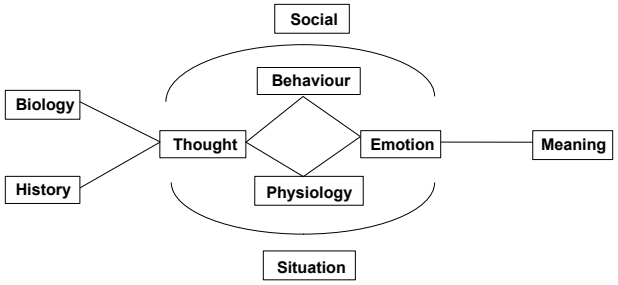
Pursuit of meaning in dry channels (competition, winning, wealth, consumerism, admiration).

Lack of meaningful activity.

Life stage crisis.

Loss/questioning of previously-held ideas re meaning (eg faith).

50



Historical Treatment

51

History usually helps explain WHY the depression started.

What's it's role in treatment?

- We can't go back in time and change things.
- History is relevant to the extent that it affects thoughts and behaviour NOW.

Cognitive work addresses current thinking.

Behavioural work addresses current behaviour.

So, no role for history?

52

Knowing the history helps us target present-day effects.

Some treatment - e.g., of trauma - involves working with memory.

In CBT-based depression treatment we MAY do some historical work.

This course offers mainly present-focused tools.

What about insight?

53

One perspective:

- The function of therapy is to assist the client to develop insight into problems.
- Once insight is achieved, the problem will resolve.

Evidence of this: Scant to none.

Many depressed clients have great insight into why they are depressed.

- This changes little.

What about insight?

54

A CBT-based perspective:

- Insight does not usually produce change.
- It is mainly useful as a guide to action.
- Insight can lead to more precise targeting of the problem.

CBT emphasizes insight into how the current situation, behaviour, and thinking is influencing symptoms.

- Then works to shift these.

55

Assessment Tools

56

Sections of the DMQ

9 Goal Setting
12 Behaviour
14 Thoughts
15 Emotion
16 Situation
17 Social
18 Meaning

57

Why use the DMQ?

It provides HINTS about possible risk factors.

There are many therapeutic options. This can help you choose useful ones.

It helps clients begin linking depression to CAUSES.

It teases the problem apart into realms.

58

The Punctuation Mark

59

Assessment

Engagement

Therapy

60

A Core Idea

Our impulse to help can sabotage therapy.

We assess the problem, then rush to treat it...

...without an invitation.

...as though we can take charge.

61

The Truth of the Matter

It is the client's life.

It is the client's problem.

The client will do the real work.

So the client must be in control.

If we try to take charge...

...it is the client's JOB to resist us.

62

Thanks & Followup

For putting up with questioning.

For completing measures.

"Were there important things we missed...?"

"Did you have questions for me...?"

63

Normalize / Depathologize

The emotional response, given the situation.

The choice of coping strategies given the situation.

Even if they made things worse.

The development of depression itself, if appropriate.

64

Empathy

Sketch the client's life situation.

Acknowledge the difficulty.

DO NOT offer solutions up front.

This step is the easiest to miss!

65

The Kidnapping Question

"Imagine if we gave 10 people your life for one month..."

Stressors, sleep schedule, relatives, work, etc.

Only the client's present, not the history.

"After a month, how would they be?"

This may open the door to change.

66

Create a Vision

"Imagine this goes really well…

We follow you with a video camera in that future.

What do we see?"

This tells us the client's goals.

And gives us a behavioural focus.

Write all their answers down!

67

Anticipate Resistance

68

A Core Idea

Client resistance says more about our errors...

...than about their personality.

69

Outcome Resistance

Ambivalence or antipathy toward the goal(s) of therapy.

"Therapy is going over there, and I'm not convinced I WANT to go there."

70

Causes of Outcome Resistance: 1

Client is in therapy as part of someone else's agenda.

- Referring caregiver
- Parents
- Spouse
- Justice system
- Employer

Why is he/she there? Ensure you find out.

71

Causes of Outcome Resistance: 2

Therapist picked the outcome, not the client.

- Never assume you know the client's goal.

"Imagine things go really well. What would be different in your life?"

"We see a video of you feeling better. What are you doing?"

72

Causes of Outcome Resistance: 3

Hidden disadvantages of getting well.

- Sometimes obvious, but usually subtle.
  - Loss of insurance / court case
  - Client takes back a hated role
  - Would have to face my fears
  - Would betray my ideals ("I SHOULD be miserable given my faults/failings")

73

Process Resistance

Ambivalence or antipathy toward the means of reaching the client's goal.

"I want that, but I don't like the way of getting there."

74

Causes of Process Resistance: 1

Client doesn't understand the rationale for the approach you suggest.

- Ensure you present the rationale before you begin.

Then check it out.

"Does that sound like a reasonable approach?"

"Is it similar to what you were expecting?"

75

Causes of Process Resistance: 2

Investment in previous therapy strategies.

- "How will this cure my biochemical imbalance?"
- "But we have to resolve my childhood issues."

Assess the client's model for improvement.

"How much have you tried that? How successful has it been?"

"Would you be willing to try another approach?"

76

Causes of Process Resistance: 3

Investment in existing coping strategies.

- "Staying home DOES help me feel better."
- "Criticizing myself will force me to change."

Assess beliefs about current strategies.

"Is it helping you long term?"

77

The Short Term Long Term Problem

Many strategies DO help short term.

- Staying home, avoiding fears.
- Long term, things get worse.

Our strategies may feel WORSE short term.

- Exercising, seeing people, doing chores.
- Long term, these tend to pay off.

78

Causes of Process Resistance: 4

Fear of the path.

- "I can't tolerate the discomfort."
- "I'm afraid to get out of the house."
- "What if I fail?"

Encourage avoidance of overly ambitious goals.

Place control firmly in client's hand.

"I will need you to choose the pace."

79

The Paradoxical Cost Benefit Analysis

Pull back gently.

Recite the good reasons NOT to change.

Give space for the client to reach out for the therapy.

DO NOT talk the client into therapy.

80

Before we begin...

Are you really ready to make a change?

(How badly do you want this?)

Are you willing to do homework?

If not, therapy won't work.

Are you willing to experience some discomfort?

How much?

81

Acculturation to therapy

82

Early sessions define the culture of your therapy.

How does therapy work?

What are the expectations?

The norms are set in the first few sessions.

If you set a norm that says therapy is a Q & A session, you may never be able to change it!

83

Set the norm for therapy early!

Clients must not see therapy as a passive, receptive process.

THEY are the true therapists. We are just helpers.

SO: Start home practice with the FIRST session.

- Questionnaires
- Goal setting handout?
- Behavioural monitoring?

84

For best results …

Start the home practice …

BEFORE THEY SEE YOU.

… and EVERY session after that.

EG, with intake forms.

85

Ready to go?

86

The "Me Guide"

Suggest that clients get a binder for handouts and worksheets you give them.

Or offer them one. They're cheap!

Otherwise your exercise and reminder sheets WILL be lost and disorganized.

87

Personal journal/ Exercise book

Strongly suggest…

Either on ruled paper in the binder, or a separate inexpensive journal.

Weekly goal lists, brainstorming exercises, thought records, and more.

88

Homework

Try listing YOUR OWN risk factors for depression - even if you've never experienced it.

Consider completing the DMQ based on your own low or dissatisfied periods.

Do you discover anything that could be useful next time you're feeling blah or down?

89

Session Two: Behavioural Activation

90

Today …

Why we generally start with behaviour.

The $10 million question.

Generating Ultimate Goals.

Defining and setting Immediate Goals.

Self-compassion in behavioural activation.

Coping with success and failure.

Behaviour or Thoughts First?

91

Where to begin…

92

CBT is an amalgamation of behavioural and cognitive approaches.

When treating depression, we usually begin with behavioural strategies.

Why behaviour?

93

Behavioural strategies generally have stronger research support.

The actual circumstances of the person's life may perpetuate depressive mood.

- Changing these may help a great deal.
- "My life is dull and I'm not getting anywhere" is sometimes not a cognitive distortion.

94

Why behaviour?

Depression produces "brain fog."

- Cognitive strategies may be more difficult to grasp at first.

We can start off doing cognitive work in the context of behavioural work.

- Helping set appropriate expectations.
- Drawing client's attention to successes.
- Later, we can make this more explicit.

95

Use your judgment

Sometimes cognitive work is the place to begin.

- The life is fine; it's the thoughts that need work.
- Distorted or unhelpful thinking will block behavioural work unless addressed.
- The client is motivated to do cognitive work.
- There isn't too much brain fog to get in the way.

96

WHICH behavioural work?

Let's start with something that can be used across most domains:

- Lifestyle / social / situation / meaning.
- Later we can zoom in on particular issues.

So: Behavioural activation / Goal setting.

97

Exercise

Write down a goal that your client may have in mind as a part of therapy:

Get in shape, eat better, get a job, reconnect with family - anything.

Come up with a good first step toward this goal that they could do this week.

Keep this in mind as we proceed.

98

Why is Behavioural Activation (BA) Important?

99

What is therapy?

Therapy
1 hr / week

Rest of client's life: 167 hrs / week

100

There is no magic.

101

A Core Idea

Therapy is weak.
Life is strong.

102

Most of BA is about
GIVING UP.

103

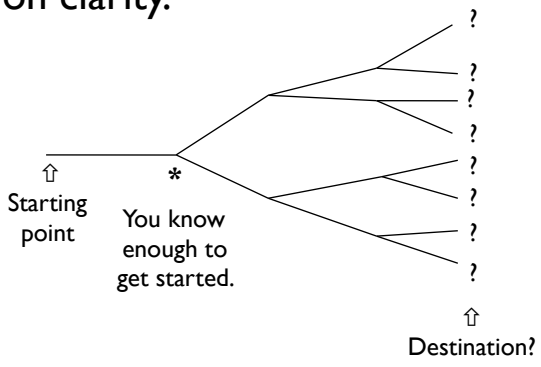
A common problem …

"I don't know where I need to go or want to do."

"How can I start if I don't know where I'm going?"

104

Answer: GIVE UP on clarity.



105

The Energy Crisis

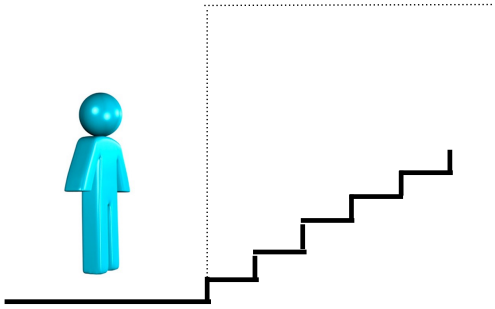
"I don't have any energy anyway."

So let's not try.

GIVE UP on achieving what you want in one step.

Refocus on a smaller step.

The Energy Crisis



106

The motivation problem

107

Motivation: The intuitive model

Feel better

↓

Get motivated

↓

Create life change

108

The reality of motivation

Feel better

↑

Get motivated

↑

Create life change

109

How do you motivate a depressed client?

You don't.

Sometimes they are TOO motivated.

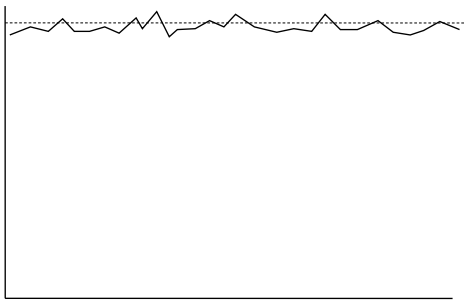
"I want to get well NOW!"

Often we need to DE-motivate them.

Much of goal setting is about GIVING UP.

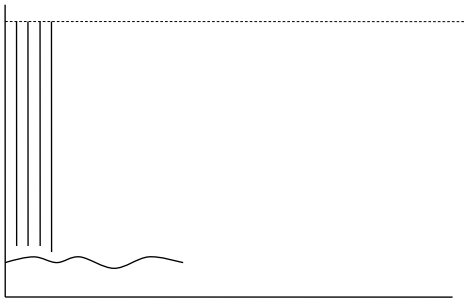
110

Expectations and performance



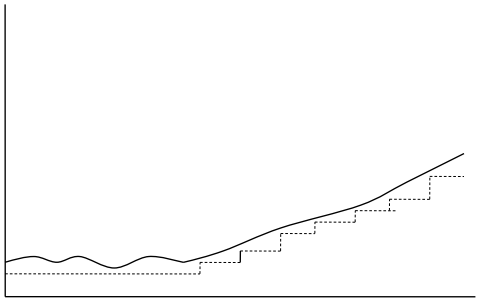
111

Expectations and performance



112

With success, gradually increase goal magnitude.



113

Goal setting by giving up

We define a destination.

We GIVE UP on getting there in one step.

We break it down to smaller steps.

We focus attention mostly on the process, not the destination.

114

115

The Therapist's Role

Usually: To SHRINK goals that the client suggests.

Everyone else is trying to RAISE them.

Again: Clients are not unmotivated.

They are usually TOO motivated.

This is what stops them.

116

Demotivating the client

Encourage client to acknowledge what they have been doing (or not doing).

Encourage client to relinquish hope for the sudden cure.

Distinguish between ULTIMATE and IMMEDIATE goals.

117

Distinguish between Ultimate & Immediate Goals

118

Ultimate Goals

ANY goal that takes more than one step.

- Do this year's taxes
- Take up rowing
- Learn Spanish
- Buy a house
- Stop drinking
- Change jobs

119

Ultimate Goals

Behavioural is better.

These may involve thoughts or emotions, but strive to make changes measurable.

- Have less than 1 panic attack per week.
- Learn to do thought challenging.

Completion criteria can be a bit vague.

- How good must the Spanish be?

120

Immediate Goals

A goal that takes only one step.

Can be done this week.

Usually in an hour or less.

It MAY serve an ULTIMATE goal.

- "Gather tax documents into one box."

Or it may be ongoing "maintenance."

- "Do dishes one time."

121

Get the vision from the client

122

Problem

Too often, therapists decide what the client needs.

Quit drinking, sleep reasonable hours, exercise.

Predictably, the client resists.

They have the power, so THEY need to pick the goals.

123

Therapy as Taxi

Clients often attend therapy because they don't like where they ARE.

We need them to take the lead in identifying where they would LIKE to be.

One difference: They will do all the driving.

The video question

124

Therapy goes really well …

6 months from now we follow you around with a camera …

What do you want to see on this video?

NOTE: We can't see how you feel or think. All we can see is what you are DOING.

The GOOD LIFE exercise

125

What is the good life?

What are you doing NOW?

What would you be doing THEN?

Problems are often easier to identify than goals

126

The problem inventory

Sometimes, clients can't come up with a positive vision.

"Umm, I don't know. Feel better?"

So: What DON'T you like? List your problems.

Every problem reveals an Ultimate Goal.

127

What to do with the problem list

Problems

↓

Goals

↓

Plans

128

Pay off my debts

I'm hugely in debt.

Improve my social network

I have no friends

129

130

What if you wanted to feel **worse**?

131

The $10 million Question

Imagine you wanted to feel WORSE, not better.

Maybe you'd win a large sum of money.

What would you do? What makes it worse?

The depressive filter makes this a simple task.

132

The $10 million Question

Every strategy is also a way to feel BETTER.

Stay in bed ➢ Get up.

Isolate ➢ See people.

Many clients see they are living as though they wanted to feel worse already.

This suggests a change of course - via goal setting.

133

The past is sometimes the best guide to the future.

134

Looking back

The future seems vague or bleak during depression.

Most clients can recall somewhat better times.

What was happening then?

What are you most glad to have had in your life?

What has been satisfying or enjoyable for you in the past?

135

Consider Suggesting the Realms

136

Daily routine
Financial
Learning & skills
Social
Vocational
Avocational
Experiential
Contributory

137

A longer handout on goals

138

Goal Setting
Handout Sequence

1. Problem list
   "Give up on solving problems, just list.
   Why list problems? Why not goals?
2. Pick one problem
   "Give up on most problems. Just pick one."

Goal Setting
Handout Sequence

3. Identify the ULTIMATE goal
   - "If you DON'T want X, you DO want ...?"
   - Every problem hides an Ultimate Goal.
4. GIVE UP on reaching it for now
   - Split it into manageable steps
   - We really only need the first of these.

139

Goal Setting
Handout Sequence

5. Make a plan for the IMMEDIATE goal
   - Follow the SMART rules

140

SMART Immediate Goals

141

142

SMART:
S - Specific

The Immediate Goal must be specific.

- Key word: HOW

Any small barrier will stop a depressed client.

Therapist: Try to anticipate problems, roadblocks.

- Eliminate vagueness!
- "How would you get there? What would you need to have with you?"

143

SMART:
M - My Own

It must be the CLIENT's goal

- Not yours
- Not their spouse's
- Something THEY want to do OR get done.

It must not depend on someone else.

- No good: "Go to movie with Frank."
- Better:

144

SMART:
A - Action Oriented

The goal must be to DO something.

- Behavioural.
- Not to like it.
- Not to think positively about it.

We have more control over actions than thoughts or feelings.

- "Visit museum." NOT "Enjoy museum."
- Let yourself feel what you feel.

SMART:
R - Realistic

Clients want a goal:
small enough to be achievable
big enough not to seem silly.

Goal

Significant

Achievable

Problem: There may be no such goal.
If it's achievable, it may seem insignificant.
This is fine.

145

SMART:
R - Realistic

Immediate Goals must be realistic.

Client must feel 95% confident the goal can be completed.

Even if this week is worse than last.

Therapist: Watch for uncertainty, or "I'll try..."

There must be a clear finish line.

Eliminate vagueness!

No finish line: No success, so no boost.

146

SMART:
T - Time-Defined

There must be a time frame for the goal.

Sometimes: This week.

Sometimes: Thursday evening, 8 pm.

Therapist: Watch out for "When I feel like it..."

The impulse will never come.

The client must do it without the desire.

147

148

More tips for good Immediate Goals

149

Encourage enjoyable activity

Anhedonia will reduce the appeal of formerly enjoyed activities.

Depressed clients often neglect these.

Push low-intensity versions of these.

They liked long backpacking trips?

Maybe one hour walking in the park.

150

Encourage anhedonic tolerance

"The first few times you bike / play cards / see friends / go out, you may not enjoy it the way you used to."

"Let yourself feel whatever you feel, and do it anyway."

"How you feel the first time is no indication of how you'll feel eventually."

151

Watch your speech!

"Try it and see. Maybe it'll be fun."

Probably not!

The client will try it, hoping for enjoyment, and most likely being disappointed.

The goal is the ACTIVITY, not the emotion it produces.

It will usually take several times before ANY enjoyment comes back.

152

Avoid 7/7 goals

"Every day, I will …"

No one does anything every day.

If they miss once, the week is a failure.

153

Make multiples into separate goals

"Run 1 km, 3 times this week."

What if they run twice?

Run 1 km.

Run 1 km.

Run 1 km.

Now they will have 2 successes, instead of a failure.

Yes, this DOES seem to help.

154

The finish line: Completion

If the task is predictable in terms of time and effort, make completion the goal.

- Hang one picture.
- Swim one lap.
- Buy one item at grocery store.
- Invite one friend to lunch.
- Prune one rose bush.

155

The finish line: Duration

If the task is vague or unpredictable in terms of effort, make duration the goal.

- 30 minutes cleaning garage.
- 20 minutes working on resume.
- 20 minutes brainstorming about possible jobs.
- 10 minutes Spanish practice.

156

A Useful Question

When was the last time you actually did this?

So what are the odds that's going to happen this week?

Let's make it easier.

Is the finish line the stop line?

157

In depression, not necessarily.

BUT: Don't redefine the goal.

"I did 4 blocks, let's see if I can do 8."

Instead: "I already succeeded at 4, but I can do more if I want."

AND: Watch out for a tendency to push on to exhaustion.

"Leave it when you still want to do more."

Is the finish line the stop line?

158

In anxiety exposures, YES.

"25 minutes in the store, then LEAVE"

Else they'll overdo until they panic.

"I managed this store and feel fine …

… let's go a little further."

Here the only stop signal will be anxiety.

We're trying to get anxiety out of the driver's seat.

The finish line rule

159

If they're working on overcoming inertia, they can do more if they wish.

If they're working on fear or physical pain, they must stop at the defined end point.

If family is helping, make sure they understand this!

160

Common Targets in Depression

Lifestyle factors: Sleep, diet, exercise

Social life enhancement

Pleasurable activity

Accumulated chores ("clearing the snowdrift")

Life goal fulfillment (resume, volunteer work, hobbies)

161

Set your priorities

Clients will identify MANY Ultimate Goals.

Encourage them to be selective, at least to start.

Energy and motivation are limited - don't spread them too thin.

Look for goals with strong likelihood of reasonably early payoff.

And goals that help several ways.

EG: Getting out of house + exercise + social.

162

Three Periods Scheduling

163

Structure

Without structure, schedule, or role, depressed clients often do worse.

- Not enough energy and focus to get themselves moving.

So a major role of therapy is the reintroduction of structure.

164

Three Periods

We want SOME structure.

ONE anchor activity within MOST periods.

Avoid days-long "schedule deserts."

This builds the skeleton around which the rest of the life will grow.

165

Three Periods

Monday	Tuesday	Wednesday
Morn	Morn	Morn
Tea w neighbour	Therapy session	Volunteering
Aft	Aft	Aft
Massage	Home Depot	
Eve	Eve	Eve
Call sister	30 min resume	Watch hockey

166

Three Periods

- Setting appts at same time of morning forces regular getting out of bed.
- Emphasize getting out of house at least once a day.
- Occasional blanks are okay.
- Discourage over-ambition. "Walk to 7-11" is fine.
- Can tack chores onto some items. Ex: Stop by pharmacy after therapy appointment.

167

Record all goals!

168

Always review goals before the end of session.

169

Let's be clear about this.

If the client has forgotten what the goals were, this is NOT resistance.

It is therapist incompetence.

Write them down!

170

Always, always, always!

Review the goals with the client before they leave.

See if there is any confusion.

Check the finish line. Is it clear?

See if there seem to be too many for the client's current state.

171

How many goals?

Initially, undershoot. For some clients, 1 or 2.

Later in therapy it may increase to 12 or more.

Some will be new, others are repeats.

"Go swimming again."

"30 more minutes cleaning garage."

172

Always review goals at the start of session.

173

Do goal review early in session.

You can reinforce their efforts.

You can start setting new goals.

- You'll have half your goals before the session is 10 minutes old.

"Want to go to the coffee shop again?"

You set the "planning tone" for the session.

174

If they succeed…

175

Why are we doing this?

To make progress toward goals.

AND to overcome a sense of inertia.

To get a sense of success and confidence.

176

The Cognitive Model

Situation ⇨ Appraisal ⇨ Response

What we pay attention to dictates our emotional responses.

If we succeed but do not pay attention, the success is irrelevant.

177

So …

Ensure clients ✓ successes.

Encourage them to look at their completions.

Dwell on success AT LEAST as much as failure in session.

Acknowledge the success and comment on its significance.

Cultivate a look of pleased surprise. Clients will want to see it again.

178

And …

Watch for and challenge clients' temptation to devalue or disqualify success.

"It wasn't perfect."

"Wait, was the goal to be perfect?"

"It was too easy."

"That's what made it a good goal."

"I didn't enjoy it."

"Was enjoyment THIS TIME the goal?"

179

And …

Sense that success isn't significant enough

"Still so far away from ultimate goal"

180

And …

Sense that success isn't significant enough

"Still so far away from ultimate goal"

Look behind you, not ahead.

Clients have a theory.

181

"I am too lazy, too hopeless, too stupid, or too depressed to accomplish anything."

Even destructive theories are preferred to NOT KNOWING.

Clients will attempt to interpret their results through that lens, and maintain the theory.

Direct their attention to evidence that does not support the theory.

If they fail…

182

If a goal doesn't get completed…

183

Two possible attributions

I am unmotivated and bad.

I was too ambitious.

Push the second.

And steal as much of the blame as you can.

184

And then …

Never set a failed goal a second time.

Avoid declaring failure and giving up on that target.

Instead, make the goal much smaller.

- "What about 10 minutes?"
- "What it it was walking just ONE block?"

Ensure the client is on board.

185

Use BA as batter.

186

Homework

Goal setting is just as valid for you as for your clients.

Be your own client.

Develop a list of Ultimate Goals, or goals for this year.

Develop a SHORT list of Immediate Goals for the coming week.

Ensure these meet the SMART rules.

Do not mix Ultimate and Immediate Goals!

Session Three: The Antidepressant Lifestyle

187

Today …

The antidepressant life.

Exercise, diet, sleep, caffeine, media.

Situational factors in depression.

Work and finances.

188

The Antidepressant Life

189

190

The Kidnapping Question

"Imagine we gave X people your current life."

"At the end of a month, how would they be?"

Many depressed clients live a depressogenic life in which low mood is a normal response.

Rather than changing the mood, we may need to work on the life.

191

The Kidnapping Question

Even when other factors clearly triggered the depression, the life subsequently adopted may be maintaining it.

192

Depressed Mood

↓↑

Current Lifestyle

193

Why work on lifestyle early?

Depressive lifestyle often drives the depression.

It's concrete, easy to understand.

"Brain fog" won't interfere too much

The strategies are particularly potent.

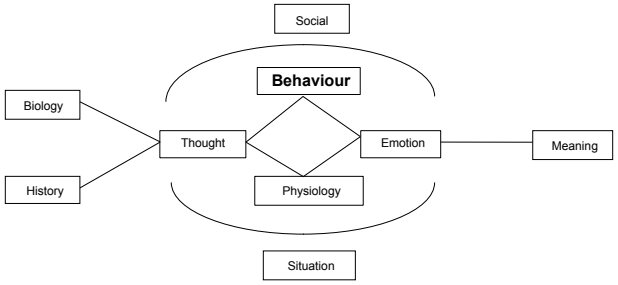
Multiple steps may take weeks.

"Walk one block" to "Work out at gym"

Effects often take several weeks to appear.

194

Behaviour and Lifestyle



195

Physical activity

196

The Problem

We evolved for one environment.

One where exercise was a part of life.

We have built another.

One where exercise is optional ...

And inconvenient.

197

The Result

Most North Americans are much less active and less fit than 100 years ago.

And: Much more frequently subject to depression.

Is there a link?

198

Risk factors (maybe including lack of exercise)

↓

Depression

↓

Low energy, low motivation, difficulty getting started

↓

Less physical activity

↓

More depression

199

Exercise and Mood

Inactive people generally have lower mood than active people.

Poor physical fitness is a risk factor for subsequent depression.

Exercisers improve more than non-exercisers.

Exercise is about equivalent in strength to cognitive behaviour therapy.

200

Sample study Farmer et al '88

1900 healthy subjects, 25-77 yrs, no chronic health conditions at start.

Those with "little or no exercise in recreation" were significantly more likely to meet a depression cutoff than those "moderately or very active".

Inactive women were more likely to show depressive symptoms at 8 yr followup than active women.

Farmer et al (1988), Am J Epidemiology, 128. 1340-51

201

The Alameda County Study

4828 subjects, studied twice, 9 yrs apart.

Those with low activity level at Time 1 were 2-4x as likely to have depression at Time 2 than high-activity participants.

Adopting better exercise habits seemed to prevent depression later on.

Camacho et al (1991), Am J Epidemiology, 134. 220-31

Blumenthal Study

156 volunteers with major depression

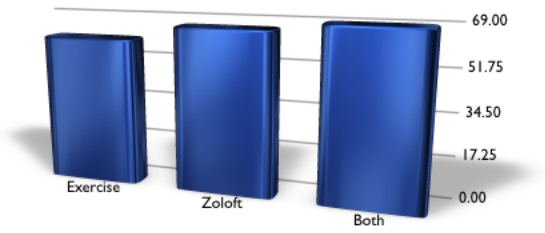
1. Exercise, 3 x 30 min aerobic cycle/jog / week
2. Sertraline (Zoloft) therapeutic dosage
3. Exercise PLUS sertraline

Blumenthal et al (1999), Archives of Internal Med, 159, 2349-56

202

Results

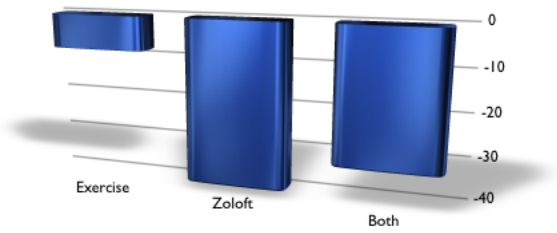
Marked improvement in 4 months



203

Results

Relapse rate 6 months later



Babyak et al (2000), Psychosomatic Med, 62, 633-38

204

205

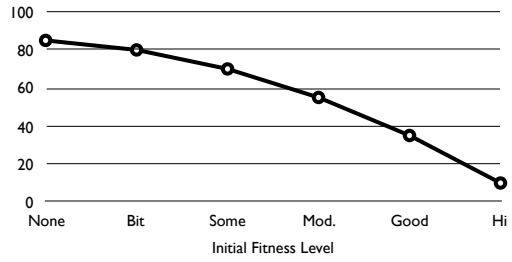
Most populations benefit

Supportive studies have included:

- Both genders.
- All ages, including elderly.
- Subclinical to hospitalized depression.
- Various anxiety disorders.
- Nonclinical groups.

206

Relationship between initial fitness & exercise?



207

Why does exercise help?

208

Improved circulation?

Unlikely.

Most studies last 12 weeks or less.

Too short for marked changes.

209

Endorphin release?

NO.

Endorphins likely account for post-exercise high.

But endorphin effects are typically short term.

The consistent improvement can't be an endorphin effect.

210

Socializing?

No.

Being involved with others may help.

Many studies involve solitary exercise.

BUT: Making exercise social would likely boost the effects.

Reduced circulating stress hormones?

211

Yes, quite possibly.

Some studies do show that exercisers have lower levels of cortisol.

Cortisol and inflammation may be implicated in depression.

Goal-setting?

212

Quite likely.

Learning to ignore the depression ("Just sit at home, you're tired...") is central to defeating it.

"I am tired, but I'll go anyway."

Setting small but achievable goals toward almost any larger aspiration is helpful.

People learn they CAN do things, and CAN make progress despite the mood. This lifts it.

Energy levels?

213

Very likely.

Exercising takes energy.

BUT it pays off in MORE energy.

As energy rises, depression tends to fade.

214

Get a physical

GP will not tell your client to avoid exercise.

BUT may make suggestions.

"With YOUR knees, ..."

We don't want to recommend something that may be harmful.

215

Pick your activities

Those you enjoy (or don't hate much).

That are convenient.

That have worked for you in the past.

216

Variety helps

Activities for summer, activities for winter.

Variety reduces boredom.

Injury may prevent one activity but not another.

Home exercise: Does it work?

217

It's more convenient than anything else.

So it SHOULD work.

And it does - for a small minority.

Most find that it doesn't.

But they hate the gym

218

Then don't go!

The pool.

Community centres.

Biking.

Running.

Frequency is more important than duration

219

One 10-hour hike ...

... or 10 one-hour hikes?

The latter is more helpful.

Aim for 3 or more times per week.

Strenuousness counts

220

Very mild exercise (e.g., strolling) has few mood effects.

- Start with something manageable.
- Then push upward.

If you can converse easily, it's not likely enough.

It need not be aerobic.

Make it social

221

Social obligation will help get them there.

- AND make it more enjoyable.
- AND social contact helps mood too.

Do they need a trainer?

222

NEED? No. BUT:

If you want certain benefits, it helps to learn about the strategies to get there.

Appointments with a trainer may force you to go.

It helps to get encouragement.

You may need to meet trainers to get a good match.

223

Don't wait to feel like it

In other words:

Desire Exercise

Problem:

They may NEVER feel like it.

Most don't - depressed or not.

Exercise because it is time to exercise, not based on how you feel in the moment.

224

Make it routine

If they have to decide when to do it every time, they'll soon stop.

Create a schedule.

Make appointments with self.

225

Start easy

No one goes from zero to a full program in one step.

First goals:

- Brainstorm your strategy (using pen & paper!)
- Investigate places & options
- Buy what you need, if anything
- Start slow - perhaps one walk around the block?

226

Embrace where you are

Initial efforts show how out of shape you are.
- You can tell yourself it's hopeless.
- Or believe that others are mocking you.
- Or use it as a tool for putting yourself down.

These may be unconsciously motivated:
- If you can make yourself feel bad enough, you get to stop.

227

Measure to motivate

How will you know you're moving?
- Most change is subtle - you may not notice.
- UNLESS you measure where you are.

Decide on your measure(s).
- Speed? Weight? Distance?
- Mood?

GIVE UP on your Eventual Goal.
- Focus on the next small step.

228

Look behind you

Our culture: "Keep your eye on the goal!"
- This only tells you that you haven't reached it.

Instead: Set your eventual goal, then let it go.
- Focus on the Immediate Goal.
- When you reach it, look BACK.
- How far have you come?

Integrate exercise into life

229

Exercise isn't just for the gym.

Be like a cave dweller: Get exercise as a side effect of living your life!

Ignore all escalators.

Elevators only for 3 floors or more.

WALK, don't drive!

Brainstorm about how to introduce more activity into your life.

What to expect

230

Mood and energy improvements take 3-4 weeks of regular exercise, on average.

So start early.

Sleep

231

232

Sleep rhythm

A 24-hour sleep/wake cycle.

- In most, this cycle takes 3-4 days to establish.
- Changing the sleep schedule interferes.

Mediated in part by melatonin release from pineal gland.

233

Medication?

Avoid most over-the-counter sleep medication.

- It works…
- AND disrupts the sleep stages.

Melatonin?

- Nightly use does not seem to help.
- For jet lag and occasional nights, may be helpful for some individuals.

234

Medication?

Recommend discussion with physician.

Some prescription meds may work better.

BUT: Even here, nightly use may quickly stop working.

The goal for most:

Regular sleep with no medication.

235

Sleep Scheduling

Regular bed-time (within a 1-hour window).
Regular rising time (with alarm clock).
Takes at least 3-4 days.

236

Naps

Avoid long naps > 1 hour.
Short afternoon nap: If needed.
No evening naps.

237

Prepare for sleep

Bright light in daytime.
Lower light 1 hr before bed.
Blue light especially suppresses melatonin secretion.
- Avoid devices (TV, phone) before bed.
- Set "Night Light" (Windows) and "Night Shift" (MacOS) features to ON.

Stimulus control

Save the bedroom for sleep.
Not work.
Not exercise.
Not television.

238

A good sleep environment

Quiet - perhaps enhanced with white noise.

239

A good sleep environment

Cool - less than daytime room temperature.
60-67 degrees F (15-19 C) room temperature.
It's easy to overheat (up to 95 F) under too-heavy covers.

240

A good sleep environment

241

Ventilated.

Atmospheric CO_2 = 400 ppm.

Enclosed bedroom may rise to >2000 ppm.

This can reduce sleep quality, increasing wakening, and impair daytime attention/concentration.

A good sleep environment

242

As dark as possible.

Ideally: Can't see hand.

Opaque curtains.

Avoid nightlights.

Light

243

244

Light and Melatonin

Bright light reduces melatonin release.

Result: More alert, less sleepy

In darkness, melatonin secretion increases.

Result: Easier to sleep

Melatonin regulates the circadian rhythm.

245

Light and Vitamin D

Most Vitamin D is self-manufactured in response to sunlight.

Dietary sources are insufficient.

In countries where sunlight is lacking, Vitamin D deficiency is common.

Artificial light does not help this.

246

Light tips

Get bright light in the morning.

Work next to a window.

Open curtains and blinds.

Get outdoors in the hours of brightest light.

Do not wear excessively dark sunglasses.

247

Light Therapy

Research is supportive.

SAD and other mood disorders.

Loaners are often available.

Use must be very regular, in the morning.

NOT in evening.

248

Diet

249

Depression

↓

Poor appetite, undernutrition

Or overeating to fill the void

↓

More depression

250

Eat by the clock,
not by your stomach.
If it's mealtime, eat.
Maybe start with very
small quantities.

251

Make it easy.
The stress of preparing may
prevent them from eating.

252

Make it nutritious.
Avoid fast food outlets
and processed food.

253

Avoid most refined sugar and foods which cause sharp rise in blood sugar.

254

Supplements

Research is generally poor.

For most clients, lack of certain nutrients is unlikely to be the issue.

Omega 3 supplementation may be useful (or not).

A general B complex may be helpful.

255

Vitamin D

Research is variable, but suggestive of a link with mood disorders.

During winter, up to 40% of Canadians are deficient.

Recommend raising the issue with GP - testing and/or supplementation.

Especially during darkest months.

256

Iron

Do not advocate supplementation without a blood test.

Iron levels can be too high!

Suggest a test if client is:

- Female
- Athletic
- Vegetarian

257

Caffeine

258

Caffeine

Is depression the sole problem?

Caffeine is probably not an issue.

If anxiety/anger are prominent: consider.

Don't assume clients know caffeine is a potential problem.

Avoid oversensitizing clients to caffeine.

259

Energy drinks

Variable amounts of caffeine.
Generally LOWER than coffee.
Red Bull: 77mg / 240 ml (8 fl oz)
Monster: 80mg / 240 ml (8 fl oz)

260

Suggestions

Limit coffee to 2-3/day, or 450 mg, or less.
- Some are more sensitive.
- Few are "allergic."

Avoid caffeine after 2 pm if sleep is an issue.
- Some don't find evening coffee interferes. Fine.

261

Addiction?

Caffeine is addictive.
- Not a disaster. Many of us are.
- Tolerance and withdrawal occur.

Average daily dose for addiction: 450 mg.
- This is highly variable across individuals.

Withdrawal:
- Headache, irritability, difficulty concentrating.
- Symptoms can last two weeks or more.

Reducing consumption

262

Avoid going "cold turkey."

- Withdrawal is generally harmless but unpleasant.

Reduce by up to 30% per step (from prior step), 5-7 days per step.

- e.g., 10 cups, 7, 5, 3, 2, 1, 0.5, off.
- Abstinence need not be the goal.

Fun

263

Having Fun

264

Clients often have negative attitudes about fun.

OR: Have little spare time.

AND: When depressed: Anhedonia

- They give up formerly enjoyed activities

265

Having Fun

When clients improve:

- They often take on the WORST of the tasks they gave up.
- These sap energy.

Emphasize enjoyable activity in goals.

Ensure clients are not waiting for the desire.

266

Remember

Desire follows action.

It's tempting to wait for anticipatory desire before doing things we used to enjoy.

Instead, do a bit without desire.

Eventually the enjoyment will come.

The desire will usually follow.

Some things (exercise, taxes) may never elicit anticipatory desire.

267

Situational Strategies

The 168 Hour Question

268

The 168 Hour Question

269

How do you spend your life?

Estimate # hrs/wk on each.

Then:

- Rate enjoyability of each
- Help achieve goals?
- Give a feeling of competence?
- Affect mood?

Screen Time

270

Screen Time

Television, Smartphone, Computer, iPad

Average hours per day, according to Neilson Media Research?

10 hours, 39 minutes.

271

Eating

Food prep

Cleaning

Nonscreen work

Childcare

Friends

Nature

Love

Fun

… and everything else in life.

272

Your smartphone is a …

Phone	Photo album	
Mail	Notebook	
Radio	Daybook	
Television	Address book	
Camera	Game	
Wristwatch	Map & GPS	Compass
Dictionary	Travel agent	Stereo
Encyclopedia	Stopwatch	Record collection
Newspaper	Calendar	Singles bar
Novel	Calculator	& more

273

The Reality Ratio

274

Do a log of time spent on screen.

- Set phone alarms for 1/hr.
- Were you on a screen or not?
- Calculate your reality ratio:
- No / (Yes + No)

The Reality Ratio

275

Imagine 16 hrs awake.

10 hours screen time, 6 hrs off.

- Calculate your reality ratio:
- No / (Yes + No)
- 6 / 16 = 0.375
- Higher is better!

Satisfaction Inventory

276

Invite client to create a list of positive life experiences.

Do not tell them this is about screen time.

- You can use it for multiple purposes.
- Goals, pleasant activity options, etc.

Note the percentage involving screen time.

277

The media fast

Invite client to identify a specific period of time (usually one day or portion) to turn off all media.

Use as discussion: Was this easier/harder than expected?

What did you miss? Learn?

Does this suggest any changes for you?

278

The media detox

A more extended period of extremely limited media.

EG a weekend; a week's vacation.

TV unplugged, computer at friend's home, etc.

Plan non-screen activities.

Compare satisfaction/stress this period with another period with screens.

279

Self-restraint tools

Many clients perceive they have limited control over their screen-seeking behaviour.

Apps exist which can turn off Net access (or access to a subset of addictive sites) for various periods.

EG Freedom.

280

The News

281

REALITY

Safe bus

Safe bus

Bus crash!

Safe bus

Safe bus

Safe bus

Safe bus

Safe bus

MEDIA

COVERAGE

Bus crash!

282

The problem

News tends to bias on the negative side.

We hear about countries at war, seldom countries at peace.

If this is your experiential world, this is all your emotions will be based on.

Most news does not give us specific guidance for our own lives.

283

Create a media buffer

During depression, defenses are down.

Recommendation: Feel free to avoid the news.

Shift to less visceral media.

This is one of the only types of avoidance we advocate.

284

The Speed of Life

285

The issue

Some clients drive themselves to their absolute limit.

e.g., Many professionals, business people, small business owners.

Or their lives are extremely demanding.

e.g., Working and/or single parents.

286

Problem 1

"Doing our very best" (pushing ourselves to our limits) can work in the short term.

And it can increase capacity.

Expecting this *constantly* is counterproductive.

287

Constant high-performance

Physical breakdown, illness.

Exhaustion.

Reduced positive emotion.

Chronic stress.

Burnout & depression.

High rates of stress leave.

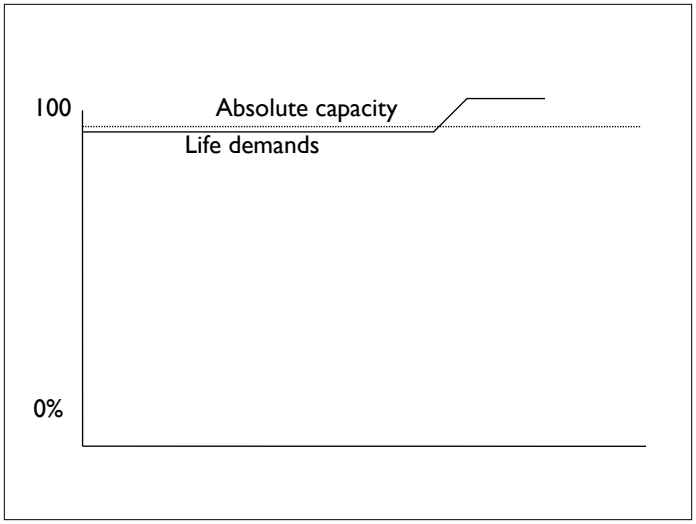
288

Problem 2

Life occasionally demands more of us.

Sick kid, special work project, car breakdown, roof leak.

If we are already working at capacity, we have nothing in reserve.



289

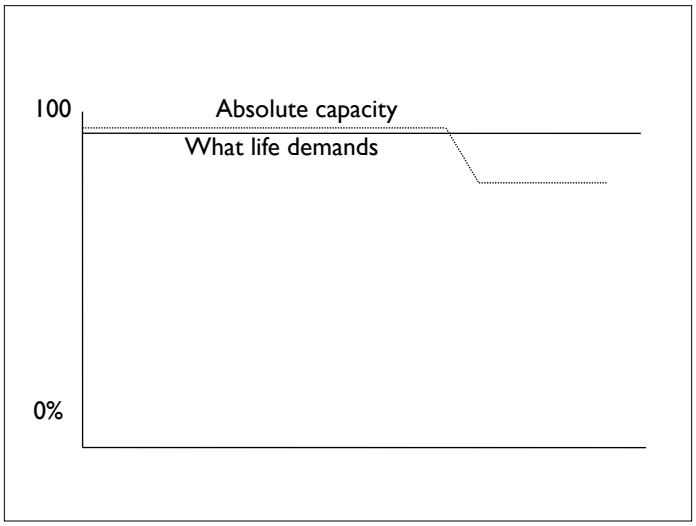
Problem 3

Our own capacity isn't constant anyway.

- We get sick, discouraged, depressed.
- Our capacity drops below the amount required to manage our life.

The only solution is to restructure life so that it's simpler and less demanding.

290



291

292

Recommendation

Always build slack into your life.

Do not expect yourself to give 100% all the time.

Do not build a life that demands you do so.

Do not berate yourself for being incapable of "doing your best" constantly.

Work with clients to simplify demands - at least temporarily.

293

Contact with Nature

294

Does nature help?

The research is suggestive but not conclusive.

Lower rates of depression correlate with:

- Proximity to green space.
- Time spent in natural settings.

Confounds are many, but controlling for these seems to support the conclusion.

Some intervention studies support being in nature as a part of treatment.

295

If so, how?

Unclear.

Lack of distraction.

Immersion in a sensory experience.

Separation from urban noise, stresses.

Being in species' natural setting?

Others?

296

Does nature help?

Many clients report that being in nature is helpful. And:

- Out of the house.
- Getting exercise.
- Sustained external attention.

297

So …

When possible,

And when clients report a sense that nature is helpful to them,

Encourage increased exposure to natural settings.

Walk in parks rather than along streets.

Integrate nature into excursions.

See friends on a hike/walk rather than restaurant or bar.

Personal Finances

298

Common risk factors

299

Excessive mortgage.

No savings.

No retirement plan.

High credit card balance.

Other debts.

Stress of living on the financial edge.

> "If I lose my job, I'm in trouble inside 2 weeks."

So …

300

Ask about financial stresses.

Have financial advisers among your referral resources.

> eg, Credit Counselling Society at nomoredebts.org
>
> Free webinars at mymoneycoach.ca
>
> How to Buy Happiness at psychologysalon.teachable.com

Have books to recommend.

301

So …

Integrate step by step financial planning and debt reduction in goal setting.

- Setting up automatic payments.
- Going for credit counselling.
- Leaving cards at home.
- Paying cash for purchases.
- Rating "happiness" with each expenditure on credit card statement.

302

Simplify Your Life

303

The problem

Some lives are just too difficult to maintain.

- Financially
- In terms of time

Sometimes getting back to that life is not the goal.

It's to create a simpler, less stress-filled life.

Work Life Balance

304

Work issues

305

There are too many to list!

… or to give you handouts for.

Much of therapy involves work-related problems.

Don't ignore these when looking at depression's origins or treatment.

Graduated return

306

Many clients are on leave.

Work with rehab coordinator on a sustainable return plan.

AND advocate for:

- Graduated return, not 0 to full in one step.
- Supernumerary status at the start.

Some work return steps

307

- Change to workday bedtime & rising time 1-2 weeks before.
- Drive rush hour traffic to work & go home.
- Get access to email and brush up on changes / developments.
- Lunch with coworkers a week ahead.
- Meet with supervisor a week ahead.
- Make & freeze meals for 1st week back.

Session Four: Overcoming Negative Thinking

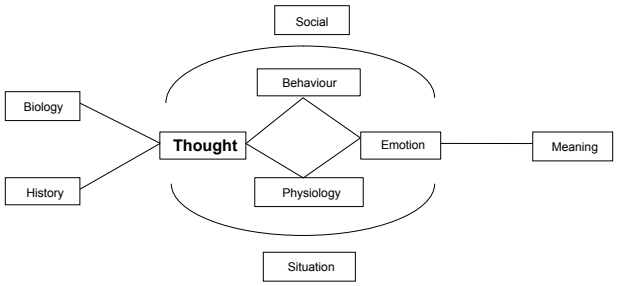
308

Today …

309

- Introducing cognitive work.
- The downward arrow.
- Core versus situation-specific cognitions.
- Depressogenic beliefs and biases.
- Cognitive challenging using column forms.
- The intended outcome: Cognitive change or cognitive detachment?

310



311

Cognitive Changes during Depression

Negative view of self, future, and world
Biased perception and memory
Easily overwhelmed
Difficulties concentrating, making decisions
Poor memory
"Brain fog"

312

Thinking is a spiral.

Depression

Negative thinking

Introducing Cognitive Work

313

Orient the client to cognitive work

Point out the intuitive model:

Situation ⇨ Emotion

Situation ⇨ Appraisal ⇨ Response
(Beh + Emot)

314

Core belief of cognitive work

We do not live in the real world.

We live in a world of perceptions, interpretations, ideas, beliefs, assumptions.

We react to what we THINK is going on.

315

316

There are two worlds.

The external world.

We call this "reality."

None of us has been there.

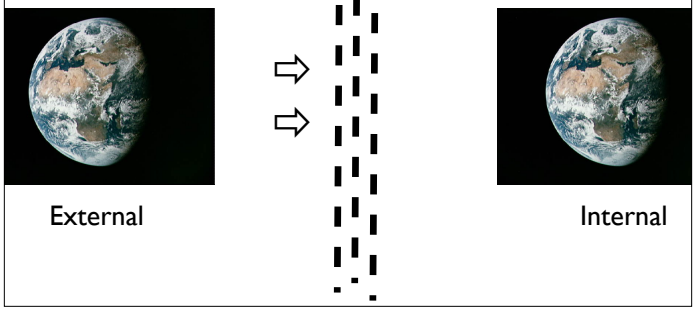
The internal world.

This is where we live.

We are alone here.

317

We perceive indirectly.

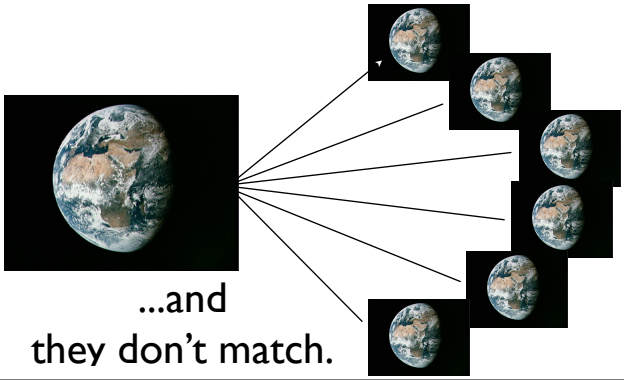


External

Internal

318

We each have our own internal reality.



...and they don't match.

How does thinking go wrong?

Situation ⇨ Appraisal ⇨ Response
⇧ ⇨ Distorted thinking
Assumptions ⇨ Faulty Ones!
⇧ ⇨ Distorted thinking
Core beliefs ⇨ Overgeneralized
⇧ ⇨ Distorted thinking
History ⇨ Idiosyncratic

319

Assumptions and Biases

320

Faulty Assumptions

Everything I do must be absolutely perfect, otherwise I am a failure.

Life is fair.

If others disagree with me, then I must be wrong.

I am only worthwhile as long as I am doing something for someone else.

321

322

Faulty Assumptions

The way to accepted by others is to give and give.

I have to do everything I am asked to do.

I have the power to change people.

Good relationships have no problems.

It is unbearable when life is not the way I would like it to be.

It is easier to avoid problems than to face them.

323

The Test

How do we know a faulty assumption is among our automatic thoughts?

NOT if we look at it and think it is correct.

INSTEAD: Do we act and feel as though it is true?

324

Thought Distortions

All or nothing thinking
Filtering
Underfocusing
Overgeneralization
Disqualifying the positive
Mind reading
Fortune telling

Thought Distortions

Magnification and minimization
Catastrophizing
Emotional reasoning
Labeling

325

Which is Primary - Thoughts or Emotions?

326

Thoughts

Thoughts ➢ Emotions

Work error ➢ "I'll be fired!" ➢ Anxiety

Life situation

➢ Depressogenic thoughts

➢ Negative affect

327

328

Emotions

Emotions ➢ Thoughts

Anger

➢ Normal spousal behaviour

➢ "What an inconsiderate oaf!"

Depression ➢ Missed bus ➢ "I do nothing right!"

329

Emotions Distort Thoughts

Our emotional state biases us in favour of thoughts which match those emotions.

The stronger the emotion, the stronger the bias.

Our perceptions of the world are filtered through the lens of our emotions.

Sadness, anger, hope, fear.

330

So which do we address?

Emotions are …

usually predictable and reasonable given the situation and the thoughts we have.

so they don't need to change.

Our thoughts are imprecise representations of reality, distorted by biases, history, and emotion.

so they can be shifted toward accuracy.

Core Beliefs

331

Problem Core Beliefs

Very broad beliefs which result in a general tendency to distort reality in an unhelpful direction.

I am unlovable/defective/unworthy/incompetent.

The world is a cold and rejecting place.

Everything will work out, even if I don't plan.

Everything gets worse.

332

Problem Core Beliefs

The problem? NOT that we have such beliefs.

We ALL have them.

We ALL have corresponding helpful ones too.

Some people's negative beliefs are more easily activated than their positive ones.

333

Three Column Forms

334

The client's own experience

335

Get a situation in the past week that …

Created emotional upset.

Probably wouldn't have been as big a deal to someone else.

IE, the reaction was possibly excessive.

Do a 3 column form on board or printed sheet.

336

Situation	Appraisal	Response
Boss criticizes report.	I can't get anything right. I will never learn this the way she wants. I am hopeless at this job. Eventually they will fire me. I wouldn't be this anxious otherwise. I'll become homeless.	Anxious Depressed Impulse to quit

337

Eliciting automatic thoughts

"What were you thinking? What else?"

"What if that was true? The worst thing?"

Client may pull back: "I know it's silly"

Emphasize "gut" feelings, hot thoughts

Central neg thoughts may ⇨ emotion.

DO NOT CHALLENGE.

Elicit Elicit Elicit!

338

How can elicitation help?

1. Many don't realize they are appraising a situation.
2. Helps therapist know: Is problem the situation, or the thinking?
3. Knowing thoughts is a prerequisite for changing them.
4. Simple awareness can help irrational beliefs flake apart.

339

One strategy

If your client goes silent and looks at their written thoughts …

Shut up and wait!

They may be noticing some of the problems in their reasoning.

Invite comment: "What do you make of this?"

Don't be the smart one who points it out.

340

Exercise: Three columns

This applies to you too!

Identify a recent situation where you had a suspiciously strong reaction.

Fill in the situation (briefly) and reaction (emotion and/or behaviour).

Identify the thoughts that led to that reaction.

341

The Downward Arrow

342

The Downward Arrow

Negative thoughts appear in chains.

"If X, then Y, and if Y, then Z, and if Z..."

The first link in the chain is usually the most accessible.

343

The Downward Arrow: How?

Find the first thought: "What were you thinking?"

Then solidify it: "Assume you're right...."

Changing the thought from a conditional to a certainty makes the next thought more accessible.

Get the next thought; and so on.

344

When do you stop?

When the client can't come up with another thought.

When the last thought provides an obvious end point (death, hospitalized forever, etc)

When subsequent thoughts elicit no emotional reaction from the client.

When subsequent thoughts start becoming ridiculous to the client.

345

The Downward Arrow: Why?

Subsequent thoughts are often more alarming

...and less realistic.

BUT: are less accessible to conscious awareness.

All thoughts may contribute to the emotional reaction.

Bringing them into awareness can help us to rethink.

You can get hints about negative Core Beliefs.

346

Exercise: The Downward Arrow

Do a downward arrow on yourself.

Identify a troubling situation.

What was the thought?

"Assume that thought was correct. What then?"

"Now assume that second thought is correct too..."

347

Invite Another Voice

348

Alternative ways of thinking

Sometimes simple awareness will cause negative beliefs to flake apart.

More often: We need to generate alternative ways of thinking.

We need to turn the negative monologue into a dialogue.

349

Gut Thoughts

Automatic thoughts are usually "gut" thoughts.

- Instinctive and fast. We may not realize we were "thinking" at all.
- Heavily influenced by the past, by hope and fear, by common human cognitive errors.
- Making them explicit (eg with a 3 column) often reveals distortions.

350

Head Thoughts

Thoughts based on careful reasoning.

- Attempting to see past the distorting influence of current emotion.
- Distinguishing between this situation and past ones.
- Weighing the evidence.
- What some call "Wise mind."

351

2 Common Challenges

1. Likelihood: How likely is that outcome, really?
   - Some negative thoughts involve probability inflation.
   - "There's a 15% chance the plane will crash."
   - "After this review, my boss WILL fire me."

Work with client to rethink the odds this will happen.

352

Notice something important:

We don't need the client to discard ANY of their thoughts completely.

Just estimating likelihoods a bit more reasonably is enough.

"I COULD get fired for this, but no one has so far."

353

2 Common Challenges

2. Impact: If that DID happen, how bad would it really be?
   - Some negative thoughts involve catastrophizing.
   - "If she turned me down, I'd die."
   - "If I fail, I'll be homeless on the street."

What would actually happen instead?

354

Challenging Style

We are not arguing with clients!

We are asking questions to lead them to alter their own thoughts.

This takes a lot of creativity!

The Distancing Technique

355

We can access "head thoughts" more easily with others than ourselves.

So: "Imagine it was your best friend in this situation. What would you tell her?"

Invite clients to have a standard same-sex friend to use for such re-thinks.

Once you've got some alternative thoughts…

356

Establish that the client has greater faith in the new thoughts (at least intellectually)

Rate the new thoughts 0-100% for believability.

Not necessarily whether they FEEL correct.

Five Column Forms

357

358

Five Column Strategy

Do a 3-column, as before.

Get 4-5 negative thoughts at least.

Leave a little room after each one.

- The truth is usually longer than the automatic thought.
- You'll need more space for it.

Get client to rate their belief in each thought, 0-100. Do all ratings before moving on.

359

Five Column Strategy

Ask client for a more "fair and balanced" thought than the first automatic thought.

"Even more true."

You can lead them to these a bit.

- "You can't get ANYTHING AT ALL right?"
- "Have you ever had this thought before and then succeeded?"

As much as possible, get them to do it.

360

Five Column Strategy

"The Truth" is often

- More nuanced: "Sometimes but not always."
- Confirms the true bits of the auto thought: "She didn't like the introduction."
- Brings in other data: "She liked the format."
- Broader in frame: This IS bad, but other things are okay.
- Often the truth is "I don't know."

Then re-rate the original automatic thoughts.

Show negative thinking in action

361

Situation	Appraisal	Response	Eval	The Truth
Boss criticizes report	I can't get anything right.	anxious depressed	80% 0%	I do payroll, data entry, and scheduling right, but this report was complicated.
	I will never learn this the way she wants.		70% 15%	I think this w every new task, then I learn it. I'll prob'ly get this too. I don't know yet.

The Two Oracles

362

If you wish, you can take on each voice in turn for the client.

"Now I'm going to tell you the REALITY."

Repeat all the automatic thoughts convincingly.

Then repeat, using the "Truth" thoughts.

After the Oracles

363

"Did you feel differently as you heard these 2 visions of reality?"

"Which felt better?"

"Which is closer to the actual truth?"

Establish that "The Truth" is really more true, and feels better.

"Does it feel unrealistically cheerful?"

Hopefully not.

Positive Thinking?

364

Oh, this is Positive Thinking!

365

NO!

Positive thinking can be as distorted - and as destructive - as negative thinking.

Much of mental health service is about overcoming the negative impacts of behaviour resulting from unrealistic positive thinking.

Positive thinking: A Few Impacts

366

- Gambling
- Bankruptcy
- Getting lost in the woods without supplies
- Relationship breakdown ("She loves me unconditionally...")
- Failure to plan financially
- Failure to get medical screens ("I'm fine...")
- Failure to study for exams
- Drug dependence ("It won't happen")
- Drunk / irresponsible driving
- Unsafe sex
- Environmental abuse ("We'll find a solution someday")
- Criminality ("I can get away with it")
- Smoking ("I'll beat the odds")
- Junk food ("What's the harm?")
- School leaving ("There are lots of jobs")
- Overfishing
- ...and more!

So what are we after?

Positive thinking

Realistic thinking

Negative thinking

367

Once is not enough

Negative thoughts have often been rehearsed for decades.

Repeating balanced thoughts once will not erase all this practice.

Repetition is necessary to make the balanced thoughts more automatic.

368

Exercise: Five Columns

Complete a Five Column form on a situation of your own this past week.

Where your reaction seemed excessive given the situation.

Get Fair and Balanced thoughts.

Try rehearsing the more Fair and Balanced perspective this coming week.

369

370

Cognitive Change vs Detachment

371

Do automatic thoughts really change?

From "I'm an idiot and will always fail!"

To "I'm as capable as anyone else."

Umm, sometimes.

372

Another goal of cognitive work

Detachment.

The same thought may occur, but it "grabs" you less.

"My life is doomed!"

"Uh huh. Whatever."

373

This is a job for mindfulness!

Mindfulness of the layer of thinking between reality and perception.

Noticing the "story" we have about what we see.

Noticing that we react to the story, not the event.

Becoming able to detach from the story.

374

Thought Monitoring

375

Thought Monitoring

Pact: Carry pen and paper for one week.

Cue: Notice mood dips (even small ones).

Task: Ask yourself the essential question.
"What was going through my mind just then?"

Write down the thought.

If a thought recurs, just put a tick beside it.

Purpose: Reveals habitual ways we lower our mood.

Noticing and Challenging Negative Self-Talk

376

Detecting Self-Talk

377

Who gives us the MOST negative messages?

Generally, us.

Sometimes we internalize an early critic and take on their voice and standards.

If we don't notice negative thoughts, they affect the emotions anyway.

Coping with Shoulds

378

379

The Worlds of Is and Should

We live on Is.

We'd rather live on Should.

Sometimes we pretend we do live there.

Much distress is caused by a disconnect between what Should be and what Is.

Acceptance of Is can help.

380

Shoulds and Expectancy

Expectations may determine mood more than actual events.

High expectations often lead to disappointment.

Moderate to low expectations lead to greater satisfaction.

381

Depressogenic Attributions

Attributions for Events

382

Think of a positive event in your life: past month.

Why did that happen?

Think of a negative event in your life.

Why did that happen?

Attributions for Events

383

Internal

- Ability (stable)
- Effort (unstable)

External

- Luck (unstable)
- Task difficulty (possibly stable)

Attributions for Events

384

A depressive pattern:

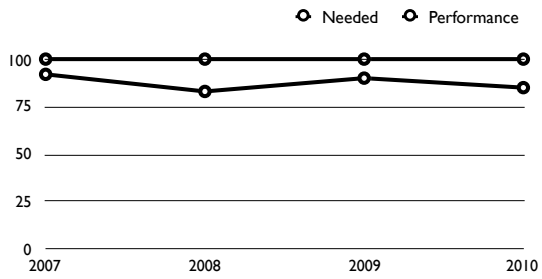
- Negative events
  - Internal, stable attributions.
  - "My fault. I'm an idiot."
- Positive events
  - External attributions (stable or unstable)
  - "Just dumb luck it didn't turn out badly."

385

Perfectionism

386

Perfectionism



387

Self Oriented Perfectionism

"I have to be perfect to satisfy myself."

A quest for excellence.

Not particularly related to depression.

May still lead to problems - wasted time, needless delay, etc.

Other Oriented Perfectionism

388

"Other people have to live up to my standards."

Not related to depression.

May relate to anger problems and lead to relationship difficulties.

Socially Prescribed Perfectionism

389

"Other people expect me to be perfect."

Strongly linked to depression.

Everything I do will be faulty in the eyes of others.

Either:

- I know really demanding people.
- I'm wrong about what they expect.

Coping with perfectionism

390

It's a phobia: A fear of imperfection.

2 steps:

- Explore thinking about the consequences of imperfection.
- Do graduated exposure to imperfection, where safe.

391

What about brain fog?

392

Depression impairs thinking

Difficulty concentrating
More easily overwhelmed
Impaired memory
Impaired decision making

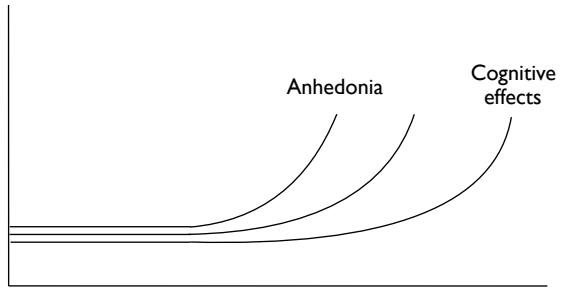
393

Depression impairs thinking

Part of therapy may be about coping with temporary cognitive impairment.
Mainly:

- Acceptance.
- Recognition that it is usually temporary.
- Practical measures to reduce demand and improve coping.

394



395

Coping with cognitive impairment

Tips to help cope

- Carry a notebook
- Walk and talk
- Go to quieter restaurants

396

Coping with cognitive impairment

Tips to train the mind back

- Read at a lower level, then work up
- Read shorter pieces
- Quiz self ("What are their names?")

397

Coping with cognitive impairment

Decision making
- Basic decision strategies
- When it doesn't matter:
- First thought best thought
- The column technique

398

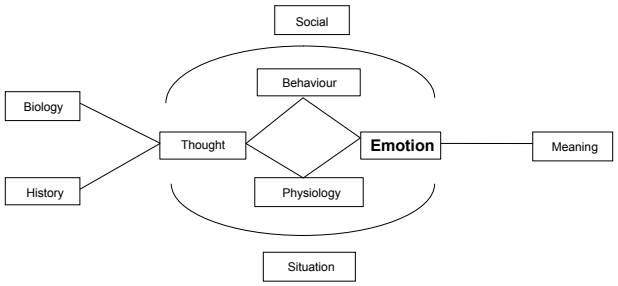
Session Five: Emotion and Social Support

399

Emotion and Social Life

Emotional acceptance
The River metaphor
Secondary appraisals
Coping with shifting moods
Additional emotion-based resources
Social life and isolation

400



401

Emotion-Based Strategies

402

Is it important to address emotion?

Situation

⇩

Appraisal

⇩

Response (Emotion & Behaviour)

403

Emotion causes problems

Mood disorders
Anxiety disorders
Anger control issues
Guilt and shame
Even hope and love can lead us astray.

404

What are emotions for?

An evolved behavioural guidance system.
Thirst makes us seek water.
Anger encourages attack.
Fear encourages avoidance.
Sadness encourages withdrawal.
Guilt encourages behaviour change.
Happiness encourages repetition.

405

One problem with emotions

They developed in primitive environments.

Modern culture makes different demands.

Hitting the boss may not work.

Result: Emotions may push us in unhelpful directions.

406

Are Mental Health Services part of the problem?

We often promote the view that emotion is bad, or dangerous.

We try to shut it off with medication or therapy.

We can imply that emotions themselves are threats.

407

Another problem...

Most emotions work best within limits of intensity.

- Fear may promote wise avoidance.
- Panic leads to incapacity.

Some problems arise when mild or moderate emotion is simply ignored.

408

The Reality

Emotions are normal.

We all have a full set of emotions.

Many are uncomfortable, and are SUPPOSED to be.

They can tell us about our lives.

They can make us unhappy, and can lead us into trouble.

Emotions themselves are not harmful or lethal.

409

Example: Depression

A fire alarm for our lives. Something is wrong.

We can try to cut the wires on the alarm.

OR we can look for the fire.

Depression will tell us to isolate, withdraw, not eat, conserve energy.

This will intensify it.

If we listen intelligently, we can learn from it.

410

Working with our emotions.

Accept them. Let them be present.

- Don't try to eliminate them.
- Don't overinterpret them.

Feel the action tendency consciously.

See if this is really the best course.

If not, evaluate the situation and see what may work better.

411

The River

The River: Echoes

412

Does this idea of allowing emotions to flow remind you of anything?

The River: Why?

413

A metaphor: Emotional resistance magnifies negative emotion.

This provides a language you can refer back to from then on.

"Let the sadness be on the river …"

Sooo … passivity?

414

ACCEPTANCE of emotional states.

- And possibly against troubling thoughts.
- Acceptance = Non-struggle.

But COMMITMENT to behaviour.

- "I may feel sad, but I'm still going to the store."
- "I don't want to work on my taxes, but I will."

415

Is the Situation-Appraisal-Response Model complete?

416

Situation
⇩
Primary Appraisal
⇩
Response
⇩
Secondary Appraisal
⇩
Response

417

Situation	West Edmonton Mall at Xmas
⇩	
Appraisal	"Too many people - don't like this."
⇩	
Response	Anxiety, hot in my coat
⇩	
Appraisal	"I can't handle it - going to go crazy."
⇩	"Maybe I'm having a heart attack."
Response	Panic

418

Some Secondary Appraisals

"It's childish to feel this way." (Shame)
"A man (woman) shouldn't feel like this." (Anxiety)
"This feeling is a sign of mental disorder." (Anx, dep)
"This sadness will never go away." (Depression)
"It's bad to feel this lust/anger/envy." (Guilt/shame)
"No one else feels this anxious." (Shame, fear)
"I can't handle ANYTHING." (Anx/Dep/Shame)

419

Or...

"It's normal to feel this way."
"I didn't know I could feel this. Interesting."
"I'm really anxious in this situation. Breathe."
"All emotions are temporary."
"Emotions, good and bad, are part of life."
"What is this telling me to do? Is it a good idea?"
"I often feel this way - one of my quirks."
"I've felt this way before, and I still lived."

420

An older perspective

Buddhist thought:
The Four Noble Truths
Life means suffering.

421

All life is suffering?

Suffering is a normal part of life.

Contradicts modern culture:

Suffering is abnormal and diseased, and needs to be treated and eliminated.

Even grief.

422

What if suffering is abnormal?

Then your suffering is a bad sign:

It shows that something is wrong with you.

You are inadequate, faulty.

Secondary appraisal: Likely to produce MORE suffering.

"My anxiety means I'm crazy."

Now anxiety is about being crazy, in addition to being in a crowded mall.

423

What if suffering is normal?

Then suffering does not indicate much about your worth or competence.

Not necessarily a sign of disorder.

Secondary appraisal:

"This is unpleasant. It'll pass eventually."

Result: Anxiety about mall continues while there, but is not magnified by belief you are "crazy."

What causes suffering?

Cognitive theory:

- Life itself (losses, disappointments, threats).
- Magnified by the way we think.

Buddhist thought:

- Similar.
- But an emphasis on attachment/craving.
- Especially an attachment to NOT FEELING THIS WAY.

424

Emotion and Time

425

Emotions in Three Times

We base much of our behaviour on how we feel.

But this is an unreliable guide.

Could we SHOW this to our clients, rather than TELLING them about it?

426

427

	BEFORE	DURING	AFTER
Gym	Yuck	Fine. Boring.	Great
Climbing	Fear	Anx/Exhilaration	Triumph
Taxes	Yuck	Not too bad	Relief
Friends	Inertia	Fun	Glad
Surf net	Tempting	Dull	A waste
TV	Easy!	Boring	Dissatisfied

428

429

Positive

Neutral

Negative

430

The point:

Anticipatory emotion: Our "temptations."

Basing our behaviour on these doesn't often lead to happiness.

Better: Base what we do on past experience.

What we have enjoyed DOING.

What we have been glad TO HAVE DONE.

The 1/3 2/3 Principle.

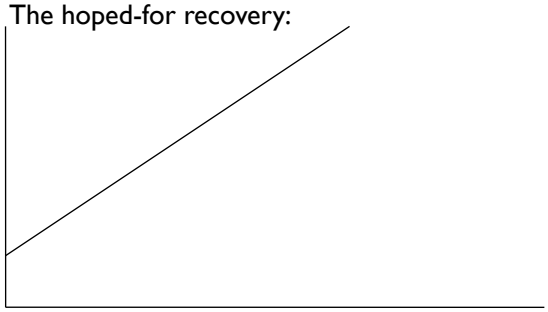
431

Working with Mood Fluctuations

432

Expectation and Reality

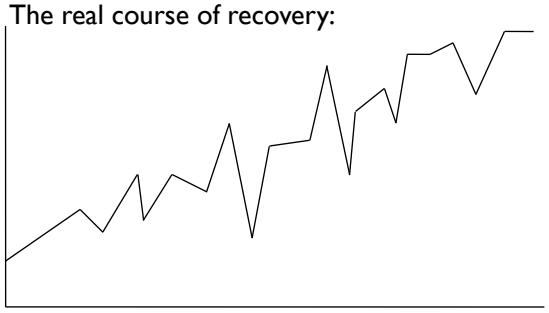
The hoped-for recovery:



Expectation and Reality

433

The real course of recovery:



Expectation and Reality

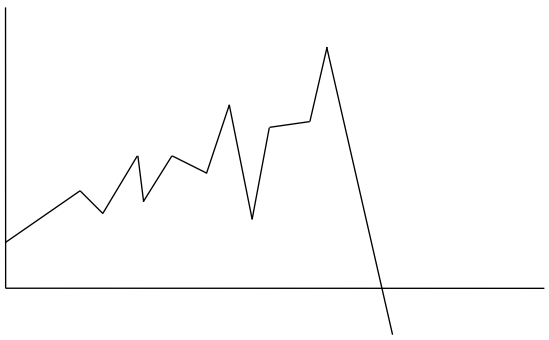
434

Hope for a steady recovery is unrealistic.

- It leads to catastrophizing.
- It produces problems when mood is falling AND rising.

Falling Mood Trap: Catastrophizing

435



436

Falling Mood Trap: Catastrophizing

If the mood should rise and rise, then something is VERY WRONG if it drops.

- Maybe it'll go to the bottom!
- This produces hypervigilance for dropping mood.

Instead:

- Expect mood to rise and fall during recovery.
- Meet mood setbacks with acceptance and activity.

437

Falling Mood Trap: Rumination

Dropping mood is significant, so figure it out!

- Sit thinking about why it's happening.
- Theories upon theories.

Instead:

- During mood setbacks, leave the past alone.

438

Rising Mood Trap: Enthusiasm

Hey I'm feeling better - maybe it's over!

- Forget step-by-step. Floor it!
- E.g., Go back to work/school full time.
- Result: Overcommitment, failure, relapse.

Instead:

- Keep your enthusiasm on a leash!

Rising Mood Trap: Mood Checking

439

Clients fear recurrences.

When it's gone, they are tempted to look for the depression.

"I want to make sure it's gone."

If they look, they will find it.

Improvement doesn't mean depression is gone, but that you don't go there.

If the depression isn't there, don't look for it.

Mood checking

440

"When it's gone, let it be gone.

"Let it come, and let it go.

"Let whatever feeling is there be there.

"And whatever feeling is gone, be gone."

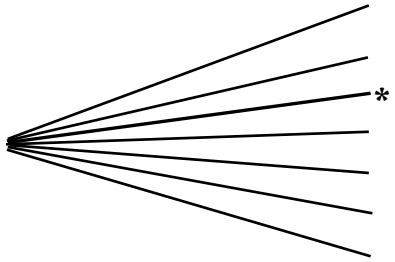
A strategy of non-resistance.

Focus on the present; remain active.

Hope

441

What is hope?



442

The Role of Hope

Usually considered a good thing.

Is hope the goal of therapy?

Could hope be destructive?

When experiencing hope, where is your mind?

Past, Present, Future?

443

PAST	PRESENT	FUTURE
Regret		
	Enjoyment	
		Hope
	Real life	
	Mindfulness	

444

The dark side of hope

445

Hope involves a focus on one of an array of possible futures.

This automatically raises the prospect of less desirable alternatives.

So: Hope and _____.

Good thing? Bad thing?

446

In depression, hope is usually a problem, not a solution.

The type of hope is often unrealistic.

Hope involves a focus on the future, not the present.

Hope and fear are opposite sides of the same coin.

Is hope always a bad thing?

447

Without an AWARENESS of possible good futures, we would not plan.

Opposite of hope: Despair - the CONVICTION that no possible good outcome exists.

Positive hope: Allowing for possible futures, and acting to bring them about.

Don't hope. Plan.

Feeling Overwhelmed

448

A Core Idea

449

The feeling of being overwhelmed
is not an enemy.

It is a great asset guiding recovery.

Feeling overwhelmed

450

Temptation: Give up.

If you feel overwhelmed, YOU ARE. Trust it!

SO GIVE UP.

Then: Scale back what you are trying to do until it feels manageable.

Guilt and Shame

451

Working with Guilt and Shame

452

Guilt: Something you've done.

Shame: Something you are.

There is a "good enough" level, and you don't measure up.

Biggest problem: The standard is vague.

So: "Guilty OF…?" "Shame ABOUT…?"

Guilt and Shame: Strategy

453

Most of our standards were adopted in early life.

Many of these are unrealistic.

We cannot change something we do not see.

We can USE guilt and shame as cues to look inside.

Guilt and Shame: Strategy

454

Define the crime:

- Guilty OF ... ?
- Ashamed OF ... ?

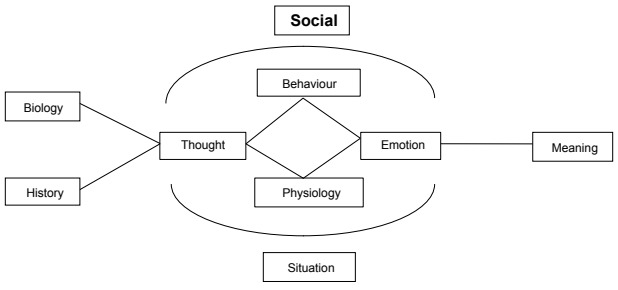
Does the standard seem reasonable?

- YES. Then keep it. Feel the guilt. Change.
- NO. Then define what WOULD be reasonable...
  - ...and talk back to the internal judge.

Additional Emotion-Based Resources

455

456



Social Strategies

457

A Core Idea

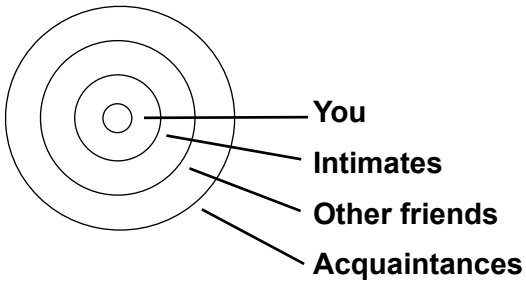
We are tribal animals.

Without the tribe, we often become dysfunctional.

Modern culture seems designed for separation.

458

The social census



459

460

Social Life: Tips to emphasize

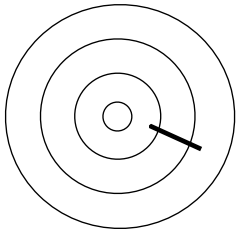
No one's social life is exactly what they want.

The ideal is what you want when you're WELL.

Don't overemphasize intimate relationships.

461

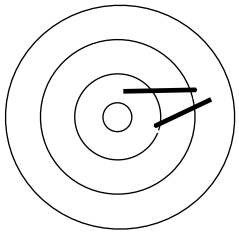
Deepening current relationships



Make relationships a priority.

462

Reviving old friendships



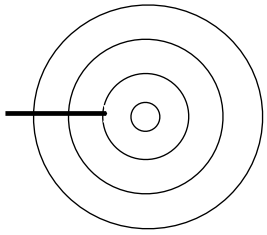
Some friends don't call.

People drift away, especially during depression.

They may desert us -- or think WE deserted THEM.

We may get impatient with their lack of understanding.

Starting new friendships



463

It is IMPOSSIBLE to meet new people.

Meeting people is always a side effect of something else.

So ask: "What ELSE do I want to do?"

Romance and Family

464

Romantic Relationships

465

Depression isn't the time to look.

Tips on communication during depression.

Dealing with depression's impact in the relationship.

Decreased libido during depression.

Managing Childcare During Depression

466

Basic strategies for reducing the demands of childcare.

Strategies for reducing the impact of the depression on the children.

Additional Social Strategies

467

A personal support team

468

Mainly for severe depression.

Enlisting supports for help with shopping, getting out, etc.

Being specific about what you want.

Limiting what you ask from any one person.

469

Social Balancing

Depression affects social relations.

Some can't talk about it.

Some can't talk about anything else.

As mood improves: A few strategies to get some balance.

470

Assertiveness

Often a core risk factor for depression.

Clients have difficulty setting / maintaining personal boundaries.

This reviews the differences between passive, aggressive, & assertive behaviour.

471

Assertiveness: The key point

Assertiveness is not about controlling other people better.

It's about giving up on controlling them…

… and controlling your own behaviour instead.

The Assertiveness Pitfall

472

When you get assertive with others, they get worse for a time.

If you give in, you reward them for pushing your boundaries.

They'll push even harder next time!

The Assertiveness Pitfall

473

So:

- Only set barriers you can defend.
- Start when you have strength in reserve.
- Do not back down.
- Do not try it with everyone at once.

Session Six: Meaning and Relapse Prevention

474

475

Today …

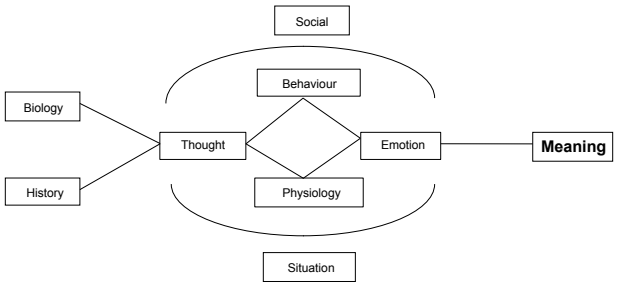
The nature of meaning.
Integrating meaning into therapy for depression.
Mindfulness and depression.
Relapse prevention.
The course of therapy.
Overview and wrapping it up.

476

Meaning

477

Meaning Based Strategies



The Nature of Meaning

478

Recovery

479

A lot of effort: Exercise, self-care, working against instinct and inertia.

WHY BOTHER?

To be healthy. Why? What for?

What is meaning?

480

A set of convictions about reality.

A sense of flow or immersion.

A contribution.

An ultimate goal.

A relationship with community.

A relationship with spirituality.

Contact with a creative impulse.

...and?

481

Meaning as a symptom

Causes of depression

⇩

Depression

⇩

Sense of loss of meaning

Here meaning may not be essential to address.

With recovery, concern will often fade.

482

Meaning as a cause

Loss of meaning (role, faith, purpose)

⇩

Depression

⇩

Exacerbation of loss of meaning

Addressing meaning may be more crucial.

483

Models of meaning

Meaning exists, independent of you.

- Your job: Discover it.
- Often theological.

Meaning is created by the individual.

- You decide what is meaningful to you.
- With or without belief in externals.

484

The Meaning Inventory

Looking back, list everything that has ever given you a sense of meaning - even for a moment.

Sometimes the past is a good guide to the future.

Some past meaning that seems inaccessible may not be after all.

E.g., childraising Volunteering at NICU.

485

Contributing

486

Contribution

Depression

↓

Feelings of worthlessness

"I have nothing to offer."

Staying home, ruminating

↓

More depression

Volunteering advantages

487

Provides social contact.
Puts clients within a role.
Mimics work life.
Gets clients out of the house.
Imposes structure: "Start at 10 am."
Proves they have something to offer.
May ignite interest or provide direction.
Flexible in time commitment.
Available in areas of personal interest.

Volunteering Examples

488

Food bank
Animal shelter
Strata council
Your political party
Faith-based involvement
Recovering urban streams for salmon
Film, fringe, comedy, jazz festivals
Unpaid research assistant at university
Friend's small business (eg flower shop)

A word on people pleasing

489

A popular term since 1970s.

What if a person gets much of their pleasure and self-esteem from helping others?

This is a societal success story, not a disorder!

Look in the mirror.

Boundaries, limits, and self-care are all good too.

Avoid pathologizing altruism.

490

Align Yourself with a Larger Cause

Contributing to something outside yourself can be a help!

- An external focus for att'n.
- Sense of community.
- Living in accord with your values.

491

Cultural Individuation

492

Cultural separation/ individuation

We get messages about meaning and happiness constantly.

Function: To sell us products, encourage conformity, live out cultural myths.

Maturation: In part, a process of rethinking the messages we have been given.

493

So...

What guides your client's life and striving?

To what extent are they obeying the messages they receive?

Could they be TOO adjusted?

Invite them to contemplate the results of their striving.

And generate possible alternatives.

494

Reclaiming the self

Quentin Crisp

Individuality: The only thing truly yours, and the one thing people are most inclined to give up.

Fashion: Conforming to expectations.

Style: Presenting the self.

495

Crises of Meaning

James Hollis

496

We are raised to be children.

Come adulthood, we are unprepared.

We build early adulthood from external models.

This works, initially: Promotions, acceptance.

Eventually: Dissatisfaction sets in.

The Middle Passage

497

Emotional discomfort or crisis caused by asphyxiation of the self.

Resolutions:

- Regress to adolescence; deny aging.
- Inward search and life course correction.

What did you have to give up in order to become an acceptable adult?

How could you reclaim that?

Welcoming the Crisis

498

Depression may be the product of a developmental stage crisis.

- E.g., mid-life

This may make it an opportunity for growth.

Use this form sparingly and cautiously.

499

Finding Meaning Through Depression

A FEW clients ultimately describe depression as a growth experience.

E.g., realizing what's important to them.

Don't use this unless the client has ALREADY said this.

500

A Spiritual Path

Loss of faith can be a trigger.

Becoming involved in a spiritual community may be a boon.

Sense of meaning, social contact, support, and more.

We must not recommend any particular faith!

501

The Courage to Backtrack

Realizing one is on the wrong life path may be a trigger.

"Wait, DAD wanted to be a lawyer, not me."

"I'm gay, not straight."

Some clients are faced with abandoning a certain life course.

Mindfulness

502

Our limits

Mindfulness merits a multi-week (or year) program of its own!

This is a very brief mention of a huge topic.

503

What is nonmindfulness? Or mindlessness?

A mind filled with distractions.

A mind that is not in the present moment.

Behaviour occurring on autopilot.

A reliance on automaticity.

Mental processes taking place without awareness.

Passive helplessness to an undisciplined mind.

504

505

Presence

Placement of the mind in the present moment.

Awareness

Of what the mind is doing right now.

Intention

A deliberate process of guiding the mind.

506

Memory

Chatter

Interpretation

External Reality | Perception | Internal Experience

Personalization

Distraction

Anticipation

507

Why do we care?

508

The present exists.

The past is over and cannot be changed.

The future is a fantasy.

The present IS your life.

509

The present is the moment of influence.

It is the only moment in which we can exert control.

It is the fulcrum of existence.

510

The present is usually less distressing.

Most of our anxieties and discouragements come from the past or future.

Terrible memories and humiliations from the past.

Fears of what might happen in the future.

Depressed clients are seldom present.

511

Preoccupied with past or future.

Current experience gets tainted.

Energy is low - little actually gets in.

Present action is lacking.

Many overuse experiential avoidance.

Mindfulness as intervention

512

Layer mindfulness with at least some goals.

513

"While eating that meal, no phone. Gently bring your mind back and back to the food."

"At that party, take moments between conversations to return to your body."

"Clear the distractions while doing your paperwork, and just do one bit at a time."

"Notice the temptation to worry while you vacuum, and return to vacuuming."

Tasks vary in their "mindfulness pull"

514

It's easy to "space out" while doing some tasks.

Others "pull us in" or demand full attention.

Find positive activities that create a mindful state more automatically.

Encourage these in goal setting, and make the point explicit.

"It's useful to do some things where you are fully immersed."

Successive Approximations

515

Begin with deliberate mindfulness practice in situations that PULL for the middle screen.

Then shift toward situations that demand it less.

Start with short periods, perhaps 5 minutes ...

... then work your way up.

Frequency is more important than duration.

Daily practice is most useful, but it can be short!

Mindfulness Meditation

516

During depression, many clients cannot focus enough for this.

They may just feel defeated or frustrated.

Start with simple present-focus practices.

Later, they may benefit from meditation training and practice.

Most evidence for mindfulness in depression is as a relapse prevention strategy.

517

Depression

Segal et al developed MBCT largely as a relapse prevention strategy for those with recurrent depression.

Evidence supports the idea that recurrence is sharply reduced with regular mindfulness practice.

Evidence for utility at resolving episodes is less clear.

During episodes, sitting practice may be less helpful than more active mindfulness & flow-inducing tasks.

518

Relapse Prevention

519

The 5 R's

Response. Noticeable improvement.

Remission. Marked improvement. Diagnostic criteria no longer met.

Recovery. Continued wellness for a specified period - often 4-6 months.

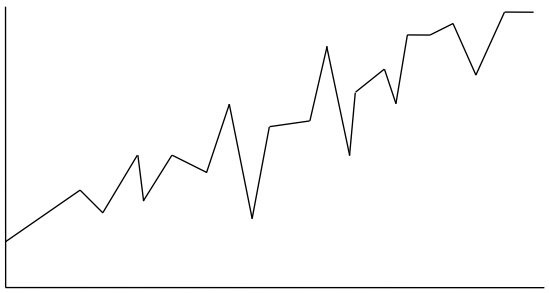
Relapse. Reappearance of symptoms from remission.

Recurrence. Reappearance from recovery.

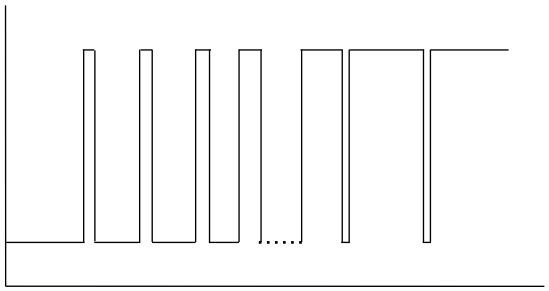
The Course of Improvement

520

521



522



523

A Core Idea

If your brain can do this, it can do it again.

We must anticipate and plan for future problems.

And accept the waviness of emotional life.

524

The Road Ahead

525

Planning Ahead for Stress

Don't rely on hope.

Make a plan.

- Returning to work
- Family holidays
- Taking a course

The Sign in the Road

526

The old self may be part of the problem.

drinking, overwork

Tempting to backslide.

Wanted: An error message.

What will you do then?

Mood Emergency Action Plan

527

WHAT IF?

Plan ahead for relapse!

Will have a plan if necessary.

Having a plan may reduce stress, and likelihood of relapse.

Ulysses Agreements

528

Some clients don't notice they are sliding.

A Ulysses Agreement gives friends or family permission to say so …

… and often, to alert healthcare providers.

529

The course of therapy

530

The course of depression therapy

Assessment

Rationale and planning

Focal therapy

Tapering sessions

Termination

Boosters

531

The therapy contract

If therapy is open-ended, there is little sense of it as a "project."

Strongly consider a discussion after assessment about an initial contract for X sessions.

Usually not signed or formal.

This does not commit either you or the client - it simply provides a guideline or horizon.

532

How many sessions?

If client is ambivalent or commitment is unclear:

4-6 sessions

This does not commit you to an extended course in which client appears but does little.

Provides a short horizon implying that we need to get to work quickly.

533

How many sessions?

If client is clearly on board with therapy:

10-12 sessions

Allows for a targeted focus on several therapy "projects."

Doesn't give such a distant horizon that work can be put off.

534

Then what?

Contracts do not commit you to ending when the contract ends.

But as the end approaches (eg session 8 of 10), discuss progress made and get feedback from client.

Decide whether to add sessions, taper, or work toward termination.

535

Tapering

Ultimate goal: Client does well without needing to see you.

Going from "once a week" to "not at all" is a big drop.

Consider spacing the last few sessions:

- Every 2-3 weeks.

Some clients: Ongoing, monthly or less.

536

Termination

Ideally, a discussion and agreement between therapist an client.

Ultimately they have full control.

In final session, review main projects of therapy.

- What worked, what was less helpful.
- What do they need to remember?
- What to do when mood dips.

537

Boosters

Discuss your open-door policy.

- Can they come back?
- Do they have to go through wait list again?
- Under what circumstances should they call?

Relapse? Continuation of therapy? New issue?

Overview

538

Understand your client …

539

And tailor your treatment.

Depression is not best treated using a cookie-cutter approach.

Don't overpathologize

540

To the degree possible, normalize the depression given …

- Life circumstances
- Personal history
- Current lifestyle

The more it's a disease, the more helpless they are.

541

Put the client in the driver's seat

Identify and pursue their priorities.

They may be right.

They will be more motivated.

But also suggest elements they may not have considered.

542

Do goal setting

Make clear inter-session goals a part of every meeting.

Progress check upon arrival.

Review of plan before departure.

543

Wrapping it up

A Core Idea

The revolution won't work.

Don't try to use everything from this program all at once ...

... but if you put it on a shelf for 2 weeks, you'll never use it again.

Find ONE thing to put into practice this week.