

*Manual for
Group Cognitive-Behavioral Therapy
of Major Depression*

A Reality Management Approach

(Instructor's Manual)

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THE COGNITIVE BEHAVIORAL THERAPY APPROACH

Preface: Origins of this CBT Manual

The first version of this manual was developed for a randomized controlled trial that found that each of three distinct components of therapy (increasing pleasant activities, interpersonal skill training, or changing the way patients think) were similarly efficacious in treating depression relative to a control condition (Zeiss, Lewinsohn, & Muñoz, 1979). The study was directed by Peter M. Lewinsohn, Ph.D., as the dissertation chair for the three other members of the team that conducted the study, Ricardo F. Muñoz, Mary Ann Youngren, and Antonette Zeiss. These four authors of the original manuals combined them and published them as a self-help book titled Control Your Depression (Prentice Hall, 1978, revised 1986). The book was then adapted by Muñoz in 1983 as the Depression Prevention Course, an 8-session manual for a randomized controlled depression prevention trial with Spanish- and English-speaking primary care patients at San Francisco General Hospital. Excerpts of the course can be found in Appendix A of The Prevention of Depression: Research and Practice, by Muñoz and Yu-Wen Ying (Johns Hopkins University Press, 1993). The development of several other manuals, including the current one, is depicted in Figure 1.

In 1985-1986, the Depression Prevention Course was expanded into a 12-session format for use at the University of California, San Francisco (UCSF)/San Francisco General Hospital (SFGH) Depression Clinic. This bilingual (Spanish/English) clinic was founded in 1985 by Muñoz, Jeanne Miranda, and Sergio Aguilar-Gaxiola to provide treatment to low-income depressed patients referred by their primary care physicians. The clinic, directed by Muñoz, was the first outpatient mental health clinic at SFGH. The Depression Clinic manual, titled "Group Therapy Manual for Cognitive-Behavioral Treatment of Depression" was prepared in English (Muñoz & Miranda, 1986) and Spanish (Muñoz, Aguilar-Gaxiola, & Guzmán, 1986). Both the 8-session Depression Prevention Course and the 12-session Group CBT manual retained the three-pronged focus on activities, thoughts, and people from the manuals of the original study, because these are key areas that influence depressed mood, and thus can be used to treat it. Most depressed patients find one or more of these areas useful to gain greater control over their depressed mood.

In 1995, the Psychosocial Medicine Division at SFGH opened up an outpatient clinic which included the Depression Clinic under its larger umbrella. Now called the Cognitive-Behavioral Depression Clinic, it has continued to provide clinical services and training in cognitive-behavioral therapy. In 1999-2000, Muñoz, two postdoctoral Fellows at UCSF, Huynh-Nhu Le and Chandra Ghosh-Ippen, the coordinator of the Depression Clinic, Eleanor Valdes Dwyer, and the Director of the Psychosocial Medicine Outpatient Clinic, Stephen Rao, decided to revise and expand this manual into a 16-session format, also prepared in Spanish and English. In addition to the three modules on thoughts, activities, and people, we added a module on the relationship of health issues and depression. Our patients are referred to us by primary care physicians, and, therefore, most have medical problems which affect the course of their depression. Following the structure of the Depression Prevention Course, we have also added an instructor's manual to accompany the participant's manual. Our intent is to make it easier for group leaders to use the protocol as intended. With the instructor's manual, the CBT protocol can be used more easily in the training of new therapists.

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Acknowledgements

We want to acknowledge the intellectual contributions of Peter M. Lewinsohn, whose pioneering work on behavioral approaches to depression guided the creation of the three initial manuals, as well as Albert Bandura, whose conceptual contributions in books such as Social Learning Theory (Prentice Hall, 1977), also provided direction for the development of these interventions.

At the San Francisco General Hospital Depression Clinic, many individuals helped shape the treatment approaches used. Among them are Jacqueline Persons and Charles Garrigues, who were very influential during the early stages of the clinic. We also want to acknowledge the many other Depression Clinic colleagues and trainees who assisted in the revision of this manual: Jennifer Alvidrez, Patricia Areán, Francisca Azocar, Drew Bertagnolli, Colleen Holt, Manuela Iturrioz, Gayle Iwamasa, Kathleen MacCormick, and Kurt Organista. A special thanks to the co-authors of the 12-session group CBT manual (1986 version), Sergio Aguilar-Gaxiola, John Guzmán, and Jeanne Miranda. The contributions of all of these colleagues are embedded in these pages. Since this time, the manual has also been adapted for use with other populations, such as African-American women, by Laura Kohn, and for other clinical problems, including work with methadone maintenance patients, psychiatric inpatients, and smokers.

Jeanne Miranda worked at the Depression Clinic for ten years. For the last five (1990-1995), she was the Director of the Clinic. Since then, she has continued to work in the area of depression in primary care. In work done in collaboration with Kenneth Wells at UCLA/RAND, she has demonstrated that the 12-session manuals can be helpful in quality improvement programs to enhance the care for depression received by primary care patients. The work of Wells, Miranda, and colleagues has appeared in the Journal of the American Medical Association (January, 2000) and other professional journals.

Organization of Manual

The revised manual includes two parts: (a) an instructor's manual, and (b) a participant's manual.

The instructor's manual is organized as follows:

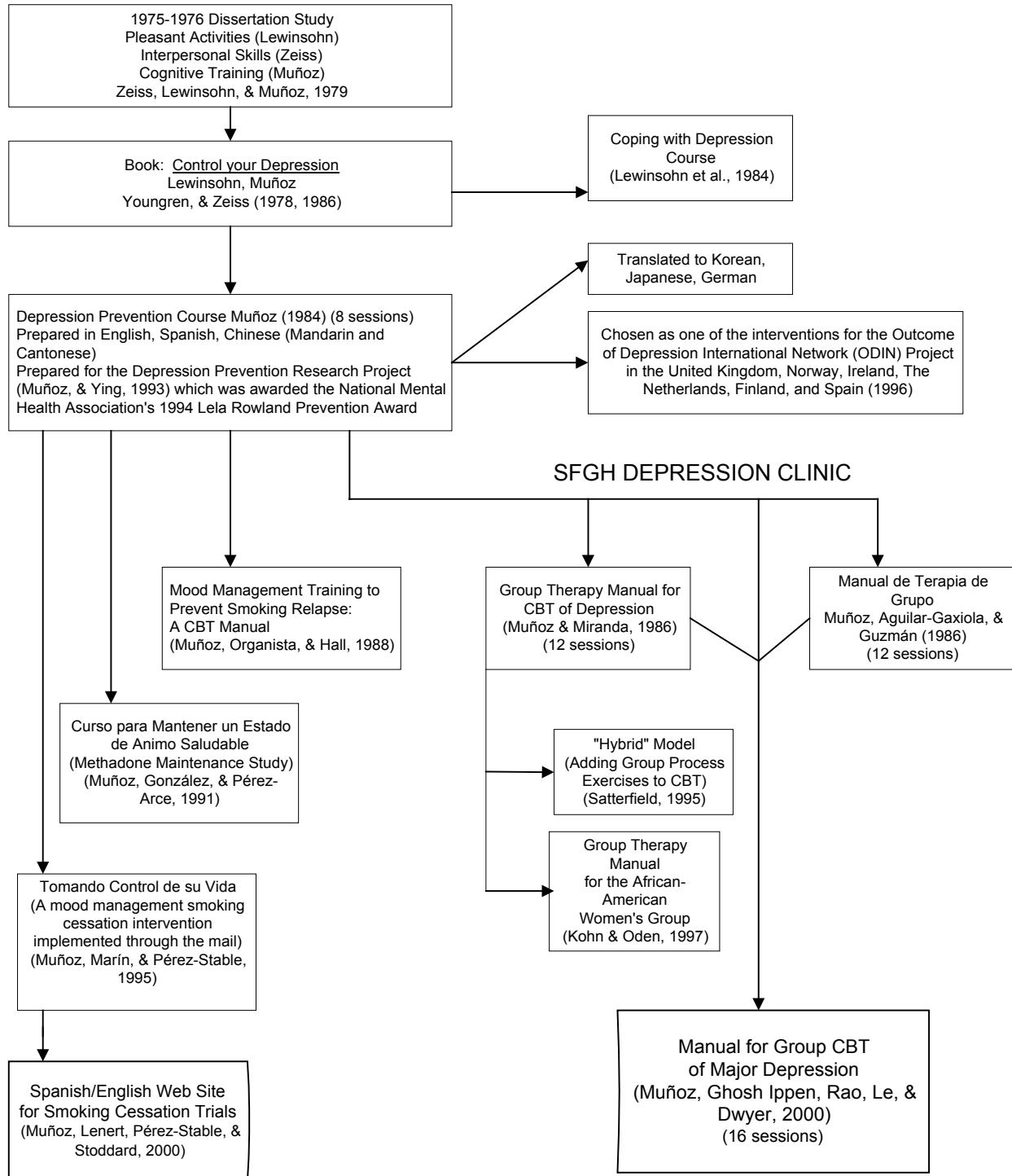
1. An introduction, including a brief explanation of the reality management approach, the social learning basis for this type of cognitive-behavioral treatment for depression, key elements of this approach, the need for rapport-building interviewing methods, levels of CBT intervention, and potential pitfalls.
2. An overview of guidelines for instructors, including the basics of group therapy, strategies to teach main concepts, and ways to attend to group processes.
3. Within each module, session-by-session instructions are provided on ways to convey the information that is to be presented to the patients.

The participant's manual includes outlines for each session, with several alternative exercises in each session, from which the instructor can select those most relevant for the current patients in the group.

We hope the current version of the manual will be useful to colleagues and continue to be useful to individuals who suffer the pain of depression.

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**Figure 1: Cognitive-Behavioral Mood Management
 Intervention Manuals for Depression Based on
 (Lewinsohn, Muñoz, Youngren, & Zeiss, 1978, 1986)**



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The Reality Management Approach: An Introduction

This manual presents a cognitive-behavioral therapy (CBT) approach to the treatment of major depression. The particular perspective to CBT described here was developed over the last 23 years by the senior author's experiences at San Francisco General Hospital. Patients at this county hospital have very few resources, they come from many cultural backgrounds, many have low levels of formal education, and many are immigrants and not English-speaking. Treating major depression in patients who have very few resources can be daunting, especially to trainees who are both learning how to do therapy and learning how to work with severe social disadvantage. It is clear that, for these patients, depression is not all in their heads, or even all in their neurotransmitters. The severe resource problems that they face make it difficult to take the time to focus on dealing with depression. Even if the time and energy are given to this purpose, the multiple problems that they face, such as not having a place to live, not enough food, and physically dangerous environments, make it important to acknowledge that our therapeutic methods may be inadequate to the task.

Rather than give up, however, we began to focus on the fact that the cognitive-behavioral approaches we use sometimes are used to great benefit by certain patients. Over the years, we have begun to see that those patients who change the way they think about their lives in certain ways, or who actually make changes in where and with whom they spend their time, can show remarkable progress. What seems to happen is that their day-to-day reality begins to change, even though they are living in the same environment, and their income and physical health status has not changed. It is this type of response to CBT that seems to have the most effect: a response in which the patients are able to modify their mental reality (their internal world), as

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well as the aspects of their objective reality (their external world), which are under their control. They begin to manage their personal reality in a healthy manner.

Over the years, Muñoz has begun to use this concept in supervision and in explaining how the cognitive-behavioral methods work when they are successful. These ideas are described in more detail in The Healthy Management of Reality (Muñoz, 1996). In brief, cognitive methods are useful in molding the mental environment of the patient, that is, in changing the patient's internal reality. Behavioral methods are useful in molding the objective environment, that is, in changing the patient's external reality. When the patient begins to see how molding these two aspects of their day-to-day life can result in significant improvement in their mood and their lives, the process becomes easier to maintain. Becoming aware of the way one's thoughts, one's behaviors, and one's moment-to-moment choices in both of these realms can lead one toward healthier or harmful mood states can give one a refreshing sense of hope and freedom. Depression becomes less something that just happens, and more something that one can modulate.

Making this process explicit by referring to it as learning to manage one's personal reality can increase the chances that the patient will get the concept. Waiting for the patient to figure this out by himself or herself might result in deeper and longer lasting learning. There is something to be said for the "a-ha!" experience. However, we have found that many patients may become demoralized by the slow progress of therapy until the flash of inspiration occurs, and may leave therapy or cease to hope for improvement. Using the concept of the healthy management of reality in presenting the cognitive-behavioral methods is intended to short-circuit the process, and hopefully increase the proportion of patients who can begin to use them to change their lives for the better.

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However, to present the reality management approach, it is important to first be familiar with the cognitive behavioral methods. After all, these are the methods that underlie the broader perspective. If one is not able to teach the patient useful cognitive and behavioral skills, the concept of managing one's reality becomes a purely inspirational thought, with not much substance. Therefore, we now turn to the cognitive-behavioral methods that are the core of the manual.

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A Social Learning-Based Cognitive-Behavioral Approach

There are many sources for the many methods that fall under the rubric of cognitive-behavioral approaches. But it is fair to say that all of these methods have an explicit educational component, and that they assume that improvement is the result of learning a series of skills that make it possible for individuals to exert greater control over their feelings.

The sources of this manual stem from the work of two mentors of the senior author: Albert Bandura and Peter M. Lewinsohn. Bandura was senior thesis advisor for Muñoz at Stanford University in 1971-1972. Bandura had recently finished his encyclopedic Principles of Behavior Modification (Bandura, 1969) and soon thereafter wrote Social Learning Theory (Bandura, 1977). Both of these books contain many of the concepts that still influence the approach to cognition, behavior, and mood that is exemplified in this manual. These concepts include the ideas of symbolic learning, reciprocal determinism, the idea that freedom is a function of the alternatives that an individual has available in any one situation, and Bandura's perspective on self-control and self-efficacy. These ideas provided a source of hope for self-direction in human agency, and were powerful antidotes against the more deterministic views presented by radical behaviorism and psychodynamic approaches of the time.

Peter M. Lewinsohn is a pioneer in behavioral approaches to depression. He began experimenting with increasing levels of pleasant activities as a treatment for depression in the 1970's. In 1975-1977, he was dissertation chair at the University of Oregon for Muñoz and two other doctoral students, Antonette Zeiss and Mary Ann Youngren. They jointly conducted a randomized clinical trial to evaluate three approaches to treating depression: increasing pleasant activities, interpersonal skills training, and cognitive training. All three approaches were significantly better than a waiting control condition, and the three were not significantly different

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from each other. The three approaches were combined into the book Control Your Depression (Lewinsohn, Muñoz, Youngren, & Zeiss, 1978, 1986). They continue to be the core of the manuals developed by Muñoz and colleagues at San Francisco General Hospital (SFGH), one of the teaching hospitals of the University of California, San Francisco (UCSF). SFGH is located in the Mission District, the *barrio* of the City of San Francisco. Thus, the manuals have been developed in both Spanish and English, and appear to work well in both languages.

Four key elements for CBT.

In their published report of the dissertation study, Zeiss, Lewinsohn, and Muñoz (1979) identified four elements that they felt were most important in providing CBT, regardless of the specific target of change (thoughts, behavior, or interpersonal contacts). These were: 1) a convincing rationale for the intervention, 2) training in practical skills to change mood-related thoughts or behaviors, 3) encouraging practice of the skills outside of the therapy sessions, and 4) attribution of improvement to the use of the skills and not to therapist contact. We strongly recommend that therapists using this manual make sure to cover these four elements during each session. Sessions should begin with a brief summary of the purpose of the group and the rationale for learning what will be taught during that session. Each session should have a specific set of skills that the group members will be taught. The group leaders must find ways to increase the likelihood that the members will actually try these skills in their day-to-day lives between sessions. We use the term “personal project” to convey the need for each patient to be working on practicing these skills in their personal world, and evaluating which work best and which need to be molded so they are appropriate for their unique environment. Finally, it is important to emphasize at each session that the therapy sessions will come to an end. However,

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if they continue to use the skills they are learning during therapy, they will become more adept at using them, and thus can expect to continue to improve even after therapy ends.

Conducting CBT

Just as the reality management approach can be best implemented by someone who is very familiar with basic CBT methods, so also are the CBT methods best administered by a therapist who is familiar with basic therapeutic interviewing methods for rapport building. CBT methods require a fair amount of work from the patient. In more open-ended talk therapies, the patient can come unprepared and is allowed to pursue whatever topics happen to be foremost in his or her mind at the time. In contrast, CBT methods ask that the patient concentrate on learning specific strategies during each session, and, during the intervening days prior to the next session, is expected to practice these strategies and bring written records of the outcomes. This is a lot to ask, especially of someone who is feeling depressed. It is therefore crucial that the cognitive-behavioral therapist become important and reinforcing in the patient's mind. This can be best accomplished if the patient sees that the therapist understands the patient's situation, empathizes with the patient's feelings, and is able to offer one or more directions out of the patient's current situation.

Rogarian interviewing techniques are very helpful in establishing rapport (Rogers, 1951). These include paraphrasing, reflection of feelings, and summarizing. *Paraphrasing* involves repeating what the patient said (in the therapist's own words) to ensure that the therapist understood correctly, and simultaneously, to ensure that the patient knows that the therapist was paying attention and got the gist of the message. If the therapist did not understand correctly or completely, the patient can then correct him or her. *Reflection of feelings* involves statements that go beyond what the patient actually said, and describe what the therapist thinks the patient is

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feeling. Again, this method is a way to check whether the therapist is accurate in his or her perception of the patient's emotional state, and letting the patient know that the therapist empathizes with his or her emotional reactions. *Summarizing* is done periodically throughout the session. It involves "tying up" the last few moments of conversation so that they can be more easily digested by the patient, labeled in a way which allows alluding to them in the future, and, hopefully, reframing the matter at hand in a way that allows the patient to see the situation from a more objective and hopefully healthier perspective.

In supervision of cases of major depression, we often instruct the therapist to remember that the patient feels that their situation is hopeless and that they are helpless against the demoralizing feelings of depression. They feel like they are drowning. It is important for the therapist to plunge into the water with the patient, to let the patient see the therapist describing the situation as the patient sees it (via paraphrasing) and conveying the feelings the patient feels (via reflection of feelings). However, having both patient and therapist stay underwater and drown in the pain does no one any good. It is important for the therapist to point toward a way out, toward the surface, and, if necessary, to begin pulling the patient up with specific suggestions, until the patient is able to propel himself or herself with the methods taught in CBT.

Levels of intervention

When conducting CBT from a reality management perspective, there are four intervention levels to note. The first is the basic level of *modifying specific thoughts and behaviors*. This level includes identifying which thoughts and behaviors have a positive effect on mood and which have negative effects. Then, one works toward increasing the frequency of the former and decreasing the frequency of the latter. The second level involves learning *self-instructional methods*. At this level, the patient begins to take over the function that has been

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played by the therapist so far. The therapist has been a kind of coach at the patient's side, helping the patient discover the connection among mood, thoughts, and behaviors. Now patients begin to comment to themselves how thoughts and behaviors affect mood, and to advise themselves to clean out their internal and external environments from emotional pollutants. (Metaphors are useful in presenting the reality management approach.) The third level is the level of *logical analysis*. This level involves such methods as those developed by Albert Ellis (Rational Emotive Therapy; see Ellis, 1962) and, later, Aaron Beck (Cognitive Therapy; Beck et al. 1979; Burns, 1980). At this level, one questions the logic of assuming certain facts, values, or perspectives, and considers other ways of interpreting one's experiences. But there are some things in life that are not necessarily logical, and for those, one needs level four, which is explicitly taking a healthy *existential stance* toward life. The work of Viktor Frankl (Logotherapy; Frankl, 1955) is very useful here, especially his concept of attitudinal values, and how, even in extreme or "hopeless" situations one can choose how one will react. The idea is to present the patient with the idea that one has options on how one will interpret what happens in life, and that one's stance toward life itself will affect the way life is experienced. Life does not need to be perfect to be loved, but it has to be loved to be perfect.

It is useful for the therapist to be aware of the level that he or she and the patient are working on. It is important, for example, not to be drawn into a philosophical discussion when the task at hand is to identify specific thoughts and behaviors that are influencing the patient's mood. It may be wise to suggest to such a patient that philosophical discussions about such things as the meaning of life are most useful when one is not clinically depressed. Similarly, when the task is to discuss the patient's existential stance toward life or toward others, the therapist must not dodge the challenge.

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It is noteworthy that this framework of levels of intervention is circular in nature: Once one reaches the level of choosing an existential stance toward life, one is inexorably drawn to the first level. An individual with an existential stance which seeks to create a healthy reality for him or herself and those around one needs to implement such a stance by engaging in specific thoughts and behaviors which will support and help create a healthy reality. Thus, the cognitive and behavioral building blocks are always being used. The shape of that being built is defined by the self-instructional methods, the logical questioning of assumptions and interpretations, but ultimately by the stance toward life the person chooses.

Potential pitfalls

One of the dangers of teaching individuals that they have some influence over their mood state is that they can then “logically” assume that they are to blame for being depressed. It is important to inoculate patients with depression against this particular thought. One can point out early in the therapy that having influence on one’s mood level does not mean that one has complete control over one’s emotions. (This is a type of all-or-none thinking, which is covered during the Thoughts module.) One can also assign patients the task of noticing if this thought enters their mind. Objectifying the thought can often reduce its power.

Another potentially dangerous “logical” conclusion of CBT methods is that they could lead to a perfectionistic stance by the patients, in that they want to always make the right choice regarding how they think and behave. Could one always pick the healthy option? A potential way of dealing with this pitfall is to point out that the ideal is something that is worth pursuing, as long as one realizes that it provides a direction, rather than a goal. Perfection is unattainable, but it can be a useful guiding star. The ancient mariners never expected to reach the guiding star. Yet these stars were useful in reaching their destination.

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Finally, it is important not to convey the impression that all cases of major depression can improve with cognitive-behavioral therapy. There is no current treatment that is 100% effective for all depressions. Interpersonal psychotherapy and pharmacotherapy have been found to have comparable effectiveness for outpatient levels of major depression, and should also be considered as alternative treatments. It is quite reasonable to combine CBT and pharmacotherapy. This should be seriously considered if a patient does not respond to CBT within 6 to 8 weeks.

The reality management approach can serve as a useful way of thinking about one's life. It helps to organize the cognitive-behavioral methods into a cohesive framework. It can even serve to help shape the therapeutic session: The ideal is to have the session serve to teach the patients new ways to see their lives in their own minds, and to shape their day-top-day existence (their external reality) so as to support their new internal reality. Both realities influence each other. It is by working on both simultaneously that the individual can successfully engage in the healthy management of reality.

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OVERVIEW OF INSTRUCTORS' GUIDELINES:

COGNITIVE BEHAVIORAL THERAPY FOR MAJOR DEPRESSION

The purpose of this section is to provide you with an overview of the instructors' guidelines. This section is based on our theoretical assumptions and our clinical experiences in treating major depression using this group approach and manual. In the first section, we review the basics of the cognitive-behavioral group therapy format, including the purpose of group, qualifications of the group leaders, and selection criteria of group members. In the second section, we present specific skills and strategies for teaching group concepts. In the third section, we address ways to increase group process. The fourth section contains components that are common to all modules and includes a discussion of how to bring new members into the group and how to address termination issues. A reference list follows this section and includes recommended readings for additional information related to CBT and group therapy processes.

Caveat: This is a guide that is based on our experience in conducting this group with public sector primary care patients. It is important that group leaders adapt the presentation of the materials to match the characteristics of their own groups.

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I. BASICS OF GROUP THERAPY

Psychoeducation vs. Psychotherapy

The group has two purposes: (a) psychoeducation, in which members can learn about major depression and ways to decrease the likelihood of becoming depressed in the future, and (b) psychotherapy, in which members who are currently depressed can gain understanding about factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disabling disorder. Individuals can use the group as either the sole form of treatment, or as an adjunct (e.g., one can be receiving individual psychotherapy and/or pharmacotherapy and also attend group).

Usually groups consist of two group leaders and 6-10 group members.

Group leaders: Qualifications

Group leaders must have a good understanding and training in the assessment and treatment of mental disorders, specifically mood disorders. Previous coursework and training in psychology, psychiatry, psychiatric social work, nursing, or counseling is essential. In addition, it is advisable that group leaders have training in the general principles of cognitive-behavioral therapy.

Group leaders who are leading a psychoeducation group using the Depression Prevention Course may have fewer qualifications than those leading a psychotherapy group with the present manual. For example, group leaders in the psychoeducation mode may be conducted by peers, provided that they have had previous training in leading groups and/or appropriate clinical supervision. For a psychoeducation group, group leaders should have access to a clinical back-up and supervision and/or consultation from licensed mental health professionals, if necessary. This access is important in cases in which group members may become clinically depressed and suicidal during the course of the psychoeducation group.

Group leaders using this manual in the psychotherapy mode should have advanced training (at least at the masters' level) in assessment and psychotherapy. The leaders must be supervised by a licensed mental health professional, in order to process and address clinical issues that arise during the course of treatment.

Group members: Initial considerations

In determining who may be appropriate for a group, it is important to consider the overall characteristics of the group. Some demographic variables to consider include gender, ethnicity, age, education, socioeconomic status, and reading level. It is important to recognize how these variables may be related to attendance, motivation level, and ability to understand the purpose of the group and follow the group structure and content. In addition, it is important to recognize the socio-environmental limitations (e.g., transportation, childcare) that are associated with the realities of the group members' lives.

Exclusion and inclusion criteria

It is important to set a-priori exclusion and inclusion criteria for group members. This decision may be based in part on the membership of the group (e.g. symptom severity, population being served, such as depressed substance abusers who are abstinent) and/or

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qualifications of group leaders and supervisors to handle the frequency and severity of symptom level.

The exclusion criteria include: (a) individuals who are currently psychotic; (b) individuals who have a treatable primary disorder other than a mood disorder (e.g., PTSD), unless it is felt the individual might benefit from managing their depressive symptomatology prior to focusing on their primary disorder; (c) individuals who are coming to group under the influence of a substance (e.g., alcoholism), as indicated by substance-related behaviors (e.g., slurred speech, inability to concentrate); and (d) individuals whose individual personality characteristics and traits may negatively affect the group (e.g., antisocial, aggressive, monopolizing behaviors). The last two criteria may apply to individuals who are already in group. All patients should be informed that they cannot participate in the group if they are under the influence of drugs or alcohol.

Inclusion criteria include individuals who meet criteria for major depression, other clinical depressive disorders, and those who have significant depressed mood along with another diagnosis.

Comorbidity

Major depression is often comorbid with a variety of psychological (e.g., anxiety disorders, substance abuse) and medical conditions (e.g., chronic pain). This group is appropriate for individuals whose level of depression affect these other conditions. For example, changing one's thoughts may affect not only one's mood but also one's anxiety level. In addition, one of the modules is devoted exclusively to health and the relations between mood and physical health.

Specific comorbid disorders that may not be appropriately treated using this group are, as mentioned above, acute substance abuse and personality disorders characterized by antisocial, aggressive, and monopolizing behaviors.

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II. BASIC SKILLS/STRATEGIES FOR TEACHING CONCEPTS (TBA)

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III. INCREASING GROUP PROCESS (TBA)

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IV. ISSUES AND COMPONENTS COMMON TO ALL MODULES

In this section, we provide a more detailed description of specific issues and components that are common to all modules. The group structure consists of four modules focusing on thoughts, activities, contacts with people, and health. A module consists of 4 sessions emphasizing each specific topic and its connection to mood.

Enrolling new group members- continuous enrollment

At the Depression Clinic at San Francisco General Hospital, new members are invited to the group at the beginning of each module. Continuous enrollment provides several benefits. First, we are able to better serve the clinic by being able to accept referrals on a monthly basis rather than only every four months. Second, group members are able to play different roles in the group (e.g. “veteran” versus new member). New members benefit from having veterans in the group who can share first hand information regarding how the group has helped them. Veterans also benefit in that they often appear to develop greater commitment to the group material and to making changes in their lives when they are sharing information with new members. Third, although the majority of patients graduate from the group after completing all four modules, having a continuous group makes it possible to allow a group member to continue when he/she has had an increase in life stressors or other circumstances that make continued participation clinically warranted. Finally, a continuous group makes it possible for new leaders to rotate into the group without an abrupt transition. One leader can rotate out at the end of a module, another leader can join, and the “veteran” leader who remains in the group can train the new leader. Typically, group leaders stay for at least 4 modules to gain familiarity with all 4 modules. This process is particularly useful in an educational institution, in that trainees can rotate through the group very smoothly.

Pre-orientation contact. We recommend that group leaders call new members prior to their first group meeting for a “pre-orientation” contact. The purpose of this contact is to provide a brief overview of the CBT group, including the purpose of the group, the specifics of the group (time, place, number of sessions), and information regarding group leaders. In addition, during the pre-orientation contact leaders can answer questions that new member may have about the group and increase the likelihood of attendance. We have also found that for group members with a significant trauma history, a pre-orientation meeting allows them to establish a connection with a group leader and feel that their unique situation is understood. By understanding their situation, the group leader can also provide appropriate support for the participants during the group should that need arise.

Case formulation, case conceptualization, and “tailor-making” treatment.

To learn more about case formulations, please see Cognitive therapy in practice: A case formulation approach by Jacqueline B. Persons.

Before and during the time that a member attends group, group leaders should familiarize themselves with the new group member’s case histories (including trauma history) to determine if he/she is appropriate for group and also to begin the case conceptualization that will inform treatment. As part of the formulation and conceptualization for each member, group leaders can focus on the following:

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Medications and health complications. Group leaders should identify whether the member is currently on any medications (if yes, what kind, dosage, compliance) and whether the member has any current, comorbid, general medication conditions and/or psychological conditions (comorbidity) that may impact the course of the group modality.

Individual case formulations within the group context. Group leaders should identify each member's issues/problems as they relate to each module's themes (e.g., way the individual thinks, activities they do, types of contacts they have with others, health problems they may have and how these factors are related to their mood). It may be helpful to have an individual case formulation checklist that leaders review before each session so that they can help group members systematically and explicitly address these themes/issues during the group.

The "Tailor-making" approach. From our perspective, the skills taught in the group apply to all individuals who want to gain greater control over their mood. However, the goal is to identify how to tailor the group to individual needs. Leaders use individual examples and illustrations to make the CBT concepts applicable to individual lives.

Identify members' strengths and resilience factors. It is important to examine the protective or resilience factors that members already have in dealing with their depression, and not just focus on individual weaknesses. It is important to verbalize this for participants during the group and have them recognize and acknowledge their helpful and healthy traits.

Structuring each session

Prioritize your time. Given that each session lasts for 2 hours and there is a substantial amount of material that can be covered, we recommend using a time-management strategy to prioritize the specific sections to be covered. This decision should be guided by the particular needs of the group members, and the applicability of the materials to the realities of the group members. We have provided many helpful elements in each session. All of them do not have to be covered to have a successful session.

Be creative. Group leaders are encouraged to be creative in structuring each session. It is important to cover the most important messages within each session (e.g., identifying individual thoughts that are related to depressed mood), but there is flexibility within the manual to add your own style of group leadership, and your own way of disseminating these messages.

Providing outreach to participants who have missed several sessions.

During the group, it is likely that some group members will miss one or more sessions, without first advising group leaders that they will be absent. Group leaders should determine a-priori how they want to deal with this issue. Here are several options:

A group leader can call the group member. A group leader calls the member and expresses concern regarding the absence and inquires as to whether the member will be able to attend next week. The group leader determines whether it might be helpful to help the group member problem solve to figure out a way that he/she may attend. Also, during this call, group leaders can review briefly the content of the missed session.

Buddy system. At the start of each module, group leaders can ask members to pair with a "buddy." Buddies are responsible for checking in with each other when one of them misses a group meeting. Buddies can also teach each other the material when they miss a session. Group leaders can check in with the buddy and with the individual who has missed the session as needed.

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The group can send a card/letter. For individuals who have missed many sessions in a row, a group leader can circulate a card or a piece of paper during the session and ask members to write a brief note to the member who has missed the session. The purpose of this card is to let the member know that he/she is thought of and is missed by the group. The group leader sends the card at the end of the session.

Lateness to sessions

There may be members who are late to the sessions. Lateness can disturb other group members, as well as group leaders and reduce the benefits of treatment. One way of dealing with lateness is to talk to the individual member after the group. Group leaders can express concern about this problem and help the member identify the obstacles to getting to group on time, and problem-solve together. It is important to check for cognitions related to ambivalence that might interfere with the individual's attending the group on time. In our work with public sector patients, we find that some members encounter a number of real obstacles, such as buses that did not come, jobs that require them to work overtime, needing to watch a sick child. We try to approach the problem with patience and understanding and commend them for making the effort to come to the group.

The first session of the module

As mentioned above, new members are invited to join the group at the first session of each module. A large part of the first session is devoted to orienting group members. The orientation includes introductions, group rules, a discussion about the symptoms of depression, and a discussion regarding the treatment model. The remainder of the session focuses on introducing the primary target for the module (e.g. thoughts) and talking about the *reciprocal* relationship between that factor and mood.

At the beginning of each module go through the material presented in the Introduction section of the manual, which follows this section. Although the material is presented in a given order, it is not necessary to strictly adhere to the order. At times, we have found it helpful to do group introductions after the participants have received information about depressive symptoms. For some groups, we have found that after reviewing group rules, it is most useful to talk about the treatment model and then talk about depression.

Termination issues

In cases in which the group is close-ended (i.e., everyone enters and leaves the group at the same time) termination takes a similar course for all group members. When the group is open-ended (members come and leave the group at different modules/times), termination can be more complicated. However, the issues in dealing with termination are similar. Termination should be discussed throughout the sessions.

Beginning. When participants begin treatment, termination is discussed in terms of the length of the group (e.g., 16 weeks).

Middle. During the middle of the group, termination can be brought up by discussing the time-frame of the group (i.e., this is the half-point) and identifying skills and concepts that members have already learned and skills that they would like to learn. At this point, leaders and group members can evaluate the group and the changes group members have made, including their level of depressive symptoms and their progress towards treatment goals.

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[sample statement]

(Names) *are now 8 weeks into the session and halfway through our group. This is a good time to think about what you have learned in the past 8 weeks. Do you feel that the tools that you've learned have been helpful? In particular, what has been helpful (or not helpful) in improving your mood? What would you like to learn more about in the next 8 sessions? What do you think you still need to learn from this group? How can we (group leaders) and the other members help you with your goals?*

End. As group members begin their last module, termination should be heavily emphasized. Termination takes time to process. In the first session of a module, group leaders should identify who will be leaving at the end of the module. Group leaders should focus some attention on these members during each session within the module. Group leaders should reinforce the skills that they have acquired and comment on the progress that they have made. Group leaders should encourage members who are staying in the group to talk about what they have learned from the graduating members. Please see page xiii for more details on how to conduct the feedback portion of the session at the last session of the module.

Saying goodbye to graduating group members: Key points. It is important that group leaders stress that termination from this group does not mean termination from the skills that they have learned. Mood regulation is a continuing process, as is coping with the usual stresses of life. Make sure that group leaders allot enough time for this section. It is important that participants have a chance to say goodbye to graduating members and that graduating members talk about what they have learned in the group.

(i) Review the CES-D scores of graduating members. It is expected that members' CES-D scores will fluctuate during the group. Typically, if the group has been effective, CES-D scores should decrease from the beginning to the end (although not always in a linear fashion). Group leaders should review these scores and ask the member's permission to graph these scores on the board so that all members can view the improvement. This will hopefully inspire the new members to see that change can be achieved through the group.

(ii) Identify the most helpful aspects of the group. Group leaders can ask graduating members to identify the specific tools and skills that have most helped them to decrease depressed mood. Group leaders can write these on the board, and, in so doing, group leaders can review the key points from each of the four modules (thoughts, people, activities, health). It is also important to focus on strengths the graduating members possess independent of the skills they learned in the group.

(iii) Address relapse prevention. This topic is related to part (ii) above. As group members identify what is helpful for them, the group leaders should remind them to look in their manuals (which they keep) to reinforce CBT strategies that helped them feel less depressed. In addition, they can use their manuals to help them identify symptoms that might suggest relapse. They can request a re-referral to treatment without waiting until the depression becomes disabling. The purpose of the group is not to eliminate all feelings of depression. This would be an unrealistic goal. The purpose is to reduce the frequency, intensity, and duration of these feelings.

(iv) Inspiring hope and the possibility of returning in the future. Just as CBT teaches avoidance of "all-or-nothing" thinking, group leaders should remind graduating members that they have the option of returning in the future if they feel that they need more support to cope with the depression (despite using all of the tools that they learned in group). There is always more that can be learned.

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(v) Future plans, including dispositions and referrals (what's the next step?). Group leaders should have an idea of what the next step/disposition will be for the graduating member. It may be necessary to set up an individual time after a session during the last module to discuss this with the member. Group members can also process their future plans in group. Possible dispositions include: a) using skills on their own; b) medication evaluation or referral; c) a support group within the community; d) another group focusing on a different problem, or e) individual therapy.

For group members who are returning: In addition to being exposed to the termination issues above, group leaders should encourage returning members to think about when their own termination will take place, and to consider some of the goals that they still would like to achieve in the remaining time. In addition, group leaders can review personal projects for next week, and do a preview of the next module and their sessions.

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General contents of a session

- I. Agenda and Announcements
- II. Review
- III. Personal Project Review
- IV. New Material
- V. Take Home Message
- VI. Personal Project
- VII. Feedback and Preview

The general outline for a session is presented above. As mentioned in the termination section, the first session and last session of each module typically also include information regarding welcoming and orienting new group members and saying goodbye to group members who are graduating. Each of the primary areas covered in a session are detailed below.

I. AGENDA AND ANNOUNCEMENTS

At the beginning of each session, group leaders typically present an agenda for that session on the board. As part of this agenda, it is important to include concerns/problems that are specific to the individual members.

The group leaders begin each session with announcements (e.g. phone calls from missing group members, changes in schedule due to holidays). The group leaders also elicit from group members, announcements about having to leave early, anticipated absences, and so on.

[sample statement]

Today we will cover (main topic of module). We'll begin with a review of homework, recap what we did last week, and then move into today's topic. Is there anything else that anyone would like to add to this agenda?

Add agenda items to the board.

There are different options as to how group leaders can address members' agenda items:

- 1) Handle the issue right away.
- 2) Ask members directly when they would like to discuss the issue.
- 3) If the issue is related to material that will be covered in the session, let members know that you will be talking about that issue later and then later make specific reference to the issue the group member brought up.
- 4) Prioritize the issues to be covered in the session. There may be situations in which many members would like to address many issues (some relevant, some not relevant), and not all issues can be covered within one session. In this case, explicitly prioritize and first address the issues that are relevant to that topic/session. Save the remaining issues until the end of session and/or for another session. Make explicit to the members that their concerns are important but may not be addressed until a later time. Ask if the priority list is acceptable.
- 5) Group leaders can meet with individual members after the group session to discuss individual issues that could not wait until the following week's session or issues that are best dealt with individually.

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II. REVIEW

The purpose of the review is to assess what group members retained and to review key concepts for group members who were not present.

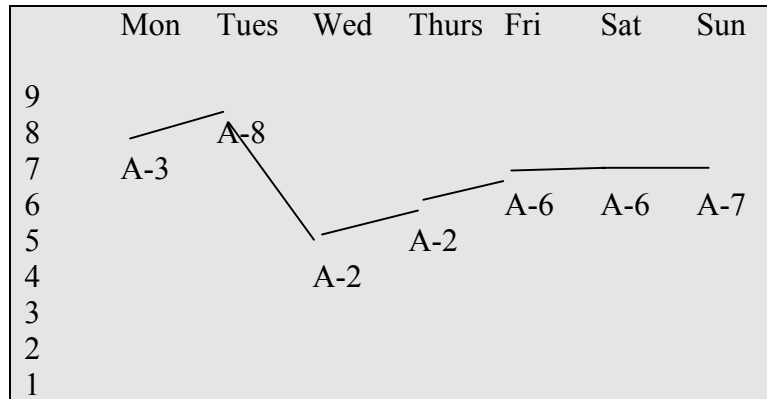
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III. PERSONAL PROJECT REVIEW

The purpose of the personal project review is to reinforce the notion that doing the personal project is helpful. It is important to review the project so that group members will view it as useful and important. Reinforce group members who completed the projects by giving them your attention.

Reviewing the Quick Mood Scale

We typically draw the mood scale on the board (see below)



Note: A=participant's initial; #=number pleasant activities

We then invite group members to share their mood scale. We ask them to tell us their mood on a given day, and we mark it on the board. We continue until we are done with the week. Then we ask them for the factor they were tracking (e.g., how many positive thoughts and negative thoughts they had each day). We write the number on the board attached to their mood on that day. We connect the dots that represent their mood on each day to show how their mood changed (or did not change) over the course of the week. We ask group members to comment on the information that is shown.

Key points to highlight include how we usually see that mood is related to the factor that they are tracking (e.g., on days where they do more pleasant activities they report improved mood). This shows participants that they can have some control over their mood.

Some group members will need more structure as they will tell you about their week in detail. We often give a summary statement and then say "and how would you rate your mood on that day?" as we point to the board. We continue by pointing at the board and saying "and how about on Thursday?"

Depending on the size of the group, you may choose to chart all group members' mood scales or select group members. We typically chart group members using their initials and different colors to distinguish them. Some group members may also feel comfortable coming to the board and charting their own mood scale.

Dealing with noncompliance with personal projects.

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Checking on the status of the projects early in each session is the best way to let members know that the projects are important. However, there may be individuals in the group who do not consistently complete their personal projects. We recommend identifying the problem as early as possible. Here are several options for dealing with this issue:

i. Identify the obstacles to completing the personal project. Is it an issue of time, reading level, forgetfulness, other responsibilities getting in the way? Once the obstacles are identified, group leaders can help the member to overcome the obstacles by modeling problem-solving techniques. Make sure to identify and dispute cognitions that contribute to noncompliance with personal projects, such as “it doesn’t matter what I do, nothing will change” or “I don’t feel like doing my personal project.”

ii. Obtain reinforcement from other group members. Group leaders can ask other group members to help problem-solve this problem with the member. It is likely that other members will volunteer information as to what has helped them to complete their own personal projects.

iii. Complete the project within the session. Group leaders can help the participant to complete or recreate their project (e.g., daily mood scale) during the session. This strategy indicates to members that group leaders take the personal projects seriously.

IV. NEW MATERIAL

New material is intended to be presented in a flexible manner. Although there are specific exercises and text in the manual, we invite group leaders to develop their own ways of teaching the material and use their own words. Nevertheless, it is important that the fundamental content be covered (e.g. the connection between mood and thoughts, identifying harmful thoughts etc.). In many sections, we have provided the leader with a number of options from which to choose. The intent is not to have leaders teach all the options to group members but rather to have the leader select one or more options that he/she feels would be helpful and most pertinent given the characteristics of the group.

Although new material is presented in a given order, which we feel allows for a logical progression, leaders need not adhere to the order. For example, if a group member brings up a topic that is covered later in the session, the group members can immediately cover that material if it seems appropriate. In addition, when appropriate, group leaders can cover material from other sessions in the module and even briefly discuss topics from other modules. We encourage leaders to adhere more to the process of the group than to the exact structure of the manual. See Roman numeral II Basic Skills/Strategies for Teaching Concepts for a discussion on how to teach the topic covered in a given session while being attentive to real problems and issues that group members bring up.

V. TAKE HOME MESSAGE

Go over take home message together as a group. Elicit participants’ reactions to the message.

VI. PERSONAL PROJECT ASSIGNMENT

In previous groups, we called personal projects “homework” and realized that the word “homework” may have negative connotations for individuals who either did not do well in school, are resistant to the idea of doing “homework,” and/or may not have had much (or any) educational background. Thus, we are now using the term “personal projects” to indicate that these are exercises that individuals can do for themselves during the week.

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Each session participants are asked to do a personal project. This is something the participant needs to work on to improve his/her mood. There is a weekly project that everyone is asked to do called the Quick Mood Scale, which involves monitoring their mood each day along with monitoring the target for that module (e.g. the number of pleasant activities they do each day). The purpose of this project is to help people understand that their mood is not fixed. Retrospectively they may report that they always feel bad, but if they monitor their mood each day they may find that some days are better than others. Moreover, by monitoring other factors, such as their thoughts and the things they do, they may come to a better understanding of which factors are related to better or worse mood.

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Participants may also choose to do an Optional Project. These projects are designed to allow participants to further explore the connection between their mood and the factor targeted by the module and to begin to make positive changes in their lives. In this way, participants can begin applying what they learn in the sessions to the rest of their lives. In our experience, participants who complete the personal projects are more likely to report greater improvements in mood.

Introducing the Personal Project

[sample statement]

“Now, I would like to talk about personal projects. Some of you may be thinking: “what is a personal project?” Personal projects are brief activities you can do on your own to learn more about your mood and to begin to improve your mood. The way we see it, you are here only for 2 hours each week. You spend about 166 hours a week outside of here, so it will be important for you to begin making changes in your life outside of the session too. Personal projects can help you make these changes at your own pace.

We will also be teaching you different ways to improve your mood. We will be giving you tools to try out. Not all of them may work well for you. For example, (address one participant) may be really good with a hammer while (address another participant) might be very good with a saw. By trying out the personal projects at home while you are still coming here, you can report back to the group and let us know what worked for you and what didn't work for you.

Each week, you will have one group project that we would like all of you to do, which is to monitor your mood. We will also suggest a number of personal projects that you can choose among. We encourage you to do these projects because they are an important part of the group module. Each week, we really only have about two hours with you to review the main concepts. To learn more about these concepts, you need to practice the skills and tools outside of group. Once the group is over for you, the skills you have learned will help you keep your mood healthy. Therefore, it is important that you try them out until you feel confident that you can use them and that they can help you improve your mood.

Make sure to go over the Quick Mood Scale with new group members. You can do it as a group or have a veteran group member explain the process of monitoring their mood to a new member.

VII. FEEDBACK AND PREVIEW

The purpose of this section is to allow group members to give the leader feedback regarding the group session. The group leader can incorporate the feedback in order to tailor the treatment to the individuals in the group.

The purpose of the preview is to encourage group members to return next week by giving them a glimpse of the topic to be covered. You can also encourage group members to read the sections that were not covered. Group members are also welcome to read ahead.

On the last session of the module, use the feedback to review the material from the past 4 sessions, determine what messages group members have learned from the module, and highlight that it is possible to make positive changes in your life.

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Possible questions to stimulate discussion include:

1. How have you made changes in what you do since beginning the group?
2. What did you learn about relationships that was most helpful, in terms of improving your mood?
3. What did you find least helpful?
4. What message will you take from this module?

It will also be important to discuss with group members who are leaving the group, how their reactions to leaving and what they have learned from the group. Possible questions to ask group members who are leaving include:

1. What did you learn from the group?
1. What are your goals and plans after you leave the group?
2. How will you continue to get support?
3. What do you need to continue your progress in managing your mood?
4. What will happen the next time you feel that you are becoming depressed?

Allow time so that other group members can also provide feedback to those who are leaving regarding how they feel about their leaving and specific things they have learned from them. Make sure you have prepared something specific to say to each participant who is leaving about their unique contribution to the group and the changes you have seen them make.

VIII. GROUP LEADER SELF EVALUATION FORM

At the end of every session there is a "Group Leader Self Evaluation Form." The purpose of this form is to help leaders evaluate the extent to which they covered the material contained in each session (content, satisfaction with teaching) and to what degree participants were engaged in the session (process).

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INTRODUCTION: SESSION 1 OF EACH MODULE

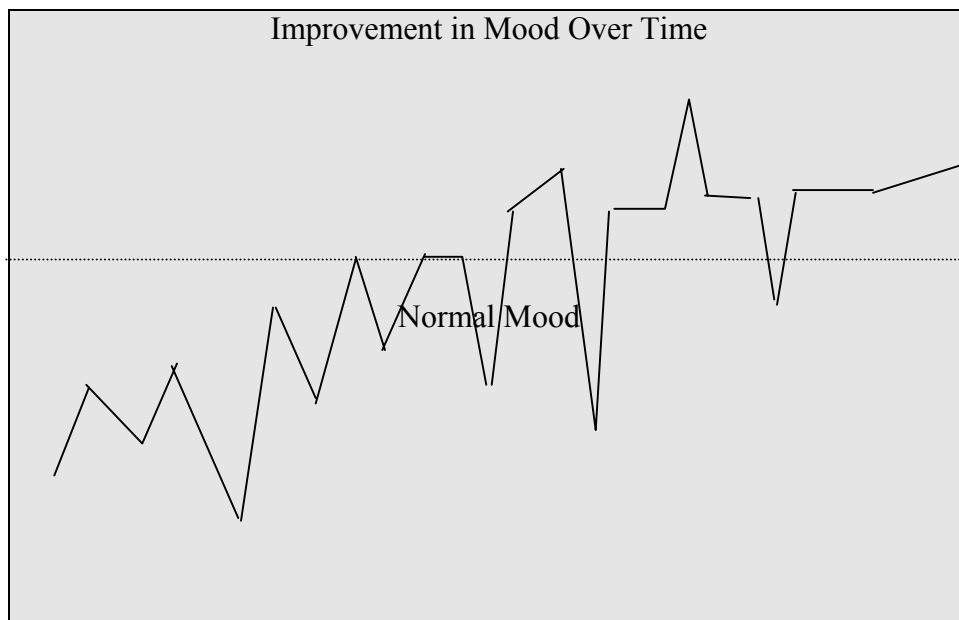
At the beginning of each module, go through the introduction presented below.

I. WELCOME

As group members arrive introduce yourself to new members. Pass out the manuals and orient them to the questionnaires we are using to measure their mood each week.

Use the CES-D (Center for Epidemiological Studies Depression Scale; Radloff, 1977) to track depression symptom levels weekly. You can explain to group members that this scale measures depressive symptoms. A score of 8 is about average. In general, people who score above 16 are viewed as having significant depressive symptoms.

Note: At some point in the group, it is important to point out that mood fluctuates over time. Some group members may report that since beginning group, they feel great. It is important to let them know that it would be normal for them to have a day when they do not feel great. Those are the days when it will be most important to use the skills they have learned in group. Let members know that we all have highs and lows in mood. We often draw the following graph to show how mood might change over time.



Once group members have arrived, welcome them and begin by explaining again that there are veteran members and new members. Congratulate new members and veteran members for being courageous enough to come to the group. Go over group rules before anyone discloses any personal information.

II. AGENDA AND ANNOUNCEMENTS

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Go over the agenda. Put the “session outline” on the board (see first page of each session [e.g. thoughts 1]) and go over the outline. Ask group members whether they have any topics they would like to add to the agenda and add them.

III. GROUP RULES

Review group rules (see page 3 of the participant manuals.) You can do this in either a structured or open-ended fashion. Make sure to cover the exceptions to Confidentiality (item #3) and elicit their reactions to this and other rules. Group rules are shown below.

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1. Try to come every week (call us [give your phone numbers] or the clinic [give clinic phone number]) if you can't make it.
2. Come on time
3. Confidentiality (What is said in the group stays in the group)
EXCEPTIONS: (things leaders cannot keep confidential: Per California Welfare and Institution Codes)
 - 1) If we hear about child abuse or neglect.
 - 2) If we hear an older adult (older than 65) is being abused or neglected (Elder abuse)
 - 3) If we hear someone is danger of hurting themselves or someone else in the future.
4. Listen to and support each other.
5. Be respectful (we respect diversity of religion, race, sexual orientation, age, and values)
6. Share time as evenly as possible
7. Complete your personal project for the week to get the most out of group
8. Tell us if you are unhappy with the group or your treatment
9. You don't have to do anything you don't want to do
10. You don't have to share everything. You have a right to keep some things private.

IV. INTRODUCTIONS

Have each group member introduce him or herself. Group leaders should also introduce themselves. It may be helpful for one leader to begin by introducing themselves, to provide a model for the group introductions. It is usually useful to have participants use the following script, which is also found on page 4 of their manuals.

- 1) your name
- 2) where you grew up
- 3) your family
- 4) what kind of work you have done
- 5) your main interests/hobbies
- 6) something about yourself that you think is special

Issue: Some group members may be tangential and/or they may describe a lot more than the script suggested above. As much as possible group leaders should guide or redirect members to follow the script above. They may either begin by modeling an introduction, or they might make a statement that orients patients to the task. A common issue is that patients will describe themselves in terms of their depression. Warning that this can happen ahead of time is a good practice: *"Many people with depression begin to think of themselves as a depressed person. You are not your depression. At this time we want to know who you are."*

[sample statement]

Now we would like to begin introductions. The purpose of this is for everyone to get to know a little bit about you. We will have plenty of time to get to understand and deal with your problems and depression, but for now, let's start with the following. On page 4 of your books there are several questions that I would like us to start with. I'll begin..."

Proceed with the 6 items above and begin modeling how you would introduce yourself.

If during this exercise, some members begin to provide more information than necessary, gently remind them that they will have time to deal with that during this group, but for now, the focus is

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on introductions. In addition, it may be helpful to ask more closed-ended questions for these individuals, and focus less on the open-ended questions. For example, you might say, “where did you grow up”... .”what kind of work did you do? . . .”

If they begin talking about their depression, stop them, point this out, remind them that they are more than their depression and that we want to know who they are and what they are like when they are not depressed.

V. REVIEW THE SYMPTOMS OF DEPRESSION

Option 1: The “San Francisco General Hospital Depression Clinic Mood Check-Up,” which is shown on page 5 of the participant manuals.

We recommend using this option as it allows you to gather information at the beginning of each module regarding whether participants still meet criteria for a Major Depressive episode. In addition, you can monitor their experience of the 9 Major Depressive episode symptoms.

You can write the items on the board and go through each symptom with the participants. As you elicit information from the group members, one group leader should chart each participants symptoms. This information, can later be included in the participant’s chart.

For returning members, this may be a good time to review their Quick Mood Scale from the past week. This will enable new members to preview what they will do in upcoming sessions.

Option 2: Open ended discussion.

Ask participants about some of the problems or symptoms they have been experiencing. Write down the problems on the board.

As participants mention a particular symptom, it is often useful to ask whether other group members are experiencing similar problems and then highlight similarities and differences among group members.

Group leaders should keep track of information that group members provide regarding what they perceive to be the causes of their depression (e.g., unemployment, medical problems, relationship problems). Group leaders can use this information to begin developing an individual case formulation.

Then review the “Depression Information” sheet on page 6 of their books. This sheet is shown on the next page. Key points to highlight include:

1. Depression is a clinical condition
2. Depression is common. You are not alone in experiencing this disorder.
3. Depression is defined by the experience of 5 or more symptoms occurring for a period of at least two weeks

Option 3: Go through the depression information sheet asking participants to share whether they feel each point applies to them.

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Depression can be:

- a) a feeling that lasts a few minutes.
- b) a mood that lasts a few hours.
- c) a clinical condition that lasts two weeks or longer.

This group is meant to treat **major depression**, which is a clinical condition. The symptoms of a clinical depression are described below. The group has also been shown to be effective for treating dysthymia and minor depression.

MAJOR DEPRESSION

Description

- Mood disorder that makes it hard for us to carry out our daily duties
- Lasts more than two weeks
- Can happen at any point in your life
- 5 or more of the symptoms listed below most of the day, almost every day

The 9 Symptoms of a Major Depressive Episode

- **feel depressed or down nearly every day**
- **loss of interest or pleasure in activities**
- significant change in appetite (increase or decrease)
- change in sleep (sleeping too much or too little)
- change in the way you move (restless or slowed down)
- really tired, fatigued
- feelings of worthlessness or excessive guilt
- inability to concentrate or inability to make decisions
- repeated thoughts of death or suicide

How Common is it?

- Nearly everyone in their lifetime feels sad.
- Most adults have had depressed moods and/or know what they are.
- 10-25% of women will have at least 1 serious episode of major depression.
- 5-12% of men will have at least 1 serious episode of major depression.

What Are Possible Triggers?

- Economic/money problems
- Loss of loved ones
- Biological/chemical imbalance
- Loss of health/medical conditions
- Use of drugs or alcohol
- Traumatic and/or stressful events
- Relationship issues
- Big life changes

What to Do

- Get help and support from family members, friends, & others.
- Discuss how you feel with your doctor, nurse, therapist, or counselor.
- Sometimes antidepressant medication can be helpful.
- Use the material taught during this group.

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- **Please let group leaders know if you have repeated thoughts of death or suicide so we can help.**

Since depression is often comorbid with other psychiatric disorders, we encourage familiarity with DSM-IV diagnostic criteria (e.g. Anxiety Disorders, Somatoform Disorders).

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VI. REVIEW THE COGNITIVE BEHAVIORAL TREATMENT MODEL FOR DEPRESSION

Option 1: A leader presents the model

Option 2: Ask a veteran member who is now on their third or fourth module to present the model or co-present it with another veteran or a leader. Suggest to those who are in their second module that next time they may be presenting this material.

SAMPLE PRESENTATION (a sample board is shown below; participant versions begin on page 7 in the participant manuals)

On the blackboard draw a spiral.

We often think of depression as a downward spiral. Usually, people enter the spiral because something upsetting has happened to them.

Give examples, writing them on the board at the top of the spiral. Use examples that are pertinent to group members (e.g. health problems, financial problems, death of family members, loss of job, relationship problems, biological changes in energy level or ability to sleep).

These problems are real and almost anyone would feel a certain amount of sadness or anger or frustration because of them. We call this part "necessary suffering." (It is suffering we have to endure). But we can also see that at different times in our lives, we may manage the situation and our reaction differently. Sometimes, we can even add to the problems and to the downward spiral. We call this part "unnecessary suffering." (It is suffering that can be prevented.) We believe that there are different factors that we can change that may add to our unnecessary suffering.

For this part elicit answers from group members whenever possible. Use specific examples whenever possible.

The first of these factors is our thoughts. When we are down, we tend to engage in more unhelpful and negative ways of thinking.

Elicit specific examples from the group regarding the types of thoughts they may have when depressed and write them down on the board in a column entitled thoughts next to the downward spiral. (e.g. may tend to worry more, be unable to focus on non-negative things, engage in unhelpful thought patterns).

These types of thoughts spiral us down further.
Draw a downward arrow.

The second factor is our behavior. When we are down, we often have less interest in doing things and as a result we often behave differently than we usually do.

Elicit examples of behaviors from the group and write them in a column entitled behavior, next to the thoughts column. Then draw a downward arrow. If you want, you can discuss how doing fewer positive behaviors can bring you down (e.g. limit your world view, no new pleasant memories to displace unpleasant ones, increase the chance that you will spend your time worrying, have more negative thoughts about yourself).

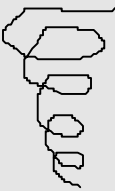
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When we are depressed, we often reduce our contact with other people. This is the third factor that can add unnecessary suffering.

Start a third column called “people” and elicit from the group the types of changes they have seen in this area. Examples typically include: increased irritability and conflicts with others, less desire for contact with others.

Finally, when we are depressed, as we have talked about, we are often tired and lacking in energy, and our physiology, that is, the way we feel physically, can really contribute to our overall mood. Start a 4th column for “your body” and write down examples from the group, again showing how they contribute to the depressive spiral.

Pause and make sure that group members understand the spiral. Elicit their reactions. Then continue.

Sample Treatment Model Diagram				
	Thoughts	Behavior	People	Your body
	why bother no one cares I can't do anything	stay inside eat not do anything	argue avoid	tired low energy

As you can see, we enter the depressive spiral here (point to the top of the spiral), but our reactions, meaning our thoughts, our behaviors, our lack of positive interactions with others, and the things that we do that affect our physical well-being can cause our mood to spiral down to here.

In this group, we use a kind of therapy called Cognitive Behavioral Therapy to help prevent this spiral. (Write the words on the board). Cognitive refers to our thoughts and behavioral refers to what we do. A number of studies have shown that this type of therapy is very effective in treating depression. What this program teaches us is that while there is a certain amount of suffering that we can't avoid (refer to the top of the spiral), we can learn to manage our thoughts, our behaviors, our contacts with others, and even the way we feel physically in order to keep ourselves from spiraling down.

The program has four modules. We have a thoughts module that focuses on the connection between our thoughts and our mood. We have an activities module that focuses on the connection between what we do and our mood. We have a people module where we talk about how contacts and support from others can be helpful and how we can improve old relationships or seek out new positive contacts with others as a way to improve our mood. We have a health module that covers basic health concerns such as sleep, nutrition, medications, and pain. The health module also talks about the connection between health and mood.

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At this point let participants know which module you will be focusing on for the next few weeks. Briefly describe some of the things they will be learning in that module.

This program teaches you skills. It gives you strategies and tools to decrease your depression. As a group, we will be talking about and learning how to use each tool. We will ask you to try to use them both in the group and at home, and we want you to tell us what works for you. As you try them out, you may find out that some tools work really well for you while others do not. For example, (use group member's name) may really like using a hammer while (other group member's name) may really like using a drill. The point of this program is to give you lots of tools so that you can have more choices. Each week we will ask you to do a personal project so that you can determine which tools work best for you.

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This treatment will be most helpful to you if, at the end, you have learned many ways of regulating your mood, and you feel confident using them in your daily life. To have this happen, you will need to practice using these skills each week. This is the purpose of the personal project. If you don't practice the skills, you won't learn them.

The goal of the group is not to eliminate all feelings of sadness or depression from your life. That would be unrealistic. The goal is to give you the tools to reduce how often you become depressed, how intense or painful the feeling gets, and how long it lasts. More broadly, the goal is to help you learn ways to shape your personal reality so your life is healthier and you have fewer reasons to become depressed. If you take these skills with you at the end of the group, your treatment will have been successful.

At this point pause and invite veteran members to comment on the treatment model and the utility of the different "tools." Invite questions from the group and answer them.