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Dr. James N. Herndon

Personalized Depression Therapy (PDT)

DR. JAMES N. HERNDON'S

Personalized Depression Therapy (PDT)

WARNING: PDT is an instructional program. It is not intended to take the place of medical advice. You are encouraged to consult with your doctor about your depression as well as about PDT. Thoughts of suicide are extremely serious. Seek medical help immediately. NEVER stop taking anti-depressants without first consulting with your doctor.

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Introduction

There are few of us who have not felt depressed at some time in our lives. In fact, most of us feel a little "down" once every month or two. Is this normal? Sure. When we mention the word "depression" to our friends or family, everyone seems to know what we're talking about. How many times have you heard someone say: "Depression? What's that?" It just doesn't happen.

But for an ever-increasing number of us, depression has another face. We don't just feel a little sad or a little down. We feel as if our entire existence were disintegrating. This isn't just depression. It's *severe* depression. Sometimes it lasts for weeks, sometimes for months. It might suddenly go away—only to return with renewed fury.

For me, there's no greater medical mystery than depression. Where does depression come from? What does it *mean*? It's now as common as the common cold. There are dozens of new pills that are supposed to make it go away. There are dozens of therapies that try to talk us out of it. But the problem keeps getting worse.

Some years ago, I decided to begin conducting my own depression research. Depression was a problem that touched people I knew, as well as people I loved. But the deeper I got into the traditional depression treatments (drugs and psychotherapy), the more I realized that only *symptoms* were being treated, not *causes*. I wanted to get down to basics, to that basic *thing* that produces the phenomenon we call depression. Well, my research continues. But I believe I have found that *thing*.

I have now conducted over ten years of depression research. The result is a program called Personalized Depression Therapy (PDT). The PDT self-help therapy has worked for thousands of depression victims and I believe that the time has now arrived to make it widely and inexpensively available to the general public.

PDT is different in significant ways from other depression treatments. Perhaps most importantly, PDT is an *active* therapy. Too often, depressed persons are led down a futile path by mental health professionals. The message is: "Just sit back, try this new anti-depressant, and we'll see what happens." And what is the depression sufferer supposed to do? Nothing. Exactly nothing.

Most psychotherapy isn't much better. "Let's talk about your lousy childhood." "Let's explore that relationship that went bad." "Tell me more about that impossible situation at work." And what is the depressed person told to actually *do* to help fight her or his depression? Nothing—just endlessly analyze the

past. Sorry, but that just doesn't cut it anymore. Something's not working—and that something is the traditional way we treat depression.

PDT was created to overcome the horribly *passive* nature of current depression therapies. My personal experience shows that *only* by taking personal charge of our own depression will we defeat it. If we're waiting for someone to cure our depression for us—good luck. It's going to be a very long wait.

The purpose of this book is to show you a way to *do* something about your depression. It is designed to provide you with a new perspective on the origins of depression and what it really means—and then to show you a specific strategy that you can use to control and ultimately defeat your depression. PDT is a therapy that is intended to be self-help in the truest sense—and it is personalized because *you* personalize it. When it comes to depression therapy, one size does not fit all.

Most PDT users have formerly taken, or are currently taking, anti-depressant drugs. At least 70% of depression sufferers who use anti-depressants find their drugs at least partially ineffective. One-half stop taking their medication completely. Recent research shows that a placebo (a pill that does nothing) relieves depression symptoms almost as well as real anti-depressants. However, I am *not* advocating that depressed persons throw their pills (or their psychotherapy) out the window. Anti-depressants are frequently a depressed person's only lifeline, and although I believe they are ruthlessly over-prescribed, their value in many cases is clear.

In fact, I caution those who are currently on anti-depressants to NEVER attempt to adjust their medication without careful consultation with their physicians. Although nearly half of the persons taking anti-depressants complain of side-effects, a sudden withdrawal from these drugs has the potential to produce significant, and potentially dangerous, withdrawal symptoms. So please discuss any desired change in your medication with your physician.

In addition, I encourage any one currently under a doctor's care to discuss PDT and to determine how it may become part of your overall treatment strategy. And if you've never seen a physician for your depression—I strongly encourage you to see one. Depression is inseparable from a person's overall physical health. A complete physical examination is a must. Finally, *any* thoughts of suicide are extremely serious. *Never* hesitate for one moment to seek immediate emergency medical assistance.

I dedicate this book to the millions who have suffered from depression and to the millions who are suffering. May it come to an end.

Dr. James N. Herndon
Phoenix, Arizona, February, 2001

Chapter 1

The Plague of Depression

Let's shatter a myth right at the beginning. Most depression sufferers I've worked with believe that they are the victims of a rare condition. Then I tell them the facts: Primary care physicians—in other words, family doctors—spend over *half* of their time treating depression. Pretty amazing. What this tells us is that depression occurs more often than *any* other illness. It is not just the most frequently occurring *mental* illness, but *the* most common illness—*period*.

Just think: If over half of the office visits to family doctors are related to depression, then *tens of millions* of persons are clinically depressed. And the majority of those who are depressed never even seek treatment. I doubt if we'll ever know the true extent of the problem.

What are the reasons behind this "plague" of depression? Is genetics playing games with our psyche? Are the stresses of modern life finally catching up with us? Researchers tend to argue both sides. Genetics may, indeed, play a role. For instance, a tendency to be depressed runs in families. But does this mean that we're born depressed, or instead, does a negative environment just get passed down from generation to generation?

This is the old problem in psychology of nature vs. nurture. That is, does nature give us certain ways of thinking and acting at birth? Or does our environment—that is, the way we're "nurtured"—"train" us to develop these tendencies? As with most issues, the answer to depression, I think, is somewhere in the middle: It is part nature *and* part nurture. In fact, my depression research has led me to this conclusion:

ALL human beings are born with what you might call a depression "switch" that can be turned on and off. We may either remain relatively depression-free throughout our lives. Or, negative environmental influences, such as dysfunctional interactions with family members, traumatic events, guilt, worry, stressful job situations, and unproductive ways of thinking and behaving, can cause this depression switch to be turned on. The bottom line: Some people are more likely to become severely depressed than others. But—all of us have the *potential* for severe depression.

Chapter 2

What Does Depression Mean?

Why would nature provide us with this depression response? Generally, the many processes going on in our bodies serve some positive, useful function. That is, they're *adaptive*, which essentially means that they are there to help us survive. My research leads me to believe that depression is also adaptive—in other words, it's there for a reason.

Think about all of the processes that go on in our bodies. They are there to help or to protect us. For example, our immune system protects us against such things as bacteria and viruses. Why shouldn't we also have built-in defenses against *psychological* attack? I am becoming increasingly convinced—this is the *meaning* of depression.

All right. So how can being depressed help us "survive"? This doesn't seem to make sense. When we're depressed, we feel terrible. But, we also feel terrible when our body is fighting an invading virus. Yet we know that we will get better and feel normal again.

But when we're depressed, we often don't even know why. Waves of depression can engulf us for no apparent reason. If our brains are really trying to "defend" us against something, then what is it? The answer to this question, I'm firmly convinced, provides the *key* insight to the problem of depression—and, I believe, a hidden strategy to *overcoming* depression.

Chapter 3

Dominance, Submission, and Depression

Most animals have an instinctive desire to dominate. This dominance involves controlling their territory or their environment, as well as attempting to control each other. This "will" to dominate is also adaptive. It serves a survival function. The better job an animal does of dominating or controlling its environment, of dominating other group members, of dominating outsiders who encroach on its territory—the better its chances of survival.

But sometimes, chance and circumstance do not allow an animal to dominate. For example, a stronger animal may attack. In this instance, nature has provided the animal with two possible ways to respond: fight or submit (often called "flight"). If the opponent is stronger, the animal is often more likely to survive if it submits.

Dominance and submission. We usually view one as "positive" and the other as "negative". But *both* behaviors have only one objective: To insure the survival of the organism. But these instinctive responses of dominance and submission don't just apply to the animal kingdom. They apply to us as well.

Chapter 4

The Root of Depression

We have now reached the central finding of my research:

Depression is our body's submission response in overload.

Once you understand the implications of this insight, you'll be well on your way to winning the depression battle. Let me repeat it again: *Depression is our body's submission response in overload.* Let me explain.

Thousands of years ago, the problems of human beings were very much like the problems of other animals—namely, having enough food to survive, and being vigilant against physical attack. Human beings, like animals, would dominate where and when they could, and would submit where their physical survival was at stake. Again, dominance and submission are two sides of the same coin. Both are instinctive. Both are there to help increase the chances of survival.

But what happened as civilization developed and became more "sophisticated"? Dominance and submission, these instincts, couldn't always "express" themselves as they had in more "primitive" times. When in a dominant mode, it was becoming less acceptable—and less necessary—to be physically aggressive. Now the instinct to dominate had to find a more social—a more "psychological"—form.

Our submission response also faced changing social and cultural conditions. As society evolved, we found less and less need to submit to a more powerful *physical* aggressor. Instead, we found more and more need to submit to powerful *psychological* attack. And more and more often, this attack would come from our own thoughts.

Chapter 5

Is Depression There to "Protect" Us?

It's unthinkable—especially to a depressed person—that depression might actually be there to "protect" us. But that is exactly what my research suggests. Again, we must consider that, just as dominance and submission exist in us for a reason, something now as common as severe depression must also be serving some "protective" or "adaptive" function.

Well, here is the key:

Inside of our instinctive capacity to *submit* lies the source of depression. *Depression is, in reality, our brain's instinctive attempt to submit—and to thereby "survive"*. But what is it trying to submit to? My research is clear—it is trying to submit to the psychological threats we create in our minds.

Chapter 6

The Feeling Factor

I don't believe severe depression would be possible if it were not for another important ingredient—the *feeling factor*. Dominance and submission also have "feelings" attached to them. Whether we're behaving aggressively, or behaving with a lack of self-confidence, a certain feeling goes along with these behaviors. In other words, much of our thoughts and behaviors have unique emotions, feelings, or moods.

At its most basic level, depression is all about feelings. When severely depressed persons are asked to describe their depression, a *horrible feeling* is the thing most often talked about. It is such a unique feeling, that words are virtually powerless to describe it. And, significantly, the words that *are* used to define the feeling of depression are always *negative* words: "hopeless", "lost", "empty", etc.

The question is: What are these feelings telling us? Do they carry a message? The answer is yes.

Chapter 7

Depression and Intelligence

Over the millennia, the human mind became increasingly self-analytical. We, as human beings, became accustomed to sitting around and just thinking about things. We could plan our aggression, for instance, perhaps delaying it to a later time. Or, in situations where we had to submit, we could sit around and brood and worry. We could wish evil things on our opponents, and increasingly, heap scorn and ridicule on ourselves for our weakness.

So what was happening? We were taking something that was formerly very behavior-oriented, very action-oriented, and starting to intellectualize it. Whereas thousands of years ago we spent little time analyzing our problems—usually because we were too busy with the problems of mere survival—we eventually began to carry on more and more inner conversations with ourselves.

In fact, the rise in our leisure time contributed to this phenomenon. But what made it particularly bad—and what makes it excruciating for a person with severe depression—is that these inner dialogues have a very powerful emotional component. They are one part intellectual, but five parts raw, churning emotions and feelings.

These inner dialogues—almost always involving some form of anger, worry or self-criticism—call up the brain's submission response. It's almost like dialing a phone number. The brain answers the call and its message is—submit, submit, submit. The brain is telling us that it is under attack and that it wants us to survive. And the signal to submit is this flood of extremely powerful, negative feelings—feelings we now interpret as being depressed.

The problem is—when you're under attack by *yourself*, how does the brain's submission response know when to "disconnect" from the "distress call" that it is receiving? That is, how does it know when the "attack" is over? Well, it never knows, because our attacking "thoughts" refuse to stop. This is how someone can spend a lifetime suffering from waves of severe depression.

But what is the ultimate twist on the intellect and depression? Something very surprising. In my research, I have found an extremely high association

between intelligence and the likelihood of becoming severely depressed. In fact, a high IQ is a good predictor of depression. Why? Simply because those with higher intelligence are amazingly "creative" with their inner dialogues.

Some of the characteristics of high intelligence are an above-average imagination, superior verbal ability, and advanced analytical skills. This is the perfect recipe for cooking-up very elaborate, and very negative, inner dialogues. And that's exactly what happens. This helps explain the well-known phenomenon of "tormented geniuses". Simply, their submission response is often out-of-control. And, despite their genius, they don't know how to stop it.

Chapter 8

Do We Learn to be Depressed?

It's important to remember how a human being—in fact how any organism—learns. For me, there's a very simple answer to this question: We learn by practicing. The more we do something, the more we practice it, the better we get at it—and the less we have to think about it. We tend to think of practice in a positive sense—like practicing a sport. But we can also practice very negative things. The problem is, we keep getting better and better at those things, too.

The same way we learn to drive a car or to play the piano—in exactly the same way, we learn to be depressed. And for many of us, we learn to be severely depressed.

And *we learn to be depressed by practicing*, by rehearsing thoughts and feelings in our minds over and over and over again until our brain's submission response is in overload. The frightening part is that when this happens frequently enough, brain chemistry changes. A whole host of anti-depressant drugs are available to help restore this balance. But the root cause is still there. The depression symptoms are merely covered-up.

Depressed persons I've worked with often resent the idea that they have "learned" to be depressed. I have frequently been told: "How dare you suggest that I have chosen to be depressed, that I have learned it. I am a victim of depression. Learning has nothing to do with it."

Right and wrong. Right because no one *consciously* chooses to be depressed. Wrong because we are all continuously engaged in *unconscious* learning. Depression is a classic example of unconscious learning. What are we unconsciously practicing? The *way* we speak with ourselves. What are we unconsciously learning? To feel depressed.

Chapter 9

Our Inner Dialogues

Depression is almost always the result of the negative "inner dialogues" we have with ourselves. An interesting pattern has emerged from my experimental and survey research into depression: Individuals rarely became severely depressed without engaging in highly submissive inner dialogues.

These dialogues are familiar to all of us. They often involve guilt, where we say things to ourselves like: "I'm to blame for what went wrong," or "It's all my fault." These dialogues can also involve thoughts of unrealistic despair, such as "It's no use. Things will always turn out wrong." Or: "My job situation or my family situation is hopeless." Or: "People are always mistreating me." Or: "I'll never be able to accomplish anything." Or: "I'm just of no use to myself or to anyone else." Or, the dialogues can involve despair about the depression itself, like: "I'll always be depressed. It's never going to get better."

Typically, individuals have strong reasons for these thoughts. A terrible family or job situation, or other interpersonal problem, can be horribly debilitating. But, by engaging in these sorts of inner dialogues, we are playing a very risky game. Simply, *we are risking overwhelming our submission response*—and thereby plunging ourselves into perhaps a lifetime of severe depression.

Often individuals who have participated in my research have said to me: "But these kinds of thoughts didn't make me feel severely depressed. Because first I felt depressed, *then* I had these negative thoughts." However, on closer examination of virtually every case, I find that these kinds of negative thoughts, in fact, *do* appear first, *then* severe depression results. Simply put—out bad thoughts produce our bad feelings.

But, like any habit, changing something we practice as much as our inner dialogues is extremely difficult, especially once we have trained our submission response to activate so easily, so unconsciously.

Depressed persons get very tired of hearing people say things like: "Just snap out of it. Be more positive. It's not that big of a deal." Well, once we have reached the stage of severe depression, it is a *very* big deal. And just simply telling

ourselves to "be more positive" is not a strategy that is concrete enough to be very helpful. What we can do, however, is to take a different approach, one that my research has shown can be remarkably effective. It is a method that takes advantage of the flip side of the submission response—the dominance response.

Chapter

10

Dominance and Our Interests

Let me briefly discuss what I found to be among the most interesting findings of my depression research—the finding that ultimately resulted in the development of Personalized Depression Therapy.

I began my research into depression by asking a large sample of individuals some survey questions. I made sure that I had a representative sample of persons who had never suffered a major depression *and* a representative sample of those who had. My objective was to see if I could pinpoint any meaningful differences between the two groups.

And so I asked questions about a lot of different areas: age, gender, lifestyles, attitudes, interests, occupation, education, diet, family history of depression, family problems, and on and on. It was my prediction that somewhere there had to be some common factors that might provide at least a partial clue to the mystery of depression.

When I began to analyze the results of my first group of surveys, many patterns emerged. But one, in particular, really struck me. When all other factors were held constant, individuals who had *developed personal interests in six areas* were far, far less likely to have suffered an episode or multiple episodes of major depression. This was strange. How could something as commonplace as someone's personal interests have anything to do with whether or not severe depression would develop?

This was simple, so I was automatically suspicious. Despite the fact that scientists are taught to look for clear, simple solutions to problems, something this simple in the field of psychology—of all things—seemed almost too good to be true. But there it was. The implications of this finding have now kept me busy doing follow-up research for the past several years. But here's basically what it boils down to:

Individuals with the fewest episodes of major depression have developed personal interests—and *actively pursue* those interests—in *each* of the following six areas: 1) objects, 2) activities, 3) places, 4) people, 5) skills, and 6) beliefs. And

these individuals spend, on average, somewhat *over 90%* of their leisure time pursuing these interests.

Guess how much of their leisure—or non-working—time depressed individuals spend pursuing their personal interests? *Less than 20%*. And a great deal of the rest of the time, they are thinking about being depressed.

My latest research continues to support these findings, and I am confident in stating that: *The lack of comprehensive personal interests in these six areas strongly contributes to the development of severe depression.* We could summarize it this way:

Persons with a comprehensive set of personal interests have more dominant "personalities" and so are less likely to engage in negative inner dialogues. In such cases, the submission response is less likely to be triggered. Thus, these persons are less likely to become severely depressed.

Chapter

11

A Closer Look at Interests

One of the most fascinating areas of psychology is personality psychology. Psychologists have debated for years about exactly what defines a person's personality. In particular, volumes of research have been written on the so called "trait" terms that we label ourselves and each other with.

For example, if I were to say that I'm "assertive" and "self-confident" or that I'm "shy" and "withdrawn", I would be using trait terms. We all use these terms, and many others, constantly. And we think we know what they mean. It's a problem, though, when we try to match up specific behaviors with specific trait terms. The association is usually pretty low. For instance, exactly what behaviors is the word "shy" supposed to describe? Well, no two individuals seem to agree. In this case, as in others, the real value of the trait term is questionable.

One of the interesting outcomes of my depression research is that individuals actually seem to define themselves—in effect, to define their personalities—not through "trait" terms, but through their personal interests. Most significantly, our personal interests seem to be areas that we perceive as our "strengths", as our "power", as our control over our environment; in other words, as our ability to "dominate".

Simply, our personal interests represent those behaviors in which we can safely and "humanely" exercise dominance, and by doing so, feel free from threat—most importantly, the threat of negative inner dialogues. We all have at least one thing we are very good at or know a lot about. This then becomes a means through which we can exercise a positive kind of strength, a positive kind of dominance.

Apparently, however, those of us who have *more* of these areas of confidence—in other words, more personal interests—are also more resistant to the sorts of negative inner dialogues that trigger the submission response. Why? Because the flip side of the submission response, the dominance response, is being triggered instead.

Let's briefly look at these six areas of personal interests.

The first is *objects*. Human beings define themselves very strongly through the objects they possess. Most of us have family mementos or prized possessions that mean a lot to us. These objects can be automobiles, homes, a book collection, a computer, a CD collection....the list is truly endless. The point is, most of us have objects that we value, that we spend time looking at, touching, or thinking about. And ordinarily these objects are of such interest to us, that we know a lot about them and are interested in learning more about them.

Second is *activities*. These are the things we like to do: swim, ski, read, watch TV, pursue a hobby, build something, create something, cook, or be with friends. Activities play a very important role in the way we define ourselves. In fact, when most people think about personal interests, they are primarily thinking about activities.

Third is *places*. We all have places that mean a lot to us, such as our home, or even a particular room. Maybe it's a city, or a neighborhood, or a particularly interesting building. For a lot of the young persons I've surveyed, it might be a place where they like to be with their friends.

Fourth is *people*. Most of us know one or more individuals who mean a lot to us, most often friends or family members. People we've never even met can also mean a lot to us, such as well known persons in history, or sports, or entertainment.

Fifth is *skills*. This is an area in which a feeling of dominance can be very strong. Skills essentially includes anything we're really good at or know a lot about. Someone might know a lot about history, or be a great skier, or be an outstanding chef, or a great auto mechanic, or know a lot about music. The development of skills, taking pride in these skills, and actively pursuing these skills, is crucial, my research shows over and over, in helping to avoid the triggering of the submission response.

Finally, sixth is *beliefs*. Personal beliefs were very important to the persons I surveyed. Beliefs can involve either a religious or philosophical framework, depending on one's perspective.

Not surprisingly, most of us with severe depression simply do not have interests in each of these six categories—especially interests that they actively pursue. I am well aware that when we are undergoing a severe depression, there is a tendency to become extremely passive. The feeling of depression is so agonizing, that the last thing most of us care to do, or care to think about, is pursuing an interest. In fact, the opposite usually occurs. Ironically, feeling depressed and thinking about our depression can become our most consuming personal interest.

It is often said that overcoming depression is a matter of will power. For me, this is meaningless. We can't just say: "I'm going to decide, here and now, not to be depressed anymore." Any depressed person can tell you that if it were just a matter of will power, there would be no such thing as severe depression. Because nobody has the will to get rid of his or her depression more than a depression victim. But a workable strategy is required to make this happen. The "will power" takes care of itself

Chapter

12

Personalized Depression Therapy: An Overview

Let me summarize PDT and the principles on which it is based:

Personalized Depression Therapy (PDT) is a new way to conceptualize and treat major depression. PDT works by replacing a "negative" set of thoughts and behaviors with a "positive" set. Simply, the goal of PDT is to replace things that trigger the depression response with things that don't.

PDT is based on the following principles:

1) Major depression is a submission response in the brain triggered by submissive behaviors and thoughts.

2) Submissive behaviors and thoughts are a negative influence on our lives. Repeated over time, these negative behaviors and thoughts can create a submission response overload. When we suffer a severe depression, our brain is telling us to submit to the negative behaviors and thoughts that are attacking it. This is what the feeling of depression means.

3) Dominant behaviors and thoughts are required to recondition the submission response.

4) Dominant behaviors and thoughts are produced in six positive areas that help define our personalities: 1) possessions; 2) places; 3) people; 4) activities; 5) skills; and 6) beliefs. Time spent doing and thinking about the things in these six areas will tend to destroy the submission response. Our depression will decrease and eventually be eliminated.

PDT is a simple therapy. In short, here's how it works:

The depression sufferer takes a self-inventory of submissive (i.e., negative) behaviors and thoughts, and a self-inventory of dominant (i.e., positive) behaviors and thoughts. During a period of six to eight weeks, actual time spent engaging in both submissive and dominant behaviors is systematically tracked. The goal is to increasingly replace the submissive behaviors with the dominant behaviors. By

doing this every day, major depressive episodes, as well as overall feelings of depression, should noticeably decrease.

Chapter

13

PDT: Exactly What Do You Do?

STEP ONE

Complete the *Submissive Activities Inventory* (APPENDIX A). This inventory asks you to list all of your thoughts, behaviors, activities, etc. that you believe to be negative. Examples are: "thinking about being depressed"; "feeling insecure about my job, family, skills, abilities, etc."; "feeling guilty about____"; "being unhappy about____".

Be as specific as you can in your answers. Remember that these are the issues that are triggering the depression response in your brain. These are the negative things that we do and the negative ways we think that must be replaced with more "dominant" patterns of thought and behavior.

STEP TWO

Complete the *Dominant Activities Inventory* (APPENDIX B). This inventory asks you to list three things that you value most in each of six categories. Your answers to these questions represent the dominant side of your personality. These positive thoughts and behaviors must begin to replace the negative thoughts and behaviors from the *Submissive Activities Inventory*. Your objective is to actively pursue the interests that you list here—and to pursue them as often as possible. This is your *primary objective* in Personalized Depression Therapy. The result will be a reduction in depression.

Obviously, you probably have more than three favorite interests in several of these six areas. I'm not suggesting that you limit your "dominant" activities *just* to the things that you list on the inventory. Instead, the purpose is to insure that you create a "well-rounded" personality profile for yourself. The more well-rounded your activities are, the less likely you are to suffer major depressive episodes. But, if you like to do some things more than others, that's fine. The main point is to DO things that represent dominant behaviors for YOU. And to do them often.

STEP THREE

Get a small pocket-sized notebook that you can carry around with you. Take very brief notes on both your dominant and submissive behaviors and thoughts for each day, and the time spent in each. (For example: "Feb. 15, 8-10 AM spent thinking about being depressed"; "1-2:30 PM spent playing tennis"; etc.)

At the end of the day, look at what you wrote down and categorize all of your thoughts and behaviors as either "dominant" or "submissive".

This can be a time-consuming task, and some persons in the PDT program give up after a few days. However, it is important that you keep going. Successfully reducing your depression depends on it.

STEP FOUR

Each day, add up the total number of hours spent on dominant behaviors and the total number of hours spent on submissive behaviors. Enter this information on your monthly *Dominant and Submissive Activities Monthly Tracking Chart* . A sample of how to fill-out this chart is also shown in APPENDIX C.

Notice that the chart lets you track up to 17 hours each day of dominant and/or submissive activities. It assumes that you will sleep on average about 7 hours per day. There is no need to track more than 17 hours each day, even if you have more. You are provided with 12 blank charts in APPENDIX D.

STEP FIVE

At the end of each day, enter an overall rating for your feelings of depression for that day on the *Depression Monthly Tracking Chart*. A sample of how to fill out this chart can also be found in APPENDIX E. Again, there are 12 blank charts for you to use in APPENDIX F.

Continue this process for at least six to eight weeks. At the end of this time, you should be able to look at your two charts and see: 1) downward trends for depression and submissive activities, and 2) an upward trend for dominant activities. Maximum benefit occurs at four to six months. Ideally, continue your tracking activity for one year.

Also, start to replace the word "depression" in your inner dialogues with yourself with the word "dominance". This has proven to be a very successful component of PDT. So, instead of saying to yourself something like, "I just feel unbelievably depressed today," replace it with: "By doing something today that I like, it's going to help trigger my dominance response."

The point of such an inner dialogue is that, even when you have feelings of depression, you're helping to break the association between the physical sensation of depression and the word "depression". This association is extremely strong in all severely depressed persons. And it's something that needs to be "unlearned".

Chapter

14

The Defeat of Depression

PDT is an active, real-world, concrete method of "de-conditioning" the submission response. And it has a high success rate. Of course, defeating depression never has been, and never will be, easy. But part of the effectiveness of PDT is that it's something you have control over. And it's something that is personal and customized for you and by you. The ability to graphically track your own process, and to literally see the results on paper, is a powerful motivator in pursuing your depression battle to all-out victory.

Please refer to my website and mailing address found below to find or request more information about PDT and depression. In addition, the materials found in the Appendices can be downloaded for free from the website.

In APPENDIX E I am also providing some real letters from people who had questions about PDT. These are typical of some of the most common questions I get about PDT. I hope the letters and my responses will be of some help to you. Of course, feel free to write me yourself.

It is my greatest wish that PDT will help you to utilize your own inner resources to defeat your depression. All my best.

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APPENDIX A

Submissive Activities Inventory

SUBMISSIVE ACTIVITIES INVENTORY

List any and all of your thoughts and behaviors that you believe to be "negative". Be as specific as you can.

APPENDIX B

Dominant Activities Inventory

DOMINANT ACTIVITIES INVENTORY

1. List the three favorite things that you own.

a._____

b._____

c._____

2. List the three things that you like to do best and that give you the most pleasure.

a._____

b._____

c._____

3. List the three places that you like best (for example, certain cities, rooms, buildings, plaœs to go, etc.).

a._____

b._____

c._____

4. List the three things that you know a lot about, or that you know how to do really well, that interest you the most.

a._____

b._____

c._____

5. List at least three persons who mean the most to you, or who you think are really interesting or important (These can be people related to you, or they can be famous or important or interesting people from history, etc.)

a._____

b._____

c._____

6. List at least three ideas or beliefs that you value the most (religious, philosophical, etc.)

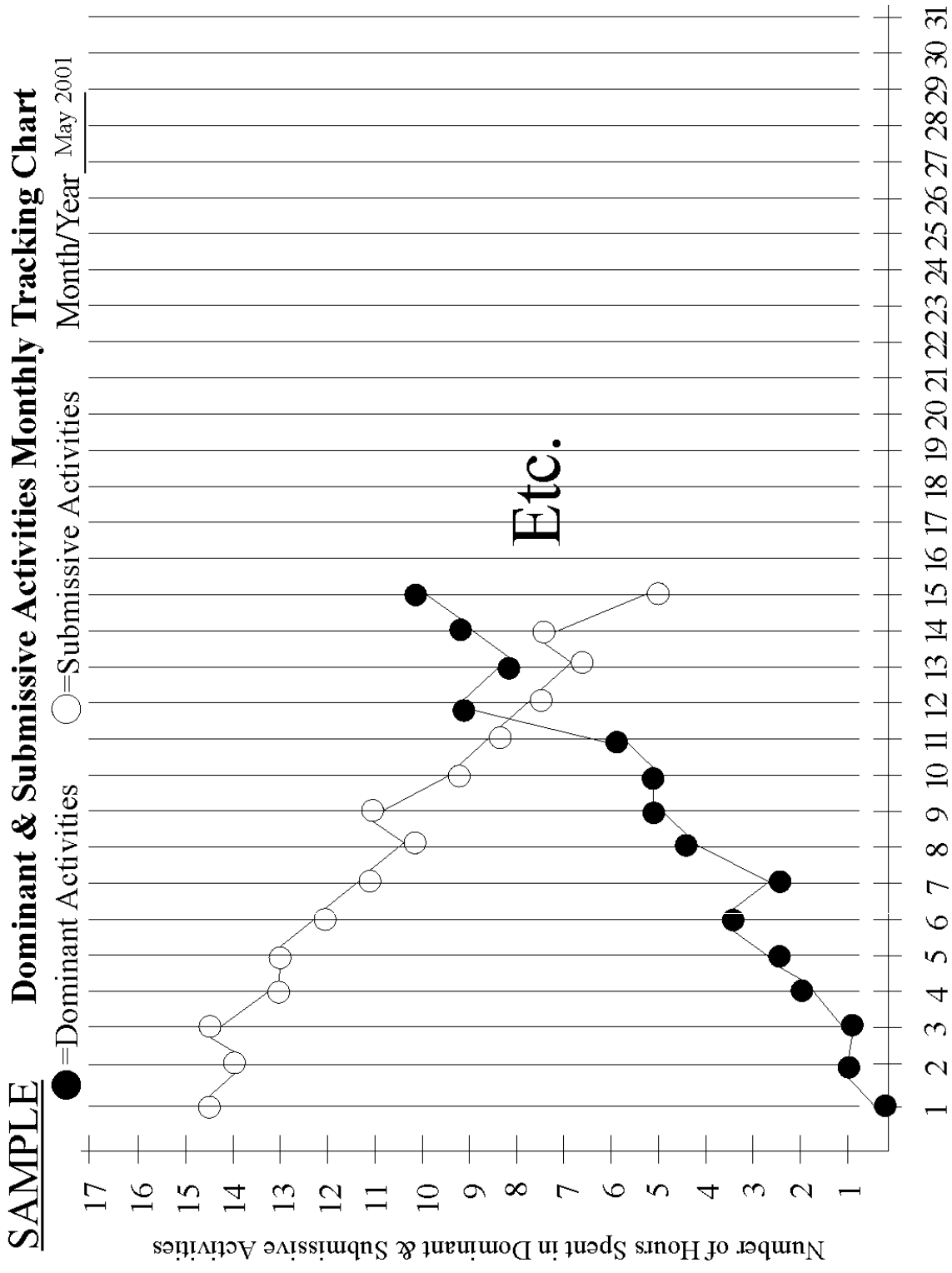
a._____

b._____

c._____

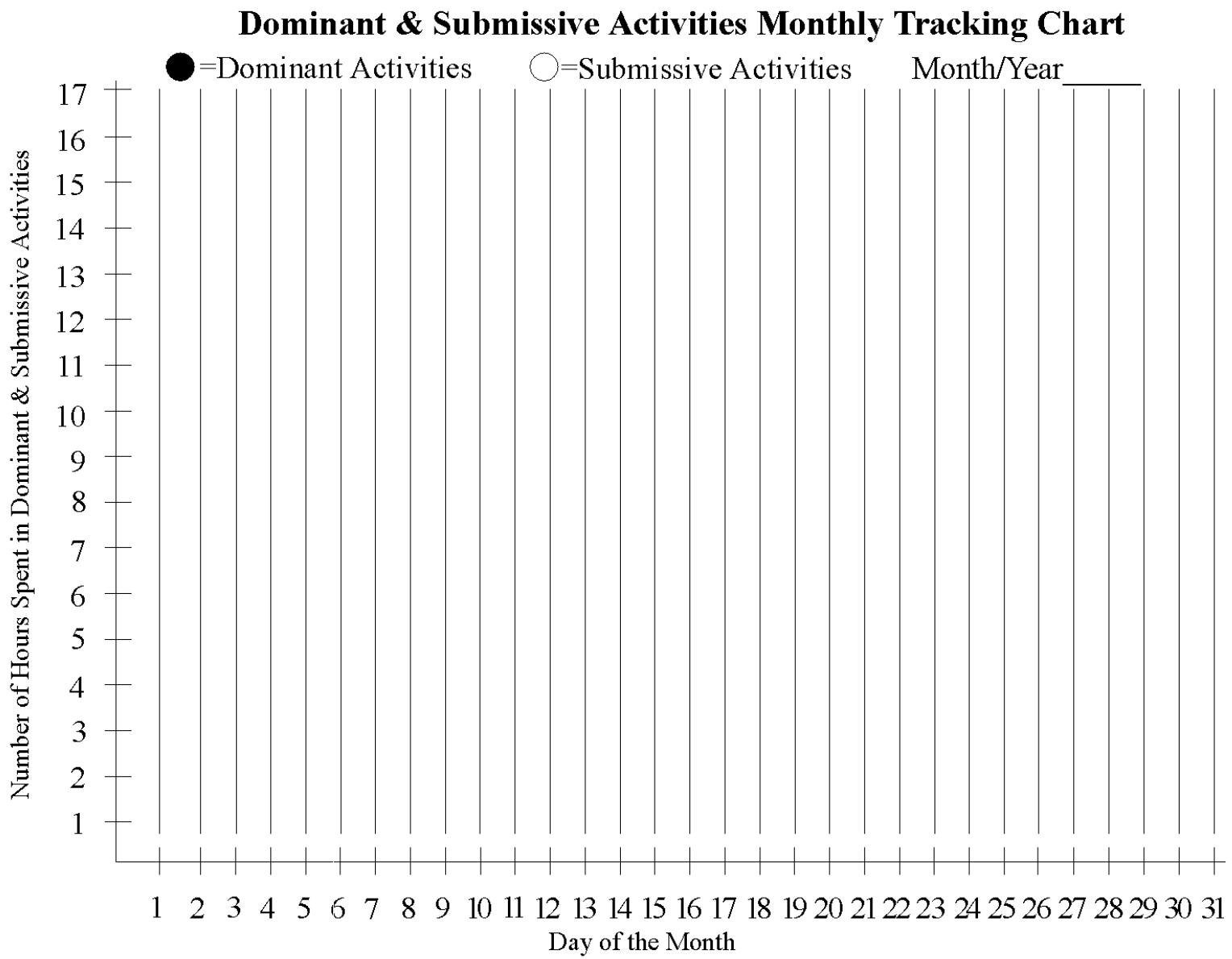
APPENDIX C

SAMPLE ACTITIVIES CHART


SAMPLE
Dominant & Submissive Activities Monthly Tracking Chart
●=Dominant Activities
○=Submissive Activities
Month/Year May 2001
Etc.
Number of Hours Spent in Dominant & Submissive Activities
Day of the Month
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

APPENDIX D

12 BLANK ACTIVITIES CHARTS


Dominant & Submissive Activities Monthly Tracking Chart
●=Dominant Activities
○=Submissive Activities
Month/Year_____
Number of Hours Spent in Dominant & Submissive Activities
17
16
15
14
13
12
11
10
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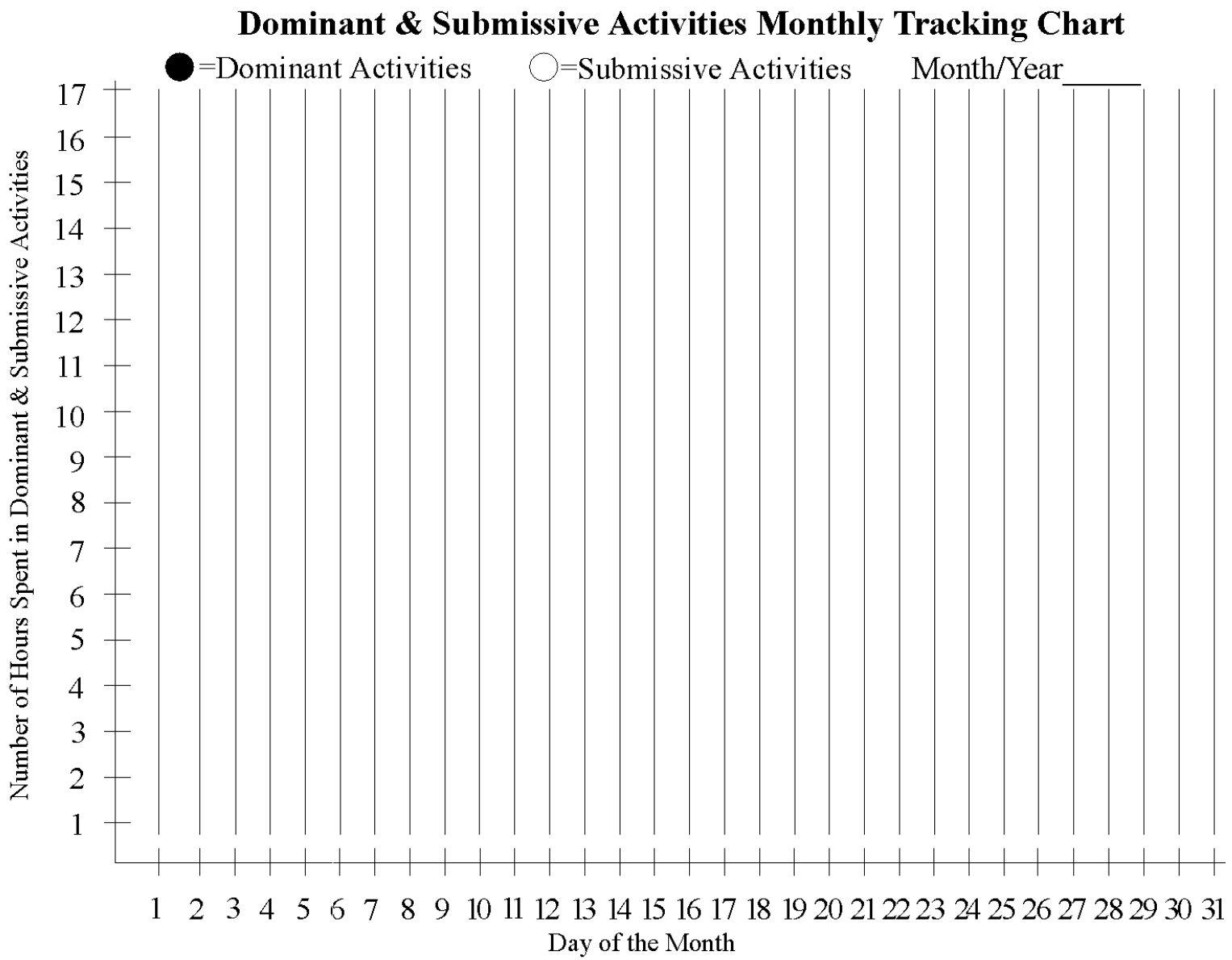
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month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Month/Year_____
Number of Hours Spent in Dominant & Submissive Activities
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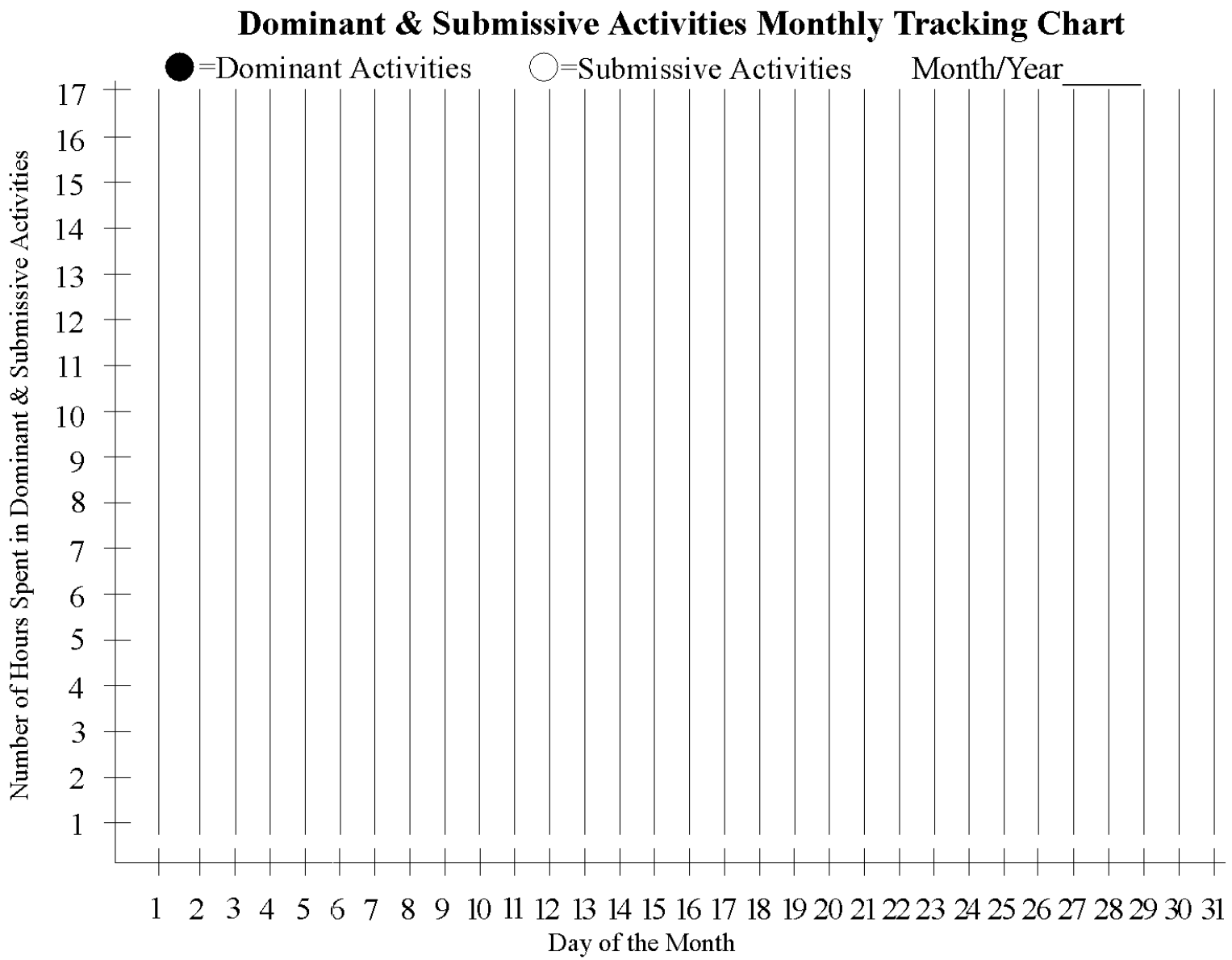
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month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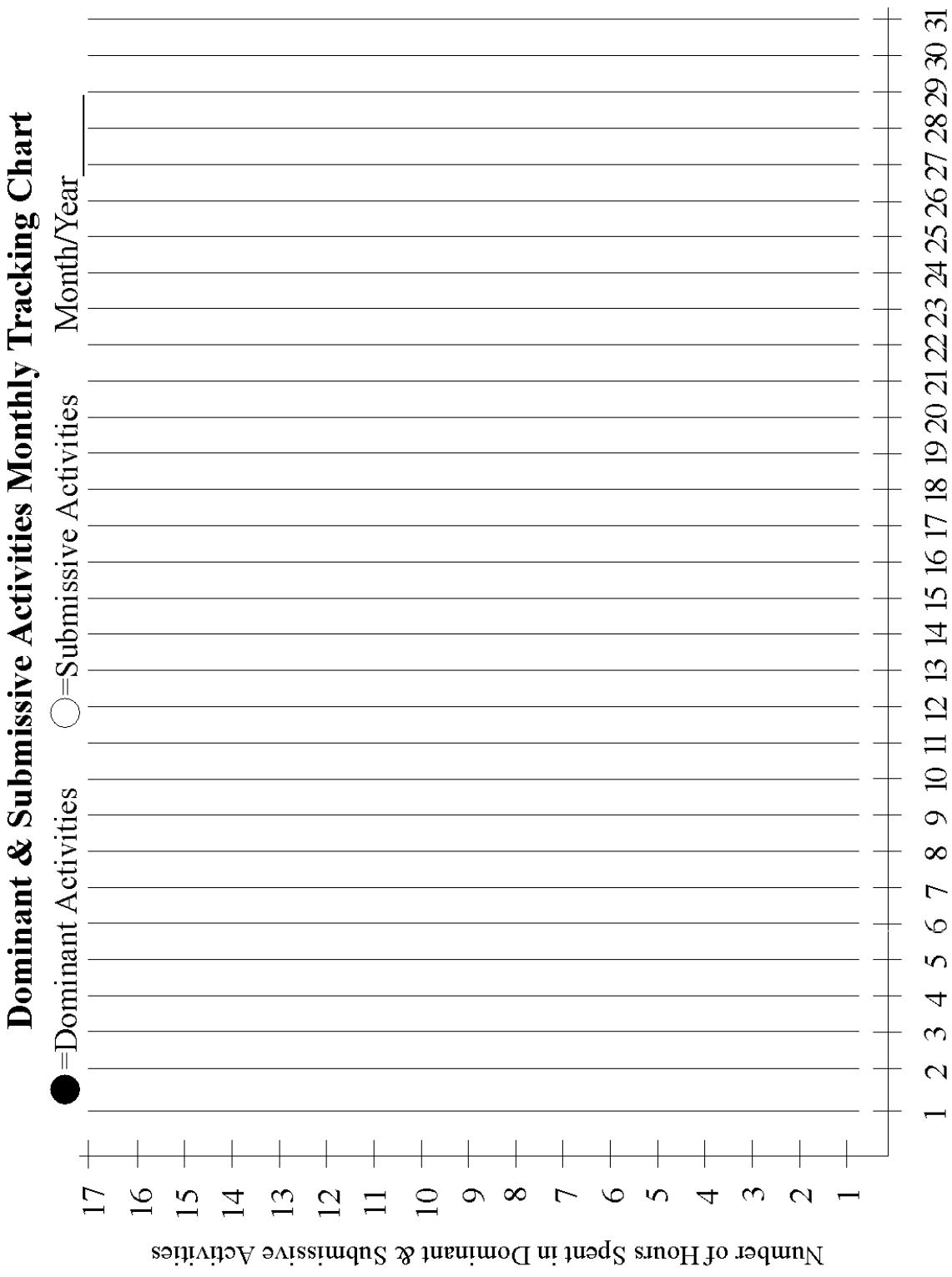
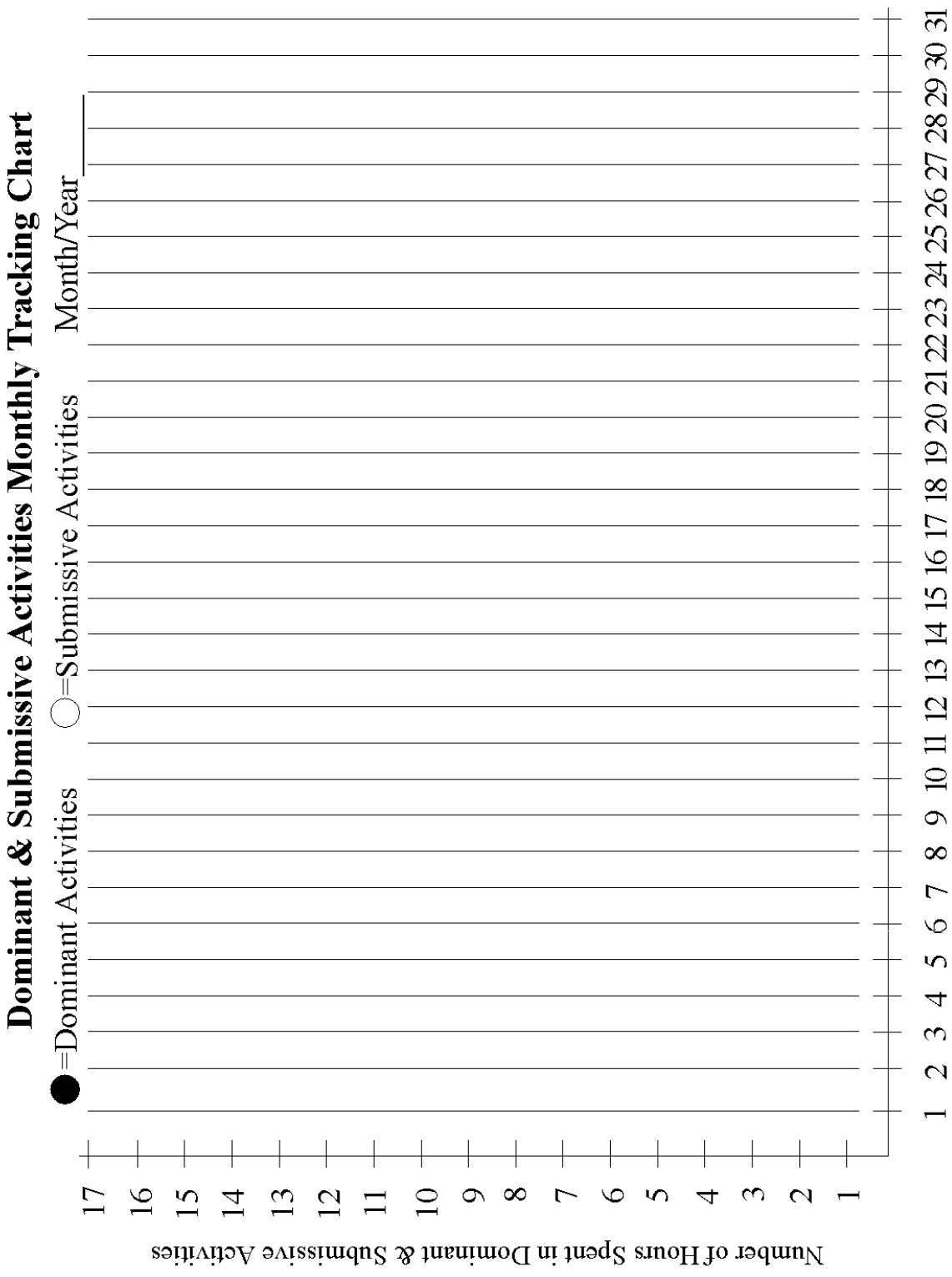
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month


Dominant & Submissive Activities Monthly Tracking Chart
●=Dominant Activities
○=Submissive Activities
Month/Year
Number of Hours Spent in Dominant & Submissive Activities
17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month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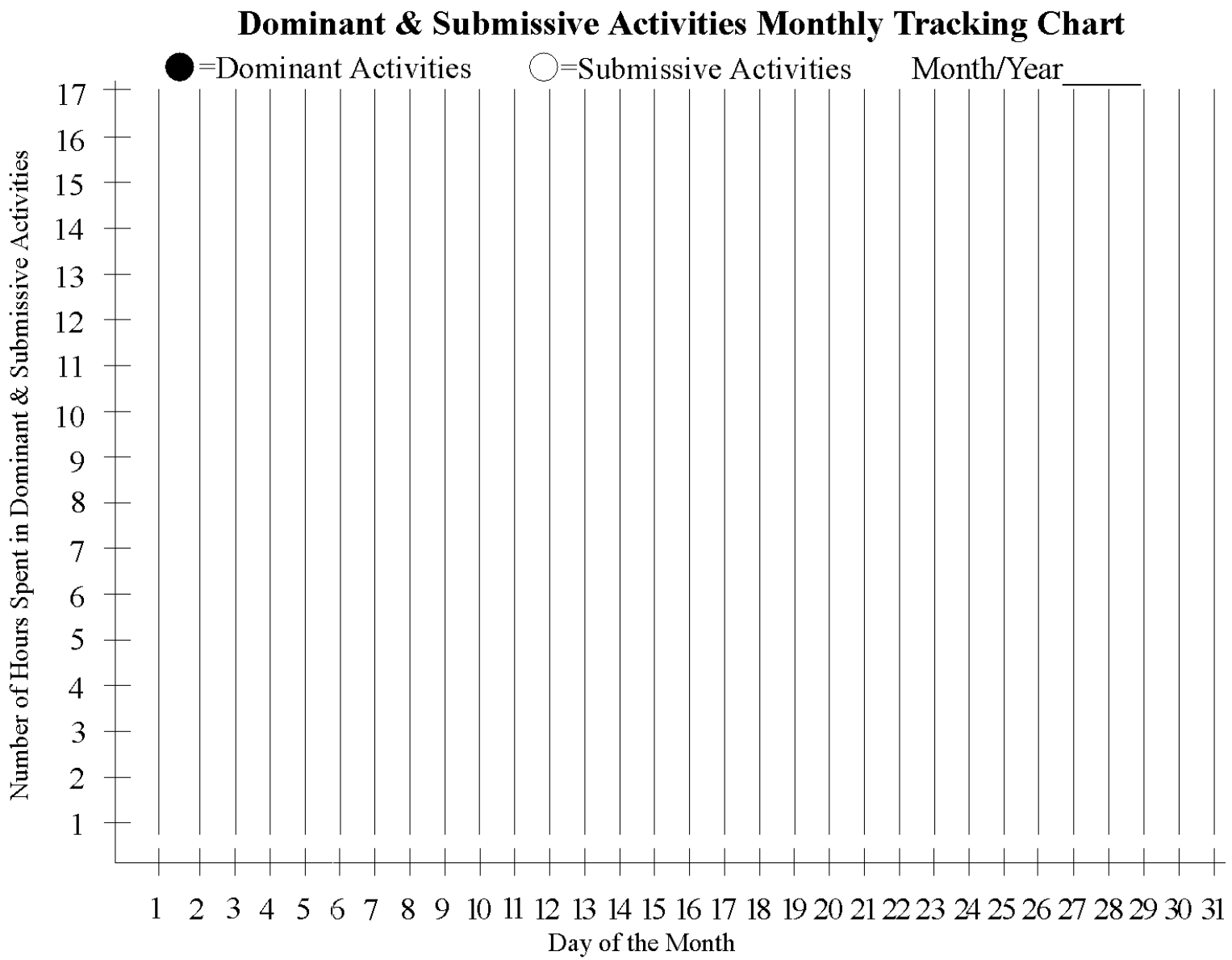
Day of the Month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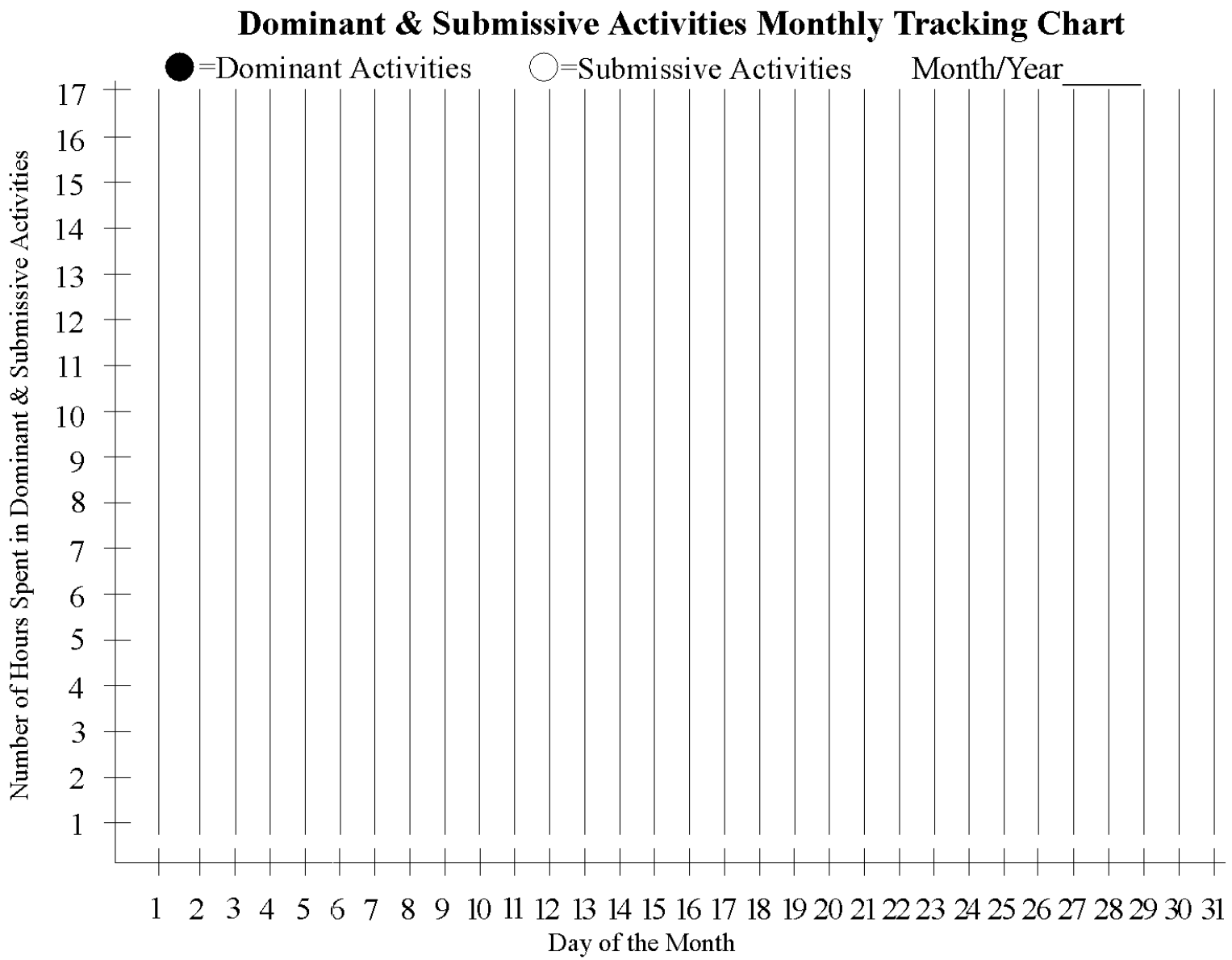
Day of the Month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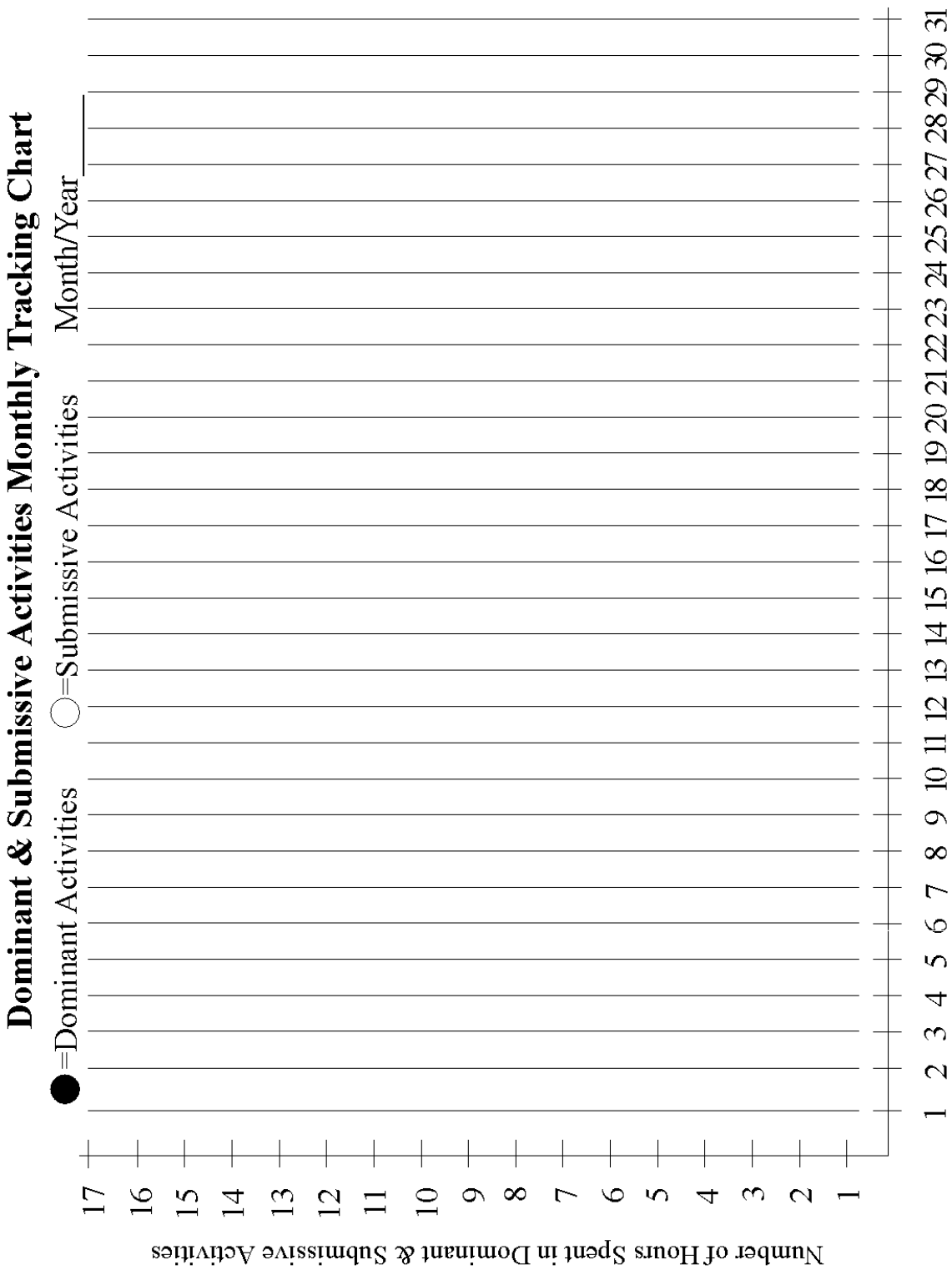
Day of the Month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●=Dominant Activities
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Month/Year
Number of Hours Spent in Dominant & Submissive Activities
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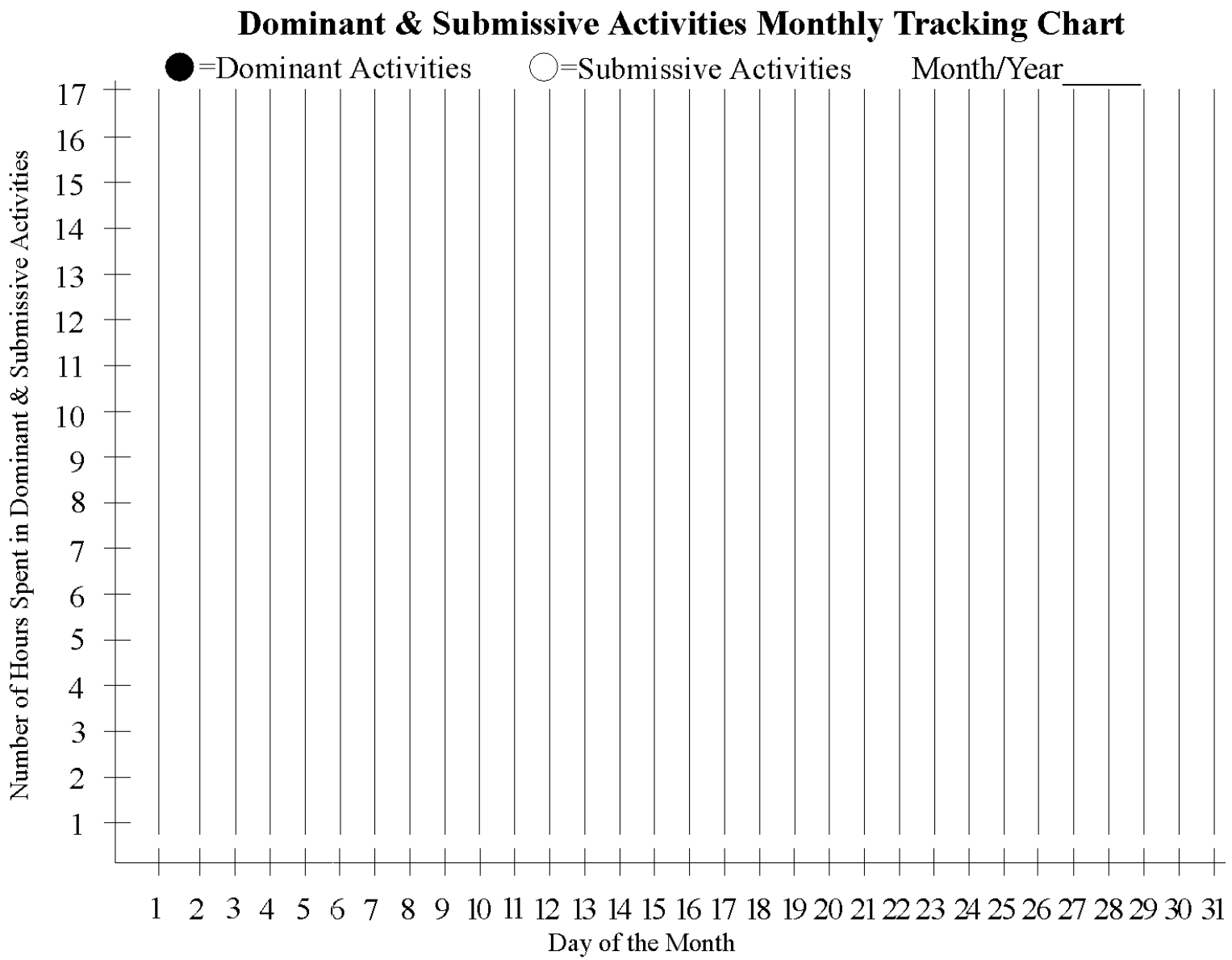
Day of the Month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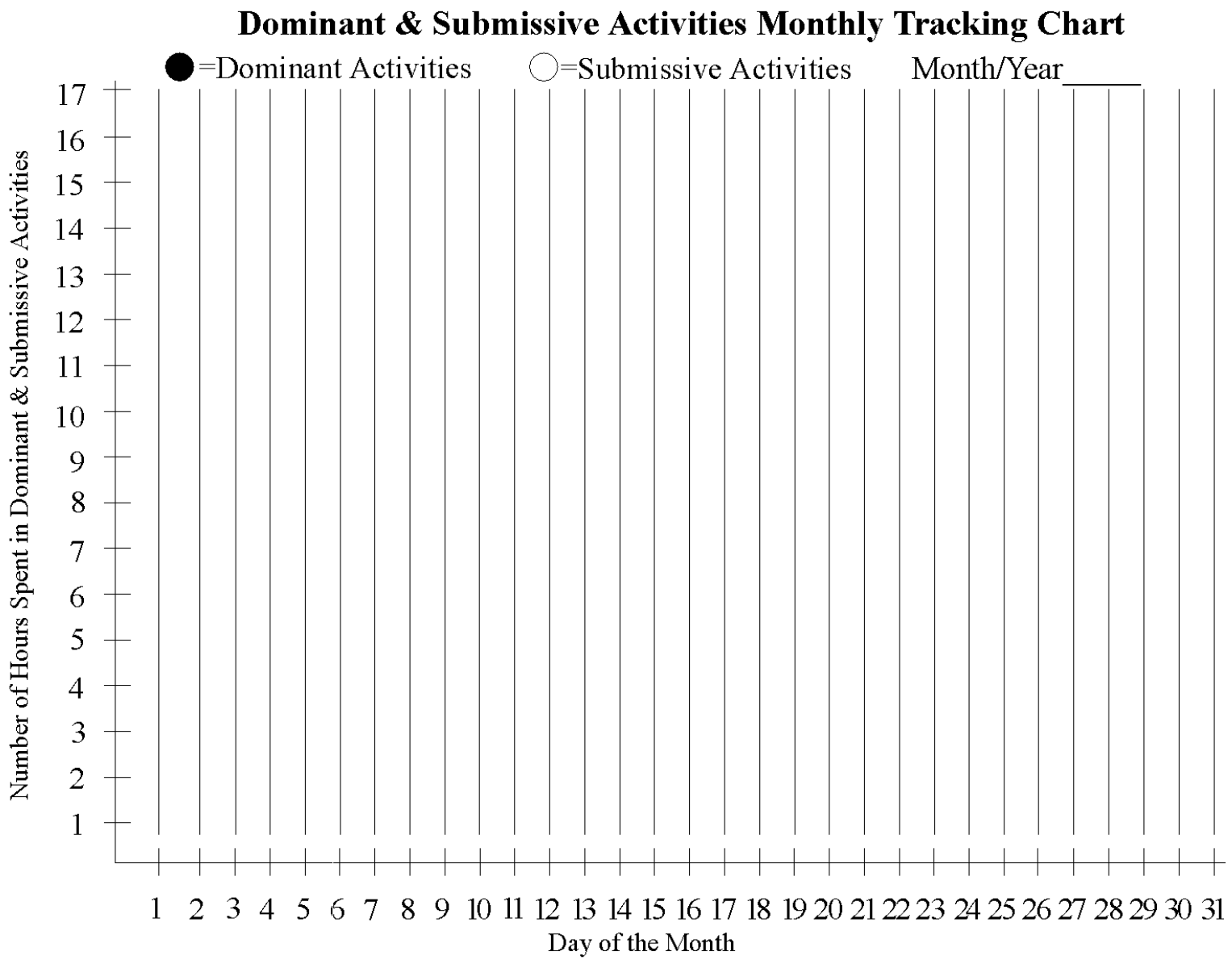
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month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Month/Year_____
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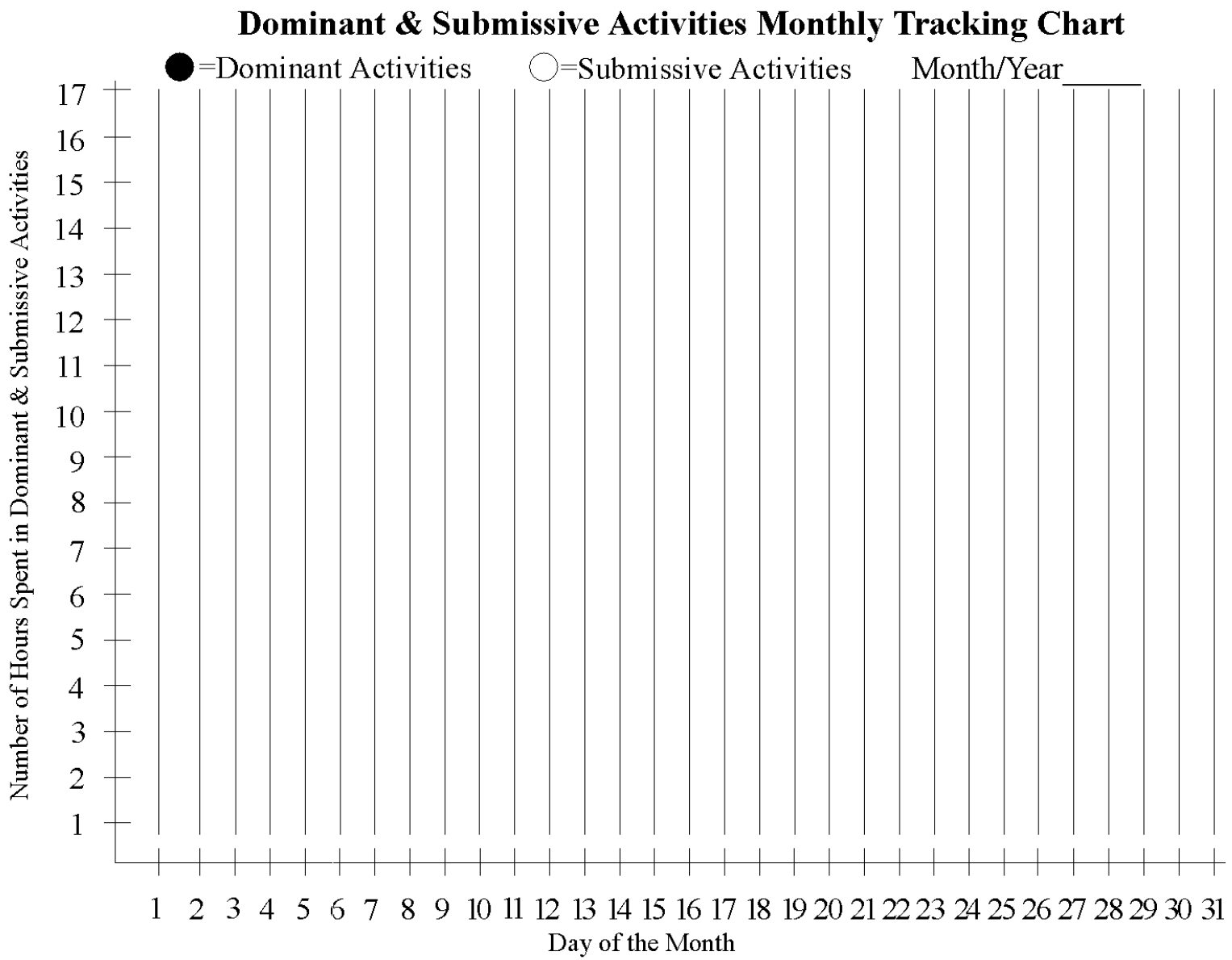
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month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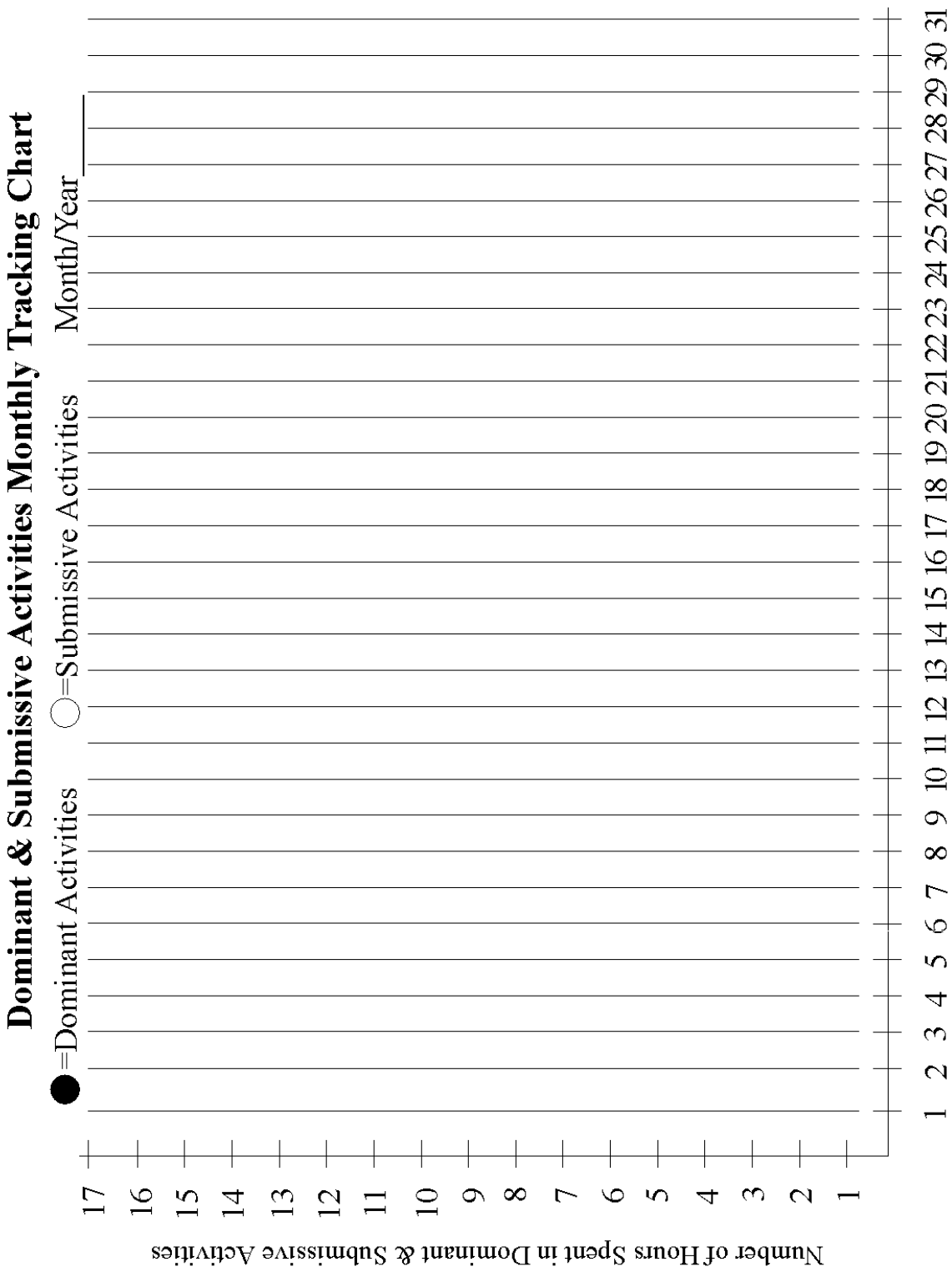
Day of the Month


Dominant & Submissive Activities Monthly Tracking Chart
●=Dominant Activities
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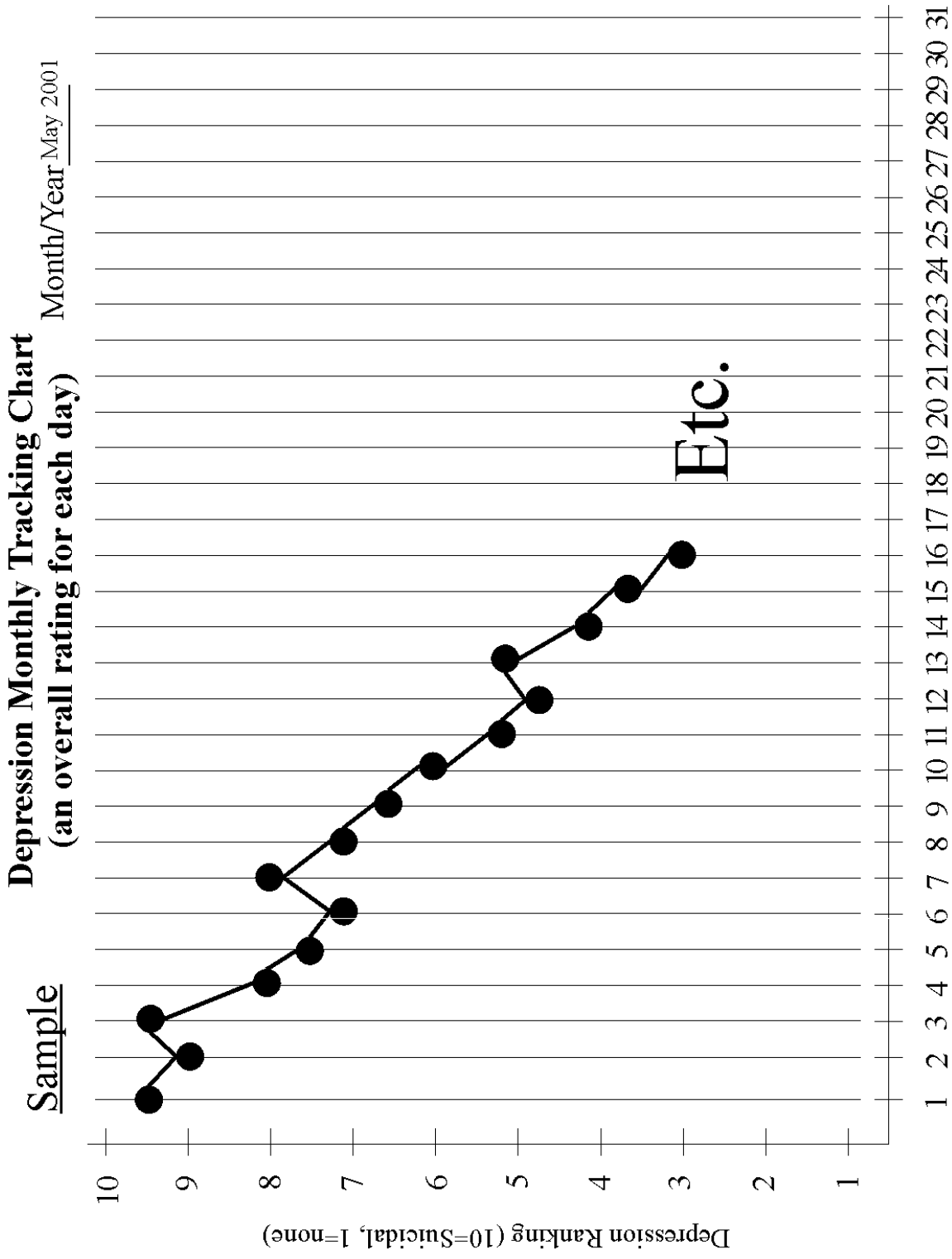
Month/Year
Number of Hours Spent in Dominant & Submissive Activities
17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month

APPENDIX E

SAMPLE DEPRESSION CHART

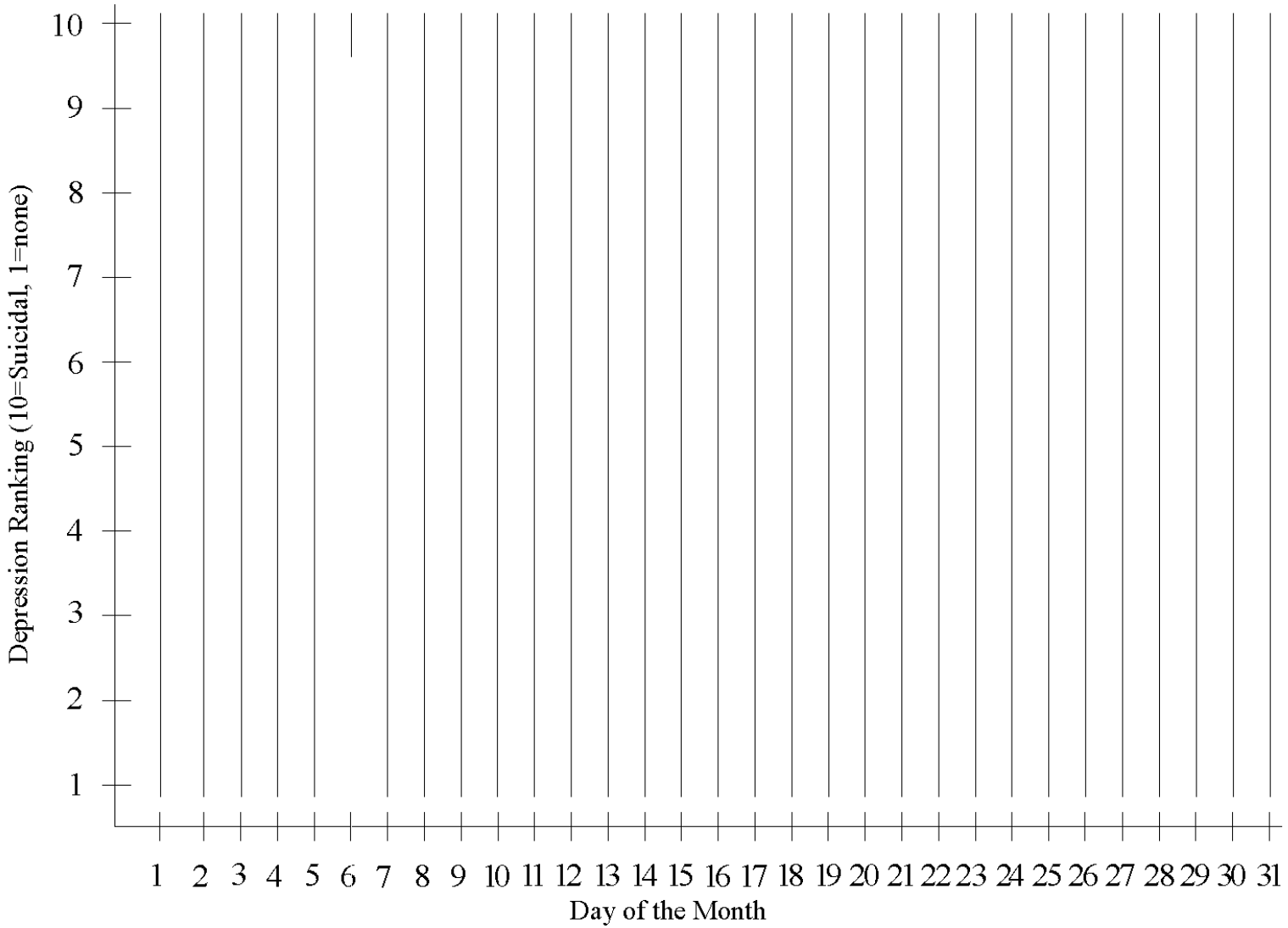

Depression Monthly Tracking Chart
(an overall rating for each day)
Month/Year May 2001
Sample
Depression Ranking (10=Suicidal, 1=none)
10
9
8
7
6
5
4
3
2
1
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month
Etc.

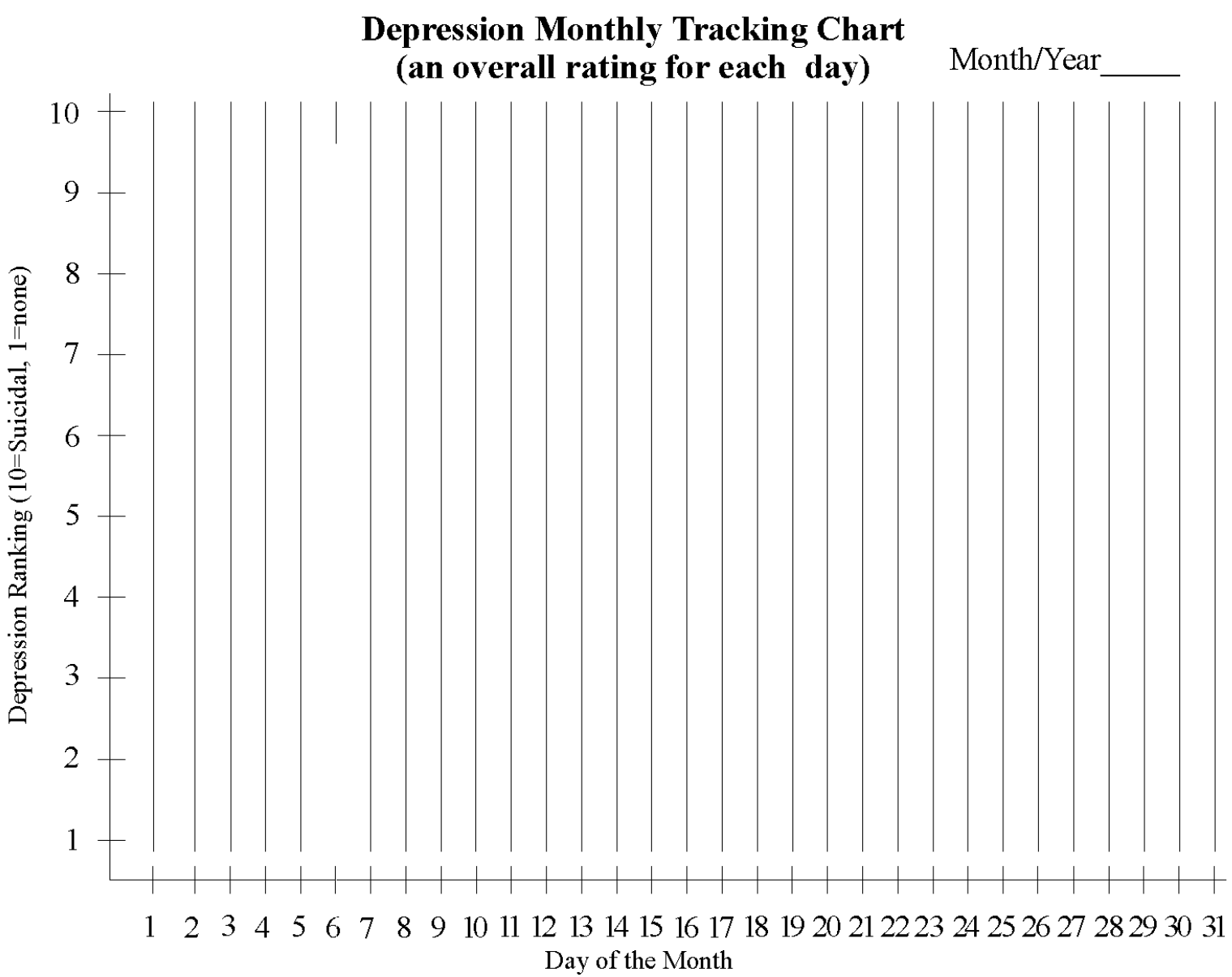
APPENDIX F

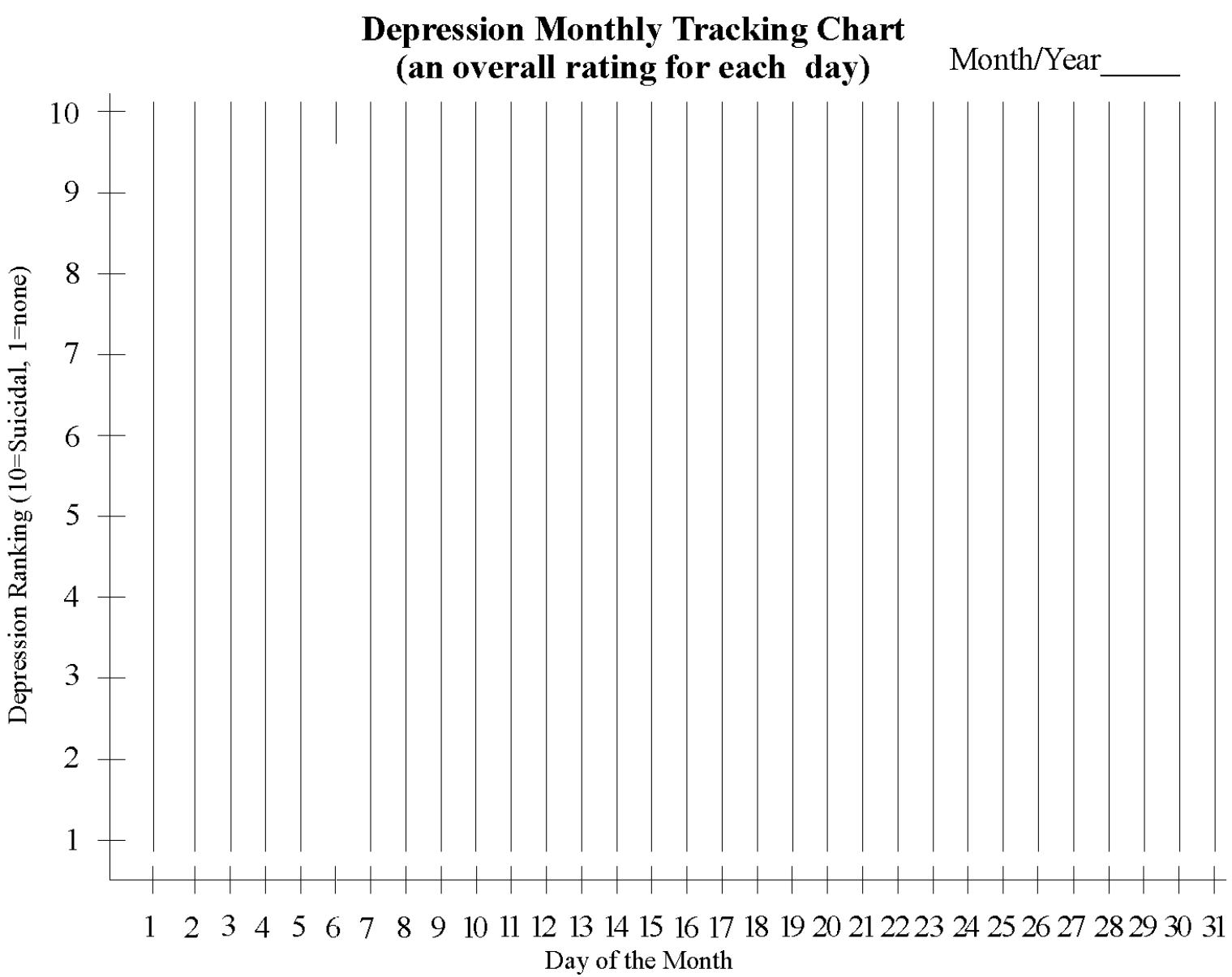
12 BLANK DEPRESSION CHARTS

Depression Monthly Tracking Chart
(an overall rating for each day)

Month/Year_____




Depression Monthly Tracking Chart
(an overall rating for each day)
Month/Year_____
Depression Ranking (10=Suicidal, 1=none)
10
9
8
7
6
5
4
3
2
1
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month


Depression Monthly Tracking Chart
(an overall rating for each day)
Month/Year_____
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9
8
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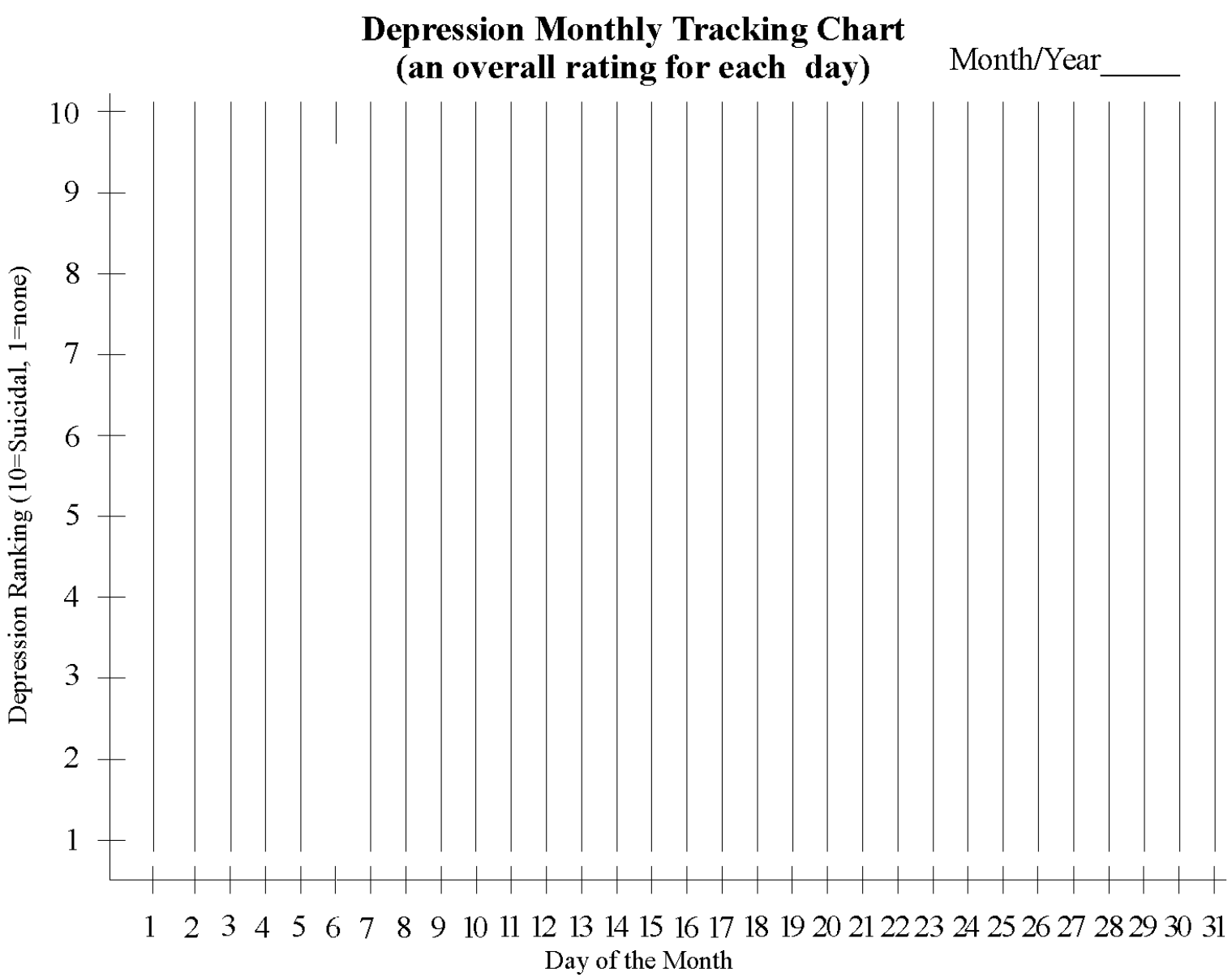
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month


Depression Monthly Tracking Chart
(an overall rating for each day)
Month/Year_____
Depression Ranking (10=Suicidal, 1=none)
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9
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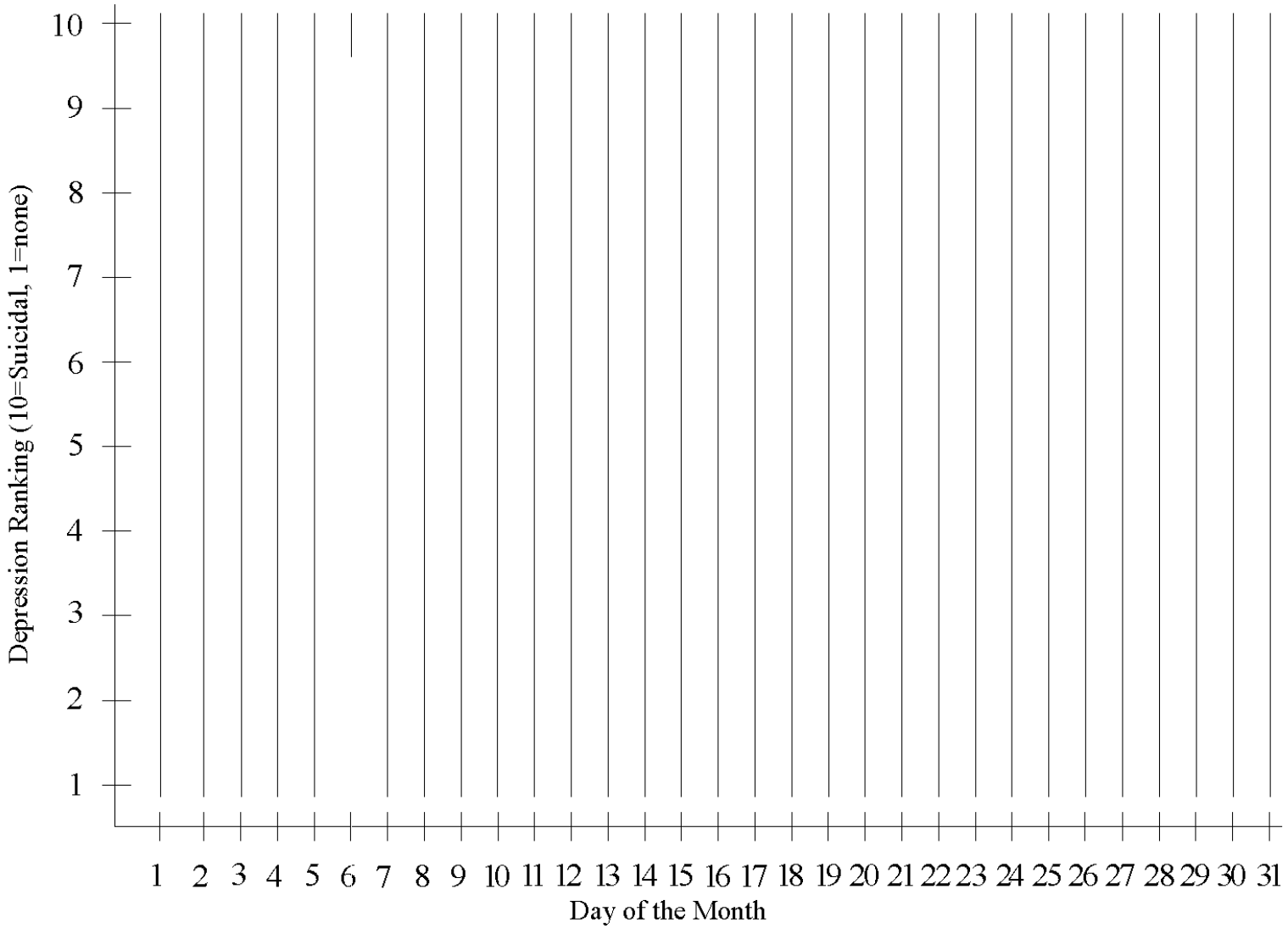
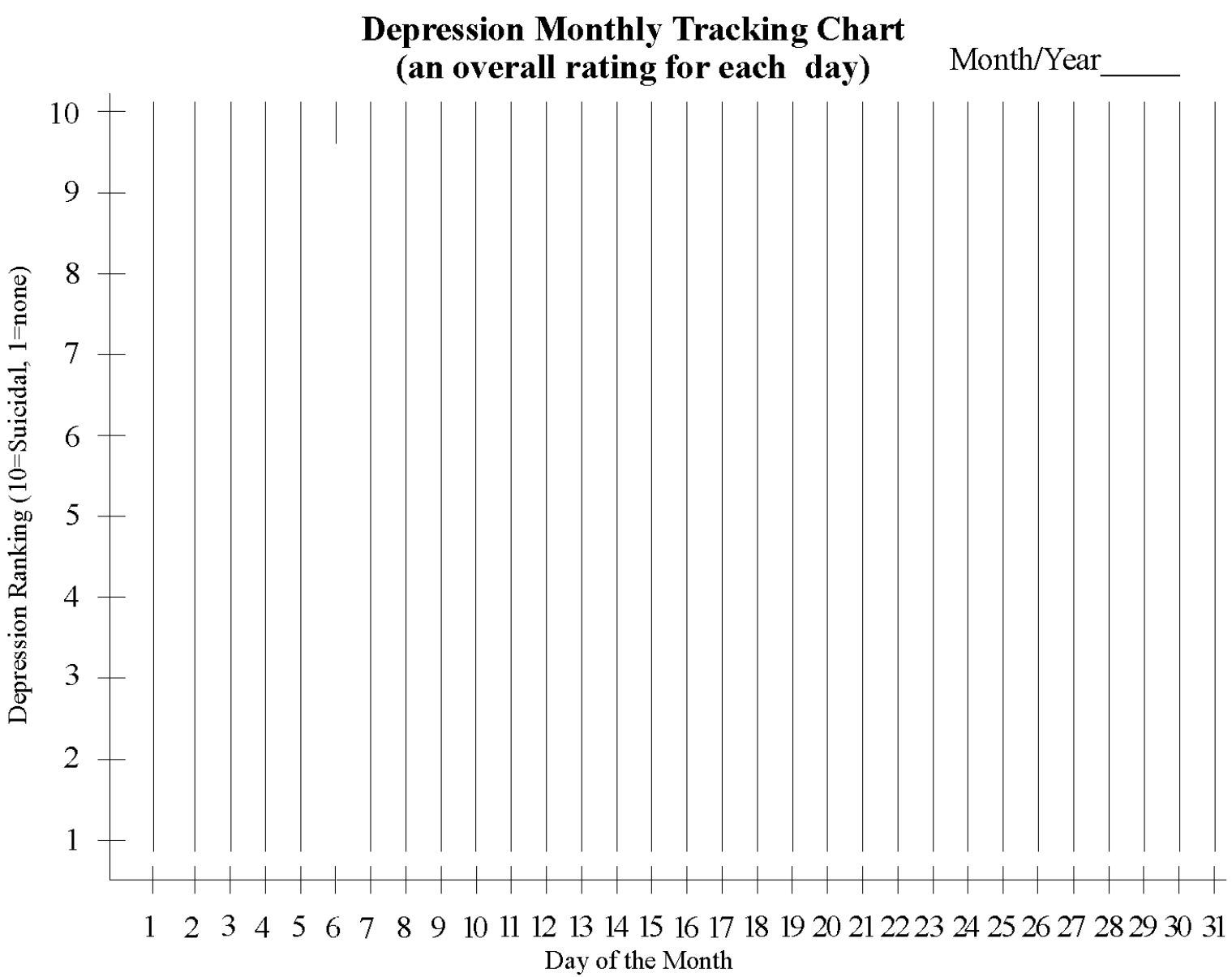
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Day of the Month

Depression Monthly Tracking Chart
(an overall rating for each day)

Month/Year_____

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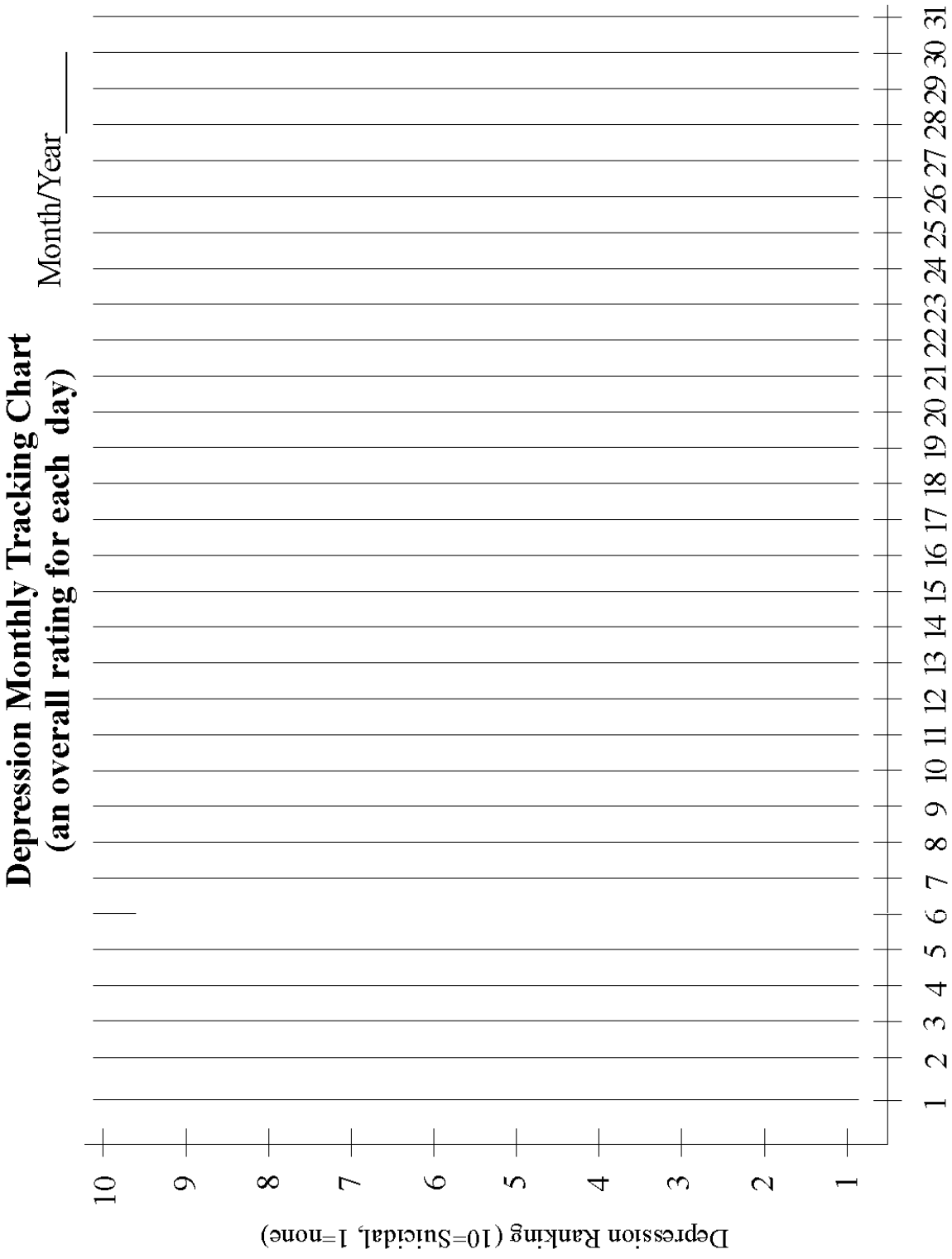
Day of the Month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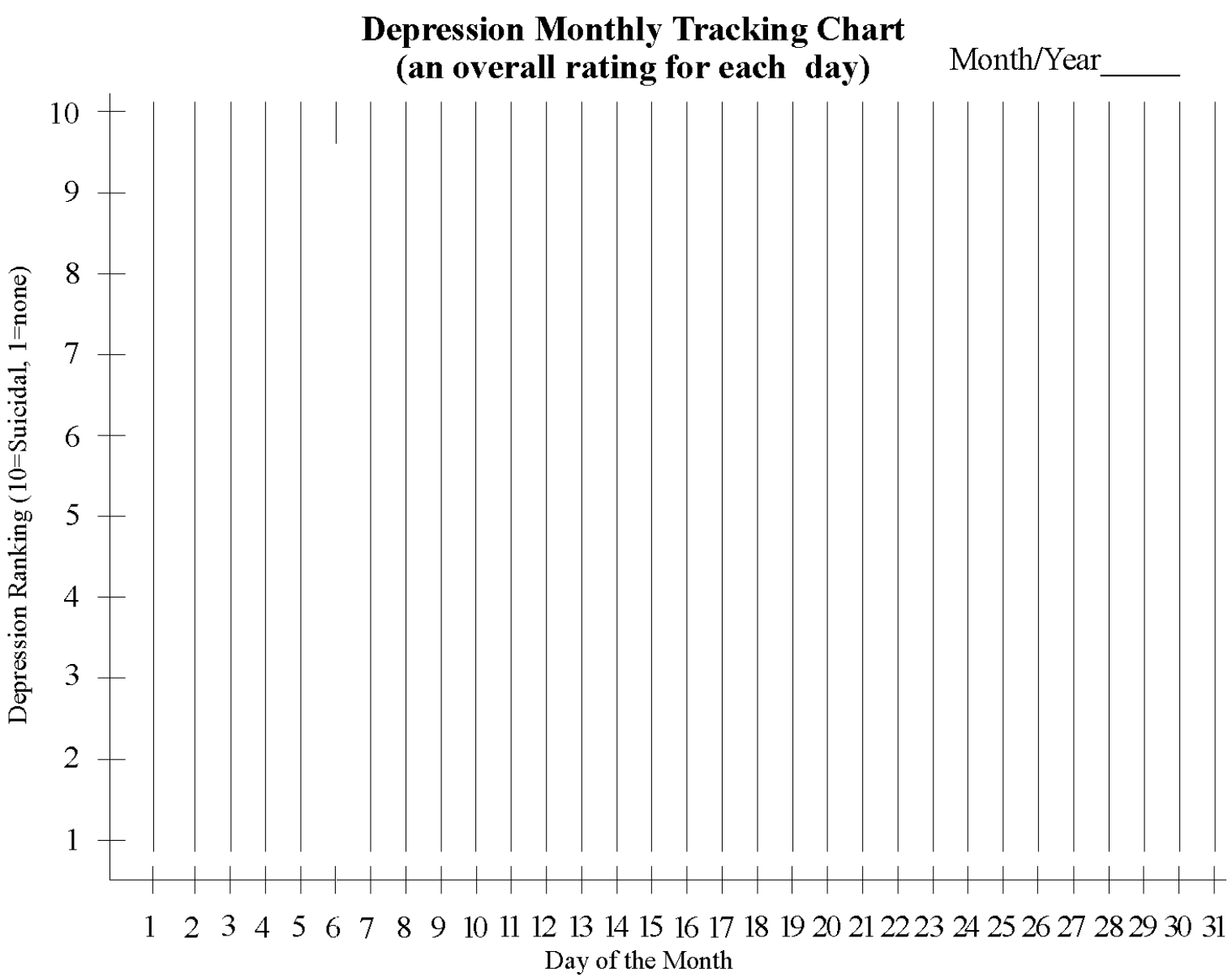
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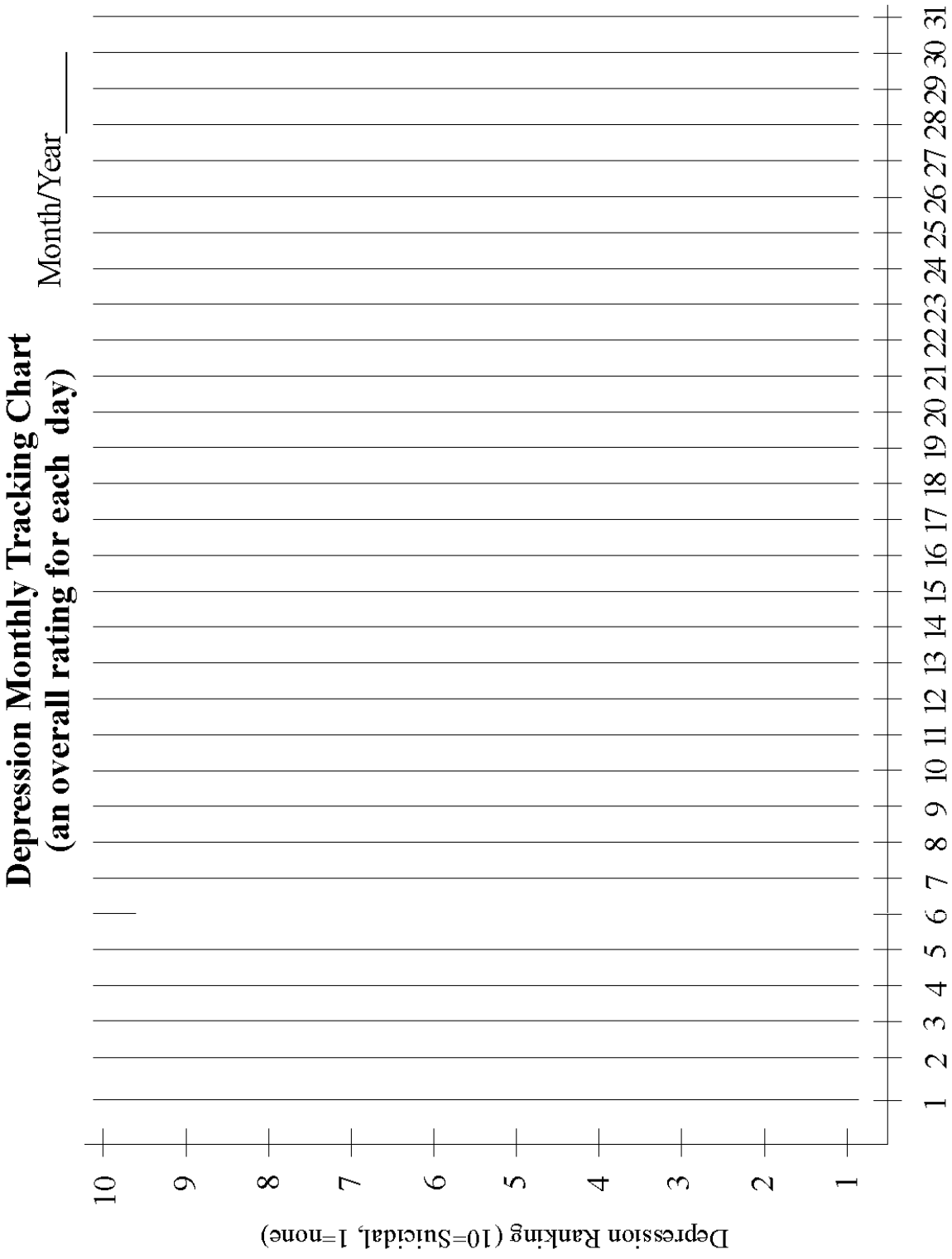
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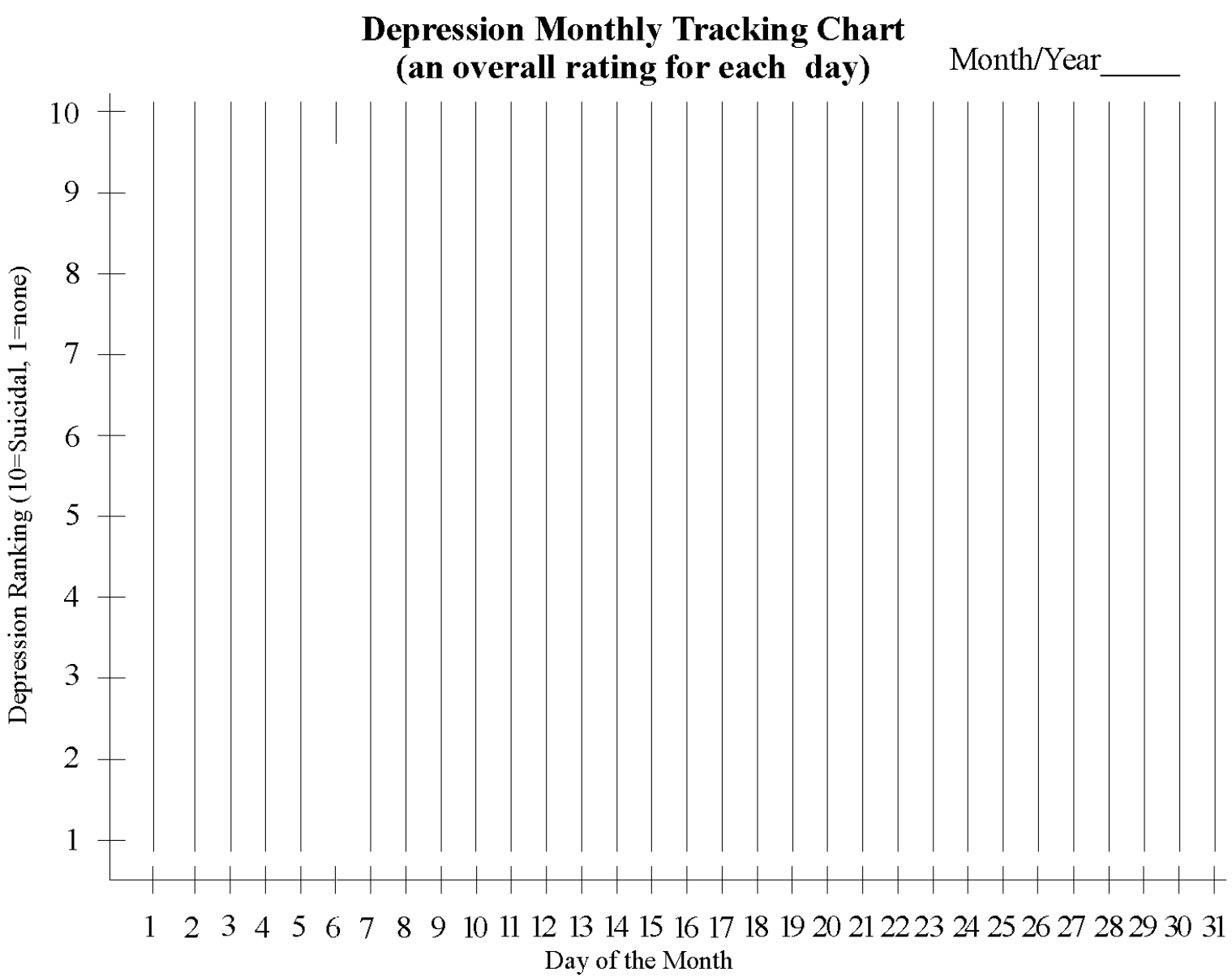
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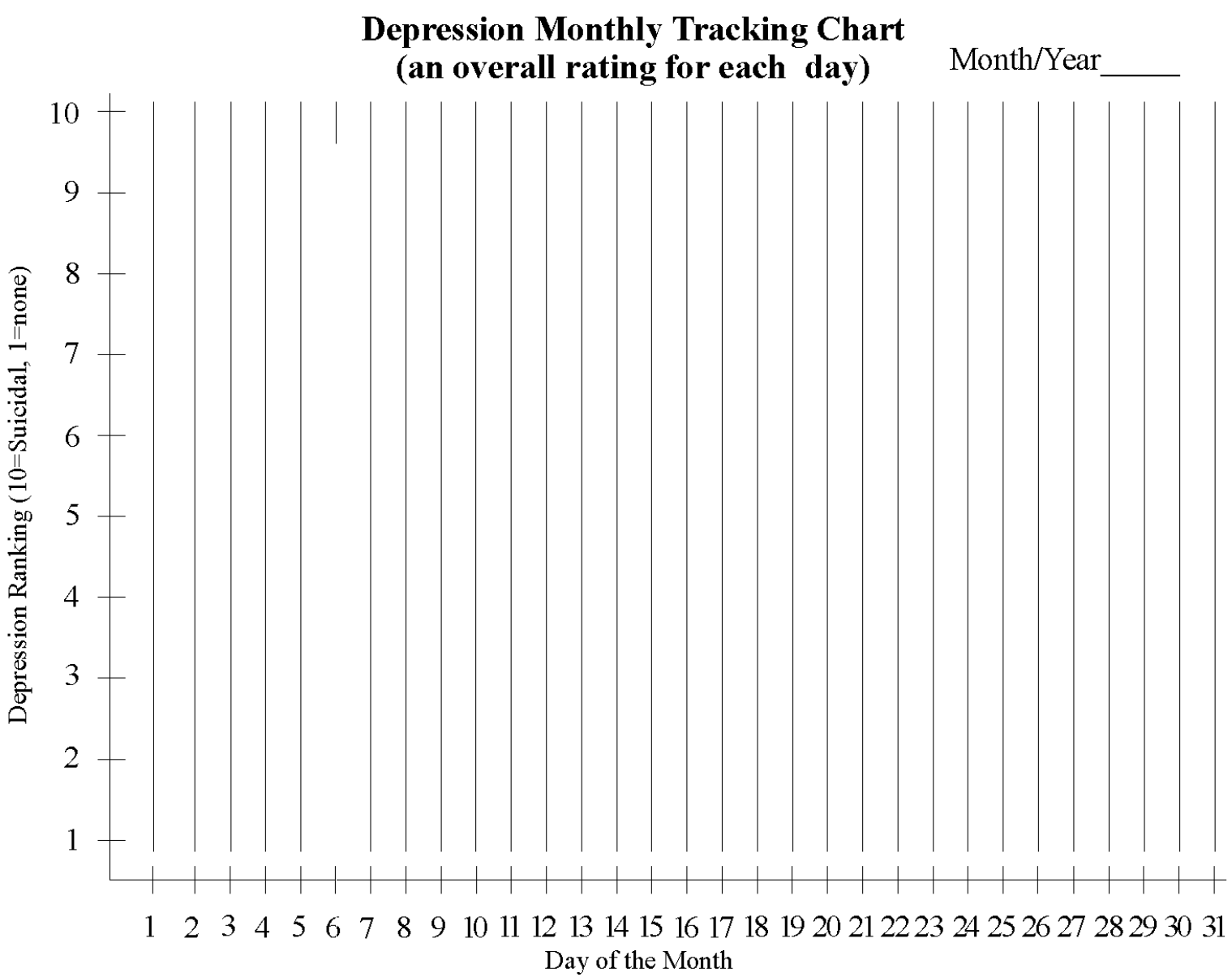
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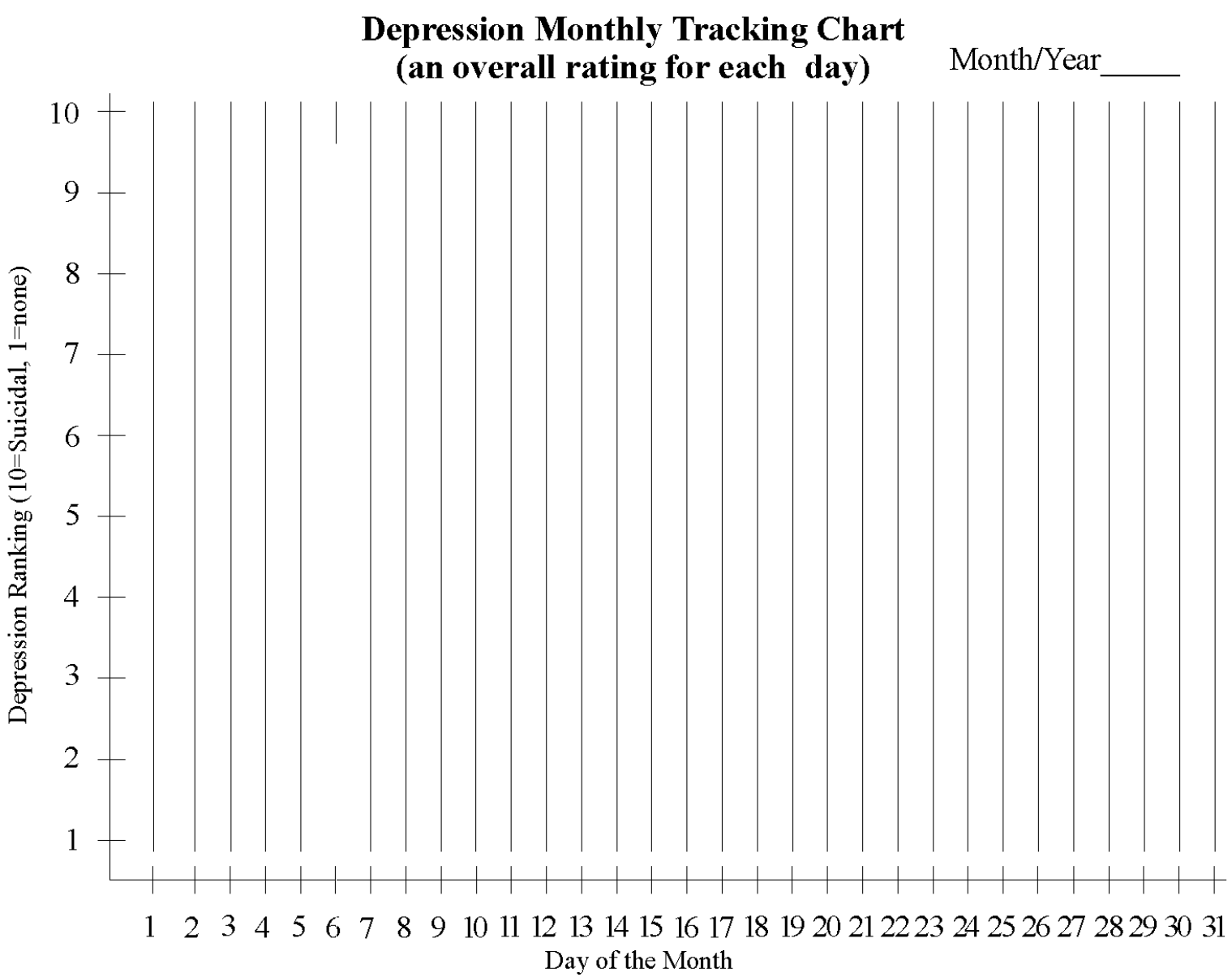
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