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MULTIMODALITY COUNSELING GROUPS AS AN ADJUNCT TO THE TREATMENT OF DEPRESSION

by

James Harrison Straub

A Dissertation Submitted to the Faculty of the

DEPARTMENT OF COUNSELING AND GUIDANCE

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF EDUCATION

In the Graduate College

THE UNIVERSITY OF ARIZONA

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THE UNIVERSITY OF ARIZONA

GRADUATE COLLEGE

I hereby recommend that this dissertation prepared under my direction by James Harrison Straub entitled Multimodality Counseling Groups as an Adjunct to the Treatment of Depression be accepted as fulfilling the dissertation requirement of the degree of Doctor of Education

Dissertation Director — March 29, 1976 Date

After inspection of the final copy of the dissertation, the following members of the Final Examination Committee concur in its approval and recommend its acceptance:*

March 29, 1976

March 29, 1976

March 29, 1976

*This approval and acceptance is contingent on the candidate's adequate performance and defense of this dissertation at the final oral examination. The inclusion of this sheet bound into the library copy of the dissertation is evidence of satisfactory performance at the final examination.

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SIGNED: James H. Straub

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ABSTRACT

Depression is probably the most common mental health problem in this country. Yet, outside of the developments in chemotherapy, effective treatment methods, for use in clinical settings are being developed at a relatively slow pace. One particular approach, the use of groups specifically oriented to the treatment and management of depression has been nearly overlooked. This study combines many of the recently developed methods for use in treating and managing depression and applies them to a group setting. The purpose of this study was to verify the effectiveness of such a multi-modality educationally oriented group as an adjunct for use in treating depression in a community mental health center.

To test the effectiveness of this procedure, 16 persons clinically diagnosed as depressed, who also scored 21 or more on the Beck Depression Inventory, were randomly assigned either to participate in their regular treatment program alone or to participate in both their regular treatment program and the depression group. A second group of five persons who were in an on-going therapy group also participated in the study. They participated in the depression group for six weeks instead of their regular therapy

group. The depression group met at the same time as their regular group and with their group leaders present.

The Beck Depression Inventory and the Behavioral Change Self-rating Inventory was again administered following treatment. The results were analyzed by using the t-test. Further non-parametric evaluation was made using the Mann-Whitney U test and the Sign test where appropriate.

The results of the study supported the hypothesis that members of the depression groups would score significantly less depressed on the Beck Depression Inventory and the Behavioral Change Self-rating Inventory.

The study presented a number of implications for future research, and for clinical use of multimodality, educationally oriented groups in the treatment of depression.

CHAPTER I

INTRODUCTION

Depression is a major health problem in this country (Braceland and Capparell 1972, Lehmann 1971, Beck 1967, Lewinsohn 1974a, and Mendels 1970). It is the most common mental health problem seen in outpatient units and clinics (Beck 1973) and the leading cause of psychiatric hospitalization in this country (Schuyler 1974). Further, it is predicted that between 10 and 12 per cent of the people in this country (when women alone are considered, the rate is nearly 20 per cent) will have at least one period of clinical depression which will need treatment (Beck 1973, Schuyler 1974, Fieve 1971). In addition, most people seen in therapy are depressed to some degree even though the depression may not be the primary problem (Hauck 1973, Gurland, personal communication 1975).

Depression appears to have been observed in all higher animals (Senay 1973) and is even considered by some as basically normal for humans (Cramer 1969). One psychiatrist decribes it as perhaps even desirable (Flach 1974) and others believe it is a part of the recouperative proccesses of the individual (Lowen 1972, Schmale 1973).

Hundreds of books and articles have been written on the subject. It has been defined and redefined, categorized and re-categorized and yet there is little consensus as to what depression is, its etiology or the most effective way of treating it (Beck 1973, Lewinsohn, 1974a, Becker 1974, Sartorius 1973). Even in describing the symptoms of depression, the area of greatest consensus, there is anything but agreement about any but the most common overt symptoms (Lewinsohn 1974a, Mendels 1970, Jacobson 1971, Beck 1974, Spiegel 1974). To further complicate matters, even these commonly accepted symptoms may be absent in masked depressions (Bieber 1974).

Depression is seen by some as a unitary phenomena, ranging on a continuum from sadness to severe psychotic depression. Whereas, clinical depression is just a more intense form of normal characteristics (Friedman and Katz 1974, Beck 1973). Others tend to see it as manifested in a limited number of ways resulting from a limited number of causes (Friedman and Katz 1974). Common in the psychiatric literature, though not with common definitions, are the separation between reactive and endogenous depressions, and neurotic and psychotic depressions. The lack of understanding is further highlighted by the plethora of theories which attempt to explain depression. Becker's (1974) recent review of the subject discusses more than 15 different theories that attempt to explain depression.

Researchers have been able to induce the symptoms of depression in a variety of ways and have been able to extract a variety of common "causes" from case studies, yet there is a great deal of conflicting data. Even the same researcher may develop contradictory information (Senay 1973). Thus, many people in the field today are moving to the position of the equifinality of depression (Zubin and Fleiss 1971, Weissman and Paykel 1974, Ferster 1974, Seligman 1974, Senay 1973). As Becker (1974) puts it, depression is "a final common pathway for many sources of distress (within and between people) with great over-lapping of expression and responsiveness to treatment regardless of source" p. 197. Even for one individual there may be multiple causes (Paykel 1973). Today most of the major questions concerning depression are still unresolved (Lewinsohn 1974a) and some believe that precise answers may never be achieved (Beck 1974).

Depression is becoming so prevalent that it has been suggested the latter part of this century will become known as the "age of melancholy" (Weissman and Paykel 1974). This, coupled with the risk of suicide, indicates that new and more effective ways of treating depression need to be developed. Of particular concern is the treatment of persons who are clinically depressed without the more severe or psychotic symptoms (Schuyler 1974). About 75 per cent of persons diagnosed as clinically depressed are not severely or

psychotically depressed and yet even less is known in terms of effective treatment methods than for persons with psychotic depressions (Schuyler 1974).

Most persons who are clinically depressed have impaired social skills, and these skills are even more impaired following depressive episodes (Libet and Lewinsohn 1973, Lewinsohn 1974b, Weissman and Paykel 1974). Considering the large numbers of people who need treatment and the social base that is often present, a group approach appears to be a viable alternative worth further research. Yet little has been reported in the literature in terms of using the group modality as a primary method of treating depression (Lewinsohn, Weinstein and Alper 1970, Motto and Stein 1973).

The bulk of the current reported research utilizing group approaches to treat depressed persons is being done by Lewinsohn and his associates at the University of Oregon (Lewinsohn, Weinstein and Alper 1970, Libet and Lewinsohn 1973). However, the major thrust of this research has been aimed at investigating and increasing the social skill levels of depressed persons. Within these groups, members have been utilized to some extent as agents of behavior change for other group members (Lewinsohn, Weinstein and Alper 1970). Lewinsohn, Weinstein and Alper (1970) reported a mean group decrease of 9 raw score points on the MMPI D-scale between pre- post-measures for an 18-session group.

Killian (1971), a student of Lewinsohn, reported in his dissertation an evaluation of two approaches to altering the behavior of depressed persons in small group settings. The first approach was to instruct group members to increase the frequency of selected behavior in the group setting. The second was to use non-depressed persons as selective reinforcers of target behaviors. No change occurred with either approach.

Motto and Stein (1973) report their experience with leading an ongoing open group for depressed persons in the psychiatric ward of the San Francisco General Hospital. The group was voluntary and lasted for eight months. Participant attendance averaged five or six persons each week and individuals attended from one to 28 sessions. All patients were receiving other forms of treatment concurrent with the group. The orientation of the group was basically psychodynamic, however, didactic material was also introduced and reported to be very useful by the authors. No objective measures were utilized and no report as to the effectiveness in terms of a decrease in the severity of depression was made.

Wilson (1954) reports his use of group psychotherapy with manic-depressives. The six-month group focused on the capacity of depressed persons to relate to one another. Wilson observed that as group members learned to relate and developed a closeness there was a decrease in symptoms. Again, no objective measures were reported.

Cameron and Freeman (1956) discussed their experiences with running groups for individuals with depressive reactions over a three-year period at the Glasgow Royal Mental Hospital, Scotland. They worked with persons who had not been hospitalized for several years. The orientation of the group was psychoanalytic and the leaders tended to be passive and encourage patients to ventilate their problems and discuss them with each other. No objective measures were reported. The authors felt the group was of benefit, but major psychic changes to the extent that relapses would not occur were not thought to have been achieved.

A different approach was used by Indin (1966) while working with a group of depressed women hospitalized for recent serious suicidal attempts in Los Angeles. He based his group on Shapiro's theory of ego pathology which indicated that more of the person may be behind their own symptoms than thought to be by those with a more traditional psychodynamic orientation. The group was both supportive and confrontive, aiming to get the person in touch with her "cruel and murderous sub-self." The open-ended group lasted one year and a total of 22 patients participated. No objective measures were reported. At the end of the treatment period there had been no successful suicides among this extremely high risk population though there had been several attempts, and no member of the original group was an inpatient in the hospital.

The bulk of the reported work in the use of groups for treatment of depressed persons has focused on the development of a relationship with others by teaching social skills, providing participants with an opportunity for feedback and establishing a setting in which they could relate. The prime benefit of relating with others is seen by Lewinsohn, Weinstein and Alper (1970) as an opportunity to receive positive reinforcement and by others as the chance to "be understood."

A somewhat different approach was taken by Ribner and Ginn (1975). Their focus was a series of educational workshops for college students based on the belief ". . . that most depressions college students experience are set off by some external event (failure, loss, rejection, etc.) and are maintained both by secondary gains (e.g., attention from peers) and by the students' belief in their own helplessness to alleviate the situation" (p. 222).

Their workshop model utilized materials from a variety of people including Ellis, Beck and Seligman. The format was two two and a half to three hour sessions for 30 to 40 college students who were mostly self referred. There was no indications the participants were depressed nor were pre- and post-data reported. However, they did survey the participants as to the perceived worth of the workshops and the response was definitely favorable.

The work of Ribner and Ginn (1975), Christensen (personal communication, 1975) and of the writer indicate the definite potenital of a personalized educational approach. Such an educational approach can gain from a group setting in which members come to learn others have the same or similar problems (which takes away some of the specialness of being depressed) and can share their own successes. Further, people will often see what others are doing to themselves and to others before they will see it in themselves. Thus, a group setting provides the opportunity for clear confrontation and insight from others who are experiencing similar symptoms. It has been the writer's experience that depressed persons will often allow themselves to hear and understand what a peer says rather than the counselor; whom they may be trying to seduce into accepting them as inadequate or incapable. This is especially so if the person being confronted was earlier confronting someone else along similar lines. It is important to point out that such confrontation should be done in a supportive manner.

Other benefits which might be derived from a group setting in which members are actively engaged in a helper-therapy relationship with each other include countering commonly indentified problems of depressives such as inactivity, and feelings of uselessness, worthlessness and purposelessness (Beck 1973, Schuyler 1974, Becker 1974).

Being actively involved with another person forces some form of participation in life, and when it is in a setting which provides a great deal of positive feedback for life participation, the level of activity will be more likely to increase. When a person has reached a point of feeling there is little purpose to his/her life and he/she feels useless and of little worth, being actively involved with another who is changing his/her life will be a countering influence. Further, other people demonstrating their faith in the person's capacity for change and growth will often be a countering influence, the writer has found.

A variety of approaches have been found to be effective in bringing about significant changes in depressed behaviors and feelings. Further, since no one method has been found effective for all persons and since several approaches may be effective for the same individual, synthesizing a number of these techniques into a coherant educational-treatment package, as can be done in a group setting, seems to warrent consideration.

Statement of the Problem

The purpose of this study was to investigate the effectiveness of a multimodality group counseling procedure in teaching individuals who were diagnosed as moderately to severely depressed to alleviate or eliminate their depression. The approach was evaluated as an adjunct to

traditional on-going therapy at a state supported regional mental health center in southern Arizona. If such an approach is effective in facilitating the individual in managing his/her depression, then it offers a way of alleviating suffering and providing services to more persons in already over-crowded mental health facilities.

The group educational approach utilized a variety of methods adapted from behavioral research and from phenomenological therapies such as Adlerian, Rational-Emotive, Transactional Analysis and Gestalt. Further, group members worked with each other in a variety of group sharing and peer counseling relationships in discussing and implementing various systematized treatment strategies.

Hypotheses

It is the general hypotheses of this study that those moderately depressed persons counseled in a group setting which utilizes group members as peer counselors and provides an educational treatment package which synthesizes various behavioral and phenomenological methods in conjunction with regularly provided treatment will be significantly less depressed than those receiving regularly provided treatment only.

Hypothesis 1

Following treatment, Group A will score significantly lower than Group C on the Beck Depression Inventory (BDI).

Hypothesis 2

Following treatment, Group A will have made significantly greater gains than Group C toward personal goals as rated on the BCSI.

Hypothesis 3

Following treatment, Group B will score significantly lower on the BDI than prior to treatment.

Hypothesis 4

Following treatment, Group B will have made significant gains toward achieving the personal goals as measured by the BCSI.

Limitations

1. The possibility of experimenter bias exists because the experimenter was also the group leader. As a means of minimizing experimenter bias, pre- and post-evaluation was made by trained professionals in addition to the experimenter, thus insuring greater objectivity.
2. The size of the sample was small. However, it lays the ground for further replication studies of the procedure and is adequate for statistical procedures.
3. The control group members received a wide variety of individual treatment procedures over varied

lengths of time. However, the purpose of the study was to see if the experimental method is a viable adjunct to current treatment procedures which are extremely varied and so the comparison seems justified.

4. There was no no-treatment control group. There are a number of reasons for this choice. It is unethical not to provide treatment to persons who are seeking help, especially when compounded by the risk of suicide. In addition, the no-treatment group will often seek relief elsewhere rather than wait (LeMay and Christensen 1968, Carkhuff 1969). Further, the initial interview and testing in itself is a form of treatment since it provides a relationship and some direction by virture of the questions asked (Goldstein 1960 and 1962).

Definitions

The following terms are defined as used in this study:

Clinical depression: The symptom complex of depression (See depression).

Confrontation: The active, supportive sharing with a person as to what he/she appears to be doing to himself/herself and others and what the person appears to be gaining

from doing it. The confrontation may be around either overt or covert behaviors demonstrated or shared during the group.

Depression: Both a mood and a symptom complex. The mood is one of sadness, emptiness, loneliness and apathy. The symptom complex is one of deviations in mood, thoughts, behaviors and physiology. The MOOD is one of depression and may also include feelings of anxiety, guilt, anger and hostility. There may be definite diurnal mood variations. THOUGHTS may include those of helplessness, hopelessness, worthlessness, self blame, self criticism, self pity, other pity, and a negative view of self, the world and the future. Delusions and indecisiveness may also be present. BEHAVIORS often include crying, withdrawal, agitation, retardation, and hallucinations. PHYSIOLOGICAL changes include insomnia, hypersomnia, weight loss, weight gain, interrupted sleep, pain (especially back, neck and face pain), constipation, menstrual irregularity, diminished sexual desire and sexual dysfunction.

Endogenous depression: Depression which arises from within. In the past it was used to refer to depression resulting from internal psychological conflicts as well as depression resulting from physiological causes. Today it is more often used to refer to the latter.

Masked depression: Also known as depressive equivalent. According to Lesse (1974), this is a form of depression in which the person does not exhibit the usual symptoms

of clinical depression. Instead, the depression is often manifested in hypochondriacal complaints, psychosomatic disorders, behavioral or acting out behavioral disturbances and alcoholism and other forms of drug abuse. Not all persons with the above symptoms are depressed, but many are.

Neurotic depression: When there is some impairment in mental functioning, but the individual generally meets life demands.

Psychotic depression: When the individual hallucinates or has delusions and his/her level of functioning is impaired to the point he/she is unable to meet ordinary life demands.

Severe depression: When the individual's level of functioning is impaired to the point he/she is unable to meet ordinary life demands. Delusions and hallucinations may or may not be present.

The above definitions of depression are adapted from the work of Zung (1973), Beck (1973), and Schuyler (1974).

CHAPTER II

RESEARCH METHODOLOGY

The overall research methodology is discussed in this chapter. Included are the general design of the study and a discussion of the sources of data, characteristics of the subjects and the counselors, instrumentation, data gathering procedures and an overview of the data analysis and statistical techniques to be used.

General Design of the Study

This study is a methods comparison and evaluation in a field setting. This study evaluates the effectiveness of the multimodality educational group treatment approach as an adjunct to a variety of current treatment procedures.

The setting for this study was the Southern Arizona Mental Health Center (SAMHC). Persons who were currently in treatment, who were willing to participate in an educational group experience, were diagnosed as depressed and scored 22 or more in the Depression Inventory, were assigned to Treatment Group A (a combination of the depression group and their regular on-going therapy) or Group C (regular on-going therapy alone).

Sources of Data

The setting for this study was the Adult Outpatient Unit of Southern Arizona Mental Health Center (SAMHC), Tucson, Arizona. The unit provides a comprehensive range of therapeutic services for the full range of psychological problems. SAMHC is a community mental health unit providing comprehensive mental health care to residents of the five counties of Southern Arizona. It is a public non profit agency operated under the direct authority of the Division of Behavioral Health of the Arizona State Department of Health Services.

Referrals into the Adult Outpatient Unit are from the SAMHC Walk-in Clinic, other units of SAMHC, and from various mental health and psychiatric units in the area. Eligibility is open to all residents of Southern Arizona who have a net family income of $13,200 or less. Those earning more may be eligible if approved by the director of SAMHC. Fees range from nothing to $20 per session.

Clients who had been diagnosed as clinically depressed were approached for an interview and testing after they had been identified by staff as willing to participate in a study of depression. They were then assigned to either Group A (experimental) or Group C (control) based on the order of acceptance. Following treatment the clients were again interviewed and tested.

A second group involved in the study (Group B) was an established on-going group for women who had been or were in the day-program. Members of the group were long-term clients who evidenced depression as well. One group member was diagnosed as primarily depressed and another member of the group who rejoined as the group started was not considered depressed and was not tested. The group members invited the writer in after they were asked by the leaders if they were interested in the writer coming in and teaching them about management of their depression.

Characteristics of the Subjects and the Therapists

The subjects participating in the study were adults diagnosed as clinically chronically depressed by the agency and who scored 22 or more on the Depression Inventory. They were persons currently in the Adult Outpatient Program at the center or in the Day Program. Length of treatment received prior to the study ranged from several months to several years. Eligibility for use of the center is residency in the counties of Pima, Cochise, Graham, Santa Cruz, or Greenlee comprising Southern Arizona and a net family income of not more than $13,200. The income requirement may be waived by the director. Most persons participating in the program were Anglo, working or middle-class, and from the Tucson area.

Persons who were retarded, severely psychotic, had experienced the death of an immediate family member within the last six months, or had given birth within the last six months were excluded from the study. Since the program is educationally based, those persons who are retarded were excluded. For the same reasons, those persons who did not have reasonably good contact with reality were also excluded. Since the grieving process is similar to but different from depression (Becker 1974), and should not be interrupted (Kübler-Ross 1969), those persons experiencing a death within their immediate family during the six-month period prior to the study were excluded. Since there is evidence of biological causes for post-partum depression (Paffenbarger and McCabe 1966) those women who gave birth during the six months prior to the study were also excluded.

The staff of the Adult Treatment Program at SAMHC include the following: one full-time and one half-time psychiatrist; four psychiatric social workers; two psychiatric nurses; one full-time and two half-time psychologists. Treatment approaches vary widely and include the use of drugs, traditional Psychodynamic Therapy, Non-directive Therapy, Gestalt Therapy, assertiveness training, and eclectic.

The leader of the depression management groups was the writer. He has been in private practice for the last

two years as a consultant to a private psychiatric center and as a staff member of a private counseling agency. Prior to that he worked in an elementary school setting as a counselor/consultant with families, children and school staff. His orientation is social-phenomenological and is derived from the work of Adler, Ellis and the Goulding school of Transactional Analysis. He is also trained in behavior modification and behavior therapy and applies aspects of these within a social-phenomenological framework. His basic style is direct, supportive and confrontive.

The center requires a staff member to participate in all groups being run through their auspices. Working as co-leader of Group A was a psychiatric nurse with a similar clinical orientation. She primarily served as a back-up and reinforcer for the writer. Another staff member sat in on several sessions with the group's permission. He did not participate.

The regular leaders of the women's group (Group B) are both psychiatric social workers. They participated more as group members, participating in many of the exercises and occasionally commenting or drawing someone out. Their style, prior to the depression group, was less confrontive and more informal than that of the writer.

Instrumentation

The relative efficacy of the treatment procedures in facilitating a reduction in the intensity of depression was evaluated by two measures. The first, the Beck Depression Inventory (Beck 1967), is a self report measure of depression. The second is an informal Behavior Change Self-rating Inventory (BCSI) for each individual.

The Beck Depression Inventory (BDI), developed by Aaron Beck, provides a measure of the depth of an individual's depression and can be used to measure the change in intensity of the depression with treatment (Beck 1967). The BDI consists of 21 multiple choice questions which are read aloud by the interviewer and silently by the client. Each question covers an attitude or symptom found to relate to depression and is rated on intensity from 0 to 3. Mean scores for none, mild, moderate and severe depression from Beck's research are 10.9, 18.7, 25.4, and 30.0 respectively. The 21 attitude-symptom categories are:

1. Mood
2. Pessimism
3. Sense of failure
4. Lack of satisfaction
5. Guilty feeling
6. Sense of punishment
7. Self-dislike
8. Self accusation

9. Suicidal wishes
10. Crying spells
11. Irritability
12. Social Withdrawal
13. Indecisiveness
14. Distortion of body image
15. Work inhibition
16. Sleep disturbance
17. Fatigability
18. Loss of appetite
19. Weight loss
20. Somatic preoccupation
21. Loss of libido

The Depression Inventory, "is probably the best developed and most widely used self-report depression measure" according to Becker (1974, p. 25). Both validity and reliability of the instrument have been established in several studies (Beck 1967, Metcalfe and Maryse 1968, Becker 1974). Beck, in a study of 606 psychiatric patients, found a split half Pearson r = .93 with a Spearman-Brown correction. Further, he found all but one of the items in the inventory showed a significant relationship with the whole beyond the .001 level. The one item which did not was related to weight loss and it was significant at the .01 level. The

inventory correlates well with both clinical ratings as to the depth of depression and with other measures of depression (Beck 1967, Becker 1974).

An informal Behavior Change Self-rating Inventory (BCSI) was developed for each person participating in the study. The items on the inventory were constructed from responses made by the subjects during a semi-structured interview (See Appendix A). Two specific areas of inquiry were used to construct the inventory. The first is "The Question" as it is called in Adlerian literature (Adler 1972). Basically The Question is aimed at discovering what aspect of the person's life he/she is avoiding with his/her symptoms. The second area of inquiry focused on what behavioral changes would indicate they are better. Participants were asked "How will you know when you are better?" and "If I were to observe you for a period of time now and again when you are better, what differences would I see?"

From the answers to these areas of inquiry an individualized inventory was constructed for each subject. The inventory was used as a pre- and post- measure for evaluating changes in the subjects. The subjects were asked to respond to each item on the questionnaire in one of the following ways: I feel no hope of achieving this in foreseeable future; I have only a little hope of achieving this in the foreseeable future; I have hope of achieving this in the

foreseeable future; I believe I will achieve this and am in the process of doing so; and This is no longer a goal for myself and I do not see it as a problem area.

For example, if a man said the things he would be doing if he were not depressed would be to, "stop feeling sorry for myself most of the time," or "attend swimming classes at the YMCA," the statements would be made into items on the inventory along with items from other statements. They would read, "I will stop feeling sorry for myself most of the time," or "I will attend swimming classes." A sample inventory is included in Appendix B .

The use of an approach which measures the degree to which treatment facilitates movement toward the client's goals is advocated by Paul (1967). The client contracts with the counselor to enter into a relationship for some purpose. To make the goals of treatment explicit and to use them as a measure of program effectiveness is most appropriate according to Lauver (1970). The use of more explicit and individualized measures are also seen as desirable by Krumboltz (1966).

Data Gathering Procedures

Groups A, B, and C each yeilded two outcome scores consisting of the difference between pre- and post-counseling measures of the client on each of the evaluation measures, the Beck Depression Inventory and the Behavioral

Change Self-rating Inventory (BCSI). The measures were administered prior to counseling and following termination of the group for Treatment Group A and B. For Treatment Group C, the pre- and post-measures were administered during the same period as the pre- and post-counseling measures for Treatment Group A and B. The evaluation of clients was done by qualified persons in addition to the leader of the group counseling.

Data Analysis and Statistical Techniques

The data were analyzed and tested for significance according to the following procedures.

Hypothesis 1

The Beck Depression Inventory (BDI) was administered prior to and following treatment for Treatment Groups A and C. Gain scores were determined for both groups. The t-test for independent samples (Glass and Stanley, 1970) was used to test the gain scores to see if the gain scores for Group A were statistically larger than those for Group C.

Hypothesis 2

The Behavioral Change Self-rating Inventory was administered to Treatment Groups A and C prior to and following treatment. Gain scores were determined for both groups. The t-test for independent samples (Glass and Stanley, 1970) was used to test the gain scores to see if the gain scores

for Group A were statistically larger than those for Group C.

Hypothesis 3

The Beck Depression Inventory was administered prior to and following treatment for Treatment Group B. The t-test for dependent samples (Glass and Stanley 1970) was used to test the pre- and post-scores to see if the pre-test scores were statistically larger than pre-test scores.

Hypothesis 4

The Behavioral Change Self-rating Inventory was administered to Treatment Group B prior to and following treatment. The t-test for dependent samples (Glass and Stanley 1970) was used to test the pre- and post-scores to see if the post-treatment scores were statistically larger than pre-treatment scores.

The .05 level of significance was used as the acceptable level for all four hypotheses.

CHAPTER III

RESULTS

The purpose of this study was to determine what effect multimodality counseling groups focused on the management and treatment of depression as an adjunct to regular therapy would have on the level of depression of people who are chronically depressed at the moderate to severe level as measured by the Beck Depression Inventory (BDI) and as assessed by the staff of the Southern Arizona Mental Health Center. The participants in the treatment groups attended up to six weekly one and one half hour sessions. Participant data were gathered by using the BDI and an informal Behavioral Change Self-rating Inventory (BCSI). The resulting data were analyzed by using the t-test for independent samples and the t-test for dependent samples. In consideration of the fact that the data do not strictly meet the requirements for parametric statistics, the following non-parametric tests were also used; the Mann-Whitney U test and the Sign test (Siegel 1956).

Analysis of Results

The analysis of the data from both the BDI and the BCSI yielded consistently significant results for both

treatment groups. These data are summarized in Tables 1, 2, 3, and 4.

Treatment Group A had a pre- to post-treatment mean gain score of 11.25 points on the BDI and Treatment Group C (control) had a mean gain score of 1.125 points. When these data were analyzed using the t-test for independent samples, the difference was found to be significant at the .01 level. When analyzed using the Mann-Whitney U test, data were found to be significant at the .001 level.

Treatment Group B (the previously existing group) had a pre- to post-treatment mean gain score of 9.6 points on the BDI. When pre- and post-scores were compared using the t-test for dependent samples, the difference was found to be significant at the .005 level. When the same data were analyzed using the Sign test, they were found to be significant at the .031 level.

The mean gain score for Treatment Group A on the BCSI was .936 and for Treatment Group C .175. Analysis of these data using the t-test for independent samples indicated the difference was significant at the .005 level. Nonparametric analysis using the Mann-Whitney U test indicated the difference was significant at the .031 level.

Table 1. Beck Depression Inventory Pre- and Post-test and Gain Scores for Treatment Group A (Depression Group) and Treatment Group C (Control)

GROUP A

Pre-test	Post-test	Gain
22	18	- 4
26	5	-21
37	26	-11
33	25	- 8
29	18	-11
26	18	- 8
42	29	-13
31	17	-14
$\bar{x}$ 30.75	$\bar{x}$ 17.38	$\bar{x}$ -11.25

GROUP C

27	20	- 7
27	25	- 2
24	17	- 7
40	42	+ 2
23	21	- 2
26	32	+ 6
31	26	- 5
22	28	+ 6
$\bar{x}$ 27.5	$\bar{x}$ 26.88	$\bar{x}$ -.875

Analysis of these data using the t-test for independent samples indicated the difference between the mean change scores was significant at the .01 level.

Table 2. Behavioral Change Self-rating Inventory Pre-, and Post-test and Gain Scores for Treatment Group A (Depression Group) and Treatment Group C (Control)

GROUP A

Pre-test	Post-test	Gain
0.82	2.07	1.25
1.00	3.29	2.29
1.33	1.62	0.29
1.00	1.44	0.44
1.54	1.62	0.08
0.93	1.47	0.54
1.25	2.00	0.75
1.00	2.85	1.85
$\bar{x}$ 1.11	$\bar{x}$ 2.05	$\bar{x}$ .936

GROUP C

1.63	1.75	0.12
2.0	1.1	-0.9
1.67	2.33	0.66
1.83	2.0	0.17
.83	1.17	0.34
1.22	2.71	1.49
2.1	1.62	-0.48
$\bar{x}$ 1.41	$\bar{x}$ 1.59	$\bar{x}$ .175

Analysis of these data using the t-test for independent samples indicated the difference between the mean change scores was significant at the .005 level.

Table 3. Beck Depression Inventory Pre- and Post-test and Gain Scores for Treatment Group B

Pre-test	Post-test	Gain
22	11	-11
26	16	-10
35	30	- 5
24	14	-10
24	12	-12
$\bar{x}$ 26.2	$\bar{x}$ 16.6	$\bar{x}$ -9.6

Analysis of the data using the t-test for dependent samples indicated the difference between the mean pre- and post-test scores was significant at the .005 level.

Table 4. Behavioral Change Self-rating Inventory Pre- and Post-test and Gain Scores for Treatment Group B

Pre-test	Post-test	Gain
0.8	2.4	1.6
0.6	0.9	0.3
1.5	2.3	0.8
1.8	3.0	1.2
1.5	2.3	0.8
$\bar{x}$ 1.24	$\bar{x}$ 2.18	$\bar{x}$ .94

Analysis of the data using the t-test for dependent samples indicated the difference between the mean pre- and post-test scores was significant at the .01 level.

Treatment Group B showed a mean gain score of .96 on the BCSI. These data, when analyzed using the t-test for dependent samples, were found to be significant at the .01 level. Nonparametric analysis using the Sign test indicated the difference was significant at the .031 level.

Experimental Hypotheses

Following is a discussion of how the results affected each of the hypotheses.

Hypothesis 1

Stated that following treatment, Group A (those persons who participated in educationally oriented, multimodality group counseling focused on the treatment and management of depression in addition to their regular treatment) would score significantly lower than Group C (regular treatment only) on the BDI. The results of the analysis supported Hypothesis 1 at the .005 level of significance.

Hypothesis 2

Stated that following treatment, Group A would have made significantly greater gains than Group C toward personal goals as rated on the BCSI. Hypothesis 2 was supported at the .005 level of significance.

Hypothesis 3

Stated that following treatment, Group B (the existing group that participated) would score significantly

lower on the BDI than prior to treatment. Hypothesis 3 was supported at the .005 level of significance.

Hypothesis 4

Stated that following treatment, Group B would have made significant gains toward achieving the personal goals as measured by BCSI. Analysis of the data indicated the gain was significant at the .01 level. Therefore, Hypothesis 4 was supported.

Because the four experimental hypotheses were supported, the general hypothesis that short-term multimodality counseling groups focused on the treatment and management of depression are of value as an adjunct to on-going therapy received strong support from this investigation.

CHAPTER IV

DISCUSSION, IMPLICATIONS AND CONCLUSIONS

Discussion

The stated purpose of this study was to verify the effectiveness of the use of short-term, multimodality counseling groups focused on the treatment and management of depression as an adjunct to on-going treatment for chronically depressed individuals. A summary of the sessions appears in Appendix C. The results of this study appear to give strong support to the use of such groups. In addition to the test results, other informal data collected seem to support the use of such groups.

The following data (Table 5), collected by questionnaire (See Appendix D), summarize participant evaluation of the group experience.

Eleven of the 13 participants suggested the groups run at least ten sessions instead of six sessions. The members stated there were enough sessions to cover the material without being rushed, but the number of sessions was too short for them to get enough practice and develop comfort with following through on the activities of their choice.

Table 5. Informal Post-group Questionnaire Results for Treatment Groups A and B.

0 - Not at all
1 - A little
2 - Some
3 - A lot
4 - Very much

	0	1	2	3	4
1. How helpful did you find this course?	0 0	0 1	1 0	6 3	1 1
2. How well have you learned to manage your depression?	0 0	1 1	5 2	2 2	0 0
3. How much better do you understand how you make yourself depressed?	0 0	1 1	1 0	3 3	3 1
4. How much better do you understand the purpose of your depression?	0 1	3 0	2 2	3 1	0 1
5. How much better do you understand the ways you can stop your depression?	0 0	1 1	3 0	2 2	2 2
6. How willing are you to employ what you have learned?	0 0	0 1	0 0	5 1	3 3
7. How helpful has this course been in other areas of your life?	0 0	2 1	4 2	1 2	1 0
8. Would you recommend this course to a friend if he/she were depressed?	0 0	0 0	0 1	4 1	4 3

The number of persons responding to each choice is listed under the number corresponding to the choice. The number responding for Group A is underlined and for Group B is not.

An indication that the group was of value to group members was the low attrition rate. Only 20 per cent of the group dropped out, whereas the normal attrition rate for groups run at the center is 50 per cent according to staff. Further, seven members of the evening group (Group A) wanted to continue. Despite a necessary time change, five of the 8 members stayed in a follow-up group. Included in the five were two persons who had been very inconsistent in meeting appointments in the past according to center staff. Further, the day group (Group B) asked their regular leaders to spend additional sessions reviewing and following up what was covered during the six-week depression group.

Another factor that may reflect on the effectiveness of the group is that three persons in the evening group discontinued their regular therapy appointments during the period of the group, returning to individual therapy only after the group ended. Since all three did improve while attending only the gorup, this may indicate that for some persons the group may be effective as the primary treatment. Because the rapid and active confrontation which goes on in this kind of group stimulates strong affective reactions which may need to be dealt with in a way that is beyond the scope of this type of group, the writer strongly believes that the option of individual or group therapy should be available.

Although no specific data were collected, staff feedback as to the progress of the group members was uniformly positive. Following the group, three group members choose to enter special treatment programs at the center with the objective of getting better rather than maintaining as they had in the past. Others participated more actively and more often in their individual therapy according to staff reports.

Implications

The present study has several implications for future research and clinical use. In the current study, significant improvement was found in post-testing after only six weeks. However, a major complaint by group members was that the group ran for too few sessions. They stated they needed more time to practice the techniques taught and to develop a habit pattern of regular use. It would be of value to find if longer running groups would be of particular value in facilitating greater change.

A further point to pursue would be whether or not similar results would be obtained by leaders with different styles and/or theoretical orientations. The writer, who led both groups maintained a direct-confrontive role of teacher and facilitator and used humor to a great extent to get points across. Further, the emphasis was on support of the individual and his/her ability to create and maintain or

manage and eliminate his/her depression. Essentially all negatives were turned around to positives and/or made into learning experiences. Group members were encouraged to take an active teaching and supportive role with each other in and out of the group. There are many other styles of leadership and theoretical orientations. It would be of value to discover which combinations are most effective in working with depressed individuals in a group setting.

Another area worth further pursuit is the use of such groups with other depressed populations. Persons who are chronically mildly depressed and those who are in an acute reactive depression rather than those who are chronically depressed at a moderate to severe level as a part of their lifestyle might benefit from such groups.

An additional area for further study would be the application of multimodality, educationally oriented, counseling groups to other problem areas. Assertiveness training is the most common group of this type now in use. The possibilities of using this type of group with other problems such as anxiety for short-term intervention seem to be of great potential value.

While this study provides strong support for the effectiveness of short-term-multimodality groups focused on the treatment and management of depression, it is obvious that there is a great need for further research in this area. It is evident that one study is not enough to warrant

large scale use of such a procedure. However, if confirmation can be obtained through other studies in other settings with other leaders, such an approach could have a significant impact on the treatment of individuals in an already over-crowded mental health system.

Conclusions

Two conclusions seem to be appropriate based on the results of this study.

First, short-term multimodality, educationally oriented group intervention can be effective in teaching people to give up or manage their depression, even if they have a history of chronic depression as a life-style. This conclusion is based on the post-test data analysis indicating a very high probability that those persons who participated in the depression groups improved as a result of their participation in the group.

Second, such a group is of interest to chronically depressed individuals. This conclusion is based on the low drop-out rate of the groups as compared to the drop out rate of the center as a whole as well as the eagerness of group members to continue the group.

In conclusion, the present investigation has shown that short term, multimodality counseling groups focused on

the management of depression is a promising method for helping alleviate a major source of suffering and dislocation in this country.

APPENDIX A

INTERVIEW GUIDE

Name_____

Marital History_____

Number and ages of children_____

Educational and work history_____

Family constellation and brief summary of childhood circumstances_____

How long in counseling or therapy, here and a brief summary of treatment history_____

Brief history of depression

First experience_____

Duration_____

Frequency_____

Description of onset circumstances_____

Descriptions of personal experience of depression_____

How it ends_____

Suicide

Attempts, number and frequency_____

Thoughts, frequency and extent_____

Where with suicide now_____

"The Question" (If I had a magic wand and could rid you of your depression and all the problems you have with it, what would you be doing differently? How would your life be different?)_____

BCSI Questions

How will you know when you are better?_____

If I were to observe you for a period of time now and a period of time after you are better, what differences would I be able to see? How could I tell you were better?

_____

APPENDIX B

SAMPLE OF BEHAVIORAL CHANGE SELF-RATING INVENTORY

Self-rating Inventory

1.	I will have a normal amount of contact with people.	1	2	3	4	5
2.	I will stop isolating myself.	1	2	3	4	5
3.	I will be sexually active.	1	2	3	4	5
4.	I will be aware of my body.	1	2	3	4	5
5.	I will stop worrying about "it" waiting for me when I have a good day.	1	2	3	4	5
6.	I will make decisions.	1	2	3	4	5
7.	I will feel alive.	1	2	3	4	5
8.	I will believe I'm alive.	1	2	3	4	5
9.	I will find eating pleasurable.	1	2	3	4	5
10.	I will feel warmth toward people.	1	2	3	4	5
11.	My memory will function appropriately.	1	2	3	4	5
12.	I will have better posture.	1	2	3	4	5
13.	I will feel relaxed a reasonable amount of the time.	1	2	3	4	5

APPENDIX C

SUMMARY OF GROUP SESSIONS

Group Sessions

The educational group approach to depression as used in this study is outlined in this section. While the same format was used with each group, the exact pacing and emphasis was varied to meet the individual needs of each group. The following outline summarizes the thrust of each session and the ideas, materials and techniques introduced during that session. The material was reviewed the week following introduction through discussion. Further, much of the material was reintroduced around particular issues and for review at later sessions by both the counselor and group members.

Session #1

Following a brief introduction by each member of the group a brief rationale of the educational basis of the group was presented. It was emphasized that the success of the members' changing depended on their following through with the suggested activities. It was up to them if they wanted to change and the leaders were not going to push them. Further, it was emphasized that it was an educational group and not a therapy group. However, there would be opportunities for group members to do work around specific issues if they wanted to later in the group. Therapy was defined as specific redecision work (Goulding and Goulding 1976) utilizing psychodrama and Gestalt dialogue and fantasy

techniques. Only one person engaged in specific work during the six weeks. However, in a follow-up group that several members requested, this made up about one fourth of the activities. The purpose of emphasizing the educational approach was to get over the initial resistance to sharing at a personal level that is often seen in groups labeled as therapy which imples that the person is sick as opposed to lacking knowledge. The report of the observers indicated that the speed and depth of sharing was much greater than in typical groups run at the Center.

Next, each member of the group was asked to complete the sentence "One way I make myself depressed is . . ." Group members were instructed to begin the sentence even if they had no ideas as to how to finish it. The sentence was repeated for several rounds with everyone participating, even if they repeated what someone else said. However, they were not to repeat themselves. The exercise served to show members that they do have control over their depression. For many it was the first time they had thought in terms of making themselves depressed. Often there was recognition laughter during this exercise and during the following lecture and discussion.

A lecture/discussion followed focusing on how people make themselves depressed emphasizing the cognitive aspect, but also including the things they say and do to decrease the amount of reinforcers they get from the environment.

Heavy use of humor and theatrics was used to keep the people involved and to de-emphasize the seriousness they place on their depression as a disease of which they are a victim (McLean, Ogston and Grauer 1973). Many examples were used that often showed members the humor in the way they behave. The cognitive process was summarized by the use of two complimentary views. One was from the Rational Emotive Therapy approach discussed by Hauck (1971) emphasizing the self-pity, other-pity and self-blame paradigm. The other came from the Gestalt Therapy paradigm of how people avoid the "here and now" by focusing on the negative aspects of the past, predicting negative events in the future or focusing on the "If only . . ." magic of being somewhere or someone else. Again, these points were presented and discussed with numerous examples, utilizing humor since one of the goals was to teach the group members not to take themselves or their problems so seriously. Further, humor is considered as incompatible to depression (Lewinsohn 1974a).

Next, the focus of discussion was turned to how group members could counter their depressive thoughts and behaviors which they used to make themselves depressed or more depressed. The objective was to have them figure out ideas for themselves and each other. This served to instill the belief that they do have control over their lives to a great extent and to start a pattern of social interest and

relating to others. Following the discussion, the leader summarized some of the points and introduced the Stop-Think technique (Cautela 1969) and Mahoney's rubber band technique (Wright and McDonald 1974) as ways of interfering with depressive thought patterns. Following the thought interruption, it was suggested that participants could further refocus their attention by: (a) attending to what they were doing, (b) if what they were doing was not of particular interest or complexity on which to easily maintain a focus, then they could change activities to one that was, and (c) if they did not want to change activities or it was not feasible, then it was suggested they utilize pleasant fantasies with high interest such as sexual fantasies, sailing fantasies or planning fantasies.

It was pointed out that changing thought patterns was a several step process. They would in the beginning probably not be aware of what they were doing to themselves until after they had already done it. This could be used constructively to review what they had done to themselves serving to take away some of the magic of depression. Next they would start catching themselves before they had gotten themselves deeply depressed, but not all the time. With more practice they would continue to catch themselves and intervene earlier and earlier in the process, but not every time. It was explained that sometimes, even when they had

regularly been catching themselves at or near the beginning of the process, they would get themselves "way down" without catching themselves and this was normal. This serves to cut down on the frustration and extreme self-criticalness that people often apply to themselves (Mosak 1974, personal communication). This is particularly important with depressed persons, who the writer has found often to be very perfectionistic.

Group members were then asked to share with each other what they could and would do in countering their own depression. This served to get a group commitment, which is more likely to be carried through and to reinforce in each person's mind his/her alternatives to continuing to think depressive thoughts.

At this point the rules for the group were introduced. They were simply that there would be no depressed talk and no talking "about" each other. If a person had something to say to another, they were to say it directly to that person. The objective of the first rule was to increase the amount of non-depressed talk and to teach the group members to relate on other than depressed terms (Ferster 1974, Robinson and Lewinsohn 1973). Further, the counselor and other group members serve as reinforcers for non-depressed talk (Burgess 1969). The second rule served to structure the setting for greater interpersonal interaction

by group members to reinforce each other and to cue reinforcers from others. The rules of confidentiality were also shared with the group members.

Another rule of the group that was not explicitly stated as a general rule was that each person was to use language of ownership instead of erasing or discounting the themselves with the words they used. That is, members were to use "I" instead of "you" or "it" in their speech when they meant "I"; "I won't" or "I choose not to" instead of "I can't"; "I choose to" instead of "it makes me"; etc.

Questions and comments were sought from the group and discussed at the end of the first session.

Session #2

This session and all subsequent sessions began with a "brag session" during which each member in turn took time to focus on and share with the group some things he/she did that he/she felt good about. Shared behaviors ranged from getting up in the morning and getting dressed to pulling one's self out of a depressed state that normally they would have continued for a long period of time. At later sessions, members were encouraged to bring things to the group such as paintings, creative writing, leather projects, etc.

Next, and at the beginning of each subsequent session, the activiites discussed in the previous sessions were reviewed and any technical problems or suggestions

were reviewed and any technical problems or suggestions group members had were discussed.

Ellis' (1962) ABC paradigm of the process one uses to create negative feelings was introduced and discussed and then applied to individuals around specific instances of their making themselves depressed. Further, the ways in which people often catastrophize events (Ellis 1962) and avoid the use of consensual reality (Shulman 1968) were emphasized. Magic beliefs are often present (Ferster 1974) and the need to actively counter these was pointed out through the discussion of the common belief among depressed persons and others that "If I worry enough about something or someone it is like a magic spell that will prevent bad things from happening". During the discussion, group members were encouraged to share other magic beliefs and thoughts they had.

Next, the concept of how many people stop themselves from engaging in activities that they might enjoy by predicting they will not enjoy them, or telling themselves "What's the use, it isn't going to make any difference, everything will be the same afterwards" was introduced. Further, it was pointed out how they could take away from the pleasure of an activity by not being involved in it and instead thinking about it and how it used to be or should be or how it does not make any difference. Then they can take

it further and use the less than satisfying experience to prove how bad off they are and that there is no use in trying in the future. This served to realign the person's thought processes away from the typical pattern of defeating oneself and preventing enjoyment of activities (Izard 1972). As is pointed out by Hammen and Glass (1975), activity alone is not enough to counter depression, but the person needs to evaluate it in a pleasurable way.

The above served to lay the groundwork for introducing structured activity sheets. Participants were paired and given the activity sheets (Appendix E). In addition, a list of potentially pleasant activities to be used for ideas, but not as a strict guide, were passed out and explained. Participants were then asked to pair up and work with each other in developing a personalized list of activities each might engage in during the coming week. The list and activity sheets were modified from the work of Lewinsohn (1974a). Each person was instructed to fill out their sheet each day and bring it to the group to share the following week.

Session #3

Following the initial activities, the main focus for the first part of the session was on the purposiveness of depression, how people use their depression (and other emotions, symptoms, etc.) for a variety of purposes. This is

discussed in much of the Adlerian literature (Ansbacher and Ansbacher 1964, Shulman 1968, Shulman and Mosak 1967, and Adler 1961).

People may use their depression as a sort of "Insurance policy" in that they can say, "If it weren't for my depression I would . . ." or "Look what I did even though I was depressed." People can also use their depression to avoid whole areas of life they may not feel adequate to deal with such as work, relating with people, getting married, etc. If they blame it on their depression instead of their own shortcomings (Becker 1974), they do not need to do anything about it.

Another common use of depression is to manipulate others. Many depressed persons use their depression as a passive form of manipulation to gain more attention, as a form of emotional blackmail to get their own way, and to avoid dealing with others and themselves in an honest way in general. It is the author's experience that acceptance-anxious people often use depression as a covert way of dealing with others.

A popular use for depression is the superiority in suffering. For persons who believe they are okay only when they are better than others and who feel they "can't" be successful in life, the moral superiority of suffering may seem to be better than nothing. People will often get into exchanges of: "I have more problems than you."; "Look how

much I suffer."; "Look how well I suffer."; "See how many people I get to mistreat me."; "See how I suffer in silence while those others talk about their problems which aren't half as bad as mine."; "Suffering is next to Godliness."; etc. Others have decided for one reason or another that their role in life is to suffer, be a victim, etc., and their depression serves to maintain them in that role in their eyes.

During discussion of the ways people use their depression, without being aware, data from previous sessions was used to personalize for various individuals with tentative hunches about how they use their depression. It was also pointed out that people are very creative and often do not let something as good as a depression go to waste by using it for only one purpose. Frequently, depression is used for several pruposes.

Members then took turns finishing the sentence, "If it weren't for my depression I would . . ." After a few rounds with this incomplete sentence, group members discussed what they had learned for themselves and what they were willing to do with the information.

Often more than simple awareness is necessary for people to deal with the other issues. For example, a woman in one group got in touch with how she was using her depression as an excuse not to leave her husband and instead feel sorry for herself and only deal with him through the weapon

of her depression. Through a brief psychodrama she saw she could leave him and chose not to. She then allowed herself to become aware of how she could deal with her relationship and her life in other ways. Most group members used this material as fodder for their regular therapy sessions.

During the last part of the session, the group discussed how nasty most depressed persons are to themselves most of the time, always thinking bad things about themselves. Further, thought interruption and refocusing techniques were often not enough in and of themselves to learn to nurture oneself. In addition, they needed to develop the habit of silently stroking themselves. At this point, Homme's Coverant Control Therapy procedure (Todd 1973, Homme 1973, Mahoney and Thoresen 1974) was introduced.

Group members then paired up to work with each other in developing lists of their behaviors and characteristics that they felt good about and to select the High Probability Behavior (HPB) to use as a reinforcer. After everyone had their lists developed and HPB selected, they returned to the group and briefly shared their list.

Session #4

Following the initial activities, time was spent reviewing what had been covered up to this point. Much of this was a part of the sharing the people did. By this time the initial rounds also included a brief summary of where

each person was in managing his/her own life and depression. This was used as a springboard into problem solving with such questions as "How did you make yourself depressed?"; "How did you get yourself out of your depression?"; "When that (something unpleasant or discouraging) happened, how did you keep yourself from getting yourself depressed like you used to?"; "What can and will you do in the future?"; etc.

Following the review, the way people often discourage themselves and hold back good feelings about things they need to do and do do by looking at the whole task at once was discussed. It was pointed out, that if people looked at all of a large project such as cleaning the house (especially, if there are young kids and an active family around) they may very easily give up before they get started. Further, even if they do do something, they often do not give themselves credit for it because they are busy looking at what is not done and/or how much less than perfect what they did do was.

At this point, the process of breaking a task down into component parts was introduced. A person is often better off breaking a task down, and completing one component at a time. Then the person should stop and spend some time feeling good about what was accomplished without considering what is left. This is a variation of a process

discussed by Jackson (1972). An example was used for demonstration purposes and the group discussed how to apply this technique to their own lives.

The remainder of the session was spent talking about how people early in their lives make rules about themselves, the way they should be and the way others and the world should be. They then use these rules, outside their awareness, as guides for their lives (Ansbacher and Ansbacher 1964, Goulding and Goulding 1976). People program themselves somewhat like a computer and then continually reinforce these rules by their early recollections, dreams, transactions with others and the way they interpret events. It was pointed out how often these rules had a great deal of survival value (Goulding and Goulding 1976) for the person as a child, but how they are often dysfunctional now.

Then a modified form of a redecision instrument developed by the writer was introduced. The people paired up and worked through the instrument with each other. While this instrument had worked very well as a catalyst for change with students in a classroom setting, it was not particularly useful in this setting with this population and will be dropped in the future.

Session #5

Following the initial activities, the main thrust of the session was on what the various members had done for

themselves and how they were blocking themselves in other areas. Further time was spent on the use to which people were putting their symptoms with a great deal of emphasis spent on group sharing. This provided a further chance to point out dysfunctional interpersonal transactions that seemed repetitive and may be used to maintain the early rules the individuals had made and/or to collect negative feelings. For example, one person who was wanting to move closer to other people and learn how to relate at an honest level without using her problems to protect herself, chose the one person in the group who most did not want to relate to people and was using his depression as a means keeping distance. This became a springboard for seeing the pattern of how she, (by picking people who would reject her) kept herself stuck and proved to herself that others would reject her. From this point, the group spent time focusing on what she did effectively and how she might do other things differently and offered specific suggestions from their experience with her. Other people used role-playing to practice working out solutions to their problems.

One of the main benefits of this type of interaction was that the group members were able to see how well they were relating to others. Further, they saw how much positive feedback and genuine help they had learned to give, focusing on others instead of drawing attention to themselves through their problems.

The final activity was for each person to share a word or phrase drawn from his/her experience in the group that was most meaningful to him/her. For one women it was "I am not God" referring to her attempts at perfection and superiority, for another who had heard "voices" for a long time the word "Stop!" referring to the stop-think method she had learned and applied to control the "voices." After each person had selected a meaningful statement for himself/herself, poster paper was passed around along with crayons. Each person then made a poster for himself/herself using his/her phrase. They then took their posters home and put them up in a conspicious spot to serve as a reminder.

Session #6

The last session, following the initial activities, was again focused on individual growth and application, again with the use of discussion and role-playing. The last of the session was spent finishing-up any unfinished business and collecting part of the research data.

The final activity was a variation of a stroking exercise often used in Transactional Analysis groups. Each group member was given a sheet of poster paper and a piece of tape to use to attach it to his/her back. Each person was also given a crayon with the instruction to write anything positive on any person's sheet he/she wanted to share.

The only restrictions were to make exclusively positive statements, to be honest and only give strokes if and to whom one wanted. The statements on the sheets were then shared with the group. This was followed by goodbyes.

APPENDIX D

INFORMAL QUESTIONNAIRE

Questionnaire

Name_____

The following questions are to evaluate your personal opinion of the course for yourself. Please place a number after each question to indicate your opinion.

0 = Not at all
1 = A little
2 = Some
3 = A lot
4 = Very much

1. How helpful did you find this course?_____
2. How well have you learned to manage your depression?____
3. How much better do you understand how you make yourself depressed?_____
4. How much better do you understand the purpose of your depression?_____
5. How much better do you understand the ways you can stop your depression?_____
6. How willing are you to employ what you have learned?____
7. How helpful has this course been in other areas of your life?_____
8. Would you recommend this course to a friend if he/she were depressed?_____

List two ways of countering your depressions you find most helpful.

_____

_____

Please list any additional comments or suggestions for this course below.

APPENDIX E

ACTIVITY SHEET

Activity Sheet

INSTRUCTION: Place check marks in each day's column to correspond to the number of times you engage in the activity that day. Also place a number in the square to correspond to the overall pleasantness of the activity for that day:

2 = a little
3 = a fair amount
4 = much
5 = very much

For Example: If you go for a walk two times on Saturday and you find it fairly pleasant, place two check marks and the numeral 2.

Activities	Thur.	Fri.	Sat.	Sun.	Mon.	Tue.	Wed.

Name_____ Date_____ R.S._____

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