

COGNITIVE-BEHAVIORAL GROUP TREATMENT FOR DEPRESSION

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Focal Group Psychotherapy

Cognitive-Behavioral Group Treatment for Depression

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Introduction

Depression is one of the most prevalent psychiatric disorders in the United States (Myers et al., 1984). Using the Diagnostic and Statistical Manual III-Revised (American Psychiatric Association, 1987), at least 8 percent of the population will exhibit symptoms of major depression or dysthymia at some time during their lives (Weissman et al., 1988). Furthermore, depression has a high rate of recurrence, so that individuals who have had an episode of depression are more likely to have such episodes in the future.

Morbidity from depression includes decreased productivity, decreased quality of life, and job and family disruption. Depression is more debilitating than most chronic medical conditions (Wells et al., 1989), and is the major risk factor for suicide, which is one of the ten leading causes of death in the United States.

Numerous studies have demonstrated the effectiveness of cognitive-behavioral group therapy in reducing depressive symptoms and increasing functioning in depressed clients. The available evidence favors homogeneous group composition and structured, time-limited interventions (Beck, 1979). Covi and Lipman (1987) demonstrated a significant superiority of group cognitive-behavioral therapy alone or combined with the drug imipramine over traditional interpersonal group psychotherapy.

Selection and Screening

Group cognitive-behavioral therapy can provide effective treatment to clients with nonpsychotic, unipolar major depression. A clinical interview that includes a complete history is necessary before beginning therapy to ensure the inclusion of appropriate clients. The Beck Depression Inventory (BDI) (Beck et al., 1961) is a 21-item scale for measuring depressive symptomatology which can be used as a measure of the severity of depression. (Copies and permission to use this scale can be obtained by writing to the Center for Cognitive Therapy, Room 602, 133 South 36th Street, Philadelphia, PA 19104.)

Although group cognitive-behavioral therapy is effective for a broad range of depressed individuals, some clients should be excluded from the groups. Clients with active suicide plans, active psychotic symptoms, or bipolar disorders should be referred elsewhere. In addition, exclude clients who are currently abusing drugs or alcohol. They should be told that it's impossible to treat depression while they are abusing substances that contribute to the disorder. Clients may contract to begin cognitive-behavioral therapy after a month of abstinence from drugs or alcohol.

You should pay particular attention to signs of dementia in the patient during the intake. Encourage clients to consult with their medical practitioner to rule out underlying medical problems that can cause or contribute to

depression. These include hormonal, nutritional, or endocrine abnormalities; drug effects; and the multiple physical consequences of systemic disease.

Exclude clients who are too hostile, asocial, or have such extensive difficulties in interpersonal relationships that interactions with other group members will be problematic. Those clients who won't accept others easily or, in turn, won't be understood by others should also be excluded. Clients who need long-term psychotherapy should be referred accordingly; although some dysthymics and dysphoric somatizers may benefit from this treatment. Concurrent individual therapy is often most appropriate for such clients.

Clients with "difficult" personality characteristics can be challenging in the group, but they often benefit from therapy. Sometimes these are the very clients whom Yalom (1970) recommends excluding from groups, such as obsessive-compulsive somatizers. Inclusion criteria should be as flexible as the goals for treatment. Clients with major depression and few other problems usually experience a full resolution of the depressive episode after therapy. Other clients with more complicated presentations often become less depressed as a result of the treatment but may need additional therapy to address some of their longer-term problems.

Time and Duration

This treatment for depression is both highly structured and time

limited. Clients attend weekly two-hour sessions, for sixteen consecutive weeks. The program is divided into three four-week modules, focusing respectively on how mood is affected by thoughts, activities, and contacts with people. Clients repeat the first module during their last four weeks in the program. Repeating the initial module allows participants to reflect on their progress and to learn material they may have missed because of poor concentration early in the group. The two-hour group time permits sharing of current concerns, as well as presentation of didactic material and working through individuals' difficulties using cognitive-behavioral methods.

Modifications can be made for different clinical settings; however, 12 to 16 sessions are recommended to cover the content areas and provide sufficient time for symptom reduction. Some programs (for example, Lewinsohn et al., 1984) have used twice-weekly meetings for the first several weeks to provide additional support and more intensive initial intervention.

Structure

Groups consist of six to ten clients and two group leaders. New members are added into the group at the beginning of each four-week module. In addition to meeting the practical demands of the referral system, this structure allows "older" members to share their experiences with new group members and to act as role models. Older members acquire a greater

sense of efficacy while modeling hope of recovery for newer members. Transitions of group members provide an opportunity for participants to deal with beginning and ending relationships in a supportive setting.

The treatment program may also be conducted as a closed 16-week group. A closed group may offer a more stable and cohesive environment. Begin with a large group to maintain sufficient group size even if members drop out.

Creating commitment to the group is particularly important with depressed clients. They may initially lack the energy to come to meetings or have little hope that they can be helped by the group. Some clients need practical assistance with clearing time away from family and work responsibilities, as well as permission to care for themselves by coming to treatment. These are therapeutic issues that are best dealt with in early sessions; they can provide powerful examples of how to alter dysfunctional thinking, to be assertive, to manage time creatively, and so on. Discussion of participants' hopes and fears about the group also provides a common ground upon which cohesion is built.

Commitment is also generated through discussion prior to acceptance into the group. Ground rules and expectations are discussed in pre-group orientation meetings held individually or in small groups of new members.

Members are expected to commit to the entire 16-week program and to come each week. Although no penalties are imposed on poor attendance, an effort is made to discuss what is interfering with group attendance and to provide alternate referrals if the participant cannot attend regularly.

More formal rules for group attendance might also be appropriate in some settings or for inclusion in research protocols. If fees are collected, we recommend that a flat fee be assessed for the entire program (rather than payment per session), to reinforce the expectation that participants will attend each session for the duration of the group.

Goals (Conceptual and Behavioral)

The overall goals of this therapy are twofold: 1) to treat the current episode of major depression so that the client is no longer experiencing significant depressive symptoms, and 2) to teach the client skills that will help prevent relapse of the depression in the future. The goals should be circumscribed—that is, clients who have a myriad of problems apart from their depression may continue to experience those peripheral problems. The goals within the context of the group are specifically related to depression.

To meet the dual goals of treating current depression and preventing future depressions, you need to cover three topics. Within each topic area, specific goals are addressed in turn.

The first area is cognition. The goal here is to teach clients to identify and to change negative, dysfunctional cognitions that precipitate and maintain depression to more positive, health-enhancing cognitions. The second area of treatment involves activities. The goal in this area is to increase the number of pleasant activities in which the client participates. The final area of treatment involves improving interpersonal relationships. The goal is individualized for each client, and may include expanding friendship networks, improving relationships with others, becoming more assertive, or learning to value friendship.

The group functions on a teaching and participation model. Therapists work on the three goals identified above: 1) modifying dysfunctional thinking, 2) increasing pleasant activities, and 3) improving interpersonal relationships. However, clients are encouraged to bring their specific problems to the group. The therapists' goal is to integrate the clients' ongoing concerns with teaching materials relevant to the treatment of depression. Clients are encouraged to share their feelings with the group; therapists work to facilitate group support for individual members.

Ground Rules

Ground rules are discussed explicitly with clients in the orientation session and the first group meeting. Commitment to the group is discussed, as

well as the expectation that clients will come each week, be on time for meetings, and complete homework assignments.

Group Process

Group process guidelines include being supportive, caring, constructive, and willing to give everyone a chance to participate. You should encourage clients to give constructive and practical feedback to one another, and to focus on positive solutions rather than dwelling on problems or negative thinking. Criticizing, confronting, pressuring, or telling others what they "should" do is discouraged. Finally, you should instruct clients to maintain confidentiality.

Homework is an essential part of the program. Clients are given the rationale that homework is a way to practice what they are learning. By practicing they will learn which methods are helpful for them, so they can continue to control feelings of depression after the group has ended. Difficulty completing assignments is discussed in the group; often other group members can provide examples of how they overcame similar difficulties or reluctance to complete assignments.

Starting the Group

The best way to begin the group is to talk about the goal of the group:

the purpose of therapy is to treat depression by teaching ways to control mood. The therapy attempts to reach four goals related to the overall purpose: 1) to diminish feelings of depression, 2) to shorten the duration of depression, 3) to teach strategies to prevent future depressions, and 4) to help members feel more in control of their lives.

Next, give the members an overview of the first session. Tell them that during this first session, you will explain how the group therapy meetings will be run and discuss the ground rules for the group. Everyone will be introduced, and therapists will discuss a new way to think about depression.

Main Concepts and Skills

A. Concept: What Is Depression

The word *depression* is used in many ways. It can mean a feeling that lasts a few minutes, a mood that lasts a few hours or days, or a clinical condition that lasts at least two weeks and causes strong emotional pain, making it hard to carry out normal activities. This therapy group is intended to treat the clinical condition of depression. Clinical depression can be different for everyone, but most people suffer from some of the following symptoms:

- Feeling depressed or down nearly every day

- Not being interested in things, or being unable to enjoy things you used to enjoy
- Having appetite or weight changes (either increases or decreases)
- Experiencing changes in sleep patterns (sleeping less or sleeping more)
- Noticing changes in how fast you move
- Feeling tired all the time
- Feeling worthless or guilty
- Having trouble thinking, concentrating, or making decisions
- Thinking a lot about death, wishing to be dead, or thinking about hurting yourself

Group cohesion is often built as members acknowledge that they share a common set of symptoms comprising depression.

When symptoms are discussed, the issue of suicide is often raised. We suggest saying, "Some people can feel so bad that they don't feel like continuing to live. If any of you find yourself feeling this way, you should contact one of therapists immediately." At this time, therapists should provide all clients with emergency resources to deal with suicidal feelings as they

occur. This might be a 24-hour emergency service or suicide prevention program.

B. Concept: Defining Cognitive-Behavioral Therapy

"The kind of therapy that we describe is called *cognitive-behavioral therapy*. Cognitive refers to *thoughts*. Behavioral refers to *actions*. Depression mostly has to do with *feelings*. By learning which thoughts and actions influence feelings, you can learn to get more control over your moods. Our treatment for depression focuses on what's going on in your life right now. The techniques you will learn in this group focus on how to control depression in practical ways that you can use now and in the future."

C. Skill: Monitoring Your Mood

An important part of therapy for depression involves teaching clients to pay attention to and monitor their moods. They need to learn what makes their mood worse and what makes their mood better. They may find that certain times of the day or certain activities or interactions with others influence how they feel. Some clients may maintain that they feel terrible at all time; but with exploration and monitoring, they will be able to track variations in their moods.

The Beck Depression Inventory is assigned weekly for the clients to

monitor their depressive symptomatology. They are asked to complete the questionnaire prior to the session and bring the complete form to group. Among other things, therapists should always check item 9, which addresses suicidal ideation. If a group member indicates that he or she feels suicidal, therapists should keep the client after group to assess the need for interventions to help protect that individual's safety.

D. Concept: Thoughts That Cause and Maintain Depression

The first unit teaches clients to decrease their depression by influencing thoughts, particularly dysfunctional thoughts. Define thoughts as "things we tell ourselves. Thoughts are very powerful. Through thoughts, you tell yourself about everything that goes on around you. Some of your thoughts have been influenced by upbringing, others by culture, and others reflect your unique way of responding to the world. Thoughts are like someone whispering in your ear all the time, telling you how to respond to the world around you. These thoughts have an influence on many things: on your body, on your actions, and on your moods.

"Thoughts are very important in influencing feelings; they have a major impact on determining your mood. Certain types of thinking can lower your mood and maintain depression. These thoughts are 'trap thoughts' that keep people down. Learning to recognize and talk back to such thoughts can

improve your mood.

"In everyday experience, things that happen around us seem to 'cause' bad moods. For example, a woman has a quarrel with her husband. She then feels sad during the following day. She may feel that having the fight with her husband made her sad.

"Perhaps she'll discover after a while a particular thought that made her feel sad: 'If my husband yells at me, it means that I'm an awful wife.'

"This thought is actually what made the woman feel sad, rather than the fight itself. She might learn to recognize such thoughts as a 'trap' for her. She can learn to replace trap thoughts with more positive and logical ones, such as: 'My husband is yelling at me because I don't do things exactly as he wants them done. Just because he yells at me doesn't mean that I'm not a good wife.' With this new thought, she is unlikely to feel so sad during the day following a quarrel.

"Some thoughts make it more likely that you'll become depressed and others make it less likely. Imagine that you have exactly one hour to get to an important meeting during rush hour. If you're sitting on the freeway saying to yourself, 'Oh, no, I'm going to be late. I can never get there on time. I'll look bad if I show up late. This might hurt my career!', you are likely to feel upset and anxious. If you are in the same situation but are saying to yourself, 'I

really can't do anything about this traffic. I might as well use this time to relax, so that when I arrive at the meeting I'll feel as good as I possibly can. I'm going to turn on the radio and relax and enjoy this time!', you might manage to make yourself feel very calm and relaxed. This illustrates how important thoughts are in terms of influencing our moods."

Thoughts are ideas that we tell ourselves. Help clients learn to "tune in" to these thoughts. Ask them to pay attention to the thoughts that are going on inside their heads. For example, "What are the thoughts you're telling yourself right now? Some of you may be saying to yourselves, 'This isn't going to work for me. They don't understand my problems. Nothing is ever going to help me.' If you're telling yourself those things, you may have trouble using this therapy. Others among you may be saying to yourselves, 'I hope this works. I'm willing to try this in order to feel better.' If you're telling yourself to try, this therapy is more likely to help you." Practicing "tuning into" thoughts will help clients learn to listen to the tape that constantly plays in their heads.

E. Concept: Identifying Errors in Thinking

After clients learn to "tune into" the thoughts running through their minds, they must learn to identify those thoughts that cause them to feel depressed. This is often best done through the method of "working

backwards." That is, ask clients to notice the times during the day or week when they feel the worst. Then have them notice what thoughts they are having during these times. Thus, they start with the feeling and work backwards to the thought.

Clients will learn to identify such errors in thinking as "all-or-nothing thinking" (believing that if you do one thing wrong, everything about you is wrong), "should" (believing that you or other people must behave in specific ways), or "overgeneralization" (believing that one example of something negative means that everything will be negative). We recommend that clients read *Feeling Good: The New Mood Therapy*, by David D. Burns, M.D. Pages 31 through 47 identify typical errors in thinking and help clients to identify their own errors in thinking.

Clients who have difficulty learning to identify their dysfunctional thinking may be helped by Burns' downward arrow technique. To use this technique, the therapist asks the client to identify situations that are upsetting to him or her. The therapist then asks repeatedly, "Why is this situation upsetting to you? What does it mean to you?" After answering these questions for each situation, the client often arrives at the dysfunctional belief.

Depressed thinking is different from non-depressed thinking. These are

some of the ways in which it differs:

Depressed Thinking

- Depressed thinking is *inflexible*. For example, a depressed person might think: "I'm always scared." Flexible thoughts that keep us from being depressed might be, "I'm scared sometime, but at other times I'm not."
- Depressed thinking is *judgmental*. A depressed person might think: "I am a terrible coward." The nonjudgmental thinker may say, "I am more afraid than most people I know, but that doesn't necessarily mean anything bad about me."

Non-depressed Thinking

- Non-depressed thinking is *reasonable* as well as *flexible*: "I am afraid in some situations sometimes." This contrasts with such depressed thinking as, "I always have been and always will be a coward."
- Non-depressed thinking looks at what you do, not who you are. Flexible and reasonable thinking says, "I have been acting in ways that are not working for me right now." Depressed thinking might say, "I am bad."
- Non-depressed thinking hopes for change: "Nothing I've tried yet has helped, but this is new and the time might be right for me to start feeling better." Depressed thinking is hopeless: you believe that nothing will help.

Teach clients to spot types of thinking that are traps for depression. Present the following three concepts:

1. *Constructive versus destructive thinking*: "Constructive thinking is the type of thinking that helps 'build yourself up' and 'put yourself together.' For example, the thought, 'I can learn to control my life to get more of what I want' is constructive. Try to work toward more constructive thinking. Destructive thinking 'tears you apart.' For example, you might think 'I'm no go at all,' or 'I've made too many mistakes in my life.' Try to turn destructive thinking into constructive thinking."
2. *Necessary versus unnecessary thinking*: "Necessary thinking reminds us of the things that we have to do, such as 'I must remember to fill out the daily mood graph before I go to sleep tonight.' Unnecessary thinking simply is worry. Examples of unnecessary thinking are, 'This country is going to be ruined,' 'I'm going to get old and sick,' or 'My kids aren't going to turn out like they should.' Such unnecessary thinking can be a trap thought for making you feel bad. Try to reduce the amount of time you spend in unnecessary, negative thinking."
3. *Positive versus negative thinking*: "You know the saying about the cup being half empty or half full. Positive thinking helps you look at what you do have in a positive light instead of focusing on what you don't have or on negative things. Depressed thinking focuses on the negative. For example, a depressed person reported going for a walk on a beautiful fall day. She walked through a lovely park, but felt that her

whole day was ruined because she had seen a dead bird beside the sidewalk. She focused exclusively on the one negative thing in the otherwise beautiful day.

"Focusing on the positive can help lift depression. An example of positive thinking is, 'Things are rough right now, but at least I'm here doing something about them.' Negative thinking only makes you feel worse, like saying, 'It's just no use.' When you're depressed, you should work to focus on the positive to help improve your mood."

F. Skill: Increasing Thoughts That Improve Mood

Present clients with the following typed list of ways to increase thoughts that improve mood. Read each item and ask if anyone tried this and how it works for them.

1. "Simply increasing the number of positive thoughts you have can make you feel better. You might make a list of good thoughts that you've had about yourself and your life. Write these thoughts down and read them over every day.

Giving yourself mental 'pats on the back' can increase your positive mood. Make yourself aware of what you really do every day. Most of the things we do are not really noticed by others. Notice the things that you do and give yourself credit for doing them.

3. "Sometimes it's most healthy to give yourself a break. Particularly if

you are a worrier, you may need to learn to say to yourself, 'Hold everything!' This means to pause and give yourself a mental 'time out.' Let your mind simply relax for a moment. Pay attention to your body's ability to be at peace. Feeling at peace can give you energy. Do this several times a day.

4. "When you're feeling bad, time projection can be really helpful. That is, imagine moving forward in time when things will feel better. Imagine how you will feel about this bad time from the perspective of the future."

G. Skill: Decreasing Thoughts That Lower Mood

Present clients with the following typed list of ways to decrease thoughts that lower mood. Read each item and ask if anyone has tried the method.

1. "If you find that a particular thought is lowering your mood, try to stop that thought. Agree with yourself that you are not going to think about that right now. Move on to other thoughts."
2. "If you are a worrier, sometimes it's helpful to set up a 'worrying time' each day. That is, set aside 15 to 30 minutes each day to worry. Do your worrying during that time and leave the rest of the day open without feeling that you have to worry. If you find yourself worrying about something, write it down so that you can worry about it during your next worrying time."

3. "If you have a good sense of humor, sometimes you can make fun of your own problems by exaggerating them. For example, if you worry about whether everyone likes you, imagine that one person doesn't like you. Then blow up the worry by imagining that person carrying a placard that says she hates you. Keep blowing up the image until you can laugh at how silly your worries might be.
4. "Often, vague fears about what could happen make us more depressed than thinking things through and facing the worst possibilities. Remember that the worst that can happen is only one of many possibilities, and just because it's the worst, it's not the one most likely to happen.
5. "As you work on your depression, learn to become your own coach. This is just like helping someone else do something difficult. Give yourself instructions. Think of this as a time when you are *learning* to feel better."

H. Concept: The ABCD Method

Clients must learn to "talk back" to or modify their errors in thinking in order to control negative moods. We suggest teaching the ABCD Method (Ellis & Dryden, 1987) to develop skills for modifying errors in thinking. Using this method, the client learns to identify *A* (activating event that precedes negative feelings), *B* (belief about the event that causes the negative feelings), *C* (the consequence of the belief, often feeling sad, lonely, frightened, and so on), and *D* (a dispute for the belief). Clients use the skills developed earlier to

identify the events, beliefs, and errors in the beliefs that underlie their depression. You can then encourage them to dispute the beliefs and replace them with thoughts that maintain or enhance more positive feelings.

For example, have one client in the group talk about a difficult time that she had in the past week. If she says that she felt sad all week because she expected her daughter to call on Wednesday and she did not, ask her what her thoughts were. She may say that she thought, "I am not a good mother because my daughter doesn't care enough about me to call me every week." On the board write "A: The activating event was that your daughter did not call you." Across from the A write "B: The belief is that you are not a good mother if your daughter doesn't call you every week." Below these, write "C: The consequence is depression." Next, ask the group to help generate alternative thoughts or beliefs. Other group members are likely to offer such alternatives as, "If your daughter doesn't call you, it's probably because she's busy—not because you aren't a good mother," or "Even if your daughter is mad at you and not calling you right now doesn't mean that you aren't a good mother. Maybe she's mad at you because she hasn't really grown up yet." Ask the client to read the alternative responses out loud. Then ask her how she feels after reading them.

Often patients aren't able to communicate clearly the dysfunctional beliefs they hold at the beginning of this exercise. They usually *are* able to

describe the situation that is upsetting to them. Use of the downward arrow technique described in concept E can be helpful. In addition, generating alternative thoughts is a time to build cohesion in the group. Ask each group member to describe an alternative way of thinking about the situation.

I. Skill: Modifying Errors in Thinking

In order to best teach clients to talk back to their negative thoughts, present them with common dysfunctional thoughts. Have the group identify the error and suggest alternative thoughts. Below is a list that can be used:

1. "I should be loved and approved of by everyone." This is an example of one of the "shoulds." An alternative thought is, "It is nice to be loved and approved of, but no one is liked by everyone."
2. "I should always be able to do things well and work hard all of the time to feel good about myself." This is another example of the "shoulds." An alternative thought is, "Some things I do well and others I do less well. I can feel good about myself even when I don't succeed at something."
3. "Some people are bad and should be punished." This is an example of all-or-nothing thinking when we think in terms of the "shoulds." No one is all bad; and we get in trouble when we think in terms of "shoulds." An alternative thought is, "Some people do things that I don't approve of some of the time. People are different and see things differently."

4. "I will feel awful if things don't go the way I want them to go." This is an example of all-or-nothing thinking. If one thing goes wrong, everything isn't necessarily ruined. An alternative thought might be, "This is important to me, so I hope that some of the things I want will happen. I realize that other people think differently at times—so some things may not go as I want them to. I will enjoy as much as I can."
5. "Other people and things are what make me unhappy." This is an example of thinking that your problems are out of your control. You think that you need someone else to behave differently before you can be happy. An alternative thought would be, "I can't control what other people do, but I can learn to control my own mood. I can learn to make myself happy no matter what others do."
6. "I'm worried about bad things that could happen." This is an example of objectifying your mood. That is, when you're anxious, you begin to believe that something bad is going to happen. An alternative is, "I am anxious. When I'm anxious, I believe that something bad is going to happen. But my anxiety doesn't predict the future. I need to relax and then I won't believe that something bad is going to happen."
7. "I can never be happy if I don't have someone to love me." This is an example of overgeneralization. If you are not happy in one area of your life, you assume that you will always be unhappy. An alternative thought is, "I can have lots of things going on in my life. Some will work out and some won't work out. I will be able to make myself happy with those things"

that do work out for me."

8. "I can't change the way that I am; I was born stubborn." This is an example of self-labeling. This doesn't look at your specific behavior, but labels you as bad. An alternative statement is, "Sometimes it's hard for me to change directions—but I can work to be more flexible."

9. "I must feel depressed because people I care about are having a bad time." This is an example of the "shoulds" and all-or-nothing thinking. First, just because others are sad, you needn't be sad yourself. This thought focuses solely on the current sadness, rather than noticing anything positive. An alternative statement is, "When people I care about are feeling down, I feel bad for them. I know things will turn around for them, and they may benefit from seeing that I don't become depressed with them. I may be able to help them feel better in time. One of the things I can do is to take care of myself and stay happy so that I can be of some help to them."

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care of myself and stay happy so that I can be of some help to them."

10. "So-'n-so will be disappointed in me if I don't do the right thing."
This is an example of mind reading (assuming you know what others think). An alternative thought is, "I am going to do my best and learn from my mistakes. The important thing is to try to please myself."

J. Concept: Increasing Pleasant Activities

The second unit focuses on pleasant activities. Depressed clients often have reduced their activity level. Increasing the number of events and activities they engage in can affect their mood. Depressed clients often don't feel like doing the kinds of activities that are likely to be a source of satisfaction for them. A "vicious cycle" ensues in which the more depressed people feel, the less active they are; and conversely, the less they do, the more depressed they feel. Generally, three kinds of activities are useful in combating depression: 1) those that involve clients in rewarding interactions with other people; 2) those that make them feel more competent, or give a sense of purpose; and 3) those associated with emotions of happiness and contentment.

In presenting pleasant events to clients, several things are important to consider. First, clients often need a rationale for having to put effort into

finding enjoyable activities. One rationale is that most depressed clients have had losses that precipitated their depression. These losses, such as loss of a spouse, job, and so on, may also involve loss of pleasant activities. Therefore, the client may need to learn different ways to enjoy activities or learn to consider different activities. Second, pleasant activities don't have to be special. Many of them are ordinary, such as taking a bath or going for a walk. Often adding simple changes in daily routines can make activities enjoyable, such as taking a relaxing bubble bath instead of simply bathing. Third, people differ in the types of activities that they enjoy. Encourage all members of the group to share examples of what they enjoy. Often leader modeling is useful in beginning this process. Stress the point that identification of individual pleasant activities adds to self-knowledge. This self-knowledge is important for learning which activities affect mood on an individual level.

K. Skill: Identifying Pleasant Activities

Clients learn to assess the degree to which pleasant activities contribute to their mood. Because those who are depressed often have a low number of pleasant activities in their lives, the goal is to increase the number of enjoyable activities they participate in. In the groups, the Pleasant Events Schedule is used to identify activities they have enjoyed in the past and activities they would enjoy now. They monitor their daily activity level and gradually increase the number of pleasant events they engage in.

L. Skill: Pleasure Predicting

Often, when clients are planning activities for themselves, negative thinking can diminish the anticipated pleasure and keep the client from engaging in the activity. Teach clients to anticipate how much pleasure a certain activity will hold for them and to write their prediction down before they engage in the activity. After completion of the activity, they write down how pleasurable they actually found it to be. They are then encouraged to see the connection between anticipatory thoughts and their subsequent experience. Often clients find that they would have missed an enjoyable activity if they had relied on their "depressed thinking" to guide them.

M. Skill: Setting Goals

Clients learn to develop and implement a self-change plan aimed at increasing the number of, or frequency of their involvement in, enjoyable activities. Initially they learn to write a contract with themselves to engage in one new activity in the coming week and to name a reward to give themselves after completing the activity. Rewards increase the likelihood that clients will continue to implement their self-change plan. Constructing a "reward menu"—a list of events and things the client wants—can be useful. Be careful that clients don't include rewards that are dependent on someone else's behavior, unless they are sure they can count on that person's cooperation.

This skill progresses into the area of time management and planning. You will teach clients to prioritize the things they want to get done in a given week. Top-priority activities are plotted into their weekly schedule where they have time to accomplish them. Lower-priority items are plotted in last where there is room. You and the clients can scrutinize their weekly plans, to ensure a balance between responsibilities and pleasant activities.

Goals set to overcome depression must be reasonable and clear. Encourage clients to set realistic goals. A goal may be too big or unwieldy and may need to be broken down into smaller steps. For example, one woman who wanted to join some activities at the senior center made it her goal for the first week to go to the center and get the schedule of weekly activities. Goals must be clear and not so expansive that it's hard to formulate a plan. "I want to be less isolated" may have to be restructured into "This week I will call one friend and ask him to go for a walk." One additional benefit involved in setting goals may be to add structure to a client's day. For example, one woman who lost her job because of medical problems was faced with empty time, which she found overwhelming. Step by step she built her own structure with a daily walk, going out for coffee, taking adult education classes, and so on.

In planning for the future, help clients think of their lives in terms of manageable pieces of time. Setting personal goals involves organizing them

into three categories: 1) short-term goals (to be realized within one or two months), 2) long-term goals (to be realized at some point in your life), and 3) life goals (your general philosophy of life or what matters most).

N. Concept: Improving Interpersonal Relationships

The third unit teaches the concept that depression is related to difficulties in interpersonal relationships and that improving contacts with people can affect one's mood. Work in this area is individualized for each client. It may include increasing one's network of friends, improving the quality of existing relationships, becoming more assertive and socially skilled, or changing one's attitude about relationships.

Clients are taught that higher levels of depression relate to 1) being with other people less, 2) feeling uncomfortable or awkward with people, 3) being less assertive, and 4) being more sensitive to being ignored, criticized, and rejected.

O. Skill: Increasing Social Activities

When clients feel depressed, they are less likely to socialize. By socializing less, they lose a good source of happiness and then become more depressed. This creates a vicious cycle of depression and isolation. In the group, clients learn that increasing social contact can reverse the cycle.

Discuss with clients the ways in which a supportive social network can be beneficial—for example, helping to cope with stress or providing involvement in meaningful and enjoyable activities. Clients may not be using the support that is available to them. It's helpful for clients to list the people in their support networks, including friends, family, neighbors, co-workers, or anyone else who is important to them. Clients who are isolated or have small networks are encouraged to enlarge their circle of contacts. Those who have an adequate network are encouraged to appreciate it and keep the relationships healthy. All clients learn to monitor their level of social activities, both positive and negative, and to set goals to initiate more pleasant social activities.

In the group, clients generate ideas for meeting others and maintaining contact with people. They are taught that a good way to meet people is to do something they really enjoy, in the company of other people. This helps to ensure that they are in a good mood and will meet people who share similar interests. Depressed clients often have difficulty initiating activities due to fears of rejection. It's important to practice asking others to do things and anticipating negative thoughts that might get in the way.

P. Skill: Increasing Assertiveness

Assertiveness is taught to help the client get greater enjoyment out of

social interactions and reduce negative contact with people. Clients first identify problem areas in their interactions with people. Assertiveness skills are then learned and practiced in the group, using situations from the participants' lives. Between sessions, they first practice with covert rehearsal and imagining assertive responses, progressing to practice in real-life situations.

Assertiveness is defined as being able to comfortably express your feelings and reactions, both positive and negative. In the group, clients discuss the differences between passive, aggressive, and assertive responses. Depressed people are often quite passive; they may feel that others take advantage of them and that they are powerless to change things. The passive person is unlikely to get people to meet his or her needs and preferences; thus resentment toward others is likely to build. Such people may then brood or avoid social contacts altogether. The aggressive client is likely to respond to negative situations with excessive anger toward others. Aggressive responses tend to alienate others and reduce the chances of a positive outcome. Some depressed clients shift from extremely passive responses to aggressive responses—for example, letting an interpersonal problem go undiscussed until it reaches the breaking point, then reacting with anger. Clients may also have difficulty expressing positive thoughts or feelings; this produces discomfort around people and limits their attractiveness to others.

Assertiveness is presented as an alternative response: stating one's feelings honestly and attempting to work out difficulties as they occur. Clients learn assertiveness skills, such as focusing on how they feel ("*I*-statements"), rather than blaming or judging the other person. It's essential for clients to identify what they want from a person or a situation, and to learn to ask for this simply and directly. Finally, they learn how to follow through on their requests with appropriate consequences and rewards.

Assertiveness is often difficult to learn, thus you should encourage clients gradually to try more assertive responses and to keep trying if they don't succeed initially. They should first practice a response to the situation, imagining what they will say and how the person will react; when they feel ready, they can try out their assertive response in the actual situation. Encourage clients to get ideas by observing others whose style they like, and to get suggestions from friends on how to handle a given situation. In the group, role-plays and discussions assist clients in coming up with assertive responses to difficult situations.

Q. Skill: Enhancing Social Skills

Some depressed people are uncomfortable in social situations because they lack social skills or they believe themselves to be socially incompetent. Social skills are taught with an emphasis on how the client comes across to

others. Group members provide one another with feedback on their appearance, facial expressions, and speaking style. Many clients also benefit from learning basic conversational skills, such as expressing interest in what others say and initiating topics of discussion. Finally, some clients may have adequate social skills but suffer from anxiety, which impedes them. These clients will benefit from learning and practicing relaxation in anxiety-provoking social situations.

R. Skill: Dysfunctional Thoughts About People

The quality of social interactions is often affected by dysfunctional beliefs about people. For example, the client who believes, "People don't really care about me, they're just out to take advantage of me," is likely to avoid close relationships and be constricted and suspicious during social interactions. Social situations are also powerful triggers for negative thoughts about oneself. The client who stumbles when speaking in public may believe, "I can't do anything right; everyone must think I'm stupid"—which then exacerbates depressed mood and makes withdrawal more likely.

Teach your clients to combat these dysfunctional beliefs and replace them with more adaptive attitudes about people. They can use the methods they learned in the "Thoughts" module (see sections E, H, and I in the Concepts and Skills section)

—for example, they can use the ABCD method for generating alternative, non-dysfunctional thoughts. In the second example above, the alternative thought might be, "I made a mistake in speaking, but others make mistakes too. I don't need to be perfect for people to like me."

Clients learn to identify which thoughts help them to be comfortable with people

—for example, "I have ideas I can share with this person; he might enjoy being with me." Other thoughts get in the way—for example, "This person could take advantage of me; I'd better not reveal anything about myself." Encourage clients to think more positively and modify their negative thoughts.

S. Skill: Maintaining Relationships

The final skill emphasizes the importance of maintaining relationships over time. Teach clients that relationships with people are important for mood because they can a) help you have rewarding experiences, b) support the values you want to live by, c) provide companionship and a sense of stability, and d) reflect an important image of yourself. Several skills for maintaining relationships are helpful for depressed clients.

First, present the rationale that relationships are worth working on. It

takes effort to maintain relationships and adapt to changes, but there are substantial long-term benefits. Second, help clients learn to set reasonable expectations for relationships. Expecting too much may lead to dissatisfaction, while expecting too little causes one to miss rewarding opportunities. Third, when relationships don't work, it doesn't help to think there is something wrong with you. Encourage clients to focus on constructive questions. For example, do both people want the same things from the relationship? Do they share interests? Can they tell each other what they think and feel clearly? Fourth, teach clients to practice listening and understanding what others say. Suggest that they try repeating back what they heard, to clarify if that is what the person meant. This technique can help avoid arguments and misunderstandings based on immediate emotional reactions. Finally, encourage clients to choose relationships and social environments that support their sense of self-worth and confidence, rather than those that hurt or demoralize them. Mention the group as an example of a supportive environment.

Main Interventions

Week 1

Introduction

Begin by introducing the purpose of the group and the purpose of this first meeting. Introduce the ground rules regarding how the group will run.

"The group meetings will be helpful in overcoming your depression. They will allow you time to share your concerns with other, to get support from others in the group, and to realize that you are not alone in having real problems and difficult times in your life.

"We're now going to introduce ourselves to one another. For now, we would like to know who you are apart from your depression; so try to introduce yourself without presenting the problems bothering you right now. It's important not to think about yourself only as a 'depressed person.' Tell us things such as where you grew up, who your family is, what kind of work you've done, your main interests, and things about yourself that you think are very important." Therapists may participate in this introduction as well.

A. Concept: What Is Depression

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 2: Group Exercise

Ask group members to describe what depression is like for them. Therapists should write on the board the symptoms that clients have

experienced. Ask what kinds of thoughts group members have when they feel down. What do they do when they're depressed? How do they feel when they're depressed? After listing the symptoms, say, "You all have similar symptoms that tell us that you're depressed. This group is intended to overcome your depression."

B. Concept: Defining Cognitive-Behavioral Therapy

Intervention 1: Didactic Presentation (See Concepts and Skills section)

C. Skill: Monitoring Your Mood

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 2: Group Exercise

Begin by having each person consider his or her own current mood. Give the following instructions: "Let's each rate our mood." On the board, draw a scale from 9 to 0. "If a 9 represents the best mood you can ever imagine and 0 represents the worst mood you can imagine and 5 represents a typical mood for you when you are not depressed, where would you put yourself right now?" Have each group member assign a number to their current mood. Clients will perform a similar rating each day during the next week using the Daily Mood Graph.

Homework

The Daily Mood Graph and the Beck Depression Inventory. Have each member complete a daily chart of his or her mood just before going to bed and assign a number to that mood. For clients whose mood varies greatly, have them assign a worst and best rating for the day, using different colors.

Week 2

Introduction

Go over the Daily Mood Graph and the Beck Depression Inventory as clients come into the group. Ask if anyone was surprised by anything they learned when filling out the graph. Ask what it was like to fill out the graph every day. Often clients can learn about important factors that influence their mood simply by filling out the graph.

Explain the purpose of the homework again. It's important for clients to understand that the group occupies only two hours of their week and that to feel better may require more active participation during the rest of the week. Encourage people who did not complete homework to keep the mood graph during the following week.

Intervention 3: Group Demonstration

Choose one client's graph to put up on the board to illustrate how the graph works. Try to tie concepts of dysfunctional thinking, activities, and interactions with others to this person's mood. For example, if the client reports that his mood was worse on a day when he stayed inside and better on a day when he went out to buy groceries, point out that getting out of the house for activities may be an important factor in raising his mood. Similarly, if the client reports that her mood was worse on a day when her daughter failed to call her, ask what she was thinking. If she responds, "...that I am a failure as a mother," point out that this thought by itself might be making her feel down.

D. Concept: Thoughts That Cause and Maintain Depression

Intervention 1: Didactic Presentation (See Concepts and Skills section)

E. Concept: Identifying Errors in Thinking

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 4: Soliciting Examples and Group Discussion

Ask a few clients to identify and share beliefs that have been keeping their mood low. Ask the group to identify errors in the thinking.

Homework

- Clients should fill out the Daily Mood Graph and the Beck Depression Inventory.
- For homework reading: David Burns, *Feeling Good: The New Mood Therapy*, William Morrow and Company, 1980, pp. 7-48.

Week 3

Introduction

Review the purpose of the treatment and how thoughts, activities, and interactions with others affect mood.

Review homework. Go over the daily mood scale. Discuss the errors in thinking studied during the past week. Ask if people noticed errors in their own thinking.

Teach the following: "Today we will focus on three things. First, we'll talk about increasing thoughts that make us feel better. Then we'll talk about decreasing thoughts that make us feel bad. Finally, we'll practice spotting errors in thinking and correcting them."

F. Skill: Increasing Thoughts That Improve Mood

Intervention 1: Didactic Presentation (See Concepts and Skills section)

G. Skill: Decreasing Thoughts That Lower Mood

Intervention 1: Didactic Presentation (See Concepts and Skills section)

H. Concept: The ABCD Method

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 3: Group Demonstration

Have two or three clients work through their errors in thinking using the ABCD method on the board. A sample discussion follows below:

Naomi: I felt very bad on Saturday when my back was hurting.

Therapist: So the event that made you feel sad was back pain. Did you feel anything besides sad?

Naomi: Yes, I felt defeated. I felt like I couldn't do anything that would be fun because I was sick.

Therapist: What were you thinking when you noticed the back pain?

Naomi: I thought that it means that I am sick again. When I am sick, I can't do anything that I like to do. It felt overwhelming, like I can never have a good time because I am always sick.

Therapist: Can anyone in the group see any errors in the thoughts Naomi is having?

Norman: Yes. She's saying never and always. I can see why she feels so bad when she is thinking she can never have any fun.

Naomi: It feels that way when I have back pain.

Therapist: I am sure that you do feel very sad when this happens to you. It might be that the thoughts you are having are what really make you feel so bad. Can anyone in the group think of an alternative thought that Naomi might have when she feels back pain that might not make her feel so sad.

JoAnn: One thought might be that even though your back hurts there are some things that you can enjoy. Can you still enjoy visiting friends or watching a movie?

Bob: She could say my back hurts now, but it's not always going to hurt. Tomorrow I may feel better and I can do something fun then.

Sara: She could say that her back hurts but that a lot of her is still well. You know, like her mind is still okay and her stomach may still be fine. She's not totally disabled by her back pain.

Therapist: Naomi, how would it feel to you if you had some of these thoughts instead?

Naomi: When I am sick, I feel totally sick. I think I may have learned that when I was little. If I was sick and wanted to stay home from school, I was expected to be really sick! But you are right, there are many things that I can do and my back doesn't hurt all day every day. I think I would feel better if I remembered this when I have back pain.

Homework

- Clients should complete the Daily Mood Graph and the Beck Depression Inventory.
- Assign the ABCD method—for everyone to practice analyzing at least one thought that brings them down during the week.

Week 4

Introduction

Check on homework. Were clients able to complete the ABCD method during the week? Go over some examples on the board.

I. Skill: Modifying Errors in Thinking

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 3: Group Demonstration

Use clients' homework to practice the ABCD method on the blackboard.

Homework

- Clients should complete the Daily Mood Graph and the Beck Depression Inventory.
- Continue working with the ABCD method.

Week 5

Introduction

Go over homework from the previous week and see if there are any

further questions about the thoughts module. Introduce the next basic concept about how actions affect mood. Explain the material didactically, giving many examples and encouraging discussion of the clients' own experiences.

J. Concept: Increasing Pleasant Activities

Intervention 1: Didactic Presentation (See Concepts and Skills section)

K. Skill: Identifying Pleasant Activities

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 2: Group Exercise

"Pleasant Events Schedule" (Lewinsohn, Munoz, Youngren, & Zeiss, 1986) is a list of 320 potentially pleasant activities generated by asking people to name 10 activities they find pleasant. You may want to adapt this model and scale the list down to 100 items that are most pertinent for your population. Leave room at the bottom for clients to write in activities that they find pleasant, but aren't on the list, such as motorcycle riding. Examples of activities on the list include: be outdoors (beach, country...), take a bath, visit friends, cook meals, and so on.

Pass out the adapted "List of Pleasant Activities" and have the group

leaders and members take turns reading each item out loud. Instruct the clients to put a check mark next to each item that has been pleasurable to them in the past or that they think they might enjoy. Ignore or line through those items that are not pleasurable for that person—for example, "talk about sports." The group leaders should do this at least once themselves to share the experience with clients.

Encourage discussion at this point about what clients discovered about themselves in terms of the number of activities checked (which will vary widely), and how long ago they engaged in each activity. Stress that for now you just want them to keep track of their activities on a daily basis for a week, and not yet try to increase them. (The list is columned off for 14 days.)

Homework

- Clients should fill out the Daily Mood Graph and the Beck Depression Inventory.
- "Put a check mark next to each of the things you did in your list of pleasant activities at the end of each day. Write the number of checks per day at the end of the list, and at the bottom of the Daily Mood Graph."
- Clients should bring the graph and the list to the next week's session.

Week 6

Introduction

Go over the homework and explore any problems or questions about adapting the list of pleasant activities. Also inquire into any observations clients are making about activity level and their mood.

Intervention 3: Group Demonstration

Have one or two clients volunteer to share their homework with the group. One leader should draw a client's mood graph on a blackboard that's visible to all group members. Then list the number of activities completed under each day. Have the client talk about the week illustrated on the board, and show the connection between activity level and mood. Talk about how an adequate level of activities makes us feel healthy. Encourage discussion about the balance between things we "have to do" and those we "want to do."

Intervention 2: Group Exercise

Often a discussion about activities leads to the complaint that most pleasant activities cost too much money. Turn this into another group exercise to generate a list of free or low-cost pleasant activities. Other group members can be very helpful with this.

Intervention 2: Group Exercise

Anticipating obstacles: how might your thoughts interfere with engaging in pleasant activities? How can you use thoughts to help you plan and enjoy certain activities? It's often very helpful to put these ideas up on the blackboard as people suggest them and to encourage note-taking.

L. Skill: Pleasure Predicting

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Homework

- Have clients make a personal contract to do a new activity from the pleasant activities list during the coming week. Have them specify in the contract that if they fulfill it they will reward themselves with _____ within two days. This is more powerful if it's written.
- Have clients anticipate how much pleasure an activity will give them. They should write this down before they engage in the activity. Afterwards, they should write how pleasurable the activity actually was and make comments about this. (Negative thinking can diminish the anticipated pleasure, and often inhibits trying.)
- Clients should fill out the Daily Mood Graph and the Beck Depression Inventory.

- Clients should go over the activities list.

Week 7

Introduction

Review all the homework and again use one or two examples up on the blackboard. Stress the lessons that can be learned from the personal contract and pleasure predicting. Point out that you don't have to wait until you feel like doing something to do it—in fact, it's better not to wait. Remind clients that they can choose to do something and it can be enjoyable even if they didn't predict it would be. They can influence their mood with their activities: the more practice they get, the more control they can achieve.

M. Skill: Setting Goals

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 5: Individual Exercise

To assist with time management, have the group do the following: 1) Make a list of everything they want to accomplish this week and assign each item a priority member: "A" items have highest priority, "B" items are next, and "C" items have lowest priority. 2) Place an "A" item somewhere in their week on a particular day. If there's room to do more on that day, add other

items. If not, have clients just do the "A" item. Make sure that they have made room for pleasant activities during their week.

Homework

- Clients should fill out the Daily Mood Graph and the Beck Depression Inventory.
- Clients should review the activities list.
- They should also carry out their specific planned activities for the week.

Week 8

Introduction

Go over the homework and let each client check in on how their plan for the week went. Be positive about attempts made and even small steps taken. Discourage any comparison or competitiveness in the group. Check for cognitive distortions about what is actually being accomplished.

Intervention 3: Group Demonstration

Repeat the blackboard exercise correlating a particular client's mood graph with his or her activity level. The more clients are able to associate

their activity level with mood, the more they will feel able to control their moods.

Intervention 5: Individual Exercise

Each group member fills out an Individual Goals form. This form divides goals into three categories: 1) short-term (within one or two months, 2) long-term (at some point in your life), and 3) life goals (your general philosophy of life or what matters most). In addition to these three categories, the form can list Maslow's hierarchy of needs. Other goals to consider include: spiritual, economic, educational, recreational, and those for your level of physical activity. It's important that clients put down only the goals they believe to be important. Have them notice which goals they've already accomplished.

Homework

- Have clients fill out the Daily Mood Graph and the Beck Depression Inventory.
- Clients should review the list of activities.

Week 9

Introduction

Go over homework from the previous week and see if there are any further questions concerning the activities module. Introduce the new module, which focuses on relationships with people.

N. Concept: Improving Interpersonal Relationships

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 6: Group Discussion of Concepts

O. Skill: Increasing Social Activities

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 2: Group Exercise

Have clients come up with ideas of places or activities that present opportunities for meeting others. Ideas that come up frequently include adult education classes, health clubs, bingo games, outing groups, cultural or political events, and parks. Clients often have very good ideas for each other, and can gently confront one another's excuses. Have clients generate ideas for activities to which they can invite others: for example, going for a walk, shopping, coffee, dinner, movies, and so on. Have group members practice or role-play inviting someone out.

Homework

- Clients should complete the Daily Mood Graph and the Beck Depression Inventory.
- Clients should review the activities schedule and note their number of contacts with people, marking whether these were positive or negative

Week 10

Introduction

This session continues the work on contacts with people, focusing on the interrelation of thoughts, feelings, and behavior which have an impact on social contacts. You will introduce skills for assertive behavior and general social skills.

Begin by reviewing the homework, emphasizing connections between positive or negative social activities and daily mood. Encourage clients to continue to try out enjoyable activities with other people. Often clients will also bring up conflicts with people which caused their mood to drop. These negative interactions can be used as examples to demonstrate assertive behavior later in the session.

P. Skill: Increasing Assertiveness

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 2: Group Exercise

Have group members practice role-playing assertive responses to situations, preferably using situations they are currently facing. For example, a client who feels that her son takes advantage of her by asking her to babysit on short notice might work on ways to tell him that she will need more advance notice so that she can make her own plans. Have group members take turns playing the assertive responder.

Q. Skill: Enhancing Social Skills

Intervention 2: Group Exercise

Have participants discuss how they appear to others. First, have them generate a list of what they consider to be socially skilled behaviors. Then have them assess their own behavior and ways in which they would like to improve. Encourage group members to be honest with one another about their positive and negative behaviors. They should consider the following questions: How do you act around others? Do you smile, make eye contact? Is your body slumped or tired-looking? Is your grooming and clothing appropriate? Is your speech too slow or soft? How are your conversation skills—do you show interest in what others say? Do you ignore them or act

critical? Do you complain a lot? Can you say what you feel and think?

Intervention 3: Group Demonstration

Role-play actual listening skills with a volunteer from the group.

Intervention 2: Group Exercise

Divide the group into dyads and have one of the pair describe a problem in relationships while the other uses active listening. Have them switch roles. Ask members to provide feedback to each other.

Homework

- Clients should complete the Daily Mood Graph and the Beck Depression Inventory.
- Regarding the weekly activities schedule, clients should note the number of contacts with people, and mark whether these were positive or negative.
- Clients should practice assertiveness with one positive and one negative situation.

Week 11

Introduction

In this session, continue to work on assertiveness and on thoughts and feelings about people. Review homework, again emphasizing connections between people's daily mood and their social interactions. Reinforce clients' efforts to expand their social network or increase social activities, assisting with any problems. Have them share their experiences with assertiveness practice. Encourage them to keep practicing; have group members help generate alternative responses to difficult situations. Try to label any dysfunctional thoughts that are interfering with relationships or assertiveness, then work on alternative thoughts in the session.

R. Skill: Modifying Dysfunctional Thoughts About People

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 4: Soliciting Examples and Group Discussion

Use the session for open discussion and problem solving around important relationships, integrating the three skills presented in this module. Encourage the group to make a mini treatment plan for each problem discussed. Often parent-child or marital relationships present recurrent problems. For example, a client mentioned earlier felt very bad about her relationship with her adult daughter. She believed that her daughter didn't care about her, and waited each night for her to call, becoming more depressed when her daughter did not. In this case, we worked first on

identifying the client's dysfunctional thought—"She doesn't care, she thinks I was a bad mother"—replacing it with "I did the best I could; I won't let her get me down." The client also adjusted her unreasonable expectation of daily calls. She realized that her own decrease in activities had made her expect more of her daughter. Finally, she identified more assertive behavior for herself, including initiating contact with her daughter and telling her daughter how she felt.

In discussing relationships, have participants consider the following areas:

1. What are your thoughts when you're around people?
2. How do you act with people?
3. What are your feelings when you're with others?

Use the group to practice solutions to problems in relationships or social situations currently being faced by participants. Have group members practice asking each other for advice and information. Each person should make a commitment to try to change an aspect of his or her thinking or behavior with people.

Homework

- Clients should fill out the Daily Mood Graph and the Beck

Depression Inventory.

- Regarding the weekly activities schedule, clients should note the number of contacts with people, and mark whether these are positive or negative.
- Tell clients: "Practice thinking and behaving differently with someone in your life. Write down problems you would like the group to help with."

Week 12

Introduction

In this session, review concepts on social interaction. Continue the focus on relationships, emphasizing their value in one's life and adaptive ways of viewing difficulties in relationships.

Review homework, emphasizing connections between mood and social interactions. Have clients share their experiences of changing their thinking and behavior in current relationships.

S. Skill: Maintaining Relationships

Intervention 1: Didactic Presentation (See Concepts and Skills section)

Intervention 2: Group Exercise

Have group members share their thoughts about relationships, including feelings about one another or any group members who may be leaving the group. Emphasize what they have learned about relationships by being involved with other group members—for example, that others appreciate their sensitivity, sense of humor, and so on. Continue to practice relationship skills, such as active listening.

Homework

- Clients should fill out the Daily Mood Graph and the Beck Depression Inventory.
- They should also continue to notice pleasant and unpleasant interactions with people, and practice skills to improve relationships.

Criteria for Measuring Change

Several outcome measures are used to assess change. The Beck Depression Inventory, administered weekly, is plotted on an individual graph kept in the client's chart, giving a visual record of the client's progress. The weekly mood graphs completed by the client also demonstrate both a change in mood and an increase in skill utilization. Each client meets individually with a therapist following completion of the group series for a second diagnostic assessment, at which time it is expected that the client will no

longer meet the criteria for major depression. Finally, the clients' own reports of a decrease in their depressive symptoms—for example, being able to sleep through the night—demonstrate significant change.

Noncooperation

Clients may have trouble adhering to the principles of the group early in treatment. An initial problem can be motivation to attend the group. We suggest tackling this problem aggressively early in the treatment. For example, at a group orientation session when describing the therapy, say: "Thoughts can keep some people from coming to treatment. Did anyone here have thoughts that almost kept them from coming today?" Work with any dysfunctional thought that might prevent attendance.

Emphasize early in treatment the importance of attendance. Outreach can be very helpful. If a client misses a group, call him or her and discuss the absence. Clients may need help problem solving situations that keep them from coming. This outreach can usually be stopped as soon as the client becomes attached to other group members.

Homework is frequently not completed early on in treatment. Two things are helpful in building an atmosphere that leads to completion of homework. First, the therapists should communicate that they consider the homework to be extremely important. Ask, "How did the homework go for

you?" Spend time explaining assignments. Second, when clients do not complete homework, use the framework of therapy to investigate the causes. Ask such questions as, "What thoughts got in the way of your completing your assignment?" *Not* completing homework provides information that can help clients learn about themselves.

Finally, group cohesion is a very helpful tool for assuring adherence to rules. Emphasize that all group members are working to overcome a common problem: depression. This emphasis often helps build group cohesion and thus results in better adherence.

Resisting—Challenging the Therapist

Although many clients can be challenging in this type of therapy, general therapeutic skills are often successful in maintaining a positive atmosphere in the group. Clients who are particularly challenging to therapists often can be dealt within the framework of the therapy. For example, clients who use group time to complain and insist they cannot change can be shown that this thinking may be helping to maintain their depression. Similarly, some patients challenge therapists by suggesting that alternative ways of thinking are not "right." The therapists can emphasize that there are no right or wrong ways of thinking, but there *are* ways of thinking that lead to positive or negative moods. The therapy is not designed to help clients discern "reality,"

but rather to help them improve their moods.

Relapse

Relapse prevention is an integral part of cognitive-behavioral treatment of depression. In this group program we emphasize teaching clients to identify early symptoms of depression so that they can prevent recurrence of a depressive episode. Clients learn to achieve greater control over their mood by observing and modifying their thoughts, activities, and interactions with people, thus averting a sustained depressed mood. If symptoms begin to recur, clients are encouraged to seek assistance early. Some clients have repeated the program during periods of high vulnerability, for example, following major stresses such as losing a job or having a death in the family. We also currently have a support group consisting of graduates of the program. This group offers informal support and operates on a drop-in basis.

Conclusion

Group cognitive-behavioral treatment of depression offers a quick and effective method for treating depression and preventing recurrence of depressive episodes. Clients benefit both from the supportive environment of the group and from learning specific skills for controlling their moods. The group therapy offers an advantage over individual therapy for many clients

by providing support, socialization, and an opportunity to practice new skills during the treatment.

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