Group Workbook for Treatment of Persistent Depression

Cognitive Behavioral Analysis System of Psychotherapy (CBASP) Patient's Guide

LILIANE SAYEGH AND J. KIM PENBERTHY

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ROUTLEDGE

GROUP WORKBOOK FOR TREATMENT OF PERSISTENT DEPRESSION

The *Group Workbook for Treatment of Persistent Depression* is a guide for patients suffering from persistent depression who participate in group therapy. The workbook provides handouts and skills training that require the help of a trained professional to teach and animate in a group format. Patients will be able to maximize their acquisition of interpersonal problem-solving skills by using this book in conjunction with Group-CBASP sessions.

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GROUP WORKBOOK FOR TREATMENT OF PERSISTENT DEPRESSION

COGNITIVE BEHAVIORAL ANALYSIS SYSTEM OF PSYCHOTHERAPY (CBASP)

PATIENT'S GUIDE

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FOREWORD

The unparalleled problems associated with Persistent Depressed Patients (PDD) are some of the most difficult that practitioners face. Drs. Liliane Sayegh of McGill University and J. Kim Penberthy of the University of Virginia School of Medicine have undertaken the daunting task of treating the PDD patient with a group approach and describe their method of treatment in two Manuals, one written for patients and the second for practitioners. The patient manual, *Group Workbook for Treatment of Persistent Depression*, is published by Routledge Press. Their novel and creative approach to administering the CBASP methodology has come to be known as "Group-CBASP." CBASP, the only psychotherapy model to date designed specifically to treat the PDD patient (McCullough, 1984, 2000, 2006; McCullough, Schramm, & Penberthy, 2015), is an empirically validated treatment for PDD.

Using groups to treat chronic patients appears feasible, efficient, and the time limitation of the Group-CBASP methodology looks to this writer to be cost effective. Given the fact that there are approximately 14 million PDD patients in the United States alone as well as a small number of professionals who are qualified to treat them, Group-CBASP is a well-timed addition to our treatment package.

At the beginning of the *Group Workbook for Treatment of Persistent Depression*, the authors provide a thorough rationale for participation for the patients who will then be administered Group-CBASP. Wisely, Sayegh and Penberthy continue their introductory-explanatory trajectory during Session 1 when PDD is defined, depression course profiles are introduced, and several other mood-tracking devices are described (e.g. Mood Chart, Medication Monitoring, and an Activity Log, etc.). The workshop course is administered in 20 sessions and the subject content throughout is jam-packed with explanatory examples, many patient exercises during each session, and homework assignments following each session.

Sessions are highly interactive, motivationally intense, and energetically conducted. Noteworthy, a strong emphasis on interpersonal encounter characterize the sessions and are consistent with the basic interpersonal-theoretical foundations of the CBASP model. This means that participants learn to become aware of their "stimulus-value" for others through their group participation and

also learn to use their stimulus value to achieve personal goals. Interpersonal encounters are also emphasized throughout the sessions to, hopefully, impart a sense of group interpersonal safety which is always a basic requisite for learning novel content.

The sessions are implemented in a step-wise fashion that facilitates the learning of the basic components of the CBASP model. For example, Session 2 teaches patients about the cycle of depression as well as informs them about the difficulties of anxiety that often accompany PDD. Situational Analysis (SA), the major technique of the CBASP model, is introduced, with participants shown how to focus on a specific situational event which they will learn how to describe in the requisite steps. Sessions 3 and 4 continue to expose the group to the second phase of SA to help them "fix" badly managed situations with effective coping alternatives. These learning endeavors enable patients to achieve their Desired Outcomes or said another way, to get what they want in interpersonal encounters. Practicing SA constitutes the work-themes of Sessions 5–8.

Sessions 9–14 then move to an in-depth exposure of interpersonal theory and practice. Patients learn further how to utilize their interpersonal stimulus value to obtain their Desired Outcomes as well as acquire experience "reading" and "utilizing" the stimulus value of others with whom they interact. The authors, Sayegh and Penberthy, have learned that it is difficult to remain depressed when one learns to live successfully. Thus, extensive teaching about how to achieve one's Desired Outcomes in interpersonal encounters is explored extensively during these six sessions.

Sessions 15–20 begin a phase of "wrap-up" and summarizing to facilitate understanding and utilization of the extensive knowledge landscape that the previous sessions have covered. The final sessions provide a time when patients can review what they've learned and evaluate how they are using the new learning to combat PDD.

I heartily endorse this step-wise group approach to treating PDD. The *Group Workbook for Treatment of Persistent Depression* is novel, clearly delineated in a clear and concise format, and the approach is highly creative.

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PREFACE

Depression is a debilitating illness and has the power to unravel and to undermine an individual's ambitions, life, health, and goals. The long-term consequences of misdiagnosed or untreated depression are known to be potentially lethal and devastating leading to under-functioning or nonfunctioning individuals, impoverished social and professional interactions, and may lead to broken homes and relationships. Depression is indeed a challenge to the sufferer who struggles to acknowledge, accept, and battle with his or her mood disorder. Depression is also a challenge to mental health professionals, family physicians and care providers, family members, and close friends of the sufferer, some of whom may feel shut-out, powerless, and inadequate when they intervene to try and help or offer support.

We undertook the writing of this manual to document what we have found to be a very empowering and effective therapeutic approach to help individuals struggling with depression. Cognitive Behavioral Analysis System of Psychotherapy (CBASP) is an engaging interpersonal problem-solving therapy that, when set in the context of a group approach, overpowers and disarms the grip of depression by breaking the silence and the isolation that each sufferer feels trapped within. We have witnessed how participants in the group are transformed by the experience of Group-CBASP when we learn together to solve "one problem at a time" as recommended by Dr. James McCullough, Jr. the developer of CBASP. Dynamic involvement among group members is contagious as all participants, including therapists, are pulled into the collaborative effort toward change and share the rewards achieved. Learning goes around the table and is reciprocal; I learn from you, you learn from other group members, and group members learn from me. CBASP has given us the theoretical and clinical framework within which to work and it is up to each one of us within the group, whether therapist or group member, to engage each other in a way that is respectful and meaningful and that models commitment and involvement throughout group therapy. We are both indebted to Jim McCullough Jr. who devoted his life's work to the development of CBASP and to the relief of suffering associated with Persistent Depressive Disorder. He is a true pioneer in the effective treatment of this chronic and debilitating disorder and we have him to thank for the current adaptation to group format.

Liliane Sayegh, Montreal, Quebec, Canada
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ACKNOWLEDGMENTS

We are very grateful for the collaboration and continued guidance of Dr. James P. McCullough, Jr., Professor of Psychology and Psychiatry at Virginia Commonwealth University in Richmond, Virginia. Jim developed CBASP to help chronically depressed patients whom he saw were not responding to other empirically based psychotherapies. Jim continues to research, teach, and implement CBASP and was crucial in our development of a group application of this powerful and life-changing psychotherapy.

We are also grateful for the collaboration of Dr. Kenneth D. Locke, Professor at the Department of Psychology and Communication Studies, University of Idaho, for his continual assistance in helping us translate the circumplex model into a useful clinical tool, for his participation in the research aspect of the project and draft reviews. Most of all, we need to acknowledge him for the circumplex scales he developed that have permitted the link to be made between the importance of one's values and perceived efficacy regarding particular interpersonal situations and achieving a Desired Outcome in that specific interpersonal situation as demonstrated by the CBASP model. Our research has indeed confirmed Professor Locke's findings that people are likely to engage in more activities if they feel more confident in their ability to do so, which they have an opportunity to develop in Group-CBASP.

Many thanks are also extended to John Swan, our colleague at the International CBASP Society (Scottish Division) and friend whose sharp clinical eyes have perused the pages of this manual. Thanks also to Anna-Majia Kokko, psychologist and CBASP trainer in Finland, who invited us to teach Group-CBASP in Finland and inspired us to formalize the manuals, thus helping to spark this project. We are also grateful for the help received from Sybille Saury in the painstaking work of editing. Special thanks go to our wonderful illustrator, Morgan Yi, whose lovely images add so much to our workbooks.

It is important to recognize the contribution of many graduate psychology students who have contributed over the past eight years to the development of the group manual with their feedback, ideas, and conceptualizations while some were co-therapists learning Group-CBASP and some contributed to the research aspects of Group-CBASP: Thank you to Elena Saimon's impeccable research assistance and to Hélène Thériault, Psy.D.; Ariane Lazaridès, Ph.D.; Leechen

Farkas-Zukor, Ph.D.; Joëlle Jobin, Ph.D. candidate; Charlotte Weber, Ph.D. and Olivia Beaulieu-Denault, Ph.D. candidate. Thank you to the exceptional psychology post-doctoral fellows who have collaborated on research and have worked hard to learn the art and science of CBASP: Christopher Gioia, Ph.D.; Andrea Konig, Ph.D.; Michelle Vaughan, Ph.D.; Jennifer Wartella, Ph.D.; and J. Nile Wagley. Thank you also to additional collaborators on research including the excellent statistical work of Joshua Hook, Ph.D. and research support from Sarah Meshberg-Cohen, Ph.D.; Aaron Martin, Ph.D.; and Stephanie Cockrell, MSW.

I (Sayegh) extend my special thanks to my family (my husband Jim and children Elisabeth and Paul) for their support and for believing in the value of this project both clinically and personally for me.

I (Penberthy) extend sincere thanks to my husband, David, and daughter, J. Morgan, for their cheerful and unwavering support throughout this process. I could not have completed this important project without them!

Most of all, we thank our patients, without whom none of this would be possible. Ultimately, this work is dedicated to all of those who suffer from persistent and chronic depression; we hope that our contribution will help alleviate suffering and promote healing.

Liliane Sayegh, Montreal, Quebec, Canada
J Kim Penberthy, Charlottesville, VA, USA

INTRODUCTION

Congratulations! You have taken the first step to overcoming your depression.

If you are reading this workbook, our hope is that you are part of a therapeutic group in which you will be using Group-Cognitive Behavioral Analysis System of Psychotherapy (Group-CBASP) to treat your persistent depression. If you have purchased this book on your own, please keep in mind that it is part of a therapeutic approach to treating depression and is meant to be used in conjunction with the therapist manual for Group-CBASP in a group setting with a trained clinician.

If you are in a therapeutic group setting and involved in using Group-CBASP to treat your persistent depression, please know that you are not alone. You may be feeling hopeless and tired of struggling with your life and that is precisely why your therapist has recommended this group. Other people may feel similarly to the way you feel. It may be reassuring to know that you are not alone with respect to how you are feeling. We invite you to remain open to the possibility that participating in this group may help you to improve your mood and functioning.

Persistent depression is a complex disorder that can have varying causes, manifestations, consequences, and outcomes. Persistent depression presents a very different profile from an acute, single-episode depression. Treatments for persistent depression are more aggressive, pervasive, and long-term than what may be provided for mild to moderate depression.

CBASP is the only psychotherapy treatment developed to treat persistent depression with its focus on the interpersonal impact of this illness on the overall functioning of the individual. CBASP is most successful when combined with medications that are prescribed and monitored by your doctor.

CBASP is best learned and practiced within an interpersonal context. You will learn adaptive interpersonal problem-solving skills within adaptive relationship experiences in the group. This will help you feel empowered to then respond to people in your environment who are important to you and to break away from isolation and entrapment brought upon by persistent depression.

CBASP is a highly structured, skills-oriented, interpersonal approach that will teach you concrete skills to help you overcome interpersonal problems, improve your functioning and mood, and help you reach tangible and attainable life goals.

CBASP RESEARCH EVIDENCE

There is a growing body of evidence from across the globe examining the effectiveness of CBASP for treating persistently depressed patients. In a multicenter randomized controlled trial in the US, Keller and his colleagues (2000) compared the acute (12-week) efficacy of an antidepressant medication (nefazodone) to CBASP when administered alone and in combination with CBASP. A total of 681 patients meeting criteria for the different subtypes of chronic depression and with a baseline HRSD-24 score of at least 20, were treated with nefazodone alone (titrated to a dose of 600 mg, $n=220$); CBASP alone (16–20 sessions, $n=216$); or a combination of both ($n=226$). Post-therapy remission and rates of improvement (based on HDRS-24 scores) were: nefazodone (48 percent); CBASP (48 percent); combination (73 percent) (Keller et al., 2000). This study stands out as the largest, most influential study of the effects of psychotherapy versus pharmacotherapy for persistent depression, according to two meta-analyses (Cuijpers et al., 2010; von Wolff, Hölzel, Westphal, Härter, & Kriston, 2012). The effects of combined CBASP and pharmacotherapy were demonstrated to be greater than those of combined Interpersonal Psychotherapy (IPT) and pharmacotherapy (Kriston, von Wolff, Westphal, Hölzel, & Härter, 2014; von Wolff et al., 2012). CBASP has also been identified as a possible monotherapy for the treatment of acute persistent depression, with comparable efficacy to medication (Kriston et al., 2014). A secondary analysis of the Keller et al. (2000) data suggests that psychotherapy in the form of CBASP provides additional benefit for those with a history of early adverse life events or childhood trauma (Nemeroff et al., 2003).

In a small randomized controlled trial ($n=30$), in a German sample, a course of CBASP (mean number sessions = 21.2) was shown to have roughly equivalent efficacy to a similar course of IPT (based on clinician-rated depressive symptoms). However, remission rates (mean HRSD-24) were higher for CBASP (57 percent) compared to IPT (20 percent). Eligible patients were required to have a diagnosis of early-onset depression with a baseline HRSD of ≥16 (mean 23.2) and were required to be drug free prior to and for the duration of the study. Seventy-two percent of patients ($n=21$) had previously experienced psychotherapy with only 21 percent ($n=6$) having had no prior treatment of any kind (Schramm et al., 2011). Schramm et al. nevertheless confirmed additional findings (Kriston et al., 2014) supporting the greater effectiveness of CBASP compared to IPT for early-onset persistent depression.

Swan et al. (2014) offered an open trial of CBASP to a cohort of 115 referred patients within primary and secondary care. Diagnostic interview and standardized outcome measures were administered before and after six months of CBASP with a trained, accredited therapist. Seventy-four patients entered therapy, with 46 patients completing. Thirty percent met criteria for remission (≤ 8 HRSD-24 score) and a further 30 percent met criteria for clinically significant change (> 8 and ≤15 HRSD-24 plus 50 percent reduction in baseline score). Thirty-nine percent made "no change." Group measures of quality of life, social functioning, and interpersonal functioning also improved for these patients. Swan and colleagues determined that CBASP is an acceptable therapy for a large proportion of patients with chronic depression and that it was associated with clinically significant change in 60 percent of completers.

Although evidence for the treatment effectiveness of group psychotherapy for persistent depression is still limited, there is indication that interpersonal group therapy (Schramm et al., 2008), cognitive-behavioral group therapy (Bockting et al., 2005; Bristow & Bright, 1995; Matsunaga et al., 2010; Oei & Dingle, 2008; Saulsman, Coall, & Nathan, 2006; Swan et al., 2004; Teismann et al., 2013), dialectic behavior group therapy (Harley et al., 2008), and behavioral activation provided in a group setting (Dimidjian et al., 2006) are effective in

significantly reducing depressive symptoms during the acute phase of the illness. Group therapy is also found to be equivalent to individual therapy in reducing depressive symptoms (Cuijpers, Van Straten, & Warmerdam, 2008; Oei & Dingle, 2008).

Furthermore, there is evidence that interpersonally oriented psychotherapies are more effective for treating depression (Cuijpers, Van Straten, Andersson, & Van Oppen, 2008) compared to other therapeutic modalities.

GROUP-CBASP RESEARCH EVIDENCE

Brakemeier et al. (2011) conducted a pilot study utilizing Group-CBASP in an inpatient setting. She examined ten patients who were provided CBASP in a group setting along with pharmacotherapy and reported 100 percent completion rates of the 24 sessions over three months. Patients endorsed high satisfaction with the treatment modality. Brakemeier et al. (2011) report significant improvements and large effect sizes in both the Hamilton Depression Rating Scale and the Beck Depression Inventory.

In a pilot study, Sayegh et al. (2012) conducted a single arm study examining the impact of 12 sessions of Group-CBASP in 44 outpatients diagnosed with persistent depression, all of whom were also receiving pharmacotherapy managed by their psychiatrist. The findings demonstrated significant decreases in self-reported symptoms of depression and in the use of emotion-oriented coping as well as increases in overall social adjustment and interpersonal efficacy when compared to their pretreatment levels. Moreover, the effects on overall depression and social adjustment were quite strong. Sayegh et al. conducted a randomized controlled study examining the impact of Group-CBASP versus behavioral activation; however, results are not yet published.

Group-CBASP appears to be a promising and efficient option for treating persistently depressed patients. With this Group-CBASP workbook, we hope to standardize the application of this therapy for a group modality and promote a feeling of empowerment about recovery.

WHY GROUP THERAPY?

The success of CBASP will depend upon you learning about the consequences of your interactions both on yourself and on others. The group is a social system that provides the setting in which learning can take place. The group becomes our learning environment in which we will all work together toward interpersonal cohesion and improved interpersonal outcomes that are reasonable and attainable.

The group provides an opportunity for each member to develop a sense of belonging, acceptance, commitment, and allegiance to the group. Feelings of attachment, support, and attraction or "pulls" toward the group's efforts to resolve difficult issues are also operating in the group's process. Finally, group members work together or separately through behavioral interpersonal exchanges that can be engaging or distancing.

Group-CBASP provides an opportunity to learn with and from others, to maximize rewards, and increase pleasures that have been missing due to persistent depression. It is also an opportunity to unlearn maladaptive coping strategies, such as avoidance behaviors and isolation, and increased levels of frustration-tolerance and acceptance.

GROUP-CBASP GOALS

The goals of Group-CBASP are related to overcoming problematic interpersonal issues affiliated with early learning. The Group-CBASP program involves an initial exercise done with the therapist individually prior to beginning the group. This exercise helps you and your therapist identify a social domain or emotional content area that may be difficult for you to deal with when you interact with others. This domain will become the focus of your work in Group-CBASP, to better understand how it functions to protect you or to impede your ability to move forward and reach your life goals. These social domains will be explained and discussed during the group's work.

The social domain that is particularly difficult for you is constructed in an "if, then" phrase based upon your early learning with significant others in your life, and is structured to relate to the current group:

> "If I let/tell group members . . . *(get close, or tell them what I think, or make a mistake, or get angry)* . . . , then they will . . ."

The first part of the sentence suggests what you would do, your behaviors, and the second part is the anticipated consequence on or from the other person(s), for example, other group members. The intense emotion associated with the outcome may strongly motivate you to avoid, dismiss, numb, react angrily, submit, please, or do other maladaptive things to alleviate tension or anxiety. We often see that these maladaptive coping strategies become rigid, unconscious, and can become ill-willed, that is, go against your personal values without you realizing this.

Our goal in Group-CBASP is to work together to learn as much as possible about your typical interpersonal coping style and about whether you are succeeding at getting what you want in your interactions with others. We will learn about the behaviors you put in place when you interact with others that may not have the impact or the effect that you had wanted or anticipated. Frustration or disappointment may result from feeling misunderstood by others while thinking that "nothing will ever change" and consequently feeling trapped within the grip of depression. We will work together to help you regain control over your life and move on to other things you want to do in life, such as feel happier, love, and be yourself.

Your Role in the Group

There are responsibilities that each group member accepts to assume throughout group therapy including:

1. **Sustaining your motivation** toward change by participating fully.
2. **Self-reflection** regarding experiences within or outside the group.
3. **Completing homework assignments** to improve learning.
4. **Increasing activity levels** using graded tasks explained in sessions.
5. **Accepting to work in an interpersonal context where feedback and emotions are shared.**

The Therapist's Role in the Group

The group therapist is committed to the following responsibilities:

1. Facilitating group members' emotional expression, the responsiveness of others to that expression, and the meaning such expression has for group members.
2. Attending to the stages of the group's development.
3. Adopting an active style of leadership, helping group members work toward their goals.
4. Suggesting reflections to the group and to individual members regarding behavioral consequences and conflictual issues.
5. Fostering a healthy and trusting group environment to promote growth and open communication.

GROUP-CBASP SESSIONS 1–20

GROUP-CBASP: SESSION 1

Session outline:

- Presentation of group members
- Group-CBASP therapy sessions outline
- Group agreements
- Assessing your current depressive symptoms
- Persistent versus major depression?
- Do you have Major Depressive Disorder?
- Do you have Persistent Depressive Disorder (Dysthymia)?
- Course profiles for Persistent Depressive Disorders
- Two types of persistent depression
- What has been the course of your depression?
- Depression Timeline Worksheet
- What has been the cost of your depression?
- The Mood Chart
- General Guidelines about medication for depression
- Homework: Activity Log

We will begin today with an informal discussion about depression, the symptoms you experience now, the ways that you cope, and the course that your depression has taken from the beginning to the present. We will look at various ways that each one of you may have arrived at a diagnosis of persistent depression or perhaps of major depression. We will discuss medication and we may decide to invite a nurse clinician to answer some of your questions about various medications and their side effects. We will also answer any questions you may have about what we will be doing together for the following 20 weeks of group therapy.

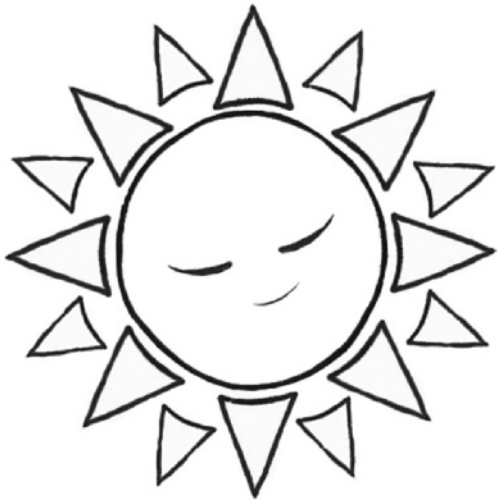
Welcome!

Homework: For next week, please fill out the Activity Log (see Appendix, **Handout 4**) showing how you typically spend your time during one entire week. Include meals, getting up, showering, naps, and even short walks. Include of course any social contacts and activities. Also, monitor your mood with the Mood Chart.

GROUP-CBASP THERAPY FOR DEPRESSION

Duration:
Time:
Therapists:

SESSIONS OUTLINE



- **Depression**
  - Introduction of members
  - What is group therapy? Set up of the sessions and group agreements, Homeworrrrrrrrk!
  - What are your objectives, your fears, your apprehensions . . .?
  - What is Persistent vs Major Depression?
  - Symptoms of depression
  - The course of depression
  - What about medication?
  - The Mood Chart
- **What is your Interpersonal Domain of difficulty that was identified at the start?**
  - Intimacy
  - Disclosing feelings and needs to others
  - Making mistakes in front of someone
  - Expressing negative emotions
- **Your lifestyle**
  - The cycle of depression
  - Diet, sleep, drugs, and alcohol
  - Physical activities

- Daily Activity Log for pleasure and mastery
- Pick up the challenge!
- Anxiety
- Little homework: Choose a pleasant activity for the week

- **The cycle of hopelessness and powerlessness in persistent depression**

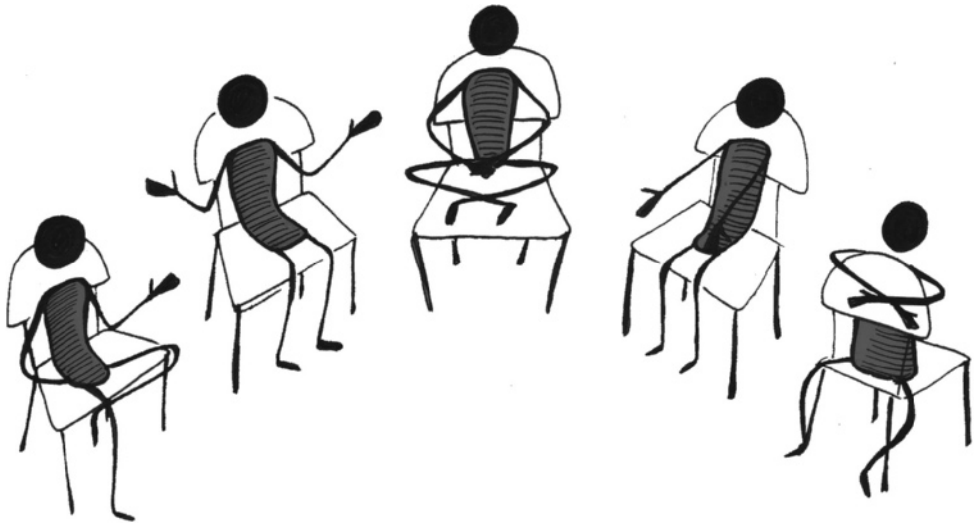
  - What is Cognitive Behavioral Analysis System of Psychotherapy
  - Using a Situational Analysis to break the cycle of powerlessness.
  - Remediation of problematic or unpleasant interpersonal situations.
  - What social skills do you need to learn to get your Desired Outcome?
  - Role-plays for assertiveness, for better communication skills
  - What problem-solving strategies have you learned?

- **What are your interpersonal interactions?**

  - The Interpersonal Circumplex
  - What are your interpersonal problems?
  - What are complementary interactions?
  - Your visible and hidden interpersonal goals and behaviors
  - Developing your interpersonal profile

- **Apprehensions or fears about group therapy?**
- **Discussion of group agreement**
- **Assessment of current depressive symptoms**

The following are some agreements and guidelines that we would like to give ourselves in our work together for the next 20 weeks. Please read them and sign the form for your own personal commitment.



We accept the following Group Agreements:

1. Group members agree to be present each week, to be on time, and to remain throughout the entire meeting.
2. Members who drop out of group therapy are not accepted back in the same group for the entire duration of this group and need to wait until another group begins.
3. Group members who miss three group sessions without calling to cancel or without a valid reason for doing so will not be permitted to continue in the same group.
4. Group members agree not to come to sessions under the influence of drugs and/or alcohol.
5. Information obtained during sessions, as well as the names of participants, must remain confidential.
6. Group members are not to form private intimate relationships outside of group sessions with other members in the group, although it is possible to exchange telephone numbers and to speak outside the group about your progress. Anything discussed outside the group is a subject of discussion within the group afterwards.
7. Group members agree to work actively on the goals established during the initial assessment period. This involves bringing Situational Analyses to the sessions, as will be explained during group therapy. These exercises are essential for learning to take place, regardless of how well you understand the actual exercise.

_____

Client's signature / Date

ASSESSMENT OF YOUR CURRENT DEPRESSIVE SYMPTOMS

An assessment of your depressive symptoms is important to obtain at intervals throughout treatment in order to measure changes taking place and to understand what may have triggered them. There are a number of reliable self-report measures of depressive symptoms available such as the Inventory of Depressive Symptoms, Self-Report (IDS-SR, Trivedi et al., 2004) and its shorter version the Quick IDS, found for free at the following website (www.ids-qids.org/). However, if you are currently in a CBASP group, your therapist may utilize a different measure to assess depression.

In this session we will begin with a baseline measure of your depressive symptoms according to how you have been feeling this past week. Please complete the questionnaire provided by your therapist and we will discuss the results for each group member in turn. Each person may have a different manifestation of symptoms, some feeling more physical symptoms and others feeling more cognitively impaired. This discussion can help everyone feel less alone with their suffering and reassured to know that others have similar symptoms and severity. We can review these results at the end of group therapy and assess the changes.

PERSISTENT VERSUS MAJOR DEPRESSION

Depression can take various forms and can have various degrees of severity. Major depression is the diagnosis given when you have suffered from a sad, depressed mood or from a loss of pleasure in all activities every day for a period of at least two weeks in addition to having four more symptoms among the seven listed below in the criteria for major depression. The more severe the symptoms, the more numerous they are and the more they interfere with your capacity to function at work and even at home to do your daily chores.

Major depression can occur only once in your life or it can recur multiple times. Many people report that when depression recurs, it is often more severe and may require a more prolonged treatment with medication and psychotherapy. A major depressive episode is said to be in "remission" if you feel an improvement in your symptoms about eight weeks after a medication has been introduced. If symptoms return during that period, you may be experiencing a "relapse." If you remain improved for longer than eight weeks, then you may be said to have "recovered" from the depressive episode, as long as you don't have any symptoms. If at a later date, however, you feel very depressed again every day for a period of two weeks, then you may be having a "recurrence" of a different depressive episode.

Many depressed patients have found that even after remission they still experience difficulties resuming "life as usual" and may feel fatigue, irritability, difficulty dealing with stress or difficulty functioning at work. These "residual" symptoms are important to discuss with your doctor because she or he will need to know that you still need help and have not completely recovered yet. In fact if these symptoms persist or worsen and you are not able to function as well as you did before the depressive episode, then you may be experiencing a persistent depression when this condition lasts for longer than two years.

DO YOU HAVE MAJOR DEPRESSIVE DISORDER?

You may have what is called major depression if you have at least **five** of the symptoms discussed below during a period of **two weeks or more**. These symptoms must cause you significant distress or impairment in at least one important

area of your life, like work or social functioning, so do not include them if they only bother you a little or you do not experience them daily.

You may have major depression if you feel **depressed or sad** or have a **lack of interest or pleasure** in things that you used to get pleasure from or were interested in. You must also have these symptoms **for most of the day nearly every day during at least two weeks** for this to be part of a diagnosis of major depression. Additionally, you **must have at least four of the following symptoms (or three, if you have both depressed mood/irritability and lack of interest or pleasure)** to make a determination that you have major depression. These additional symptoms that you may have include:

1. Significant changes in weight or appetite, such as weight loss even when you are not dieting or weight gain or decrease or increase in appetite nearly every day;
2. Problems with sleep, in the form of either sleeping too much or having problems falling or staying asleep almost every day;
3. Feeling either too agitated or too slowed down nearly every day;
4. Suffering from fatigue or excessive feelings of being tired almost every day;
5. Feeling worthless and/or having feelings of guilt and shame that are excessive for the situation;
6. Having difficulty thinking or concentrating such as having problems making decisions almost every day;
7. Having repeated thoughts about death or killing yourself or having a plan to kill yourself or having tried to kill yourself in the past.

If you have five of these symptoms (including at least one of the first two) and they have lasted for at least two weeks and cause you significant distress or interfere with your functioning, then you may have major depression and it is best that you consult your doctor about your symptoms.

DO YOU HAVE PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)?

You may have what is called persistent depression or dysthymia if you have depressed or sad mood for most of the day nearly every day for at least **two years**. Also, during this same two-year period if you suffer from persistent depression you may have at least **two** of the following symptoms:

1. Increased or decreased appetite or eating behavior;
2. Difficulties either falling asleep and staying asleep or sleeping too much;
3. Having low energy or excessive fatigue;
4. Having low self-esteem;
5. Difficulty concentrating or making decisions; and/or
6. Feeling hopeless.

During the two-year period, you have probably never been without these symptoms for more than two months at a time. These symptoms cause a lot of distress and interfere with your ability to function socially, at work, and in other important areas of your life. Persistent depression may take on a different course for each person:

1. **Dysthymia:** A mild to moderate depression, which lasts two or more years, usually beginning during adolescence.
2. **Double depression:** A single major depressive episode or recurrent major depression without recovery between episodes, on top of a dysthymia.
3. **Recurrent major depression:** This depression is called "major depression, recurrent, without full recovery between episodes and with no dysthymia." Some symptoms usually persist between episodes.

4. **Chronic major depression:** Full criteria for a major depressive episode with two or more years' duration.

If you recognize that you have the symptoms above and they have lasted for at least two years without any significant amount of time of feeling better, you may be suffering from persistent depression or what is also called dysthymia. This is a chronic and debilitating disorder and it is best that you consult your doctor about your symptoms. Group-CBASP is an effective psychotherapy designed to treat both major depression and persistent depression.

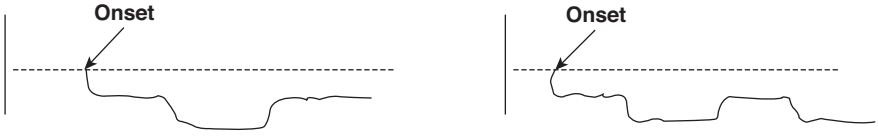
COURSE PROFILES FOR PERSISTENT DEPRESSIVE DISORDERS

The course of depression for each of these four profiles is depicted in the graphs below (J. P. McCullough, Jr., personal communication).

Pure Dysthymia

Course ≥ 2 years

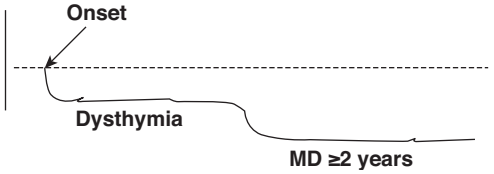
Double Depression



Recurrent Major Depression

Course ≥ 2 years

Double Depression/Chronic Major Depression



Two Types of Persistent Depression[1]

Your diagnosis of chronic depression, now called Persistent Depressive Disorder, means that you have been depressed for more than two years. Many of you, however, may have been depressed for much longer. The disorder involves both biological and psychological origins. Research supports that adequate treatment involves receiving both antidepressant medications along with CBASP psychotherapy. You may learn more about the biological aspect of your depression with your doctor. We will focus here on the psychological issues regarding your persistent depression.

1. **Early-onset depression:** When chronic depression begins during childhood or adolescence, before the age of 21, it is said to have an early onset. If this is the case, you may describe a family life that was difficult and you may even use stronger language to describe what it was like growing up in your family. You may have experienced emotional trauma, stress, unhappiness, family conflicts, abuse, or mistreatment by the people who raised you. You may have experienced physical or sexual abuse, or grown up in a family where no one cared what you did, where you were, or when you came home. Some people tell us that things were so bad in their homes that all they could do was try to "survive the hell of the family."

   What was it like for you growing up? (Describe some scenarios on these lines)

   _____

   _____

   _____

   _____

   _____

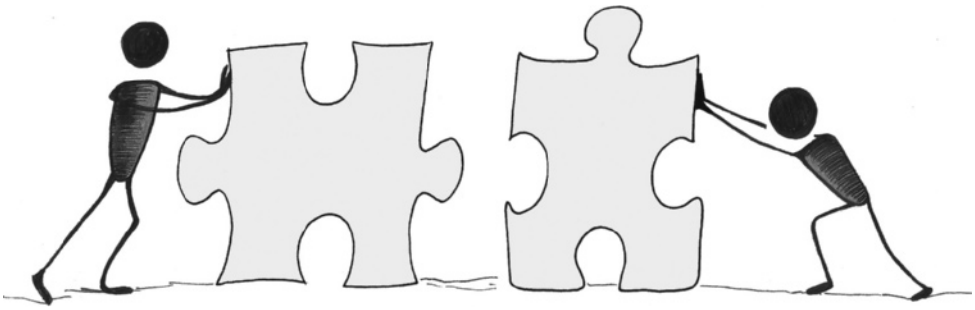
   _____

   _____

2. **Late-onset depression:** When chronic depression begins after the age of 21 or in adulthood it is said to have a late onset. There are exceptions to the age when depression begins among late-onset depressed individuals, but the majority of these people report that their depression began before they turned 30 years old. Most of these people describe their developmental years in less severe terms than do patients with early-onset beginnings. For example, they often remember one or more significant people whom they found to be helpful, loving, nurturing, and who enjoyed having them around. They also describe their early home environments as being less disruptive and not as conflict-filled as the environments described by people with early-onset depression. However, this is not to say that the family life of most late-onset patients was never difficult—not at all!

1 Adapted from McCullough (2003)

What was it like for you? (Describe some scenarios on these lines)



What has been the Course of your Depression?

Describe in a few sentences how depression began in your life and how it has evolved over time. You can use the grids below (see Depression Timeline Worksheet below and in Appendix—**Handout 1**) to help you keep track of changes in severity of your depressed mood each month and also identify events that may have triggered mood changes.

Use the timeline to write significant personal events in the month slots for the previous two years (for example, birthdays, anniversaries, divorce, marriage, deaths) or any other positive or negative event that helps you recall your mood changes. When a change occurred in the severity of your symptoms was there an increase or a decrease of the severity, compared to now? Mark the month when the change occurred and how long it lasted.

HANDOUT 1

DEPRESSION TIMELINE WORKSHEET

INSTRUCTIONS

1. We are going to determine the history and course of your depression using the grids below. How long have you been feeling the way you feel now? We will work from left to right on the grids and according to the severity of the depression. The lettered row above the grids represents calendar months from right to left. Circle the letter of the month we are in and write the date.
2. Then place an X on the lines of the grid underneath today's date indicating the severity of the depression this month using the following ratings:

   - **Normal** = no symptoms of depression
   - **Mild** = dysthymic disorder or mild form of a major depression, still able to work
   - **Moderate** = your level of impairment is noticeable by others at work or at home
   - **Severe** = major depression with inability to work or function at home or socially

3. How long have you felt the way you are feeling right now? (Place Xs in the slots moving toward the right to indicate the months' duration of depression or up to the starting date of the depression.)
4. We now want to place an X for each month at which there have been changes in the severity of the depression (write the date when important events, for example, birthdays, anniversaries, divorce, marriage, deaths, or any other positive or negative event took place that affected your mood) going back in time, and how long these changes lasted. Then, you can link all the Xs with a line to see the course profile of the depression.

Date of this assessment: _____

MONTHS	**D**	**N**	**O**	**S**	**A**	**J**	**J**	**M**	**A**	**M**	**F**	**J**	**D**	**N**	**O**	**S**	**A**	**J**	**J**	**M**	**A**	**M**	**F**	**J**
I. Present																								
Normal																								
Mild																								
Moderate																								
Severe																								
II. Past																								
Normal																								
Mild																								
Moderate																								
Severe																								
III.																								
Normal																								
Mild																								
Moderate																								
Severe																								

WHAT HAS BEEN THE COST OF YOUR DEPRESSION?

How has depression affected these different areas of your life?

1. ***Physically***: weight gain or loss, chronic pain, fatigue
2. ***Professionally***: job loss, disability, un-employability, low stress tolerance
3. ***Socially***: friends don't call, you don't feel understood
4. ***Personally***: low self-esteem, shame, low self-confidence
5. ***Psychologically***: poor concentration, memory loss, feeling hopeless

The Mood Chart on the next page can help you pay attention to fluctuations in your mood and learn about events that trigger these changes. The chart is also helpful for your doctor to better understand how the medication is working for you.

HANDOUT 2

MOOD CHART

You can use this Mood Chart (also in Appendix—**Handout 2**) to check your mood at the beginning or at the end of the day. Place a check (✓) in the box that best describes how you feel today. The top row of numbers is the days of the month. If you feel better, put a check in the boxes above the "0." If you feel worse, put a check in the boxes below the "0."

You can also record at the bottom of the page the number of hours of sleep you had each day.

HANDOUT 2

MOOD CHART

Fill in a square on the chart in the <u>morning</u> or <u>bedtime</u>:

How has your mood been today?

Name: _____

Month/Year: _____

DAY →		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Extremely good all the time	+5																															
Feeling good almost all the time	+4																															
Feeling good most of the time	+3																															
Feeling good a lot of the time	+2																															
Feeling good more often than bad	+1																															
Not feeling good or bad particularly	0																															
Feeling bad more often than good	–1																															
Feeling bad a lot of the time	–2																															
Feeling bad most of the time	–3																															
Feeling bad almost all the time	–4																															
Extremely bad all the time	–5																															
Hours of sleep last 24 hours																																
Minutes of activities per day																																

MEDICATION FOR DEPRESSION

What about Medication? How much and for how Long?

- Medical treatments for chronic unipolar depression are aiming at a **full remission** of symptoms. Otherwise, the chances of relapses or recurrences are greater and you might have only partial recovery between future episodes of depression.
- After remission, medication needs to be continued for another six to 12 months at least.
- Long-term continuation of medication is recommended for those who have had several episodes of depression or a good response to the medication.
- Depression may have a long-lasting effect on the brain and may decrease the effectiveness of treatment if it is allowed to progress and is left untreated. It is best to begin treatment early in the course of the illness.
- Combinations of medication or giving medication in sequence with psychotherapy as an add-on treatment are recommended for chronic or persistent depression. Other biological interventions are also being developed for depression that is resistant to treatment.

General Guidelines about Medication for Depression
By: James Farquhar MD, FRCPC, psychiatrist

Antidepressant medications are an important component of a comprehensive treatment approach for persistent depression. For many patients therapy and medication together give a better result than therapy alone or medication alone. Specific research has focused on antidepressants used along with CBASP and found that a combination of CBASP with antidepressants frequently helps patients more than CBASP alone or medication alone (Arnow & Constantino, 2003; Keller et al., 2000), particularly for persistent depression.

There are a variety of options with respect to medications and it is best if you work with a prescribing physician to find the medication or combination of medications that works best for you. Below you will find a brief review about different antidepressants. This summary is intended to provide some basic facts to help you better understand potential medication options, but is not a substitute for obtaining ongoing medical care from your prescribing physician.

Since the 1990s, newer generations of antidepressants are more widely available and have fewer side effects than some of the earlier antidepressants. Commonly used antidepressants include the selective serotonin re-uptake inhibitors (SSRIs). This family includes fluoxetine (Prozac), citalopram (Celexa), escitalopram (Cipralex, Lexapro), paroxetine (Paxil), sertraline (Zoloft), and fluvoxamine (Luvox). Serotonin is a neurotransmitter used by some nerve cells in the brain to transmit electrical signals. These particular brain cells are involved in emotional circuits in the brain that regulate mood. The medications increase the amount of serotonin available to these cells. Often, but not always, boosting the serotonin leads to improved mood and decreased depressive symptoms. This effect may be more noticeable in people with moderate and severe depression than in people with mild depression.

More recently, another group of antidepressants has emerged that work in a similar way, boosting both serotonin and another mood-regulating neurotransmitter called norepinephrine. These antidepressants include venlafaxine (Effexor), desvenlafaxine (Pristiq), and duloxetine (Cymbalta). Another antidepressant, bupropion (Wellbutrin), boosts norepinephrine and dopamine.

The newer antidepressants do not necessary work better than the old versions. On average, it appears that each antidepressant is about as effective as the others, and the primary differences between them are the kinds and severity of side effects. In some individual cases, a person may see more improvement on a specific medication versus others.

The positive effects of antidepressants are not seen immediately, and may take two or three weeks to take effect. The same delay, of two or three weeks, is observed every time the antidepressant dose is changed, upwards or downwards. The same is true if one antidepressant is stopped and another one is started.

The newer antidepressants have few side effects, with the most common being headaches and nausea. Also, weight gain is sometimes seen with some antidepressants. Most commonly, weight gain can occur with paroxetine, fluvoxamine, and sertraline. Some weight loss can occur with other antidepressants including citalopram and bupropion. In addition to weight changes, there may be sleep changes with antidepressants. Some medications may increase sleep or sleepiness, and others may reduce sleep. Also, some medications can cause sexual side effects. Most commonly, if this occurs, a man can have an erection but takes a longer time to reach orgasm. The increased time to reach orgasm can also occur in women. Also, for both sexes it may take longer to become sexually aroused when taking the medications. The exception is bupropion, which can increase sexual interest and enhance function and pleasure.

If you stop taking antidepressants abruptly or "cold turkey," you may experience a withdrawal syndrome. This may include poor sleep, too much sleep, feeling sick as if one had the flu, fatigue, and unpleasant changes in mood. If this happens, it is generally mild and rarely lasts more than a few days. As with any medication, it is important for you to follow the physicians' instructions, which would usually advise tapering off the medication rather than stopping it abruptly.

Many years of research on antidepressants have led to official guidelines for their use by physicians. The American Psychiatric Association and the Canadian Psychiatric Association have developed the most widely used guidelines. There are also widely accepted guidelines by the Canadian Network for Mood and Anxiety Treatments. All guidelines state clearly that medications are only one aspect of the treatment of depression, and that psychotherapy may be the most helpful treatment, whether alone or in combination with medications. The guidelines give suggestions about which antidepressants might be tried first, and what medication strategies may be helpful if the first medication chosen is not effective. These strategies include changing one antidepressant medication for another; or adding on another antidepressant or another class of medication. The add-on treatments include lithium, thyroid hormones, and antipsychotic medications. Antipsychotics may be used as mood stabilizers or as add-on treatments for depression (Komossa et al., 2010). These medications include quetiapine (Seroquel), olanzapine (Zyprexa), and aripiprazole (Abilify).

There is always a risk of side effects with all antidepressants, including the development of mania or hypomania, even in people who have never had these before. You should be aware of these risks and you may wish to watch for these symptoms and can ask your prescribing physician about the common side effects of the medications you are taking. You should always inform your treatment providers if you notice any significant symptoms or changes that worry you. Like all medications, antidepressants can sometimes have severe effects or complications, including death in rare cases. If you decide to take antidepressants, it is up to you to get the information from your doctor which will let you make an informed decision.

GROUP-CBASP: SESSION 2

Homework review:

Did you bring your Activity Log? If not, here are some extra ones to be filled in now.

Session outline:

- What Interpersonal Domain do you have difficulty with?
- Your Activity Log
- The cycle of depression and inactivity
- Activities:
    - *Taking care of yourself*
    - *Taking care of your environment*
    - *Taking care of your relationships*
- Deal with anxiety that is linked to depression

Today we will begin looking at the consequences of depression on the way you interact socially with others. To do this, we will discuss the one area of your social functioning that you and your therapist selected during the individual session before group began as a focus for your work in this group. We will call this your Interpersonal Domain. There may be other areas of your social functioning that become more important for you as our work progresses in the group and it is also possible for you to change this Interpersonal Domain to one that becomes a priority.

We will then discuss your daily lifestyle and the way that you spend your time, focusing particularly on your sleep hygiene, eating habits, personal hygiene, daily physical activities, and social activities. We would like to discuss whether you take pleasure in certain activities and what challenges you face.

Homework: For next week, choose a physical and social activity. Plan it and/or try it out. Write it out in your Activity Log (see Appendix, **Handout 4**) and check it off when you've done it. Assess your mood after the activity.

THE INTERPERSONAL DOMAIN

The Interpersonal Domain is an area of your social functioning in which you may experience particular difficulty. During the first individual session or two with the group therapist you answered some questions about how significant people in your life have influenced you to be the person you are today. Then you and your therapist constructed a sentence which best describes one interpersonal behavior that you most often avoid because you are afraid of a negative outcome. These behaviors are related to the following areas of your social functioning:

1. Experiencing closeness with others
2. Disclosing to others one's needs and feelings
3. Admitting to making a mistake or to not understanding how to do something, and
4. Expressing negative emotions to others.

You should now have a sentence in which the Interpersonal Domain is written out with the behavior you tend to avoid and a second sentence in which you identified how you would like to change this behavior. We will read and share these sentences together after you write out the first sentence below (see **Handout 3** below). If you have not formulated a second sentence about change, you will have plenty of time to discuss this with the group and use the one that your therapist may have formulated in the meantime for you.

Here are some examples of the sentences that some individuals who have been in this group before have written out:

"*More often than not I feel that* if I express my negative emotions to others, then I won't be able to deal with conflict, I can't stand confrontation."

"*More often than not I feel that* if I express my negative emotions to others or acknowledge an error, then they might judge me negatively, not trust me."

"*More often than not I feel that* if I let anyone get close to me, then I'll get hurt."

"*More often than not I feel that* if I let others in and express my needs and feelings, then they won't like me the way I am."

"*More often than not I feel that* if I disclose my needs and feelings to others, then I'm weak and vulnerable and they will judge me negatively."

"*More often than not I feel that* if I let others get close to me, then I'm afraid they'll be angry with me; I could let them down."

"*More often than not I feel that* if I admit my mistakes to others, then I'm not perfect and people won't like me."

HANDOUT 3

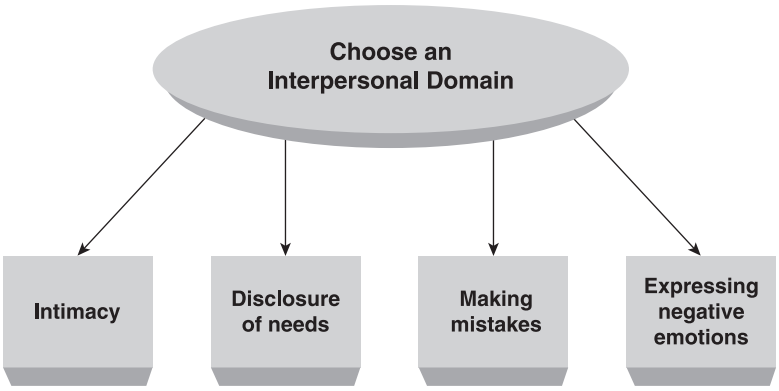
YOUR INTERPERSONAL DOMAIN

1. **What is your Interpersonal Domain, as discussed at the individual sessions before group started? Please write out below the sentence developed in the individual session before group started, given to you by your therapist. This sentence represents your Interpersonal Domain of difficulty.**

_____

_____

_____



If I *(get too close) . . . (express my needs) . . . (make a mistake) . . .* **or** *(express my anger)* **in front of others in the group, then** . . .

2. **What change in this domain have you identified as being important for you to make?** What is the one thing you would like to change about the sentence in number 1 just above?

_____

_____

_____

3. **Do you think some of your behaviors in this group might reflect the Interpersonal Domain that you have the most trouble with?**

- Would you show others your feelings or needs? (disclosure)
- Would you allow others to get to know you? (intimacy)
- Would you acknowledge to others your difficulties, errors? (making mistakes)
- Can you express some negative feelings that you may be experiencing? (expressing negative emotions)

_____

_____

_____

_____

4. **If you think you have difficulty with any of these, then what behaviors do you think you might use to protect yourself from the consequences of the Domain most difficult for you?**

For example, do you think that you might be a person who wants to please others too much in order to be liked or to avoid problems? So by pleasing others you might protect yourself from rejection.

_____

_____

_____

_____

5. **Do these behaviors agree with your values? Is this how you want to live your life? Are these behaviors excessive?**

For example, do you like to see yourself as a people-pleaser? Do you like to see that you tend to be too submissive?

_____

_____

_____

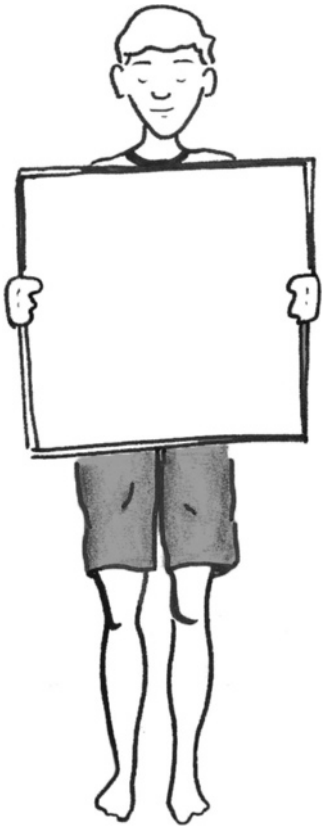
_____

YOUR ACTIVITY LOG

We would like to discuss today the homework that was given at the end of the last session. You were asked to complete an Activity Log (see Appendix, **Handout 4**) in which you indicate how a typical week unfolds for you regarding meal times, times at which you wake up and go to bed, times at which you engage in personal hygiene activities, times at which you go out, do physical activities, even answer the phone, etc. We will go around the table to each one of you and listen to what your current lifestyle is like. Then we will have another discussion, following this one, in which you will each identify an area in your daily functioning that needs to change to help you resume a healthier and more active life.

The following **Handout 5** help focus our discussion on the topic of the vicious cycle of inactivity and depression. Symptoms of chronic depression—like fatigue, sleep disturbance, loss of appetite, or loss of concentration, loss of interest and others—are often mentioned as being the cause of your inactive lifestyle. Some of you may think "When I feel better and have more energy then I'll call a friend or go for a walk." Unfortunately, this is not the way recovery will take place. Inactivity will contribute to lowering levels of interest, mood, and physical endurance and may even succeed at pushing others away whom you have refused to see or return their calls.

You may read the following **Handout 5** at home. Today we will discuss together what a healthy lifestyle can be for each one of you.



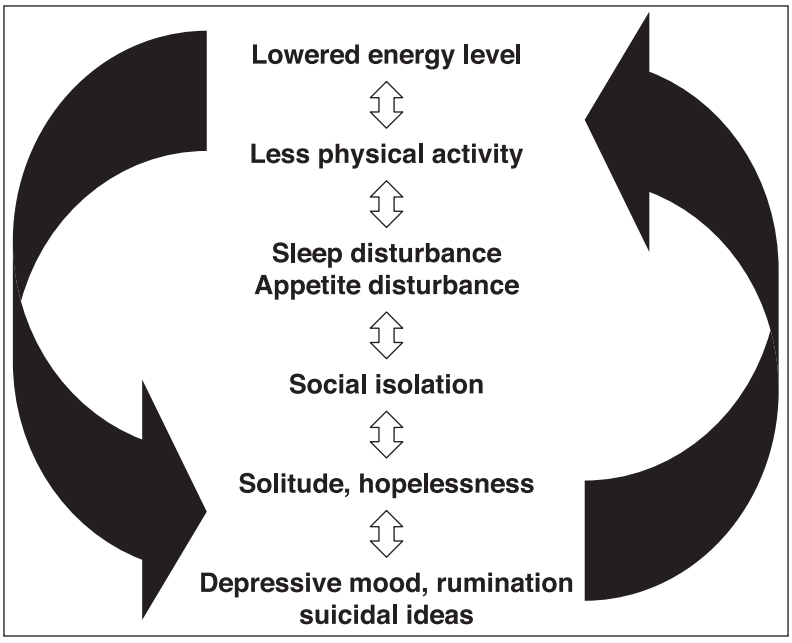
HANDOUT 5

THE CYCLE OF DEPRESSION AND INACTIVITY

When depressed, most people don't do or don't feel like doing the activities that help improve their mood.

However, if you stop taking care of your wellbeing or doing things you like, your life may become more boring and depressing.

You may feel like you're comforting yourself by being inactive, but your inactivity may actually worsen your depression. Therefore, you're finding yourself in the cycle of depression.



HANDOUT 5

LINK BETWEEN INACTIVITY AND DEPRESSION

Depression leads to **inactivity,**
but **inactivity** intensifies **depression**

⇧ **Inactivity** ⇔ ⇧ **Depression**

So what should you do?

By becoming active **=**
⇩ **Inactivity** ⇔ ⇩ **Depression**

Refuel your train!

ACTIVITIES

Activities—taking care of yourself

Activities—taking care of your environment

Activities—taking care of your relationships

ACTIVITIES—TAKING CARE OF YOURSELF

Your hygiene

When depressed, we tend to neglect our hygiene, not get dressed, bathe less frequently, and not take care of our appearance. This leads to even lower self-esteem, less appreciation for ourselves, and increased social isolation.

Tips: Get dressed every day.

Take time every day to shower and take care of your appearance.

Your self-esteem

People suffering from depression tend to undervalue themselves, to feel guilty and to put themselves down. Depression has depleted rewards that are usually obtained from living an active life, working, or participating in leisure activities. Without a feeling of mastery over daily challenges that are undertaken, depression tends to undermine one's self-confidence and self-image. Some may react by withdrawing to avoid feelings of shame thinking they don't have much to contribute to conversations with others. That only results in further isolation and lowers your self-esteem further.

HANDOUT 5

WHAT ABOUT TIME TO ENJOY YOURSELF?

What do you enjoy or what did you enjoy before your depression?
Here are some suggestions:

See a movie	Draw	Play video games
Fool around	Write letters, poems, or in a journal	Watch a television show
Read	Sew or knit	Visit different places
Cook	Talk on the phone	Go to an exhibit
Garden	Take a course	Go to the theater
Listen to music	See a show	Go to a gallery opening
Go shopping	Play cards	Do crossword puzzles
Decorate a room	Go camping	Dress-up
Photograph something pretty	Take care of your pets	Visit a museum
Go dancing	Observe birds in nature	Take a dance class
Volunteer	Wash your car	Go to the library
Look at photo albums	Go for a walk	Go bowling or play pool

Do you have any other suggestions?

_____

_____

_____

_____

_____

_____

_____

Your mind

It is stimulating to learn new things and share and enrich our knowledge. Even if you have the impression that some of your cognitive capacities (memory, attention, concentration) are less productive due to depression, it is still important to stimulate these faculties.

Some use the analogy of memory being like an elastic which we have to continue stretching. It's the same for other faculties that need to be trained and nourished to become more productive.

Enriching Activities

"Your mind becomes enriched from what it receives . . ."

- Watch a report
- Read
- Watch the news
- Go see a movie, an exhibit . . .
- Visit a new place

Your body

Physical Activities

Physical activity doesn't mean running a marathon, but being a little physically active every day.

New research shows that being moderately active for 30 minutes per day **reduces the risk** of heart problems, obesity, hypertension, cardiovascular accidents, and **depression**.

The benefits of physical activity:

- Better health
- Better physical state
- Better posture and balance
- Better self-esteem
- Better weight control
- Muscle and bone reinforcement
- Increased energy
- Increased relaxation and stress management
- More autonomy as a senior citizen.

The risks of inactivity:

- Premature death
- Heart problems
- Obesity
- Hypertension
- Diabetes
- Osteoporosis
- Cerebrovascular accidents
- Depression
- Colon cancer.

Which Physical Activity Do You Do?

- Go for a 15-minute walk

You can also turn an activity into one that is useful and enjoyable by taking your or a neighbor's dog for a walk, mail a letter, run errands (pharmacy, news stand), take the bus or walk to an appointment instead of driving . . .

- Stretch
- Watch an exercise show and copy the movements
- Take a physical activity class in your community center or a private gym
- Follow the seasons with your sports
- Ask a friend to do a physical activity with you

ACTIVITIES—TAKING CARE OF YOUR ENVIRONMENT

Our environment influences our mood.

You may have heard that the color of a room could provoke a certain emotion or impression, the same occurs with your general environment.

Do you feel good in your environment?
What needs to change?

You might work hard to prepare your house if a guest is coming over but you wouldn't think of doing it for yourself, why not?

How you take care of your environment reflects how you take care of yourself.

Which Activity Would You Like to Do or Have Done?

- Organizing your apartment
- Cleaning up
- Adding something creative to your home
- Redecorating a room
- Rearranging the furniture
- Throwing out or giving away unused objects
- Airing out your home, opening the windows for 15 minutes per day
- Adding a fragrance to your apartment with candles or incense

ACTIVITIES—TAKING CARE OF YOUR RELATIONSHIPS

Much research demonstrates the importance of social support in people's lives. Difficult life events seem easier when surrounded by people who like or appreciate you.

We need interpersonal relationships the same way a plant needs water, sun, and fertilizer. . . . Your relationships need care and this seems so difficult in depression.

Depression puts you in a cycle that reduces your ability to give and receive from others and this causes you to avoid others more and more, leaving you feeling increasingly alone.

It is important to break this cycle of social isolation progressively and learn more effective ways of coping with interpersonal problems.

Social Activities

- Go for coffee with a friend
- Invite a friend over for a meal
- Call a relative to hear his or her news
- Accept a friend's invitation
- Plan an activity with a friend, old or new . . .

Now, let's move to action so you can
"Run your train"

PLAN ACTIVITIES (PHYSICAL AND SOCIAL)

Imagine the Possibilities

Write a list of all the possibilities that you would find enjoyable.

HANDOUT 5

Choose a New Physical AND Social Activity from the List Above

Evaluate each activity in your list in terms of cost (time, money, equipment).

Choose two activities, physical and social, that are reasonable and realistic; write them below.

Develop an Action-Plan

Determine when, where, and how you will do these two activities. Maximize your chances by setting realistic goals and reward yourself for each accomplished effort. Write in the calendar below the precise day and time when you plan to do the activity that you selected in the exercise above. You may still change your mind when the time comes to do the activity but at least you've made the commitment to yourself in writing.

Write it in your schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9:00							
10:00				**Walk to Library**			
11:00					**Skiing**		
12:00							
13:00							
14:00							
15:00	**See friend**						
16:00							
17:00		**Cook with sister**					
18:00							
19:00							
20:00							
21:00							

Example: Monday 15:00, go for coffee with a friend.
Thursday 10:00, go for a walk to the library to take out a book.

Example: Tuesday 17:00, cook with my sister.
Friday 11:00, go skiing.

It is also important to recognize that you may need to learn some strategies to help you deal with tension, anxiety, or with fear about becoming more active in your life. For some of you these are often important to learn first before making a commitment to undertake a sport or a social activity.

DEAL WITH ANXIETY THAT IS LINKED TO DEPRESSION

- Relaxation techniques, diaphragmatic breathing, oxygenating your brain, and meditation can help you gain a sense of control over your life.
- Progressive relaxation is a technique that you can use to relax your muscles, one at a time.
- Diaphragmatic breathing is learning to breathe from your diaphragm and not just from your throat.
- Mindfulness is a form of meditation that is focused on attending to your breathing with acceptance.

Overcoming depression is often more difficult if you also worry to the point of becoming ineffective at problem solving and overly anxious about anticipated outcomes. It is important to discuss with your therapist some relaxation strategies to help you turn off the alarm that is triggered by generalized anxiety.

GROUP-CBASP: SESSION 3

Homework review:

Did you bring your Activity Log? If not, here are some extra ones to be filled in now.

1. What activities did you do or choose to do this past week?

Session outline:

- How maladaptive thinking can lead to maladaptive coping
- The cycle of hopelessness and powerlessness leads to persistent depression
- How can we break the cycle?
- The Situational Analysis (Coping Survey Questionnaire)
- Understanding steps of the Situational Analysis within a group
- Example of a Situational Analysis

The previous two sessions have opened our eyes to some of the emotional and physical difficulties you may be experiencing. Some of you may also feel powerless to change and this is why we wanted to suggest some small steps you can take every day to improve your lifestyle and feel healthier physically.

Today, we will also explore how your way of approaching problem situations may contribute to making you feel overwhelmed and unable to get the help you need from others around you.

Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group.

HOW MALADAPTIVE THINKING CAN LEAD TO MALADAPTIVE COPING

(Adapted from McCullough, J. P., Jr. (2003). *Patient's Manual for CBASP*. New York: The Guilford Press. Copyright Guilford Press. Reprinted with permission of The Guilford Press)

You may have noticed how some of you in the previous sessions described your difficulties in ways that may appear to us or to yourself as being overwhelming emotionally. This may be related to the way that persistently depressed people approach problem situations by describing their difficulties in global terms, generalizing about the situation or about what they think is going on. Some of you might describe your past, your present, and your future all at the same time, as being mostly negative and out of your control. This way of thinking can encourage maladaptive ways of coping or behaving, especially in the face of interpersonal problems.

A Global way of thinking about problems takes one situation and extends it to all others with words such as:

*"I'll **never** have a good relationship."*
*"I **always** loose, I'm incompetent."*
*"I can **never** do anything right."*
*"I'll **never** get my life back."*

This way of thinking is also vague and doesn't help anyone understand the problem, let alone find a solution. This is why we find that global thinking can also lead to feeling ***defeated***. When you feel defeated you might say to someone:

"Why bother, I'm always depressed."
"There's no hope, this is my life."
"No matter what I do, it's never enough."

Defeatist thinking will also never lead to problem resolution but instead will lead to retreat or submission in interactions with others. The depressed person tends to withdraw, feeling powerless as a result of thinking that nothing they do matters to others. Problems are left unresolved, pile up and this may elicit in others a complementary reaction which is to tell the depressed person what to do and try to counteract the helplessness. Therefore, the defeatist thinking and submissive behaviors of the depressed person draws others into a more dominant role in an attempt to provide the reassurance or support that the depressed person is perceived to need. Sometimes others are tempted to become angry toward the depressed person who has adopted a "one-down" position in the face of current problems. These reactions from others are not well received by depressed individuals who often report feeling rejected, misunderstood, unheard, discredited, and sometimes judged negatively even by significant others.

Social avoidance and isolation are the result of repeated frustration from unsatisfactory relationships, and this can happen even with significant others. You may find that you share similar experiences with others in this group regarding the tendency to withdraw from others and to socially isolate. However, prolonged social isolation often results in feeling that your behaviors are not important, have no significant impact on others—that is, have ***no consequence***. This is when depressed individuals can sometimes convince themselves that their own children would be "better off" without them, or can begin to feel like a "burden" to others and may experience suicidal thoughts, hopelessness, and despair. Feelings of loss of control over one's life develop and global thinking that "things will never change" triggers the cycle of hopelessness and powerlessness all over again.

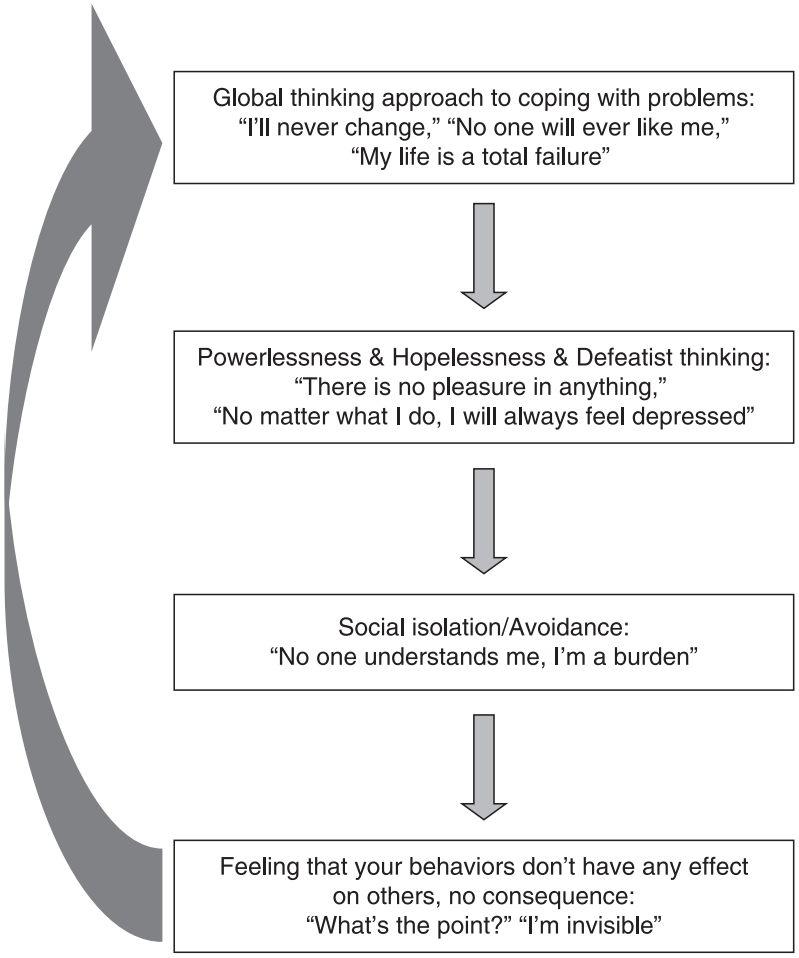
Follow the cycle of hopelessness and powerlessness on **Handout 6** below and then take the next page (**Handout 7**) and fill in the empty lines with:

- Your own examples of **global** thinking, generalizing your problems
- Then describe how you come to feel powerless or **defeated**; what do you say to yourself or to others? Do you feel despair?
- Do you withdraw, avoid others, isolate? How do you behave when others take charge?
- With time, what impact do you feel you have on others around you?

Now you can understand how you have come to feel that you are losing control over your life. You are right in thinking that we will help you regain control over your life by working together to learn to become a good problem-solver. You can learn skills to solve interpersonal problems and turn around the self-sabotage or self-destructive negative approaches you have been using.

HANDOUT 6

THE CYCLE OF HOPELESSNESS AND POWERLESSNESS LEADS TO PERSISTENT DEPRESSION



. . . and from this we can get the impression that we are losing control over our lives.
This is how persistent depression can develop . . .

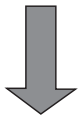
HANDOUT 7

WHAT IS YOUR CYCLE OF HOPELESSNESS AND POWERLESSNESS?

Your global thinking: _____

_____

_____

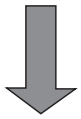


Your feelings of powerlessness: _____

_____

_____

_____

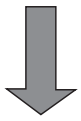


Your social isolation/avoidance: _____

_____

_____

_____



What effect do you have on others? _____

_____

_____

_____

_____

HOW CAN WE BREAK THE CYCLE?

We can break this cycle of powerlessness if we learn to solve

One problem at a time.

We will learn to identify the link between what we do and the consequences on others and on the environment by using examples of specific interpersonal situations that you experience every day.

THE SITUATIONAL ANALYSIS (SA) (COPING SURVEY QUESTIONNAIRE)

Dealing with one problem at a time:

- We cannot solve more than one problem at a time.
- The **Situational Analysis** (SA), is an interpersonal problem-solving exercise that focuses on one "slice of time" when a particular interpersonal problem occurred during an exchange you had with someone.
- The SA can help you counter the defeatist "what-I-do-doesn't-matter" approach to problem solving. SA requires you to look at the consequences of your behavior during that "slice of time."

  You have to face the results of what you did or did not do during a period of time when you had a problem with your partner, a friend, your boss, or a business associate.

- With SA, you learn quickly how you personally influence situations to come out the way they do.
- If you don't like the way a situation came out, then we will help you revise what you did so that you can learn to reach a more desirable outcome next time. We'll help you learn how ***not*** to make the same mistake again.

You may be thinking to yourself:

> "How will solving one problem at a time help me cure my persistent depression?"

- Most people with persistent depression have problems with other people and these problems fall into a very limited number of categories. Once you learn to identify and effectively address these limited interpersonal problem areas, you will begin to see an improved pattern in your interpersonal encounters across a variety of situations. You will notice a decrease in your depressive symptoms because it is hard to remain depressed when you feel in control of your life and know that you can cope effectively with your problems.

THERE ARE SEVERAL BENEFITS GAINED FROM LEARNING TO DO SITUATIONAL ANALYSES (SA)

1. The SA will focus your attention on a specific problem that occurs at a particular time and place with another person.

   Outcome: Your global thinking will be countered and replaced with a more focused perspective on that one "slice of time."

2. The SA will teach you how to identify the effects (consequences) that you have on other people.

   Outcome: Your defeatist "it-doesn't-matter-what-I-do" thinking will be neutralized and extinguished as you see that you can change the impact you have on others.

3. The SA will show you that you are interpersonally connected to the world in which you live.

   Outcome: Learning that your behavior has consequences will produce a sense of empowerment in you and end your isolation.

4. The SA will expose the interpersonal problem behaviors that cause you to have difficulties with others.

   Outcome: We will help you remedy your interpersonal problems with behavioral skills-training.

5. The SA will teach you to become a goal-oriented thinker.

   Outcome: You will learn to think about situational goals at the *beginning* of encounters with others, not *after* the fact.

The Situational Analysis (SA)

"Let's try it out with one of your examples"

HANDOUT 9

THE SITUATIONAL ANALYSIS (SA) (FOR GROUP THERAPY)

(Coping Survey Questionnaire—CSQ)

Your Name: _____

Name of person reporting the situation: _____

Therapist: _____

Date of Situational Event: _____

Date of Therapy Session: _____

Instructions: Select one stressful interpersonal event that you have confronted during the past week and describe it using the format below. Please try to fill out all parts of the form. Your therapist will assist you in reviewing this Situational Analysis (SA) during your next therapy session.

Situational Area: Family_____ Work/School_____ Social_____

Step 1. Describe WHAT happened: (Write who said or did what, then describe clearly how the interpersonal event ended—the final point.)
Note to group members: *The person reporting the situation speaks, the other group members write down what he or she said about the situation.*

Adapted to group therapy from: J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press, page 107. Adapted with permission of The Guilford Press

Step 2. How did you <u>INTERPRET</u> what happened during the event? (How do you "read" what happened; what thoughts did you have which indicate how the interpersonal event unraveled from the beginning to the end of this exchange. Make a sentence for each interpretation. Try to limit yourself to three interpretations.)
Note to group members: *If the situation in Step 1 is not yours but that of another group member, then imagine yourself in a similar situation and write a thought that you might have experienced in such an exchange. Write at least one sentence.*

a. _____

_____

b. _____

_____

c. _____

_____

Step 3. Describe what you <u>DID</u> during the situation, your behaviors: (How did you say what you said? What were some of your nonverbal behaviors, tone of voice, eye contact, etc.?)
Note to group members: *We are describing here the behaviors of the person reporting the situation in Step 1 (name the person), we are not describing the behaviors of other group members in their imagined situations. How do you think she or he behaved in the situation in Step 1?*

Step 4. Describe <u>HOW</u> the event came out for <u>You</u> (The <u>ACTUAL OUTCOME</u> (AO)): (What *ACTUALLY* happened at the end of this exchange; what was observable? Write one complete sentence describing observable behaviors.)
Note to group members: *Now we are looking at the AO for the person who reported the situation in Step 1 (name the person). In your own words, how did the situation end for her/him?*

Adapted to group therapy from: J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press, page 107. Adapted with permission of The Guilford Press

HANDOUT 9

Step 5. Describe how you <u>Wanted</u> the event to come out for you (The <u>DESIRED OUTCOME</u> (DO)): (How would you have *<u>WANTED</u>*** the event to come out for you? What ***<u>goal</u>*** would you have wanted to achieve, that is realistic, attainable, and depends on you. Describe it in behavioral terms using a complete sentence.**
Note to group members: *Here, again, if the situation in Step 1 is not yours, then imagine yourself in the same situation as you did in Step 2 and now think of* ***<u>your</u>*** *DO for* ***<u>yourself</u>****. How would* ***<u>you</u>*** *have wanted the situation to end if* ***<u>you</u>*** *were there?*

Step 6. Did you get what you wanted? YES___NO___ Why or why not?
Explain why you think you do not get what you want in similar situations:
Note to group members: *Every group member can also think about whether he or she would get what he or she wants in similar situations.*

_____

_____

_____

_____

_____

_____

After the Remediation Phase of the exercise, identify:

<u>My Action Interpretation</u>: Write out a thought that you need to tell yourself (like a coach speaking to you in your head) that will help you reach your goal, your DO, in this particular interpersonal situation described in Step 1.
Note to group members: *Even if the situation is not yours in Step 1, think about what your internal coach needs to tell you to reach* ***your own*** *DO.*

_____

_____

_____

_____

_____

_____

Adapted to group therapy from: J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press, page 107. Adapted with permission of The Guilford Press

UNDERSTANDING STEPS OF THE SA WITHIN A GROUP

Choosing a "Slice of Time"

To become skillful at solving interpersonal problems we first need to adopt a one-situation one-problem approach. That means concentrating on one particular interpersonal exchange **you** had with **another person** that you found unsatisfactory or stressful, or perhaps successful. So instead of making global statements about your problems that are vague, you will choose a specific situation that has a beginning point, an endpoint, and a story in between. This is called a ***"slice of time"*** in which you describe an exchange between you and another person and it can last from five minutes to one hour. It is best to keep the slice of time short to make it easier to focus on the important part. We will then work through this situation together to find a realistic and attainable outcome for you, a strategy and solution to reach that outcome and discuss how you will implement it. By doing this you may find that a solution that works in one situation may also work for many more problematic situations.

Step 1. Describe WHAT happened:

- The best way to begin describing the situation in Step 1 is to tell us, as if you were an observer, who did or said what, focusing on behaviors only within the *"slice of time"* that was selected. Don't tell us at this step how you felt or what you make of it, stick to the facts. We will write your description on the board and each group member will copy **your** situation on their own SA form to work through the steps together.

Step 2. How did you INTERPRET what happened?

- Looking back at your description in Step 1, **what** do you think was happening between you and the other person? **What** did the situation mean to you, **what** are your thoughts about it? These interpretations will inform us about **what** the other person was doing, **what** you were doing, and **what** direction the exchange between you was taking.
- Please make one complete sentence for each interpretation or thought.
- This step will help anchor you or ground you in the exchange you had by guiding us through the situation from the beginning of the exchange to the way it ended.
- *If the situation in Step 1 is not yours but that of another group member, then imagine yourself in a similar situation and write a thought that you might have experienced in such an exchange. Write at least one sentence about your thoughts.*

Step 3. Describe your BEHAVIORS during the situation:

- Can you describe your behaviors during this exchange, that is, what you did? Please include observable descriptions about the tone of your voice, your body language, whether you made eye contact or not and whether you stayed or left the situation too quickly.
- Looking at your behaviors in this step will help us understand how you arrived at the outcome or "endpoint" in the exchange you had with the other person. It will help us see why the situation turned out the way it did.
- This step will help you learn to ***stop***, ***look***, *and* ***listen*** before responding in a situation that is important to you.
- *We are describing here the behaviors of the person reporting the situation in Step 1 (name the person), we are not describing the behaviors of other group*

members in their imagined situations. How do you think she or he behaved in the situation in Step 1?

Step 4. Describe <u>how</u> the event came out for <u>You</u>:

- In this step you will describe how this exchange ended for you, in behavioral terms. This is called the **Actual Income (AO)**. The end of the situation is the same as the endpoint of the "*slice of time*" you chose. It is important to stay within the event you described in Step 1 and point out what you got out of it.
- Please describe the **AO** using one complete sentence.
- Would you say that you were satisfied with the outcome of this situation?
- This step will help you learn to accurately recognize the outcome in an interpersonal exchange, see the impact you have had on the other person, and understand what behaviors you may need to change in order to reach your goals in your interactions with others. This is essential in helping you overcome your depression.
- *Now we are looking at the AO for the person who reported the situation in Step 1 (name the person).*

Step 5. Describe how you <u>Wanted</u> the event to come out for <u>You</u>:

- How would you have liked the situation to end, particularly if you were not satisfied with the way it ended? This step asks you to propose an outcome that you would have wanted instead of the one you obtained in the situation; this is called the **Desired Outcome (DO).** Ask yourself: "How would I have wanted this exchange to end?"
- This step asks you to pay attention to what you want and to formulate your answer in terms of a **behavior** that is under your control and that you can reach. Then you need to make one complete sentence describing one single **DO**.
- Do you think your **DO** is attainable? Would the other person give you what you want? Is this **DO** under your control?
- Is your **DO** realistic? Can you reach this goal with the skills you currently have?

*Here again, if the situation in Step 1 is not yours, then imagine **<u>yourself</u>** in the same situation as you did in Step 2 and now think of **<u>your</u> DO** for **<u>yourself</u>**. How would **YOU** have wanted the situation to end if you had been there?*

Step 6. Did you get what you wanted?

- This step gives us an opportunity to think about the consequences of your behaviors as observed in the **AO**, using this particular interpersonal situation as an example.
- How do you understand the difference between the outcome that you did get, the **AO**, compared to the outcome that you would have wanted to get, the **DO**?
- What are some explanations that you can think of to help you and the group understand why you don't get what you want?
- Are there other interpersonal situations in which you also see similar consequences of how you behave?
- *Every group member can also think about whether he or she would get what he or she wants in a similar situation.*

Now we can move to the Remediation Phase of the SA to determine what you need to do DIFFERENTLY to obtain the DO.

EXAMPLE OF A SITUATIONAL ANALYSIS (SA)

Patient: Mary

Therapist: Dr. Smith

Date of Situational Event: January 30, 2005

Date of Therapy Session: February 2, 2005

Instructions: Select one stress event that you have confronted during the past week and describe it using the format below. Please try to fill out all parts of the questionnaire. Your therapist will assist you in reviewing this SA during your next therapy session.

Situational Area: Family_____ Work/School_____ Social__X__

1. Describe what happened:

Attended the company picnic. The company photographer was taking pictures of everyone. He took Susan, Jane, Phyllis' pictures but not mine. [ENDPOINT] Camera man never offered to take my picture, and I never got my picture taken at the picnic.

2. How did you interpret what happened:

a. The photographer doesn't like me (*mind read*: inaccurate, irrelevant)
b. I never get what I want (to get my picture taken): (*irrelevant*: not situationally anchored)

**** (*Add Action Interpretation*) Got to ask for what I want!**

3. Describe what you did during the situation:

Said nothing to change the situation. Tried to be friendly with my colleagues.

**** (*Add assertive behavior*) Ask to have my picture taken**

4. Describe how the event came out for you (*AO*):

I never got my picture taken at the picnic.

5. Describe how you wanted the event to come out for you (*DO*):

Wanted to have my picture taken at the company picnic.

6. RATE: Did you get what you wanted? YES_____ NO__X__

GROUP-CBASP: SESSION 4

Homework review:

1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

- The Remediation Phase of the Situational Analysis
- What is a Future Situational Analysis?

Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

SITUATIONAL ANALYSIS (SA): REMEDIATION PHASE

It may be uncomfortable for you to see that you don't get what you want in many interpersonal situations and you may ask yourself, "What am I doing wrong?" We will continue this SA exercise together with a "*slice of time*" that you described in Step 1 of the SA, and with the help and support of the group we will be able to answer this question.

We will be looking at your thoughts or interpretations described at Step 2 of the SA and ask ourselves whether and how each interpretation contributes to your getting what you want, or reaching your Desired Outcome (DO).

The GOALS of SA remediation are:

- To revise thoughts and behaviors that get in the way of you getting what you want in this interpersonal exchange.
- To see that behavior has predictable consequences.
- To understand what you need to change in the way you interact, in order to regain control of what you get from others and overthrow the powerlessness of depression.

Now, let's go back into the situation that you described in your SA and see what you might have changed to get what you wanted.

Step 1:

A. We first look at your interpretations in Step 2 of the SA. In the first interpretation, you said . . .

1. Is this interpretation **grounded** in the event? Does the interpretation reflect what actually happened in this situation described in Step 1 of the SA? If yes, then it is a relevant interpretation. A relevant interpretation plants your feet solidly in the event.
2. Is this interpretation true or **accurate**? Do you think the interpretation accurately describes what is happening between you and the other person, or is it describing something that is happening within yourself: your feelings, thoughts, etc.?

Rule: If your interpretation is relevant and accurate, we will keep it. If it is relevant but not accurate we will need to modify it. If it is neither relevant nor accurate, we will acknowledge that it is not helpful and cross it out on our paper or on the board.

3. Finally, how does this interpretation help you **get to your DO** (Step 5 of the SA)? That is, how do your interpretations help you get what you want in that situation?

- Sometimes your interpretations may not directly get you what you want but they may be relevant and accurate and it may be the best that you can do at this stage in this particular interaction or situation. It is also important to know when we need to be patient and keep repeating what we want to the other person until some agreement or compromise is reached or until you can be certain that the

DO is not attainable with this person and that you need to modify this goal. You are the best one to judge whether you think you need more time or whether your DO is unattainable.

- If an interpretation doesn't help you get to your DO, we will need to cross it out on the board or on your forms and look at the next interpretation from Step 2.

Rule: If you now find that your DO is unattainable or unrealistic after revising an interpretation, you may need to revise the DO first before continuing.

Now go over Step 1A of the Remediation with the second and third interpretations . . .

B. Now, after reviewing your interpretations, you may find that you need an ***ACTION INTERPRETATION*** which will prepare you to move toward getting what you want. This is a thought that you say to yourself about what you need to do to reach your DO, your goal, in that specific situation. This **Action Interpretation** is like your *inner* positive life coach or cheerleader encouraging you to "go ahead," "you can say it or you can do it!" What can your *inner* cheerleader be telling you to get you moving?

All group members can think of what their inner cheerleader would say to help them reach a DO. We will discuss this together in the group to share ideas and to brainstorm.

Step 2:

Now that you have revised your interpretations and found an ***Action Interpretation***, how do you think your behavior would have changed if you had used this ***Action Interpretation*** during the exchange with the other person described in Step 1 of the SA?

If you had behaved this way, would you have gotten what you wanted, that is, would you have achieved your DO in that particular situation?

You may feel that you are not ready to change your behaviors yet with this particular person. That is alright! At least you will know what to do when you decide that you do not want to continue getting the same unsatisfactory outcome with this person.

What are the behaviors that you need to change and those that you need to learn in order to get what you want in this situation?

_____

_____

_____

_____

_____

The goal of this step is to learn to do what you need to do to be a more effective problem-solver, once you have identified problem behaviors and corrected them.

You can now practice your DO in the group, using a role-play with another group member. We can give you feedback about how convincing you sound and we can all discuss how you can get what you want in other similar situations.

Now you can see how your behaviors can have different consequences, it **DOES** matter what you do!

Step 3:

Can you all summarize at this point what you've learned in doing this exercise? Take a moment and write down a few words. We can also discuss the learning together with others in the group.

_____

_____

_____

_____

_____

Step 4:

Are there other similar situations to which you can apply what you've learned here? Describe a similar situation and discuss what you might have done based on what you learned here today:

_____

_____

_____

_____

_____

How can you begin to apply what you have learned here to other interpersonal situations?

_____

_____

_____

_____

_____

HANDOUT 11

FUTURE SITUATIONAL ANALYSIS (SA)

A future SA is used when you are thinking about what you want to say to or do with someone in the near future. In a future SA you will focus first on what you want, on your goal in the exchange you plan to have, within a specific "*slice of time*" with another person.

Step 1: Formulate a "behavioral" Desired Outcome (DO) (something that you can do: a *realistic* DO):

_____

_____

_____

_____

Step 2: Write the "interpretations/reads" that must be in place to achieve the DO (you will need one ***Action Read*** that can be repeated to yourself):

_____

_____

_____

_____

Step 3: Identify the "behaviors" that must be present to achieve the DO (you may need to do some *role-playing*):

_____

_____

_____

_____

Other suggestions:

(1) Don't worry about an Actual Outcome (AO) (it is a future event)
(2) Keep the SA simple—not complicated
(3) Review the Future SA after the situation has taken place

Adapted from J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press.

GROUP-CBASP: SESSION 5

Homework review:

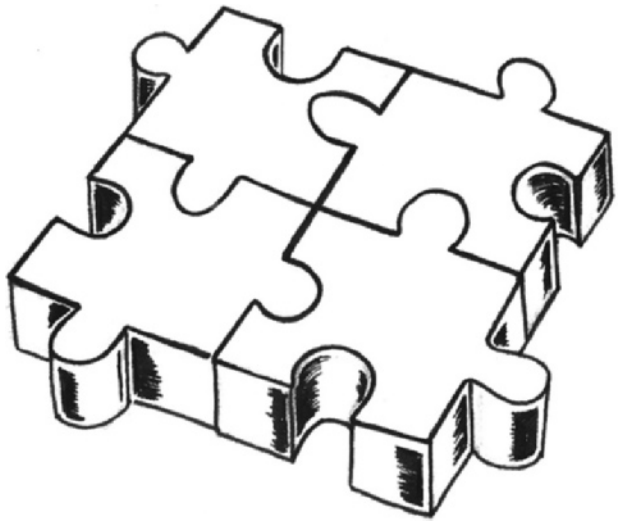
1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

PRACTICING THE SITUATIONAL ANALYSIS (SA) WITH ELICITATION AND REMEDIATION PHASES

- Using the Situational Analysis to understand the impact of our interpersonal behaviors on others within or outside the group

This session is devoted to practicing Situational Analyses with Elicitation and Remediation Phases. We will repeat this exercise for many sessions throughout group therapy.



Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

GROUP-CBASP: SESSION 6

Homework review:

1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

- Your Interpersonal Domain
- How is this Domain expressed with others in this group?
- Using the Interpersonal Domain to understand the impact within the group of our interpersonal behaviors
- Is this your DO?

Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

YOUR INTERPERSONAL DOMAIN

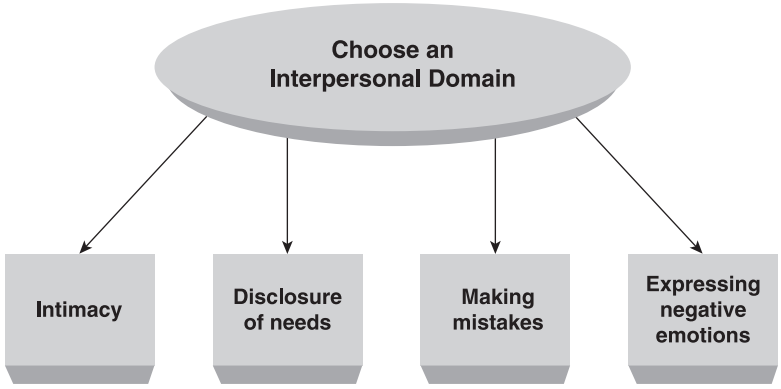
Let's look again at your Interpersonal Domain, at the sentence you constructed about what behaviors you avoid in your interactions with others. You wrote out this sentence at Step 1 of Handout 3.

_____

_____

_____

_____



What change in this domain have you identified as being important for you to make? What is the **ONE** thing you would like to change about the sentence just above?

_____

_____

_____

_____

Do you notice how your behaviors in this group may reflect the Interpersonal Domain that you have the most trouble with?

- Have you yet shown others your feelings or needs? (disclosure)
- Have you yet allowed others to get to know you? (intimacy)
- Have you yet acknowledged to others your difficulties, weaknesses? (making mistakes)
- Have you expressed some negative feelings that you are experiencing in your life? (expressing negative emotions)

HANDOUT 12

Do you think you have taken any risks here in the group by expressing one of the four Interpersonal Domains? If yes, then how difficult was it for you to do it?

1 5 10

Not difficult - Very difficult

____

____

____

____

How would an important person in your life who has misunderstood or abused you (a Significant Other) have responded to you if you had taken this risk in front of him or her?

____

____

____

____

How have we responded to you in the group when you took this risk?

____

____

____

____

What is different about *what* you experienced with your Significant Other and *what* you have experienced here with us?

____

____

____

____

What meaning will this have for you if we can respond differently to you here and now? What do you learn from this?

_____

_____

_____

_____

If you think you haven't taken any risks and not expressed any of the four Interpersonal Domains in the group or outside, then what behaviors do you use to protect yourself from the consequences you imagine getting from others in the Domain that is most difficult for you?

_____

_____

_____

_____

Do these behaviors agree with your values? Is this how you want to live your life? Does this help your mood?

_____

_____

_____

_____

What impact do you have on others around you with these protective behaviors? You can ask group members how they see you. What is that **one** thing you want to change about the impact you have on others?

_____

_____

_____

_____

HANDOUT 12

Now think about your Desired Outcome (DO) when you use protective behaviors. Are you getting what you want from others? Is the protective behavior more important for you than what you want in an interpersonal exchange?

_____

_____

_____

_____

GROUP-CBASP: SESSIONS 7 & 8

Homework review:

1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

PRACTICING THE SITUATIONAL ANALYSIS (SA) WITH ELICITATION AND REMEDIATION PHASES

- Using the Situational Analysis to understand the impact of our interpersonal behaviors on others within or outside the group

These sessions are devoted to practicing Situational Analyses with Elicitation and Remediation Phases. We will repeat this exercise for many sessions throughout group therapy.

Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

GROUP-CBASP: SESSIONS 9 & 10

Homework review:

1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

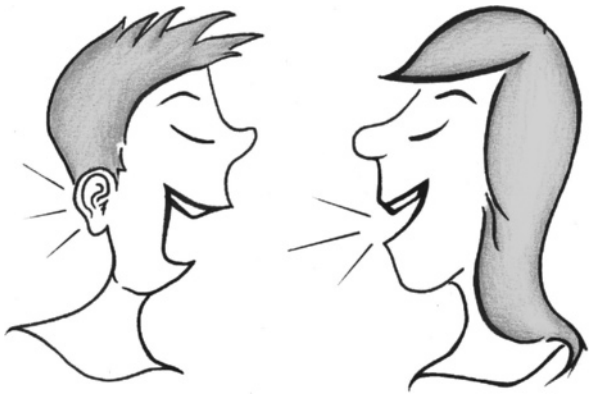
Session outline:

- Understanding our interpersonal interactions
- Your Interpersonal Circumplex
    - *Your Interpersonal Values*
    - *Your Interpersonal Efficacy*
- How is your interpersonal profile related to your interpersonal behaviors within this group?
- Eight Styles of Interpersonal Relating

Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

UNDERSTANDING OUR INTERPERSONAL INTERACTIONS

(Adapted from Horowitz et al., 2006)



It may be apparent to you now that if you want to achieve a specific outcome and feel satisfied, it is important to know *what* you want in an interpersonal interaction. However, you may have found yourself wanting or expecting less from yourself and others because of persistent depression. The more passive interpersonal position associated with persistent depression can have a negative impact on others that you may not be aware of and that can complicate communication.

It may be helpful to think about some particular rules that govern our interpersonal interactions and that have been studied by researchers in the field of Interpersonal Psychology. There are some interesting theories about how we interact with each other and why some interactions become frustrating and others satisfying. We can discuss how these theories relate to your own interpersonal style of interacting with others. In addition, we can look at the results of some of the questionnaires that you completed at the beginning of the group that help us develop a profile of your interpersonal characteristics and dispositions such as your interpersonal values and your feelings of competency about interacting with others.

We have found in our research that the more competent people feel about the way they interact with others, the more likely they are to increase their interactions with others and the less depressed they feel.

We also know from our own and other research that depressed individuals report problems in their interpersonal interactions. These problems may contribute to feelings of being misunderstood by others as we reviewed at the beginning of the group.

The Interpersonal Circumplex (Figure 1) is a useful visual tool to understand how our interactions are most often motivated by what we want from each other and by how we get what we want.

Most of our interpersonal interactions are driven by motives which underlie them. That means, we usually want something from each other, consciously or unconsciously, when we speak to or interact with one another. These interpersonal motives can also be seen as goals that help orient how we behave with one another.

Interpersonal motives or goals can be placed under two broad categories including goals concerned with closeness to others and goals concerned with influence or control over others.

- We speak to each other often in an attempt to get closer or to move away from someone or at other times to influence or to ask for help from someone. When we don't understand another person's motives, it is difficult to know what he or she wants from us and even more difficult to anticipate our reaction or the impact this person may have on ourselves.

The Interpersonal Circumplex reflects the relationship between these two categories of interpersonal motives:

- **On the horizontal axis is the dimension of *Affiliation* or Communion, which represents motives for closeness or intimacy with others, for feeling loved or establishing friendships with others around us.**
- **On the vertical axis is the dimension of *Agency* or control, which represents influence, dominance, or power over others. It includes motives for autonomy and self-definition as well.**

These two dimensions represent the two challenges that we are faced with since childhood; that is to learn to get along with others and to learn to move ahead in life with independence and autonomy.

- *The meaning of our interpersonal behavior, then, often depends on the underlying motive or motives. That is, how we behave with someone has a lot to do with what we want from the interaction with that person at that particular time. What we want also has a lot to do with what we consider important in our interactions with each other. What we consider important also becomes part of our values. Sometimes we want more than one thing from another person. For example, you might want to influence a person and also to get close to that person or hope she or he likes you. On the other hand, we can have two conflicting motives without realizing it, such as needing help from someone but not following their advice. In this case, we would first need to know what our two conflicting motives are, then prioritize them and sacrifice the less important one.*
- *When motives underlying a behavior are not clear, the behavior is usually ambiguous. For example, you might feel that another person is manipulating you if they are not clear about what they want from you. Ambiguous behaviors may lead to misunderstandings and sometimes to feelings of distress and unhappiness.*

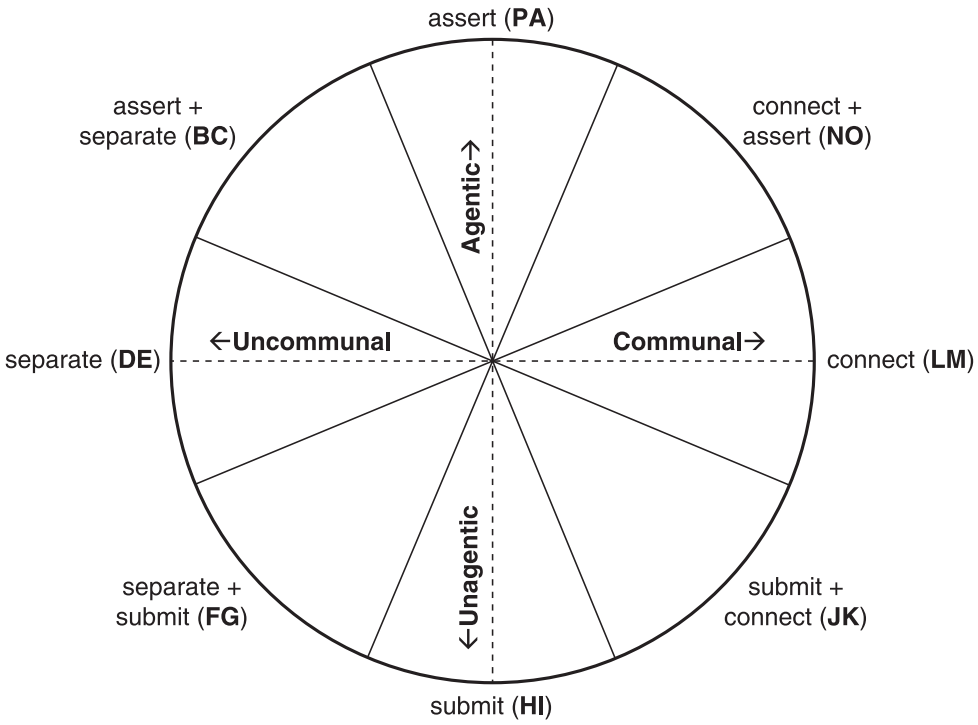
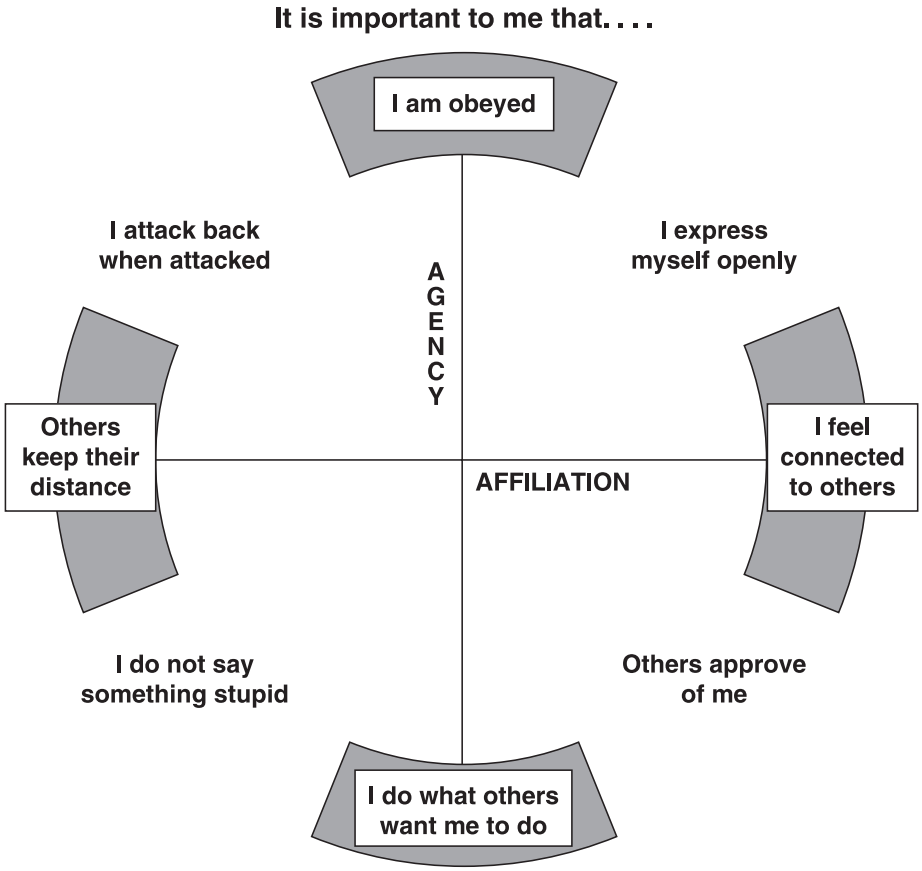


Figure 1 The Interpersonal Circumplex

Locke (2006, 2011)

HANDOUT 13

YOUR INTERPERSONAL CIRCUMPLEX– VALUES/MOTIVES



Locke (2000)

Adapted from Locke (2000). Circumplex scales of interpersonal values: reliability, and applicability to interpersonal problems and personality disorders. *Journal of Personality Assessment, 75*(2), 249–267.

The interpersonal style of an individual that motivates him or her to behave a certain way with others can be understood by examining four different aspects of interpersonal interactions:

1. The individual's interpersonal wishes and fears represented by **Interpersonal Values** (Locke, 2000, for patients to access these scales: Download circumplex scales free at www.webpages.uidaho.edu/klocke/);
2. The individual's beliefs about what interpersonal behaviors he or she can or cannot do (confidence and competency), indicative of **Interpersonal Efficacy** (Locke & Sadler, 2007, for patients to access these scales: Download circumplex scales free at www.webpages.uidaho.edu/klocke/);
3. The individual's reported distress about **interpersonal problems** or behaviors he or she does too much or not enough (Horowitz, Alden, Wiggins, & Pincus, 2000);
4. The **impact** or influence of the individual's interpersonal behaviors on how others perceive or feel about him or her (Kiesler & Schmidt, 1993).

Assessing your own individual interpersonal style and disposition with the above-mentioned circumplex scales yields a particular interpersonal configuration along eight octants of the Interpersonal Circumplex that we just discussed. Table 1 outlines the eight interpersonal styles with corresponding characteristics for each of the four scales just described. All four scales are easily hand-scored to obtain means that are placed on the eight octants of the Circumplex. These will show your predominant style in the submissive, dominant, friendly, or distant quadrants of the circumplex. You can now see how your predominant interpersonal disposition may contribute to difficulties you may experience in obtaining a DO in your interactions with others. You can also get some information from your scores on the degree to which you might be more rigid or more adaptable in your interactions with others as well as how much interpersonal distress you experience.

We can discuss together your interpersonal styles as depicted on the Circumplex and the impact you think you can have on others with these particular interpersonal dispositions.

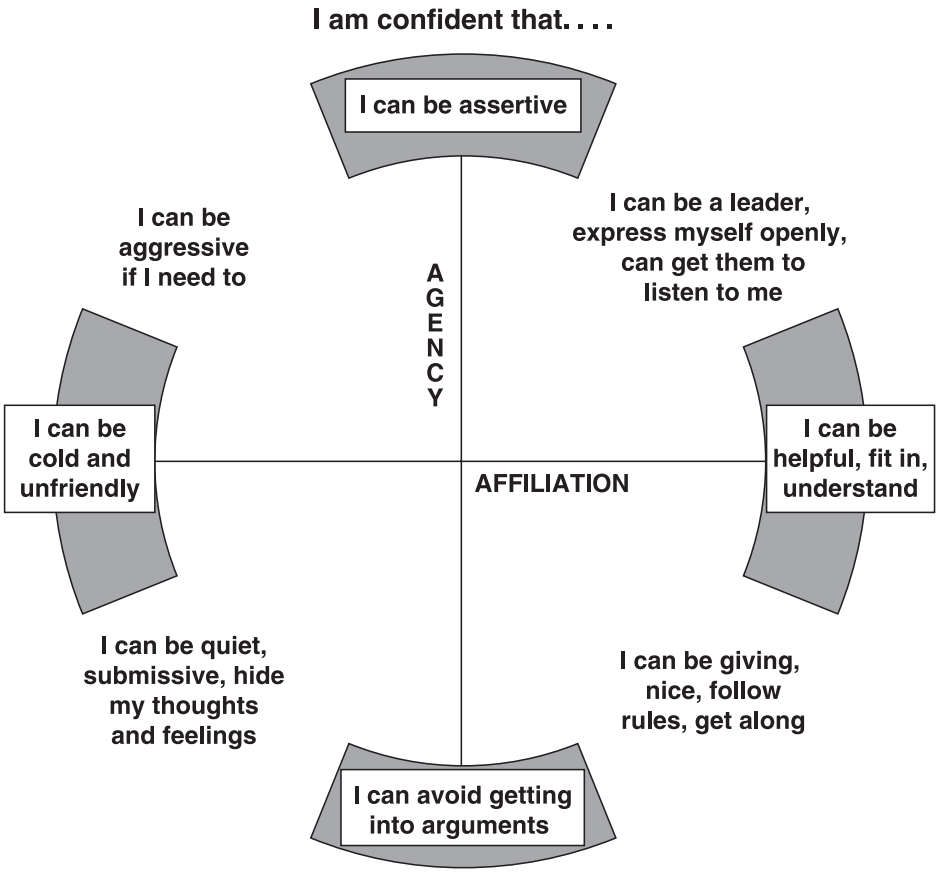
The **Interpersonal Values** scale indicates the importance that you attribute to various interpersonal events, such as, for example, appearing confident or aloof, and the importance of being understood or of taking charge and many other values. The **Interpersonal Efficacy** scale indicates the degree to which you feel confident in your own ability to perform a particular interpersonal behavior, such as, for example, being assertive, expressing yourself openly, being submissive, etc.

The scale measuring the **Impact** of your behaviors on others or, vice versa, the impact of another person's behaviors on you, also depicts along the eight styles of the Circumplex how you may be brought to feel, to think, or to behave toward this person or how he or she may feel, think, or behave toward you.

The last scale measuring **Interpersonal Problems** will be discussed below with more information on how to understand extreme scores.

HANDOUT 14

YOUR INTERPERSONAL CIRCUMPLEX–EFFICACY



Locke & Sadler (2007)

Adapted from Locke & Sadler (2007). Self-efficacy, values, and complementarity in dyadic interactions: Integrating interpersonal and social-cognitive theory. *Personality and Social Psychology Bulletin, 33*(1), 94–109.

HOW IS YOUR INTERPERSONAL PROFILE RELATED TO YOUR INTERPERSONAL BEHAVIORS WITHIN THIS GROUP?

How do you understand your interpersonal profile? Do your behaviors within this group reflect the interpersonal values that are important to you? Is it important to you to assert yourself and feel dominant, that you are "Agentic" or in control of your life? Perhaps it is also important for you to "Affiliate" with others, to feel connected with others? Do you feel confident that you can disclose to others how you feel, get close to them, express your opinion or your disagreements? The results on the questionnaires that you may have been given by your therapist to complete before the start of the group can help you see a profile of your interpersonal behaviors. Now you can better understand the impact that you have on others in this group and outside the group with significant others in your life.

HANDOUT 19

EIGHT STYLES OF INTERPERSONAL RELATING

We may find on the Interpersonal Circumplex **eight styles** depicting typical modes of interacting that result from the combination of the two dimensions of A*gency* and A*ffiliation* (Locke, 2006, 2011). These are the following:

Table 1 Eight Styles of Interpersonal Relating

Style	**Interpersonal Values "It is important that I . . ." (Locke, 2000)**	**Interpersonal Efficacy "I am confident that I can . . ." (Locke & Sadler, 2007)**	**Interpersonal Problems "I am too . . ." (Horowitz et al., 2000)**	**Interpersonal Impacts "When I am with this person, he/she makes me feel . . ." (Kiesler & Schmidt, 1993)**
Dominant (Assert)	appear confident, correct, in authority	be assertive; forceful; take charge; speak when I have something to say	domineering/ controlling	bossed around
Dominant & Distant (Assert & Separate)	appear forceful, having the upper hand, avenging any attacks or insults	be aggressive if needed; keep the upper hand; tell them when I am annoyed; win an argument or competition	vindictive/ self-centered	that I want to stay away from him/her
Distant (Separate)	appear cool and detached, being guarded and concealing my thoughts and feelings	be cold and unfriendly when I want to; be cruel or tough when the situation calls for it; get them to leave me alone	cold/distant	distant from him/her
Yielding & Distant (Separate & Submit)	avoid ridicule and rejection by avoiding blunders or concealing my feelings	be quiet; submissive; can disappear into the background when I want; hide my thoughts and feelings	socially inhibited	that I should tell him/her not to be so nervous around me
Yielding (Submit)	avoid arguments and anger by going along with what others want and expect	avoid getting into arguments; avoid making them angry; can be a follower; let others take charge	non-assertive	in charge

Table 1 continued

Style	Interpersonal Values "It is important that I . . ." (Locke, 2000)	Interpersonal Efficacy "I am confident that I can . . ." (Locke & Sadler, 2007)	Interpersonal Problems "I am too . . ." (Horowitz et al., 2000)	Interpersonal Impacts "When I am with this person, he/she makes me feel . . ." (Kiesler & Schmidt, 1993)
Yielding & Friendly (Submit & Connect)	get others to like and approve of me by putting others' needs first	be giving, nice, follow the rules, get along with others	overly accommodating	that I could tell him/her anything and he/she would agree
Friendly (Connect)	feel connected with, genuinely cared about, and supported by others	be helpful; fit in; I can soothe hurt feelings; understand others' feelings	self-sacrificing	appreciated by him/her
Dominant & Friendly (Connect & Assert)	express myself openly, be heard, respected, have an impact	be a leader; express myself openly; get others to listen to what I have to say; smooth over any difficulties	intrusive/needy	that I could relax and he/she'd take charge

GROUP-CBASP: SESSIONS 11 & 12

Homework review:

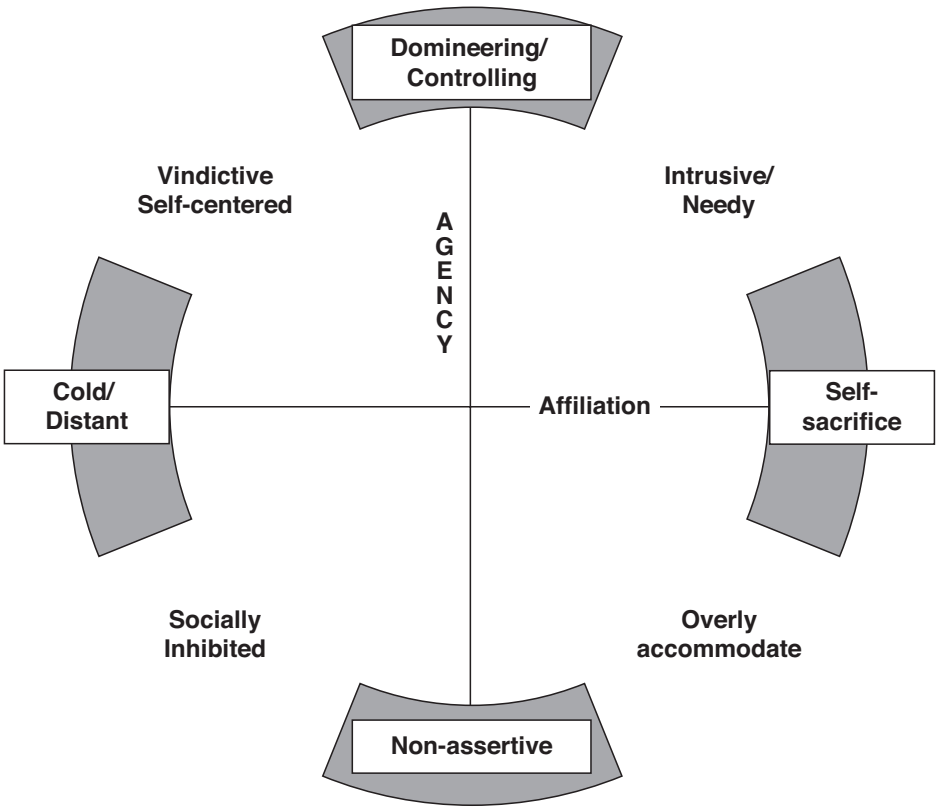
1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

- Your Interpersonal Circumplex—Inventory of Interpersonal Problems
- Understanding extreme scores of interpersonal conflict
- What typical behaviors would you use to reach your goals; think of what you have done in the past, your AO?
- Understanding some typical interpersonal patterns of individuals with persistent depression
- Do you think you are more rigid or flexible in your interpersonal interactions?
- What are the consequences of interpersonal avoidance for you?

Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

YOUR INTERPERSONAL CIRCUMPLEX– INTERPERSONAL PROBLEMS



Horowitz et al. (2000)

Adapted from Horowitz et al. (2000). *Inventory of Interpersonal Problems (IIP) – Manual*. San Antonio, TX: The Psychological Corporation, a Harcourt Assessment Company.

UNDERSTANDING EXTREME SCORES OF INTERPERSONAL CONFLICT

The Interpersonal Circumplex for your interpersonal problems (Inventory of Interpersonal Problems; Horowitz et al., 2000) shows whether you report problems in your relationships with others and how much distress you feel. If you have extremes scores (above 70) in one of the eight quadrants, then this suggests a predominant style of relating in times of conflict.

1. Positive scores at the extreme end of the *friendly* dimension suggest problems with being too concerned with getting positive reactions from others and with having a hard time setting limits and boundaries.
2. Negative scores at the extreme *distant* dimension suggest problems with being too guarded and distant and with having a hard time being open, close, and loving.
3. Positive scores at the extreme *dominant* dimension suggest problems with being too controlling, independent, and argumentative and having a hard time listening to or caring about others.
4. Negative scores at the extreme *submissive* dimension suggest problems with being too easily persuaded and embarrassed, and with having a hard time being confident and assertive.

(Matano & Locke, 1995)

How does your profile of interpersonal problems, revealed in your answers to the Inventory of Interpersonal Problems, relate to the AO that you obtained in the SA that you previously shared with us in the group? Did you get what you wanted in this interpersonal situation? Where would you place your AO on the Circumplex along the dimensions of Agency and Affiliation? If this AO was not satisfying to you then you may need to describe to yourself and to understand those maladaptive behaviors that you tend to use but that don't get you what you want from others. You may find that only in particular interpersonal situations do you tend to have a recurring pattern of maladaptive behaviors. The best way to find out is to write-out as many SAs as you can and to identify whether the AO = your DO, that is, whether what you did corresponded with what you wanted to do in that situation. Then place your behaviors on the Circumplex in the appropriate quadrant that best describes how you behaved: were you assertive, submissive, did you distance yourself, or did you move toward the other person?

Our goal in this group is to work together to understand how some of our behaviors can be maladaptive when they do not get us what we want: to assert or refuse a request, to express an opinion or need, even when these behaviors are indeed under our own control. Our goal is also to learn adaptive behaviors and Action Interpretations that enable us to achieve our DO. To do this, we need to learn more about our behaviors, about whether we tend to be adaptable or more rigid in the way we behave.

- *Indeed, some people have a more restricted or rigid repertoire of interpersonal behaviors compared to others. This means using the same strategy over and over again, for example avoiding the person you may in fact want to speak to. If you are more rigid in your interpersonal behaviors, you may have more extreme scores within one or two particular styles on the Circumplex. It may be beneficial sometimes to have a more rigid repertoire that would limit the amount of choices you have available, making it easier to make a decision if too many options are given. For example, some individuals who are shy often use the same interpersonal strategies to help them feel confident and overcome social anxiety.*
- *Other people have interpersonal behaviors that are more evenly spread out around the circumplex. This may be beneficial in enabling you to be flexible*

and adapt to requirements in certain situations and to respond to others in a more complementary fashion.

- *Sometimes you may find that you have competing interpersonal motives or intentions when you interact with someone. For example, you may want to ask your boss for a favor but also don't want to lose a particular privilege, such as leaving early on Friday. If you are a more flexible person and are able to compromise, then you may decide to sacrifice the favor you wanted and hang on to your privilege of leaving early on Friday. Some people, however, may show ambivalence, appear confused, or feel vulnerable when they are uncertain about which interpersonal motive to prioritize when speaking with someone. Having difficulty tolerating uncertainty can generate a lot of anxiety. It is helpful to use the Future SA to think about how to prioritize your DO and take one step at a time.*
- *Research has shown that scoring high on behaviors associated with* ***Agency*** *(dominance) and* ***Affiliation*** *(friendliness) is also associated with positive feelings and wellbeing. It is important for all of us to feel that we can influence others and feel connected to others as well.*
- *Our research has shown that people who suffer from chronic depression often report problems with feeling too inhibited, too non-assertive, and too accommodating in their interpersonal interactions. These interpersonal styles are found in the lower quadrants of the Circumplex. Some reasons behind these behaviors may include hidden motives such as the need to be loved, validated, or some may want to avoid attention and appear invisible. Unfortunately, these behaviors don't help a depressed person reach a DO when interacting with another person.*
- *Depressed individuals appear to place more value on behaviors that seek to avoid conflict, self-assertion, and disapproval than non-depressed individuals. Avoiding conflict can become the over-riding motive over and above wanting to reach a DO that may be quite realistic and attainable.*
- *Depressed individuals are often less dominant in their behaviors than non-depressed individuals and seem to feel less confident about their ability to maneuver in difficult interpersonal situations. They report a lack of confidence about being expressive, assertive, or aggressive, even in situations that require a forceful response. If you don't practice assertiveness because you have avoided others during the depressive episode, then you can quickly lose confidence in your ability to do so.*
- *Depressed individuals who report the lowest levels of interpersonal dominance also often report the highest levels of depression, in our research. The feeling of losing control over your life by being too passive or too submissive can lead to a feeling of "learned helplessness"and despair about the future. The first step to move out of this position is to solve* ***"one problem at a time"*** *as we discussed earlier in this manual.*
- *Individuals who have restricted or rigid patterns of interpersonal values and interpersonal efficacy (confidence) tend to also report the most problems with being too submissive and exploitable. These individuals also show a pattern of avoidance in their interpersonal coping strategies. It may be much more taxing and demanding to feel that you are always at the other's "beck-and-call" and that you will never be able to change this pattern of behaviors because you may think that others will judge you negatively. The consequence is often to avoid others altogether although this reinforces isolation and even more depressive symptoms.*

With a limited behavioral repertoire, chronically depressed individuals often find it easier to isolate themselves from others and tend to abdicate in the face of adversity. You may find, however, that some interpersonal behaviors that you

most often show others, during a depressive episode, don't agree with your values. Many depressed individuals have reported that "I don't feel myself!" This may indeed be true since you may have a different idea of who you are and who you want to be.

What does this mean about the ability to express your anger or your disagreement?

What complementary responses will you receive from others when you choose to avoid expressing your anger or when you act non-assertively? We will see in the following section that others will tend to be more dominant toward you and want to give you advice, thinking they are helping you.

Perhaps avoiding others becomes your interpersonal goal or motive, whether you intended this or not? Nevertheless, how will others understand your behaviors if your motive or intention is unclear? Your behaviors may show avoidance but if you don't express what you want to another person, then you might come across to that person as being unclear, confusing, or ambiguous. Others may not even know that you're avoiding them, just that you haven't called back five times. Does this avoidance agree with your values?

If you are currently in a chronic depression and your interpersonal motive is to keep others away, then you have probably succeeded in reaching this goal. You may then feel alone and may find yourself in even more psychological pain.

What are the likely ways that others will respond to you when you adopt such a position of withdrawal?

We can find out by looking at what "complementary interactions" are and how others may respond to your behaviors.

GROUP-CBASP: SESSIONS 13 & 14

Homework review:

1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

- What are complementary and non-complementary interactions?
- Are you getting what you want from others?
- Do your hidden motives push others away?
- What is your DO?

Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

COMPLEMENTARY AND NON-COMPLEMENTARY INTERACTIONS

(Horowitz, 2004; Horowitz et al., 2006)

We have discussed the fact that people are often not aware of their interpersonal motives or don't know what they want from each other and this is often found in people with persistent depression. The importance of a motive at a particular place and time in your life may not necessarily be clear to you. Some motives may have been important at one time in your life but are less important at another period later on in your life. What we want from another person can also change from one situation to another. Nevertheless, we generally find that when an important interpersonal motive is satisfied, we feel contentment and when it is frustrated we feel upset or disappointed (Lazarus, 1991).

- *When you get what you want in your interaction with another person, you are likely to feel satisfied. When you don't get what you want you often feel frustrated, disappointed, or sad.*

According to Horowitz et al. (2006), in our interactions with others we usually seek to elicit, invite, or evoke a response or a reaction from another person that we want or expect and that will fulfill our motive or goal. The other's response is called the "complement" of the behavior we emit. If the other person responds to you in the way that you expect, then the response is said to be complementary and you are likely to feel satisfied.

- *The **complement** of a behavior is the reaction from the other which satisfies the motive or goal underlying your behavior.*

    1. *A behavior and its complement are **similar** with respect to the horizontal dimension: Friendliness invites friendliness and distance invites distance.*
    2. *A behavior and its complement are **reciprocal** with respect to the vertical dimension: Control invites submission and submission invites control.*

If the other person responds to you in a way that does not meet your expectations, then this response is said to be non-complementary.

- *A **non-complementary** behavior is one which does not satisfy your motive or goal with that person.*

    - *A person may interpret accurately your motive but decide to reply with a non-complementary behavior. This person may refuse to give you what you want. You may accept this or you may feel hurt.*

- *When important motives are repeatedly frustrated, negative feelings result which may bring about interpersonal problems for one or for both people in a dyad.*

We can now examine another SA in light of this discussion about complementary behaviors and about the clarity of your interpersonal motives. Is your AO equal to your DO even though you may not get what you want from the other person?

HIDDEN MOTIVES

(adapted from Horowitz et al., 2006)

There are interpersonal motives which serve to protect us from feeling weak or protect us from feeling too vulnerable with regards to interpersonal schemas, such as the "abandonment" schema. A person who fears abandonment may use particular strategies, such as learning to become dependent on others, to avoid abandonment. The fear of abandonment may become a hidden motive that the person may not be aware of. The person might show that he or she needs the other's help, related to a motive of dependency, although the fear of being left alone may not be expressed. If the person does not get the help that was requested, then he or she might react in a very negative way when feeling abandoned. However, the other who refused to help may be quite confused about the person's intense reaction, not being aware of any abandonment issue.

- *Chronically depressed individuals often behave directly or indirectly in ways that push others away. The motive that is hidden may be "I don't need anyone," or "I'm a failure."*
- *The more conflict there is in the interpersonal motives we hold, whether these are hidden or not, the more we may experience negative feelings, depression, or physical symptoms such as fatigue.*
- *When strategies used to protect yourself from feeling too vulnerable or from feeling abandoned fail and the goal in an interaction with someone is frustrated perhaps because the other person did not understand your DO, negative feelings result and we tend to resort to coping behaviors to deal with these negative emotions. These coping behaviors can become extreme and maladaptive when they include alcohol abuse, binge-eating, self-mutilating, or over-sleeping and other numbing behaviors.*

We may sometimes use behavioral strategies that deter attention away from our true motives, which we prefer to conceal from another person, such as in the example of courting behaviors. This can also be adaptive and can "save face" if this other person is not interested or attracted. It is not a bad thing to protect ourselves from feeling vulnerable but there are adaptive ways of doing it such as disclosing to the person that you **want** to distance yourself for whatever reason, or that you **want** to express your discomfort or disagreement regarding issues between both of you in the exchange.

Write some lines describing your interpersonal profile:

_____

_____

_____

_____

_____

Do you know what drives, what motivates, most of your interactions with others? What is an important goal for you when you interact with others? That is, what do you often seek to get from others: approval, to be liked, to impose your opinion, etc.?

_____

_____

_____

_____

_____

Does the Interpersonal Domain, discussed throughout this group and that you have difficulty with, give you some clues about how you behave when you are afraid of others and need to protect yourself?

_____

_____

_____

_____

_____

How do you cope and what do you do when you don't get what you want from others because you haven't expressed it? Do you tend to sleep too much, numb your feelings with food, alcohol, drugs, or do you avoid people as much as possible?

_____

_____

_____

_____

_____

What is your DO? What would you like to do differently? The best way to proceed is to solve ONE PROBLEM AT A TIME, using the SA.

_____

_____

_____

_____

_____

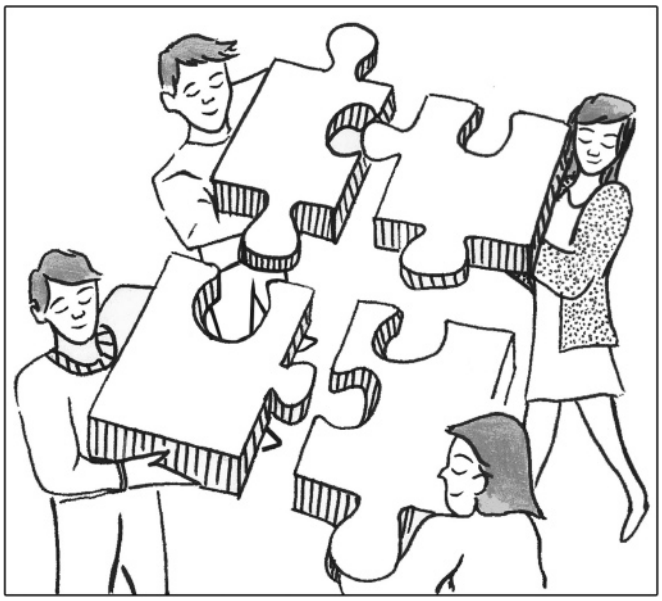
GROUP-CBASP: SESSIONS 15 & 16

Homework review:

1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

- Putting it all together
- Using the Situational Analysis to understand what you want and learn how to get it
- Your Interpersonal Profile



Homework: For next week, choose an interpersonal situation that you found difficult to manage. Try to complete the Situational Analysis as much as you can and bring it in for the next group. We will do the Remediation Phase together.

PUTTING IT ALL TOGETHER

Choosing a DO that is under your control and that is realistic and attainable means that you are learning to express what you want from others.

Learning about what you want and how to get it is what helps you feel competent and good about yourself. It is positive problem-solving behavior and it will reconnect you with yourself and with others around you. You will see that what you do does matter and you will understand the impact of what you do on others.

Using adaptive coping skills is protective against depression!

Now ask yourself:

- "Am I clear about my goal when I interact with someone?"
- "Am I getting what I want in my relationships with others?"
- "Is what I want something that is under my control, that I can reach?"
- "How satisfied am I about exchanges I have with others?"

YOUR INTERPERSONAL PROFILE

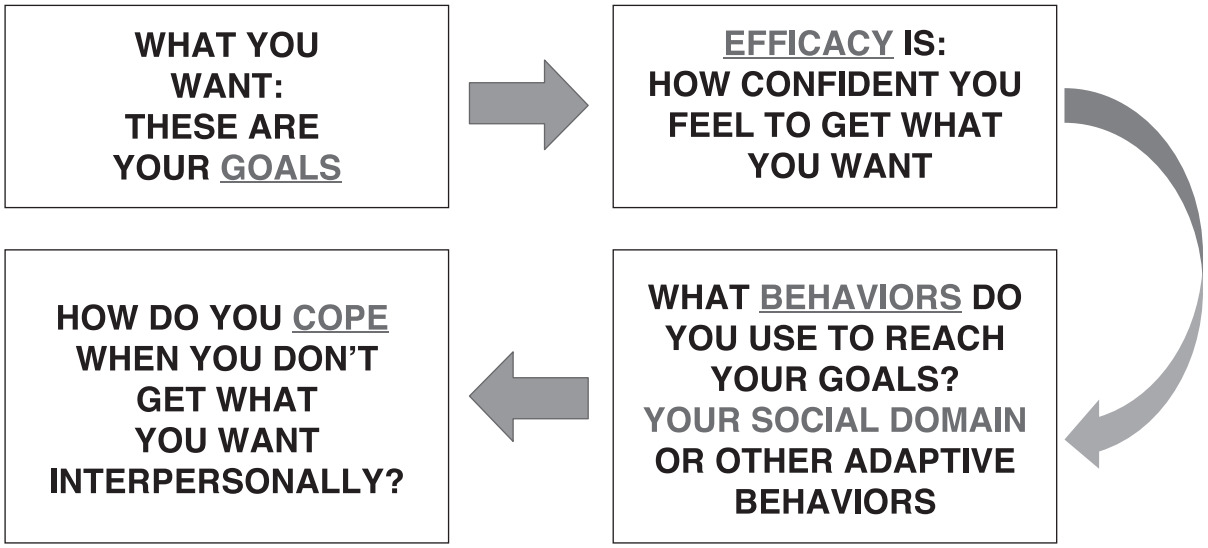
Putting together the pieces of your interpersonal profile begins with asking yourself what is **important** for you.

- Your interpersonal values will help you decide what you want, what your **GOALS** are, according to what is important for you in your interactions with others.
- Choosing a DO that is under your control will help increase your **CONFIDENCE** in your ability to get what you want.
- The **BEHAVIORS** you use need to be effective and adaptive in reaching your goals, that is in having the impact you want to have on others. You might use behaviors that do not help you get what you want, that is, get your DO, and these may need to change. Also, the social domain that you have problems with might drive you to behave in ways that stop you from getting what you want. You may think that what you want is to keep others away but you now see that this has resulted in being alone and depressive symptoms have not gone away. For example, if it is more important for you to not appear weak, then instead of asking for help, you might try to complete a difficult task alone and not succeed. So asking for help, which is an appropriate DO under your control, would be replaced by another behavior aimed at protecting your pride or saving face or perhaps avoiding fear of rejection. Here you have two motives that are in conflict: needing some help and protecting yourself. If neither one is fulfilled to your satisfaction, then how would you tend to react?
- Your **COPING** strategies used when you don't get what you want, no matter what behaviors you use, may include extreme emotional reactions, intense anger, substance or alcohol abuse, or other self-destructive behaviors, even suicidal thoughts. Many depressed individuals over-sleep to avoid interpersonal situations altogether because they feel frustrated about not getting what they want in interactions with others. Learning adaptive ways to cope, like the problem-solving SA, will help you solve one problem at a time and avoid defeatist thinking that leads to maladaptive behaviors.

Understanding how your interpersonal profile can work best to help you get what you want, reach your goals, and feel in control of your life is a very effective way to avoid relapses in depression.

HANDOUT 16

YOUR INTERPERSONAL PROFILE: HOW CAN IT HELP GET WHAT YOU WANT?



Locke, 2000; Locke & Sadler, 2007; Horowitz et al., 2006

Adapted from Locke (2000). Circumplex scales of interpersonal values: reliability, and applicability to interpersonal problems and personality disorders. *Journal of Personality Assessment, 75*(2), 249–267; Locke & Sadler (2007). Self-efficacy, values, and complementarity in dyadic interactions: Integrating interpersonal and social-cognitive theory. *Personality and Social Psychology Bulletin, 33*(1), 94–109; Horowitz et al. (2006). How interpersonal motives clarify the meaning of interpersonal behavior: A Revised Circumplex Model. Personality and Social Psychology Review, 10(1), 67–86.

GROUP-CBASP: SESSIONS 17 TO 20

Homework review:

1. What activities did you do this past week?
2. Did you bring in a copy of the Situational Analysis with a difficult situation to discuss?

Session outline:

- Prepare for termination
    - Assess your learning
    - Reviewing your goals and saying good-bye

Homework: Keep using the Situational Analysis as an effective problem-solving strategy for all interpersonal situations that you find difficult to manage.

PREPARE FOR TERMINATION

We have done a lot of great work together throughout treatment and you have accomplished so much. You have worked very hard!

When you look back at your Activity Log from the first week of treatment and compare it to your Log from the last week of treatment, what do you see? You can choose to live a healthier lifestyle, as you have done during this group, and observe the effect on your mood.

At this point, you have learned a number of interpersonal skills that can help you be a better problem-solver and feel better about yourself. It is extremely important that you continue to practice getting your DO in each interpersonal situation you're in and use the skills you've learned.

Practicing these interpersonal skills will keep you feeling connected with others and this is a protective factor against depression. It is important to continue to monitor your lifestyle and observe whether you are "getting what you want" in your interpersonal relationships, regardless of how you feel! This means being in control of your life and understanding the impact you have on others in each interpersonal situation.

Finally, it is important to remember that depression is far less likely to persist when you live a healthy, meaningful, and fulfilling life in reciprocal interactions with others.

No matter what has happened to us in the past, it is possible for every one of us to make changes to our lives and in our relationships in the present, to make the best of our circumstances, and to spend our time being involved with others in relationships that help us feel fulfilled and help us reach our life goals with as much pleasure as possible.

Good luck to you in all of your future endeavors!

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APPENDICES

DEPRESSION TIMELINE WORKSHEET

INSTRUCTIONS

1. We are going to determine the history and course of your depression using the grids below. How long have you been feeling the way you feel now? We will work from left to right on the grids and according to the severity of the depression. The lettered row above the grids represents calendar months from right to left. Circle the letter of the month we are in and write the date.
2. Then place an X on the lines of the grid underneath today's date indicating the severity of the depression this month using the following ratings:

   - **Normal** = no symptoms of depression.
   - **Mild** = dysthymic disorder or mild form of a major depression, still able to work.
   - **Moderate** = your level of impairment is noticeable by others at work or at home.
   - **Severe** = major depression with inability to work or function at home or socially.

3. How long have you felt the way you are feeling right now? (Place Xs in the slots moving toward the right to indicate the months' duration of depression or up to the starting date of the depression.)
4. We now want to place an X for each month at which there have been changes in the severity of the depression (write the date when important events, for example, birthdays, anniversaries, divorce, marriage, deaths, or any other positive or negative event took place that affected your mood) going back in time, and how long these changes lasted. Then, you can link all the Xs with a line to see the course profile of the depression.

Date of this assessment: _____

MONTHS	**D**	**N**	**O**	**S**	**A**	**J**	**J**	**M**	**A**	**M**	**F**	**J**	**D**	**N**	**O**	**S**	**A**	**J**	**J**	**M**	**A**	**M**	**F**	**J**
I. Present																								
Normal																								
Mild																								
Moderate																								
Severe																								
II. Past																								
Normal																								
Mild																								
Moderate																								
Severe																								
III.																								
Normal																								
Mild																								
Moderate																								
Severe																								

HANDOUT 2

MOOD CHART

You can use this Mood Chart to check your mood at the beginning or at the end of the day. Place a check (✓) in the box that best describes how you feel today. The top row of numbers is for days of the month. If you feel better, put a check in the boxes above "0." If you feel worse, put a check in the boxes below "0."

You can also record at the bottom of the page the number of hours of sleep you had each day and the minutes you spent doing an activity.

HANDOUT 2

MOOD CHART

Fill in a square on the chart in the morning or bedtime:

How has your mood been today?

Name: _____

Month/Year: _____

DAY →		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Extremely good all the time	+5																															
Feeling good almost all the time	+4																															
Feeling good most of the time	+3																															
Feeling good a lot of the time	+2																															
Feeling good more often than bad	+1																															
Not feeling good or bad particularly	0																															
Feeling bad more often than good	–1																															
Feeling bad a lot of the time	–2																															
Feeling bad most of the time	–3																															
Feeling bad almost all the time	–4																															
Extremely bad all the time	–5																															
Hours of sleep last 24 hours																																
Minutes of activities per day																																

HANDOUT 4

ACTIVITY LOG

Write in the space each activity you do or plan to do, your self-care, mealtimes, your sleeps schedule, etc. **Check** the box when you have done it!

Rate the level of challenge on a scale from **1----- to -----10** (1=easy; 10=very difficult)

Date:

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00							
30							
7:00							
30							
8:00							
30							
9:00							
30							
10:00							
30							
11:00							
30							
12:00							
Noon							
30							
13:00							
30							
14:00							
30							
15:00							
30							
16:00							
30							
17:00							
30							
18:00							
30							
19:00							
30							
20:00							
30							
21:00							
30							
22:00							
30							

ACTIVITY LOG CONTINUED

Write in the space each activity you do or plan to do, your self-care, mealtimes, your sleeps schedule, etc. **Check** the box when you have done it!

Rate the level of challenge on a scale from **1----- to -----10** (1=easy; 10=very difficult)

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
23:00							
30							
24:00							
Midnight							
30							
1:00							
30							
2:00							
30							
3:00							
30							
4:00							
30							
5:00							
30							

HANDOUT 17

THE SITUATIONAL ANALYSIS (SA) (FOR INDIVIDUAL THERAPY)

(Coping Survey Questionnaire—CSQ)

Name: _____

Therapist: _____

Date of Situational Event: _____

Date of Therapy Session: _____

Instructions: Select one stressful interpersonal event that you have confronted during the past week and describe it using the format below. Please try to fill out all parts of the form. Your therapist will assist you in reviewing this Situational Analysis during your next therapy session.

Situational Area: Family_____ Work/School_____ Social_____

Step 1. Describe WHAT happened: (Write who said or did what, then describe clearly how the interpersonal event ended—the final point.)

Step 2. How did you <u>INTERPRET</u> what happened during the event? (How do you "read" what happened? What thoughts did you have which indicate how the interpersonal event unraveled? What did this event mean to you—what sense did you make of what happened, from the beginning to the end of this exchange? Make a sentence for each interpretation. Try to limit yourself to three interpretations.)

a. _____

_____

b. _____

_____

c. _____

_____

Step 3. Describe what you <u>DID</u> during the situation, your behaviors: (How did you say what you said? What were some of your nonverbal behaviors, tone of voice, eye contact, etc.?)

Step 4. Describe <u>HOW</u> the event came out for <u>You</u> (The <u>ACTUAL OUTCOME</u> (AO)): (What *ACTUALLY* happened at the end of this exchange; what was observable?)

Step 5. Describe how you <u>Wanted</u> the event to come out for you (The <u>DESIRED OUTCOME</u> (DO)): (How would you have *<u>WANTED</u>* the event to come out for you? What *<u>goal</u>* would you have wanted to achieve, that is realistic, attainable, and depends on you? Describe it in behavioral terms.

Step 6. Did you get what you wanted? YES___NO___ Why or why not?

Explain why you think you do not get what you want in similar situations:

_____

_____

<u>My Action Interpretation</u>: Write out a thought that you need to tell yourself that will help you reach your goal, your DO, in this particular interpersonal situation described in Step 1.

_____

_____

EXAMPLE—CBASP SITUATIONAL ANALYSIS (SA)

Step 1. Describe what happened:

Leila had asked me two days ago to fix the lawn mower. Today she told me to put it in the shop, and I explained that I had already fixed the mower on Tuesday. I also told her that I had fixed the tank on the toilet. Her comment was that she had seen the toilet repair and that "it wasn't done right." It needed adjusting. I looked at her and said "you fix the toilet the way you want it." *She asked me if she was being too critical and I said, "yes," and walked away (ENDPOINT).*

Step 2. What did the situation mean to you? (How did you <u>read</u> the event?)

a) I told Leila about the lawn mower repair (relevant, accurate).
b) I also told her of the toilet repair (relevant, accurate).
c) Her comment about the "toilet needing adjusting" really angered me (relevant, accurate).

**<u>Add an Action Interpretation</u>: *Got to tell Leila she just hurt my feelings*.

Step 3. Describe what you did in the situation:

Told her what I had done. Then, I told her to adjust the toilet herself and that she was being too critical and walked away.

**<u>Add assertive behavior</u>: *Leila, you just hurt my feelings by saying what you did.*

Step 4. Describe how the event came out for you (What was the *AO*?)

I told her to adjust the toilet and that she was being too critical.

Step 5. Describe how you wanted the event to come out for you (*DO*)

I wanted a simple "thanks" from her *(NO; take DO out of the Environment and place it in the patient's court)*

**<u>Revise DO</u>: *You hurt my feelings by what you just said.*

Step 6. Did you get what you wanted here? Yes _____ NO __X__

J. P. McCullough, Jr., personal communication

THE SITUATIONAL ANALYSIS (SA) (FOR GROUP THERAPY)

(Coping Survey Questionnaire—CSQ)

Your Name: _____

Name of person reporting the situation: _____

Therapist: _____

Date of Situational Event: _____

Date of Therapy Session: _____

Instructions: Select one stressful interpersonal event that you have confronted during the past week and describe it using the format below. Please try to fill out all parts of the form. Your therapist will assist you in reviewing this Situational Analysis during your next therapy session.

Situational Area: Family_____ Work/School_____ Social_____

Step 1. Describe WHAT happened: (Write who said or did what, then describe clearly how the interpersonal event ended—the final point.)
Note to group members: *The person reporting the situation speaks, the other group members write down what he or she said about the situation.*

Adapted to group therapy from: J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press, page 107. Adapted with permission of The Guilford Press

Step 2. How did you <u>INTERPRET</u> what happened during the event? (How do you "read" what happened? What thoughts did you have which indicate how the interpersonal event unraveled from the beginning to the end of this exchange? Make a sentence for each interpretation. Try to limit yourself to three interpretations.)
Note to group members: *If the situation in Step 1 is not yours but that of another group member, then imagine yourself in a similar situation and write a thought that you might have experienced in such an exchange. Write at least one sentence.*

a. _____

_____

b. _____

_____

c. _____

_____

Step 3. Describe what you <u>DID</u> during the situation, your behaviors: (How did you say what you said? What were some of your nonverbal behaviors, tone of voice, eye contact, etc.?)
Note to group members: *We are describing here the behaviors of the person reporting the situation in Step 1 (name the person); we are not describing the behaviors of other group members in their imagined situations. How do you think she or he behaved in the situation in Step 1?*

Step 4. Describe <u>HOW</u> the event came out for <u>You</u> (The <u>ACTUAL OUTCOME</u> (AO)): (What *ACTUALLY* happened at the end of this exchange; what was observable? Write one complete sentence describing observable behaviors.)
Note to group members: *Now we are looking at the AO for the person who reported the situation in Step 1 (name the person). In your own words, how did the situation end for her/him?*

Adapted to group therapy from: J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press, page 107. Adapted with permission of The Guilford Press

Step 5. Describe how you <u>Wanted</u> the event to come out for you (The <u>DESIRED OUTCOME</u> (DO)): (How would you have *<u>WANTED</u>*** the event to come out for you? What ***<u>goal</u>*** would you have wanted to achieve, that is realistic, attainable, and depends on you. Describe it in behavioral terms using a complete sentence.**
Note to group members: *Here again, if the situation in Step 1 is not yours, then imagine yourself in the same situation as you did in Step 2 and now think of* ***<u>your</u>*** *DO for* ***<u>yourself</u>****. How would* ***<u>you</u>*** *have wanted the situation to end if* ***<u>you</u>*** *were there?*

Step 6. Did you get what you wanted? YES___NO___ Why or why not?
Explain why you think you do not get what you want in similar situations:
Note to group members: *Every group member can also think about whether he or she would get what he or she wants in a similar situation.*

_____

_____

_____

_____

_____

_____

After the Remediation Phase of the exercise, identify:

<u>My Action Interpretation</u>: Write out a thought that you need to tell yourself (like a coach speaking to you in your head) that will help you reach your goal, your DO, in this particular interpersonal situation described in Step 1.
Note to group members: *Even if the situation is not yours in Step 1, think about what your internal coach needs to tell you to reach your own DO.*

_____

_____

_____

_____

_____

_____

Adapted to group therapy from: J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press, page 107. Adapted with permission of The Guilford Press

HANDOUT 18

SITUATIONAL ANALYSIS (SA)
(ONE-PAGE POCKET-BOOK FORM)

(Coping Survey Questionnaire—CSQ)

Patient: _____

Therapist: _____

Date of Situational Event: _____

Date of Therapy Session: _____

Instructions: Select one stressful interpersonal event that you have confronted during the past week and describe it using the format below.

Step 1. Describe what happened: (Write who said or did what, then describe clearly how the event ended—the final point.)

_____

_____

_____

Step 2. How did you interpret what happened: (How do you "read" what happened? What did this event mean to you?)

a. _____

b. _____

c. _____

Step 3. Describe what you did during the situation: (How did you say what you said? What were some of your behaviors, tone of voice, eye contact, etc.?)

_____

Step 4. Describe how the event came out for you (Actual Outcome): (What *actually* happened? Describe in such a way that an observer would have seen.

_____

Step 5. Describe how you wanted the event to come out for you (Desired Outcome): (How would you have *wanted* the event to come out for you? What *goal* would you have wanted to achieve, that is realistic and attainable? Describe it in behavioral terms.

_____

Step 6. RATE: Did you get what you wanted? YES_____ NO_____ Why or why not?

My Action Interpretation:

_____

_____

FUTURE SITUATIONAL ANALYSIS (SA)

A future SA is used when you are thinking about what you want to say to or do with someone in the near future. In a future SA you will focus first on what you want, on your goal in the exchange you plan to have, within a specific "*slice of time*" with another person.

Step 1: Formulate a "behavioral" Desired Outcome (DO) (something that you can do: a *realistic* DO):

_____

_____

_____

_____

Step 2: Write the "interpretations/reads" that must be in place to achieve the DO (you will need one ***Action Read*** that can be repeated to yourself):

_____

_____

_____

_____

Step 3: Identify the "behaviors" that must be present to achieve the DO (you may need to do some *role-playing*):

_____

_____

_____

_____

Other suggestions:

(1) Don't worry about an Actual Outcome (AO) (it is a future event)
(2) Keep the SA simple—not complicated
(3) Review the Future SA after the situation has taken place

Adapted from J. P. McCullough, Jr. (2000). *Treatment for Chronic Depression: CBASP*. New York: Guilford Press.

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