

Lewinsohn's cognitive behavioral group therapy course for depression: structure, application and efficacy.

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Summary

The Coping with Depression Course (CWDC) by Lewinsohn, Antonuccio, Steinmetz-Breckenridge & Teri (1984) is a cognitive behavioral treatment program for depression. It is a structured psychoeducational program based on social learning theory and its clinical application, behavioral therapy. The program is consisted of 12 sessions and 2 follow up sessions that take place 6 and 12 months respectively, after the completion of the course. Its psychoeducational structure allows it to be used in book-based approaches (self-help) as well as a prevention method. International bibliography reveals the worldwide application it has in adolescents, adults, elderly populations, clinic outpatients, minority groups, elderly caretakers, as well as patients with chronic depression that do not respond to antidepressant therapy. A series of research shows that it is an efficacious therapy even for cases with chronic and resistant depression that did not respond to previous treatment. The course has been translated and adjusted for the Greek language and it is being applied in the Therapy Department of the Institute of Behavioral Research and Therapy, as well as in counseling centers in 3 major Greek Universities. Although its application has taken place with a variety of groups, and in different therapeutic settings, its efficacy has still not been presented for a Greek population. Further research is needed so as to compare the program's efficacy to other psychotherapeutic and medicinal treatments.

Key words: group cognitive behavioral therapy, coping with depression course, psychoeducation, depression

Introduction, theoretical context

Depression is a disorder that affects a person's mood and is usually accompanied by reduction in energy levels and increase of tiredness. A person suffering from depression most often experiences changes in appetite, weight, sleep, in the way they view themselves (reduced self-appraisal and self-trust), their relations with others and in the manner they experience life situations. Depressive affect is intense, lasts for extended time periods and leads in reduction of a person's functionality in most life areas [1,2].

Cognitive Behavioral Therapy (CBT), which is most often the therapy of choice for depression, is based on Aaron Beck's [3] model. This model consists of three basic concepts which are the cognitive triad, schemas and cognitive distortions, and aim to describe the psychological underlayer of depression. In depression the concept of cognitive triad refers to the negative manner by which people view themselves (inadequate, unworthy, unlikeable, diseased), the world around them (demanding, rejecting) and the future (grim, holds continuous hardship, frustration, losses). The concept of schema refers to a cognitive construction partied by stable interpretation patterns for a specific set of stimuli. In depression, dysfunctional schemas that prevail lead to a systematic distortion of reality (negative beliefs). These negative distortions also maintain a person's faith about the righteousness and validity of their negative beliefs, despite contradictory evidence. Most common categories of cognitive distortions are arbitrary inference, selective abstraction, overgeneralisation, magnification and minimisation, personalisation and dichotomous thinking [4].

A Cognitive Behavioural group intervention follows the basic principles of Cognitive Behavioural theory. It is based upon three elements: keeping an agenda for each session, providing feedback and maintaining clarification of goals⁵. Simultaneously, in a secondary

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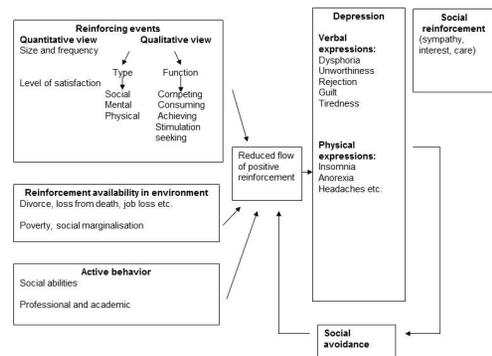
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level, the group dynamic is being used in order to facilitate goal achievement. Up to now, Cognitive Behavioural group interventions have been developed for a wide range of adult clinical syndromes, such as stress and affect disorders, schizophrenia, food intake disorders and post traumatic stress disorder, as well as for children's and adolescent's psychological and learning difficulties, such as attention deficit-hyperkinetic disorder, mental retardation, pervasive developmental disorders, basic somatic functioning disorders and learning and communication disorders. At the same time, interventions have also been developed for specific problems and difficulties, such as anger or pain management, chronic health problems, achieving self control etc. In our country, group interventions have been applied to the management of stress and stress disorders in adults, but also to children, adolescents and school teachers, for the psychosomatic health through the reinforcement of self-effectiveness expectations in adolescents with insulin dependent diabetes, as well as to children with kidney failure syndrome [6].

Cognitive Behavioural group interventions are brief in regards of time, sufficient and effective. They appear to be more effective compared to other types of group interventions (psychodynamic or interpersonal) as participants maintain the therapeutic gains [6,7]. Also, in comparison to personal therapy in regards to efficacy, group therapy was not found to differ significantly, but both types of intervention were found to offer significantly better results in comparison to the waiting list [8]. Both personal and group interventions for depression are proven to be equally effective, with the main difference between them being cost, in regards of time and money [7].

Lewinsohn's [9] theory for depression (figure 1) is based on the relation between depression and reinforcement frequency. In particular, a low level of positive reinforcement acts by causing depressive behaviour. Positive reinforcement depends on life circumstances and activities, learning history, age, sex etc. It also depends on the availability of reinforcers, the condition and the abilities of each person. Reinforcement by others (sympathizing, pitying etc), especially by people in the close social environment, is responsible for the maintenance of depression, since it prohibits the depressive person from trying to restore the reduced flow of positive reinforcement by affecting the factors that have caused it's reduction. According to this

model, therapy is focused in the increase of positive reinforcers, since the depressed person spends most of their time with passive occupations that do not allow for positive reinforcement. At the same time, therapy needs to focus in the development of social activity as depressed people tend to lack the ability to act in such a manner that will allow for their company to feel comfortable with them (staring the floor, low voice, lack of feedback in a conversation, lack of interest in the conversation content and in other people). They do not know how to openly express their negative feelings and instead they nag and act hostile. Finally, they need to work on the way they communicate (nagging, lack of ability to comprehend another person's intentions etc.) [10].

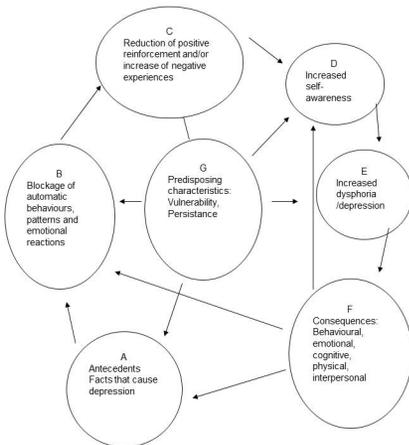


(Figure 1: Schematic overview of the aetiology and maintenance of depressive behaviour [11])

Lewinsohn, Hoberman, Teri and Hautzinger [12] constructed a more integrated theoretical model for the pathology and maintenance of depression (see figure 2). This model hypothesises that a large number of personal and environmental factors that coexist are related with the development of depression. It also supports the opinion that depression can be minimised by changing attitudes, thoughts, feelings and the person's environment.

According to this stress-vulnerability model, depressogenic procedures begin with the existence of predisposing factors, or facts of life that cause depression. These stressogenic factors lead the person to experience such a strong depressive episode that their ability to develop positive behaviours is impaired. This blockage of positive interactions between person and environment contributes to a change in the quality of

interactions and leads to the appearance of negative affect (dysphoria). The continuous failure of the person to receive positive reinforcement leads them to increased alert, leading the person to self criticism, maximisation of negative impact and withdrawal. This alertness leads the person to maximise the belief that they fail to face up to situations, a fact which causes more negative judgement and withdrawal, and all these lead to further dysphoria and depression. Therefore, the person is experiencing more negative interactions, which create a vicious cycle that maintains depression. According to this model, the therapy for depression is in reference to the existence of stressogenic life facts and negative, dysfunctional cognitions and its aims are the increase of pleasant positive activities and the development of social activities [13].



(Figure 2. An integrated model for depression [14])

The “Coping with Depression Course”: structure and application

The “Coping with Depression Course” was developed by Lewinsohn and Clarke [13] and it is a cognitive behavioural group intervention for depression. It is a strictly structured psycho-educational therapy, based on the social learning theory,[15] according to which behaviour (depression) is the result of a learning procedure shaped by the interaction between the person and their environment. The problems which depressed people face are regarded to be the result of dysfunctional learning that has to be un-learned or re-learned [16]

The course consists of 12 sessions (each lasting two hours) and 2 follow ups, after one month and six months after the end of the course. It lasts for eight weeks and for the first four weeks two weekly sessions take place. During the first two sessions the rules of the group, the therapy rationale, the role of social learning theory for depression are being discussed, while simultaneously instructions are being given for self-regulation skills. During the next eight sessions emphasis is being given in the increase of pleasant activities, social abilities are being taught, the control of negative or dysfunctional thoughts, according to the model of Ellis [17], is being practiced and training in relaxation techniques takes place. The last two sessions focus on topics that refer to the maintenance of the therapeutic result and relapse prevention. All sessions include a short introduction by the therapist based on the rich material in the “Instructor’s manual”, review of homework, conversation, role playing that takes place with the therapist’s assistance and structured activities. During the course, a self help book (Control your depression [18]), a participant’s workbook and an instructor’s manual are being used. All of the above have been translated and adjusted for the Greek language in a manual that is under publication [21]. It is advised that the number of group members includes 6-10 participants and one or two instructors [13].

The candidate participants undergo a two hour interview, where personal history information is being collected and information is being given regarding the course, in order to facilitate their decision to participate in the course after being sufficiently informed. Exclusion criteria include mental retardation, severe hearing or vision impairment, bipolar disorder, schizophrenia or substance abuse [13].

The instructor’s role is more educational rather than therapeutic and the participants are regarded more as trainees rather than as patients. The traditional therapeutic relation between therapist and patient, as it is familiar from self-awareness groups, does not exist in this case. The instructor is expected to be enthusiastic, clear spoken, warm and motivated in maintaining the group cohesion, but his main concern should be the precise application of all the elements that apart this strictly structured intervention course. The creation of a therapeutic alliance is not a main element or goal, as it is usually expected in other kinds of interventions (psychodynamic, interpersonal), but it is regarded as facili-

tating for the application of therapeutic techniques [16].

The course is flexible and adjustable for application to population with special characteristics. Although it was initially designed in order to be applied to adults, it has also been used, after appropriate modification, to other populations. An intervention manual adjusted to the needs of adolescents has already been developed, while a course for parents is also available, as well as for elderly population with a reduced number of sessions and techniques that are less tiring, outpatients, minority groups and elderly caretakers [16]. Also, it has been applied to patients with chronic depression who were not responsive to previous anti-depression treatment [22].

In Greece, this course has been applied for groups in the Counselling Centre for students in the University of Athens as well as in the Institute of Behavioural Research and Therapy (IBRT). Presently, two group courses for the management of depressive symptoms are taking place in IBRT, and a notification of results is shortly expected.

Effectiveness of the course

During the past, a vast number of studies have proven the effectiveness of personal psychotherapy for the therapy of depression [23, 24, 25]. The effectiveness of any therapeutic method has been correlated with severity of depression prior to therapy, expectations of participants, level of satisfaction in important life areas, support from family environment, physical health, lack of suicidal behaviour, level of personal control in life [13].

Specifically, reviews have shown that Lewinsohn's "Coping with Depression Course" is effective for the therapy of depression and its effectiveness can be compared with other forms of psychotherapy. In a meta-analysis by Cuijpers [16, 20] researches were included, chosen on the basis of particular criteria. The studies included experimental design (use of control group, random distributions in conditions, information about the people who dropped-out and evaluation of effectiveness after the completion of the therapy), collection of data before and after the course application, satisfying description of the procedure and the use of appropriate statistical analysis (reliability and validity of the instruments).

In three out of the ten studies in Cuijpers's [16]

meta-analysis, where the "Coping with Depression Course" was being compared with a control group, it was found that the impact factor [26] was 0,65, which suggests a great effectiveness of the program. Also, the impact factor (d) was calculated by comparing the improvement before and after the course application, and was found to be 1,21 (extremely high impact). The impact factor was also calculated for 1 month, 6 months, 1 year, 2 years after the completion of therapy. The impact remains stable for one to six months. There appears to be even more evidence of improvement, after one year of the completion of the course.

Although these studies are regarded as high quality studies, their results should be treated with great caution, since the number of studies is relatively small and there is no control group in the recurrent comparison after 1-2 years. Additionally, in four out of the five groups that provide data for the after 1 and 2 year impact, participants were adolescents. It is, therefore, unclear whether these results can be generalised for other groups. There were cases in which groups with less than ten participants were included. Even more, in most studies the control group was consisted of people in the waiting list. Studies have shown that there are differences between a control group consisted of people in a waiting list, a placebo group and a no treatment group.

We also have to mention that the criteria by which participants were chosen differ from study to study. In 8 of the studies, participants met the DSM criteria for depression but in the rest, participants either did not meet all depression criteria or non clinical interviews for the diagnosis were used. Furthermore, only two studies compared the "Coping with Depression Course" with another intervention [16]. Despite all the limitations however, a meta-analysis is necessary as it offers a general view in regards to the effectiveness of this course, in this case a view of optimistic results.

With the intention to compare the effectiveness of the "Coping with Depression Course" in relation to other treatment programs, the impact factor of this study was compared in another meta-analysis. In Robinson's, Berman's and Neimeyer's [27] meta-analysis for the use of psychotherapy in depression, the impact factor was found to be slightly larger (0,73). The small difference could be due to differences in the method employed, to the choice of studies (studies on book-therapy) or participants (drug users, elderly care-

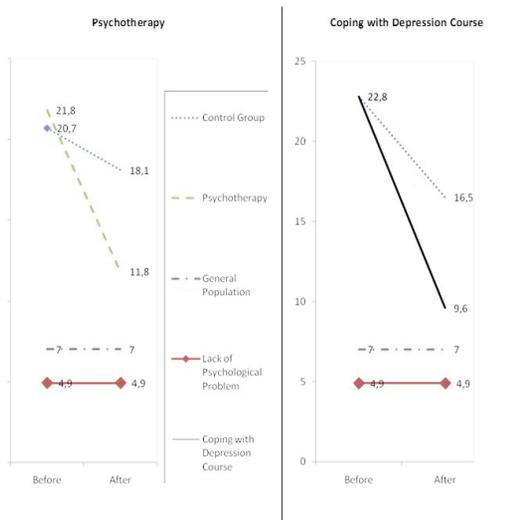
takers). If we therefore focus on the “Coping with Depression Course” for adults, the impact factor is 0, 84. Additionally, data from the Beck Depression Inventory (BDI) were compared before and after the application of the course (figure 3). It has to be mentioned however, that this comparison focused on one set of data only, the BDI scores. The headline “Psychotherapy” in figure 3 included traditional types of cognitive behavioural group therapy, behavioural or interpersonal therapy, and drug treatment therapy.

Discussion

Conclusively, the “Coping with Depression Course” manages to combine social learning theory with research data, so as to further establish its theoretical background [30]. It appears to be an effective depression treatment, keeping in mind the relatively small number of studies and their limitations. Its effectiveness further applies to chronically depressed patients who were unresponsive to past treatment [22].

The fact that it is a group intervention, establishes it as a superior choice to personal therapy, as it costs less, since a single therapist treats at the same time a number of patients in a limited time period, while at the same time it provides the opportunity for role-play among the participants in order to practice their social skills, the lack of which is a main characteristic of the disorder and their practice contributes to relapse prevention. Also, since each participant’s problems are different, it provides the opportunity to all participants to be exposed to a number of problem solution techniques, a fact which aids their knowledge generalisation and hence their ability to solve new problems that may appear in the future. Additionally, group therapy raises the possibility of negative social comparisons to take place among the participants, a fact which provides opportunities for change that may not appear during a personal therapy. It also provides the opportunity to each person to pinpoint cognitive errors of other people and to re-evaluate their thoughts. This procedure is a starting point for the person to begin re-evaluating their own thoughts and hence to maximise their ability to correct their dysfunctional behaviour [31].

The psycho-educational structure and the choice criteria of participants aid to more easily attract people, who under different circumstances would not seek treatment, since it is known that a large proportion of the depressed population do not receive any professional help. The fact that it is a structured treatment program that teaches skills, additionally aids patients to feel in control of their behaviour and their ability to get over depression. Another advantage is the fact that it has a relatively short duration while at the same time it is an effective program in the long term that can be easily adjusted to a variety of populations, in a variety of circumstances. Also, because it is a structured program it can additionally be used in book-therapy approaches, as well as a method for relapse prevention



(Figure 3: The effect of different forms of psychotherapy and Lewinsohn’s “Coping with Depression Course”, based on BDI scores)

In a research with chronic depressive patients who were not responsive in other therapy applied in the past, it was found that depression symptoms were significantly reduced, quality of life was improved after the course completion and these results remained stable even after 26 weeks [22]. Also, in a research with patients with subclinical depression symptoms, “Coping with Depression Course” was found effective in reducing symptoms and in increasing pleasant activities²⁸. In the long term, those who were mostly benefited were those who initially had mild depression levels²⁹. It is therefore possible that the course with a few modifications could be used as a precaution method for depression.

[16].

Further research is needed in order to compare its effectiveness to other psychotherapeutic and pharmaceutical approaches [32]. It also is of importance other control groups to be used and to assess other functionality areas of the participants, such as their interper-

sonal and professional lives. It would be of use to test the effectiveness of the program in other populations such as dysthymic and bipolar, and to be used as a prevention method for patients with mild depression. Lastly, with interest, we are expecting the evaluation of the Greek version of the program.

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