Depression & Major Depression Co-Occurring With Substance Disorders

Evidence Based Practices (EBP): Integrated System of Care; Universal Dual Diagnosis Capabilities; Principles of Empathy and Hope; Motivational Interviewing Approach; Stages of Change Model Design; Strength Based; Skill Building; Solution Focused; Neurochemistry Based Disorders of the Brain; Symptom Identification; Symptom Management; EBP Curriculum Topics, i.e. Nutrition, Stress Management, Cognitive Behavioral, and more…

Consistency in the Group Setting

The importance of *consistency* in a treatment setting can't be overstated. This is especially true when people are placed in vulnerable situations. *Inconsistency* can, at best, increase uncertainty and insecurity for the person receiving services. At worst, unpredictability can create a sense of helplessness while simultaneously decreasing a person's development of self-reliance. In fact, all human beings benefit from a dependable approach in the treatment of chronic disorders. When a person learns they can rely on consistency, they are less stressed and more relaxed. Consistency in the group setting includes the group structure, psychoeducational material, and the approach.

Each agency or facility will have different requirements – such as group receipts or paperwork – however, consistency can still include a structure similar to the following:

1. Group members pick up: a. Clip Board, b. Paper, and c. Pencil/Pen as they enter the room.
2. Group facilitator picks up the group receipts from each person in the group, and/or the group facilitator passes out the sign-in sheet for the group members to sign.
3. Group facilitator provides a Positive Group Beginning, Consistent Psychoeducational Material, Consistent Approach, and a Positive Group Closure.

Psychoeducational Groups and Crisis Event Processing (when requested)

Notes to Facilitator(s):

1. *The Basics, Second Edition* meets the definitions and goals of Psychoeducational Groups, Skill Building Groups, and Cognitive Behavioral Groups.
2. Group participants who have become accustomed to Interpersonal Processing Groups – as well as staff who have facilitated them – may find it a challenge to now facilitate Psychoeducational Groups.
3. Likewise, facilitators who may have followed a more lecture-style education presentation, may find it challenging to now devote at least 1/3rd of group time to specific topic discussions and interactions.
4. Both types of groups (Interpersonal Processing Groups and Psychoeducational Groups) are extremely important, yet each has different goals and structure.
5. The structure of Psychoeducational Groups, Skill Building Groups, and/or Cognitive-Behavioral Groups in no way means that there will not be *interaction* – far from it. It just means that the interactions, discussions, and exercises will be about the topic(s) of each group.
6. Facilitators *may* – or not – still want to allow time in each group for the group member(s) to discuss a crisis that may have occurred since the last group.
7. We do know, of course, that *every* person in group is typically experiencing many challenges each and every week; however, most of these incidents are often best resolved in ways other than group time where the event does not pertain to every group member.
8. Suggested responses to a challenge, problem, or crisis can also include suggesting the person contact their primary care provider; schedule a 1:1 appointment; reschedule their next 1:1 to an earlier time; or, meet with the facilitator after group to explore options and develop a plan.
9. A facilitator would, of course, not *"grade"* an event as being worthy or not for group time. If a person requests individual time in the group, then that would be accepted as valid and time allotted at the end of the group.
10. Over time, the group begins to understand the differences between a situation, a challenge, a problem, or a crisis and can make decisions to utilize group time or continue with the current psychoeducational topic.

Prepare Professionals

Suggestions for professionals to prepare themselves for group typically includes:

1. Review all content material, appendices, and/or handouts *prior* to group to avoid a lecturing style.
2. Decide beforehand the *key points* to be covered in each group to produce flexibility for group responses, discussions, or questions.
3. Gain an overall understanding of the content so summarizing is possible in order to create an interactive facilitation style.
4. Determine the group structure to achieve the essential balance between education and discussions.
5. Check group room to be sure there are enough clipboards, pencils or pens, and markers or chalk for the board.
6. Make enough copies of any handouts *before* group.
7. Write any group content on the board *prior* to the beginning of group whenever possible.

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Master Guide & Master Tips to Professionals

Note: *The Master Guide* (located at the beginning of Volume I & II) and the *Master Tips to Professionals* (located at the back of Volume I) have many topics to assist in the group process like Master Tip #39: Suggestions For Managing Handouts For Groups (pages Master Tips 64-67). Other tips include:

1. Master Guide: Interactive Style (pages Master Guide 10-11)
2. Master Tip #1: Suggestions for Beginning Group (pages Master Tips 1-4)
3. Master Tip #3: Empathetic Treatment Approach (pages Master Tips 7-9)
4. Master Tip #4: Promoting Hope (page Master Tips 9)
5. Master Tip #5: Maintaining a Consistent, Nonjudgmental, and Positive Attitude (pages Master Tips 10-13)
6. Master Tip #12: Responding to Requests for Copies of APPENDICES (pages Master Tips 27-29)
7. Master Tip #13: Depth of Psychoeducational Content (pages Master Tips 29-30)
8. Master Tip #14: Group Closure Suggestions (pages Master Tips 30-31)
9. Master Tip #16: Motivational Interviewing (pages Master Tips 31-32)

Present Curriculum/Topic

1. It is extremely important that each group participant leave every group with more Psychoeducation than they came in with – which may also include discussing a "familiar topic" yet with a "present-day" focus. Psychoeducational Groups are designed to provide education about all areas related to the management of Substance Use Disorders and Psychiatric Disorders. Psychoeducational Groups are not Interpersonal Processing Groups – even though interaction and processing the particular *psychoeducational topic(s)* is essential to individualizing the topic(s) or skill(s) presented.
2. It is recommended that a minimum of 1/3rd of group time be devoted to interaction (therapeutic counseling *topic* discussions). This can be accomplished – depending on the individual style of the group facilitator(s) – by any "present education-interact/discuss – present education-interact/discuss" combination while still structuring the group to include the curriculum/topic education to be covered.
3. The presentation of material will, of course, be modified by the facilitator to match the functioning skills of group participants. It is important to note, however, that *THE BASICS, Second Edition* was written in a conversational language while taking into consideration a wide-range of symptom acuity and severity. Persons with co-occurring psychiatric and substance disorders benefit from learning about their disorders and how to manage them, as do all individuals with any chronic disorder(s). Each group participant will retain what is meaningful to them at the present time.

Group Beginning Suggestions

A positive group beginning (and ending) is extremely important. There are many ways to begin (and end) a group in a positive way. Suggestions to choose from can include:

1. Reading the Thought For The Day from a meditation book. (Note: Meditation books that also contain an index at the end of the book – such as *Easy Does It* – are helpful in choosing a specific reading that matches the topic(s) presented in group like Self-Esteem.), *or*
2. Reading an inspirational or humorous curriculum handout from *THE BASICS, Second Edition, or*
3. Practicing a deep breathing or a stretching exercise, *or*
4. Sharing of one thing that each person is grateful for today, *or*
5. Sharing of one positive thing that he/she did that contributed to their recovery in the past few days, *or*
6. Reading an AA Slogan with a brief explanation or AA/NA/Dual Recovery inspirational reading.

* Recommended Beginning: Breathing Exercise (located on page Master Tips 3)

Practice Curriculum/Topic

Practicing subject material is the best way participants can internalize and personalize the curriculum content. Practice includes the group interactions, worksheets, exercises, handouts, and content discussions.

Based on a 2-Hour group: Two 50-Minute Segments	Time-Frame
Group Beginning and Prepare Group	**20 Minutes Total**
Positive group beginning (suggestions are located on the previous page).	5 Minutes
1. Brief Group Introductions: (Note: The *interactions* in a psychoeducational group are discussions about the *topics,* not interpersonal processing or case management questions which do not apply to the entire group.) a. Ask the group members to tell the group their name. b. Welcome any group members who are new to this group or phase. 2. Crisis Processing (when requested and optional): a. Ask the group if anyone has experienced a crisis since their last group, and if they need/want additional time in this group to discuss it, i.e. what happened, how they managed the crisis, and/or explore options and develop a plan. b. Let the person(s) know that you will allow time at the end of this group for them to share their experience and receive support from their fellow group members.	10 Minutes
<u>Summarize Introduction of the Group Topic and Why It's Important</u>: It's not difficult to see why a person in treatment for Substance Use Disorders would feel depressed. A person may look back to a history of struggles, difficulties, and perhaps missed opportunities – often referred to as "the wreckage of the past." Looking ahead may include treatment, court, housing challenges, employment difficulties, family issues, child custody problems and more. Just *giving up* substances that make a person feel *more* of something or *less* of something can be depressing enough! A depressive disorder is actually common among people who are diagnosed with a Substance Use Disorder. It does not mean there is something weak or wrong with a person, it just means that they are experiencing less "feel good" chemicals in their brain. These brain chemistry deficiencies then affect a person's mood, their thinking, and their behavior. Yet, there's a big difference between the common and understandable – although uncomfortable – depression related to the recovery process of Substance Use Disorders and the depression of a diagnosable Mood Disorder. When a Mood Disorder goes *un*diagnosed and *un*treated it's *extremely* difficult – if not impossible – for a person to be successful in the recovery of Substance Use Disorders. Substance Use Disorders and any co-occurring Mood Disorder *must* be treated at the *same time*. There are four types of Mood Disorders. Today we will focus on depression and Major Depression.	5 Minutes

Psychoeducation Part I: Topics & Focus	Pages & Location	Presentation Suggestions	Time-Frame
Mood Disorders	Subject 2-8	Summarize one paragraph.	30 Minutes
Types of Mood Disorders	Subject 2-9	List the types of mood disorders in the table below:	

1	Major Depression	2	Dysthymia	3	Bipolar Disorder	4	Cyclothymia

Major Depression	Subject 2-9	Summarize one paragraph.	
Clinical Depression Is Different From Sadness	Subject 2-9	Summarize three paragraphs.	
Symptoms of Major Depression or Bipolar Disorder Depressive Episode	Subject 2-11	Discuss/explain the symptoms of Major Depression in the following areas (Note: Examples of each criteria of the table are located in the text.):	

Physical Symptoms	Cognitive/Thinking, Emotional, and Behavioral Symptoms	Spiritual Emptiness
Significant Changes in Appetite or Weight	Cognitive Problems	Loss of Capacity for Pleasure and Joy
Sleep Problems	Persistent Depressed Mood	Recurrent Thoughts of Death (not just fear of dying)
Fatigue	Feelings of Worthlessness or Excessive Inappropriate Guilt	
Psychomotor Agitation of Retardation (muscle activity related to mental processes)	Functioning Impairment	

To Facilitator(s):

1. It is recommended that any group content for this particular group be written on the board *prior* to the beginning of group whenever possible.
2. This group is never intended to diagnosis a Mood Disorder or Major Depression. It *is* intended to provide enough information for participants to decide how they relate to the symptoms of depression.
3. In many cases individuals will identify their "sadness" as a part of the depression associated with the withdrawal process and/or the early recovery process of Substance Use Disorders.
4. Facilitator(s) can suggest that the person(s) be aware if *either* of the following happens in the future: a. *If* something *does change* like depression becoming more acute, *or* b. *If* something *does not change* like depression not lessening with abstinence or harm reduction. If *either* of these do occur then the person(s) is encouraged to bring this up with their primary counselor for further discussion or assessment.
5. For any individual(s) who *do* see a strong identification with the symptoms of depression – or perhaps have a history of depression – it would be recommended that they follow-up with their primary counselor as soon as possible.

Psychoeducation Part I: Topics & Focus (continued)	Pages & Location	Presentation Suggestions	Time-Frame
<u>To the Group</u>: 1. It's important to remember that in order for a person to actually *be* diagnosed with a Mood Disorder or Major Depression the person would need to: a. Experience *specific* symptoms, *and* b. Experience a set *minimum* of symptoms, *and* c. Experience those symptoms for a certain *length of time*, *and* d. Experience a *disruption in functioning level* as a result of the symptoms. 2. What symptoms of depression do you currently relate to? 3. Have you experienced these symptoms for a very long time? 4. Was your depression worse during times of abstinence? Better? The same? 5. Do most of the symptoms on the list (located in the text or on the previous page) seem to be related to a Substance Use Disorder? 6. Do you experience symptoms of depression that seem more bothersome than the depression associated with substance use, substance withdrawal, or the early recovery of a Substance Use Disorder?			continued ↓
Break			**10 Minutes**

Psychoeducation Part II: Topics & Focus	Pages & Location	Presentation Suggestions	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
<u>To Facilitator(s)</u>: You will – of course – need to pick and choose, summarize, paraphrase, or skip some information altogether to allow time for the *Skill Building Exercise and Discussion* in this group.				
The Basics About Major Depression (#1, #2, #3 in the table)	Appendix II-1 – II-3	1. Summarize *#1 Prevalence* found in the table. 2. Summarize *#2 Men & Women* found in the table. 3. Briefly mention the main points in *#3 Risk Factors*.	10 Minutes ↓	15 Minutes ↓
Causes (#4 in the table)	Appendix II-3 – II-5	1. Summarize point 1. and 2. in the table. 2. Summarize a., b., c., d., and e. located in the text and in the table below:		

a. Genetics	c. Social and Environmental	e. Major Depression Without a Family History
b. Biological	d. Hormones	

Skill Building Exercise and Discussion Suggestions

Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
20 Minutes	25 Minutes

To Facilitator(s): The following table (below) and the graphic (next page) are located on page Subject 7-19. However, since the graphic and table are provided in this lesson plan, there's no actual need to refer to page Subject 7-19, Volume II.

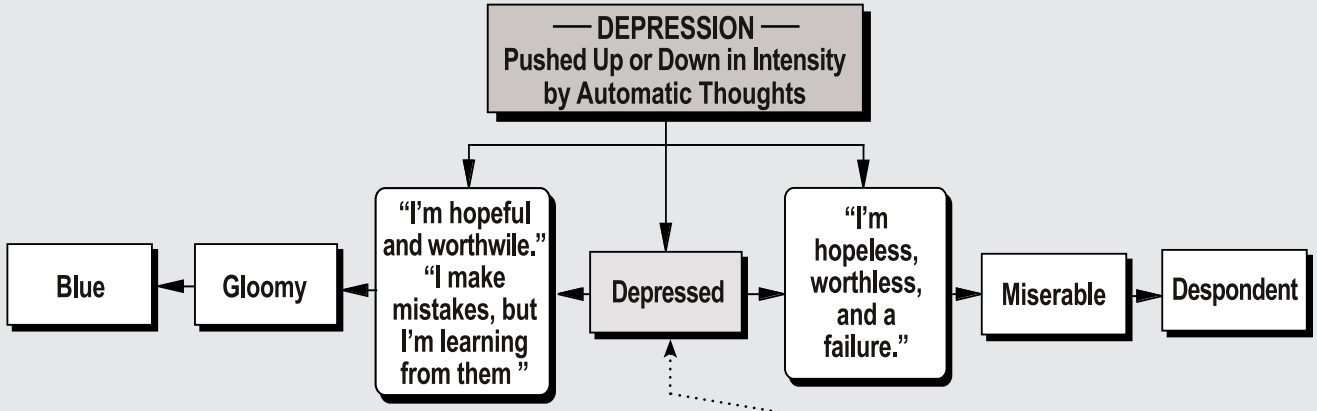
To the Group:

1. *Changing thinking patterns* is a part of the recovery process for depression, Major Depression, and the depressive episodes of Bipolar Disorders.
2. *Benefits* of becoming aware of depressive thinking patterns applies to individuals that experience substance-induced depression that typically lessens with abstinence or harm reduction, as well as those who experience more serious and persistent depressive disorders.
3. Let's take a look at the emotion of depression, the common themes of depression, and the common automatic or familiar thoughts related to depression.

Emotion	Common Themes of The Emotion	Common Automatic or Familiar Thoughts
Depression	1. Hopelessness 2. Worthlessness 3. Helplessness	1. I'm worthless, I can't do anything right, I'm unlovable, No one loves me. 2. It's hopeless, Nothing good ever happens to me, I'll never amount to anything, There's nothing I can do to change things.

4. Which themes of depression do you relate to?
5. What are some of the automatic or familiar depressive thoughts that you have?
6. Many people express their depression with anger – especially men. Does that apply to you?

All emotions have a range of intensity. Familiar thoughts can either push emotions *up*, worsen them, or increase their intensity, or *down*, lessen them, or reduce their intensity. It all depends on your self-talk or what you tell yourself. Examples of how this works with depression can include (see graphic on the next page):

Skill Building Exercise and Discussion Suggestions	Time-Frame with Crisis Processing	Time-Frame without Crisis Processing
To the Group: (continued)  Let's look at the squares to the left and right of the middle square (Depressed): 1. What thought(s) do you have that can push your depression or sadness up or increase its intensity to Miserable or Despondent? 2. What depressed thought(s) do you have the most often? 3. When you are feeling depressed or sad, what thought(s) do you have that make your depression better? 4. What thought(s) could you develop and practice that will lessen or push your depression down to a lesser intensity of Gloomy or Blue?	continued	continued
Crisis Processing	**Time-Frame**	
1. Ask the group member(s) to tell the group what happened. 2. Explore options and/or develop an immediate plan for coping. 3. Allow the group to offer support.	10 Minutes	
Group "Paper Work"		**Time-Frame**
Group participants fill out Group Evaluations.		5 Minutes
Group Closure		**Time-Frame**
1. Ask each group member to name one additional helpful thought that they will begin to practice to replace a depressed thought, *or* 2. Read a daily thought for the day or a positive closure of your choice.		5 Minutes