MANAGING DEPRESSIVE SYMPTOMS IN SUBSTANCE ABUSE CLIENTS DURING EARLY RECOVERY

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TIP 48

- MANAGING DEPRESSIVE SYMPTOMS IN SUBSTANCE ABUSE CLIENTS DURING EARLY RECOVERY

Overview

- Depressive symptoms are common among clients in substance abuse treatment. Some studies indicate that as many as 98 percent of individuals presenting for substance abuse treatment have some symptoms of depression
- When they occur, depressive symptoms can make working with clients more difficult. They can also interfere with clients' recovery and ability to participate in treatment.

Consensus Panel Recommendations

- All substance abuse clients should be screened for depressive symptoms
- Become aware of: how depressive symptoms are manifested in clients and, how those symptoms affect recovery
- Build awareness of how depressive symptoms affect client participation in treatment

Consensus Panel Recommendations *cont.*

- Treatment for substance abuse and depressive symptoms clients should be client centered and integrated.
- Several intervention methods are successful: behavioral, cognitive behavioral, supportive, feelings expressive, 12-Step facilitation, and motivational interviewing.
- Helper self awareness

Concepts

- the first few months of treatment are when depressive symptoms are particularly common.
- Depressive symptoms are sometimes referred to as “mild depression” and/or “minor depression (mD)” in the literature.

Working Definition

- The term “depressive symptoms” refers to symptoms experienced by people who, although failing to meet DSM diagnostic criteria for what used to be called mood disorder, suffer from sadness, depressed mood, or “the blues” and one or more additional possible typical depression symptoms.

Drugs that Precipitate or Mimic Depressive Disorders

Depression and Dysthymia

- During Use:
  - Alcohol
  - benzodiazepines
  - opioids
  - barbiturates
  - cannabis
  - steroids (chronic)
  - stimulants (chronic)
- After Use:
  - Alcohol
  - benzodiazepines
  - barbiturates
  - opioids
  - steroids (chronic)
  - stimulants (chronic)

Drugs that Precipitate or Mimic Depressive Disorders

Mania and Cyclothymia

- During Use:
  - Alcohol
  - inhalants (organic solvents)
  - hallucinogens
  - steroids (chronic, acute)
  - stimulants (chronic)
- After Use:
  - Alcohol
  - benzodiazepines
  - barbiturates
  - opioids
  - steroids (chronic)

Sadness or Depression

- Depression is ongoing, sadness is time limited
- Sadness is bound to something, depressive symptoms are not bound. They are attached to “nothing and everything”
- Sadness is a “first order feeling” Depression is a “second order feeling

Sadness or Depression

- Sadness has survival value for the individual and the species.
- Depression does not have survival value.
- Always ask WWWWH?

Depressive Symptoms

- Hitting bottom, entering treatment and beginning a sober lifestyle can precipitate depressive symptoms.
- The use of or withdrawal from certain substances can lead to depressive symptoms. These symptoms can last as long as an individual continues to take substances and may or may not improve with abstinence.

- Some problems with depressive symptoms can linger for 3 to 6 months after abstinence.
- Even though depressive symptoms may be related to substance use or withdrawal, they still must be addressed in counseling.
- The issue of whether the depression is an artifact of or pre-existing to the substance abuse is irrelevant to treatmenmt in early recovery

- Appropriate treatment for depressive symptoms has been shown to improve substance-related outcomes. Therefore, addressing depressive symptoms must be of concern to you as a substance abuse treatment counselor.

Depressive Symptoms and Related Feelings and Behaviors

- Loss of interest in most activities
- Significant change in weight or appetite
- Sleep disturbances
- Difficulty in concentration
- Decreased energy, chronic fatigue, or tiredness
- Feelings of guilt
- Feelings of low self-esteem, low self-confidence, or worthlessness
- Feelings of pessimism, despair, or hopelessness

Depressive Symptoms and Related Feelings and Behaviors (cont.)

- Social withdrawal
- Frequently agitated, restless
- More frequently withdrawn, reclusive, prefers being alone
- Feelings of irritability or excessive anger
- Decrease in activity, effectiveness, or productivity
- Difficulty in thinking, reflected by poor concentration, poor memory, or indecisiveness
- Excessive or inappropriate worries
- Being easily moved to tears
- Anticipating the worst and hypervigilant
- Hopelessness and Thoughts of suicide

How Depressive Symptoms Affect Treatment Participation

- Difficulty in concentrating
- Trouble keeping appointments.
- Lack of energy to participate or lack of interest in substance abuse treatment program activities
- Lack of perceived ability or lack of motivation to change.
- Belief that he or she is beyond help.
- Being overwhelmed by feelings
- Terminal “uniqueness”

Suicidality

- All clients with substance use problems and depressive symptoms should be screened for suicidality.
- Suicide Scales can be used as aids, but are not sufficient alone.
- Chief barrier to talking about suicide is counselor reluctance.

Common Misconceptions about Suicidality

- Clients will follow through with a pact not to harm self
- Talking about suicidal thoughts will only make the problem worse
- People become suicidal because of events in their lives and reversing the events (or getting a client to see an event in another light) will change the suicidal intent
- The risk of a suicide attempt is lowered if the client doesn't describe a plan for how he or she will commit suicide.

Some "to do's" for working with clients who are suicidal

- Seek clinical support
- Obtain informed consent to confer
- Encourage client to talk about suicidal ideation, plans, methods, etc.
- Listen to the client's experience and feelings without judgment.

Some "to do's" for working with clients who are suicidal

- Don't allow yourself to be sworn to secrecy about the client's suicidal thoughts or intent.
- If possible, involve the client's family and significant others in supporting the client.
- Have a clear understanding of the ethical, legal, and agency guidelines in working with clients who are suicidal

The Reality of the Client With Depressive Symptoms

- *Jumping to conclusions—*
- *Emotional reasoning—*
- *Discounting the positive—*
- *Disbelieving others—*
- *Black and white thinking—*
- *Selective comparison*

What is the job?

- Psycho-education
- Integration of tx for depression and CD
- Understanding depression
- Negative thought reframing
- Reality testing
- Coaching for behavior change
- Developing coping skills
- Emotional Management skills
- Support and motivation enhancement

Selected Major Evidence Based Interventions

- Behavioral Interventions
- Cognitive-Behavioral Therapy Interventions (CBT)
- Supportive Therapy
- Expressive (affectively based) Therapies
- Motivational Interviewing

Depressive Disorders

Benefits of involvement in a 12-step program

- Ready regeneration of a natural, organic network
- Intrusive nature of some members makes isolating harder
- Early recovery high is good bridge to more durable change
- Good place to invest excess energy
- Pacing through artificial controls of tradition and cliché

Depressive Disorders

Impediments to accessing a 12-step program

- Tendency to isolate when they most need not to
- Occasional resistance to medication regimen by well meaning members
- Content of meetings may serve as craving cues
- Being high maintenance they can wear out fellow members
- High tendency to relapse discourages sponsors and others in the program
- Craving Cues" are more complicated than for others
- Personality disorder like behaviors

Depressive Disorders

Interventions that facilitate the use of 12-step programs

- Promote "old-timer" sponsor network
- Establish regular meeting schedule with home group and "home away from home" groups
- Good mix of meetings with early emphasis on discussion meetings
- Beginner meetings to help build a recovery cohort
- Find "double trouble" meetings where there is an over representation of co-occurring disordered members

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