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GROUP LEADER'S MANUAL

Building Recovery by Improving Goals, Habits, and Thoughts

A Group Cognitive Behavioral Therapy for Depression in Clients with Co-Occurring Alcohol and Drug Use Problems

Kimberly A. Hepner • Jeanne Miranda • Stephanie Woo • Katherine E. Watkins
Isabel Lagomasino • Shelley H. Wiseman • Ricardo F. Muñoz

Sponsored by the National Institute on Alcohol Abuse and Alcoholism

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The research described in this report was sponsored by the National Institute on Alcohol Abuse and Alcoholism and was conducted in RAND Health, a division of the RAND Corporation.

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GROUP LEADER'S MANUAL

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A Group Cognitive Behavioral Therapy for Depression in Clients with Co-Occurring Alcohol and Drug Use Problems

Leader's Introduction

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Preface

The purpose of this manual is to assist practitioners and programs in implementing Building Recovery by Improving Goals, Habits, and Thoughts (BRIGHT). BRIGHT is a manualized group cognitive behavioral therapy (CBT) program for depression in individuals with co-occurring alcohol and drug use problems. The treatment program was developed and evaluated in residential substance abuse treatment programs in Los Angeles County. For more information about BRIGHT's effectiveness, please see Watkins et al. (in press).

We designed BRIGHT so that non–mental health practitioners and practitioners with less formal training than professional mental health counselors could deliver the program with acceptable fidelity, thus providing evidence-based depression treatment to individuals who often do not receive it. Thus, while BRIGHT can be delivered by mental health practitioners with experience in CBT, we also believe that BRIGHT can be implemented by a broad range of practitioners and settings to address the needs of individuals with both depression and alcohol and drug use problems.

Readers may also wish to consider using a related treatment called BRIGHT-2 (Hepner et al., 2011b; Osilla et al., 2009). While BRIGHT is designed to treat depression in individuals with co-occurring alcohol and drug use problems, BRIGHT-2 is a more integrated treatment designed to treat *both* depression and alcohol and drug use problems.

We would like to thank the many individuals who contributed to this manual, including Michael Woodward for his imaginative use of graphics that complement the original art work and make the books more interesting and easier to use; Elizabeth Gilbert, Ph.D., for thoughtful review and editing; and Lynn Polite and Catherine Chao for formatting. Finally, BRIGHT is an adaptation of an existing treatment manual of group CBT for depression (Muñoz et al., 2000). We are grateful to the original authors, who allowed us to build on their work to address the needs of individuals with co-occurring depression and substance abuse.

This manual has three parts: a group leader's introduction, a session-by-session group leader manual, and a group member's workbook.

This work was sponsored by the National Institute on Alcohol Abuse and Alcoholism (Grant number R01 AA014699). The research was conducted within RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

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THANK YOU for your interest in the BRIGHT Cognitive Behavioral Therapy (CBT) program. This program is designed to treat depression in people who also have alcohol and substance abuse problems. As a group leader, you will play an important part in helping your group members learn new skills that they can use to feel better.

INTRODUCTION TO THE BRIGHT TREATMENT MANUAL

This Group Leader's Introduction is one of a series of resources that serve as practical resources for implementing the BRIGHT group cognitive behavioral therapy (CBT) program for depression in people with alcohol and drug use problems. We recommend that you **read this Group Leader's Introduction module first**, as it will provide initial background about the treatment approach as well as guidance on how to use the other resources.

The name BRIGHT refers to Building Recovery by Improving Goals, Habits, and Thoughts. Goals, habits, and thoughts are key treatment targets in a cognitive behavioral therapy approach. The BRIGHT manual provides direct instruction on how to use effective cognitive behavioral techniques to improve clients' outcomes, particularly in terms of increased mood stability and sobriety.

Mental health professionals have found that CBT can be very successful in helping depressed people learn how to manage their depression and feel better. Yet, there have not been enough group leaders—usually well-trained psychiatrists, psychologists, and licensed clinical social workers—to provide CBT to all of the people who might benefit from it. There are many CBT treatment manuals available for the treatment of depression and/or substance use (as well as for many, many other types of problems). However, unlike other CBT treatment manuals, which are geared toward professionals with advanced graduate training or those who already have considerable expertise in cognitive behavioral therapy, the BRIGHT manual is intended for use by a wider audience of treatment providers. The authors believe that CBT can be presented successfully by a broad group of people—nurses, social workers, substance abuse counselors, and other caring, committed people. This manual

is intended to help more practitioners deliver group CBT, as well as serve as a user-friendly resource for more experienced CBT practitioners.

BRIGHT is designed for use by a broad range of practitioners, including both practitioners who are new to CBT or treating depression and more highly experienced, licensed CBT practitioners. The BRIGHT manual, however, was designed specifically to provide the additional support that many practitioners may need when first implementing CBT for depression. Thus, throughout the BRIGHT materials, we encourage the new BRIGHT counselor to receive supervision or consultation from an experienced CBT supervisor.

The following BRIGHT resources are available:

Group Leader's Introduction (this module)

Group Leader's Manual (4 modules)

- Module 1: "Thoughts and Your Mood"
- Module 2: "Activities and Your Mood"
- Module 3: "People Interactions and Your Mood"
- Module 4: "Substance Abuse and Your Mood"

Group Member's Workbook (4 modules)

- Module 1: "Thoughts and Your Mood"
- Module 2: "Activities and Your Mood"
- Module 3: "People Interactions and Your Mood"
- Module 4: "Substance Abuse and Your Mood"

All nine of these resources are needed to fully implement the BRIGHT CBT Program. More information about the structure of the treatment is included later in this Introduction.

How BRIGHT was developed

The first version of this treatment program was developed as a set of three manuals for a research study to see whether the program could be helpful to people who were suffering from depression. The study was directed by Peter M. Lewinsohn, Ricardo F. Muñoz, Mary Ann Youngren, and Antonette Zeiss at the University of Oregon (Zeiss, Lewinsohn, & Muñoz, 1979). The authors of the original manuals combined them and published them as a self-help book titled "Control Your Depression" (Prentice Hall, 1978; revision published in 1986). The book was the source of several versions of this approach developed as treatment and prevention manuals at San Francisco General Hospital, a teaching hospital of the University of California, San Francisco (Muñoz & Mendelson, 2005). BRIGHT and BRIGHT-2 were adapted from 2000 version of the group cognitive-behavioral treatment manual for depression developed by Professor Ricardo F. Muñoz and colleagues (Muñoz, et al., 2000).

What are the best treatment settings and types of patients for BRIGHT?

BRIGHT is intended for use in outpatient and residential substance abuse treatment programs as a **treatment for depression** in clients who have elevated levels of depression symptoms. BRIGHT clients are expected to receive treatment for substance abuse via another intervention method.

Another closely related treatment approach, also developed by our intervention team, is called BRIGHT-2 (Hepner et al., 2011b). **BRIGHT-2** is an 18-session **integrated group treatment for *both* depression and substance abuse**. Thus, while BRIGHT is a 16-session treatment **solely for depression** in individuals who also have substance abuse problems, BRIGHT-2 is a treatment for both depression and substance abuse.

BRIGHT can be implemented in a variety of settings, including outpatient or residential substance abuse treatment and community mental health centers. Less ideal settings for the group include those settings with philosophies or approaches that are not complementary or that are in direct conflict with CBT. For example, it might be disorienting for group members to attend a CBT for depression group in treatment settings where a confrontational addiction therapy is the primary treatment modality. In CBT, trying to "break someone down" or "break through defenses" is seen as counterproductive and possibly harmful, particularly in cases where clients are also depressed.

How to use the manual

This "Group Leader's Introduction"

This is the **Group Leader's Introduction**. It provides background information that should be helpful to you, the group leader. For example, it:

- Explains what depression is and what the CBT treatment program is all about.
- Describes the structure of the CBT program.
- Discusses issues that you might encounter in managing the CBT group.

Group Member's Workbook

The **Group Member's Workbook** goes through the CBT lessons. Group members are encouraged to write in their books and will keep their books when they finish CBT.

Group Leader's Manual

The **Group Leader's Manual** includes the same material provided to group members, except that it also includes instructions, highlighted in shaded text boxes, to help you present the CBT material.

- Every box is labeled "Leader Tips."
- The "Leader Tips" boxes do not appear in the Group Member's Workbook.
- In the Group Leader's Manual, the boxes are printed in a different kind of type than the information intended for group members.
- The bold lettering at the top left tells you (1) how much time to allow for that lesson and (2) what page in the Group Member's Workbook the box relates to.

- The italicized text in the boxes—*text like this, for example*—suggests actual words you might use when you are talking to your group. The non-italicized text provides more general directions. It is for you to read, but not to read aloud to the group.

Leader Tips

[THIS IS A SAMPLE BOX.]

Time: 5 minutes

Group Member's Workbook: Page 22

1. **Review** the key messages.
2. **Say:** *Which of these key messages will be most helpful?*
3. **Lead** a group discussion.

Organizational support and training

Successful implementation of BRIGHT requires strong organizational support for initial training and ongoing supervision of group leaders. The substantial commitment of time and effort required, particularly for counselors learning to become new BRIGHT group leaders, necessitates organizational flexibility in the form of release time and work support for counselors. Further, it is crucial to ensure that systems are in place for integrating BRIGHT into the usual care provided by the treatment site. For example, staff not directly involved in the delivery of BRIGHT should be made aware of what the treatment involves, the types of clients appropriate for referral to the treatment, and how the treatment can complement other services that clients typically receive. Presentations to staff of improved client outcomes provide another means to obtain broad-based staff support for the BRIGHT intervention and can help maintain the motivation of counselors delivering the intervention.

Group leaders

We recommend that BRIGHT be conducted with two group leaders. However, this is a recommendation, not a requirement. We also recommend that group leaders have the following knowledge and skills, either from previous experience or through training received prior to leading the BRIGHT group:

- A good understanding of, and training in, the assessment and treatment of depression and substance abuse.
- Previous coursework or training in psychology, psychiatry, psychiatric social work, nursing, or counseling, and in the principles of CBT.
- Specific training in the use of BRIGHT from a licensed mental health professional.
- A plan for supervision or consultation from a licensed mental health professional who has experience with CBT and with working with people who are depressed.

Group leaders can be employed at the treatment site or can be brought in from outside the treatment site to deliver only the BRIGHT intervention. CBT works best if the same leaders stay for the entire 16-session program, conducting all four modules. However, if a leader cannot complete the program, another leader can step in. If possible, the switch should be made at the first session of a new module, and group leaders should give group members as much notice as possible—four weeks, for example—before the switch takes place. Ideally, both leaders should not leave at the same time.

Training for Group Leaders

Experienced licensed mental health professionals with training in CBT for depression and substance abuse may be able to implement BRIGHT without additional training and supervision. However, it is expected that counselors and other providers with less CBT and mental health treatment experience will receive training and supervision before implementing BRIGHT.

We have documented our recommended training approach elsewhere (Woo et al., under review). This training approach includes an intensive two-day, in-

person training that serves as a comprehensive introduction to BRIGHT and the principles of CBT, as well as ongoing weekly supervision until the group leaders have mastered the approach. The two-day intensive training includes information on depression (e.g., symptoms, relationship with substance abuse, assessment of, impact on clients' presentation in group) and introduces basic CBT concepts (e.g., the interrelationship between thoughts, activities, and mood; assignment of homework activities to clients). CBT-specific competencies that are essential to develop through training include (1) gaining comfort in explaining the CBT model, (2) collaborating vs. advice giving, (3) following a session agenda and staying present-focused, (4) learning ways to individually tailor the treatment, and (5) utilizing behavioral principles in group. Please visit the BRIGHT website for the latest information on training resources (http://www.rand.org/health/projects/bright.html).

The important role of a supervisor

As discussed above, it is important that group leaders are supervised by a licensed mental health professional (psychiatrist, psychologist, or licensed clinical social worker) who is knowledgeable about BRIGHT, CBT, and treating clients with depression. Supervisors can offer practical and emotional support to group leaders, answer questions, and handle any problems that come up with the individuals in the groups.

While supervisors do not have to be employed at the same site as group leaders, supervisors should provide emergency phone numbers and the names of backup professionals and their phone numbers, in case a group leader needs help immediately or after hours. The supervisor's role is particularly important in cases where a group member indicates that he or she is having suicidal or violent thoughts, or is being hurt by or hurting someone else. The group leader should contact the supervisor as soon as possible. How to handle situations in which a group member indicates that he or she is having suicidal or violent thoughts is discussed in further detail below in the "Managing the Group" section.

Supervisors can also help determine which patients might benefit the most from CBT and thus should be included in group therapy, as well as those who should *not* be included in a group. Information regarding screening and selecting clients for BRIGHT is discussed in the next section.

What is depression?

Depression is a mood disorder. It involves a person's thoughts, actions, interactions with other people, body, appetite, and sleep. Depression is not the same as a passing blue mood; it is never a "normal" part of life. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better.

- Depression is quite common. At any given time, there are between 15 million and 20 million people in the United States who have depression.
- A person of any age, race, or ethnic group may suffer from depression.
- Without treatment, depression can last for weeks, months, or years.
- Depression can be very serious. Up to 15% of people diagnosed with depression eventually commit suicide, so treatment is very important.

Symptoms of Depression

If a person has all or most of the symptoms listed below for most of the day, during most days, for at least two weeks, it is likely that he or she has depression that requires treatment. Some people experience mild depression, while others experience severe, disabling depression. Not everyone who is depressed experiences every symptom of depression.

1. Feeling sad, depressed, down, or irritable nearly every day
2. Loss of interest or pleasure in activities such as hobbies, socializing, or sex
3. Significant change in appetite or weight (increase or decrease)
4. Change in sleep (sleeping too much or too little)
5. Change in the way a person moves (restless or slowed down)
6. Feeling really tired, fatigued
7. Feelings of worthlessness or excessive guilt
8. Inability to concentrate or make decisions
9. Repeated thoughts of death or suicide

Causes of Depression

Scientists have been studying depression for a long time, but we still do not know for sure what causes it. Many factors may contribute. They include childhood experiences, biochemical processes in the brain, and stressful events in daily life, such as getting divorced, losing a job, or the death of someone close. More stresses make a person more vulnerable. Also, if a person has been abused physically, verbally, or sexually, he or she may be more likely to become depressed.

People who develop depression seem to think about things in a way that makes them feel worse. They tend to think that life will never be good again and that there is nothing they can do to deal with their problems. In the example below, two people respond differently to getting divorced; Person B is probably less likely to become depressed.

> Person A: "I will never find happiness now that my partner, who was going to love me all my life, has rejected me. There is something wrong with me that makes me unlovable."
>
> Person B: "I learned a lot from this marriage and believe that I will meet the right person and make a happy marriage next time. I will be very careful to make sure that I marry someone who is right for me."

Patterns of thinking are not the only factors that increase the likelihood that a person will become depressed:

- Some types of depression run in families.
- Natural changes in the body or changes in the seasons can make depression more likely. For example, the birth of a child may trigger depression for women.
- Some medications, such as corticosteroids, can cause depression.
- Alcohol and some drugs are "depressants," and using them or withdrawing from them can cause depression.
- Physical illnesses, such as strokes, heart attacks, thyroid problems, certain cancers, and other illnesses, can cause depression. Depression can make the person's medical situation worse—depressed people are less able to take care of themselves, which means that it takes them longer to recover from a physical illness.

Depression and Substance Abuse

Depression is even more common among people who abuse drugs and alcohol. People with substance abuse problems are two to four times more likely to have depression than people who do not abuse substances. Of all the people that seek treatment for substance abuse, an estimated 35–40% also have depression. If a person who has depression gets treatment for it, the person is more likely to be able to get sober and stay sober.

A note on terminology: In the BRIGHT materials, when we refer to "relapse," we are referring to a relapse in depression symptoms. In cases where "relapse" is meant to refer to a return to substance use, this is made explicit.

Screening and Selecting Group Members

BRIGHT is a treatment for depression in clients who also have alcohol or drug use problems. There are several ways to screen for depression and track a person's progress as he or she begins to feel better. BRIGHT uses two measures that are built into the treatment modules—the PHQ-9 (so named because it is a "Patient Health Questionnaire" with questions about the nine symptoms of depression) and the Quick Mood Scale (which allows group members to see how their mood changes over time). The PHQ-9 is included at the back of this Group Leader's Introduction. The Quick Mood Scale is included in the Group Member's Workbook.

The PHQ-9 is a useful tool to assess a person's level of depression symptoms and can help to decide whether they would be appropriate for BRIGHT. We recommend that clients have a score of 5 or higher (corresponding to at least mild depression symptoms) to be invited to participate in BRIGHT. A particular setting may decide to allow clients with lower scores on a case-by-case basis (e.g., if a client has a history of depression). In some settings, clients may undergo formal psychological assessment and diagnosis prior to group referral. In these cases, clients who are diagnosed with major depression or even clinically significant symptoms of depression would be appropriate for BRIGHT. Clients may have other co-occurring disorders (e.g., anxiety disorders, eating disorders) and this typically does not prevent them from benefiting from BRIGHT (though some exceptions are listed below). Note that BRIGHT does not require the client have a diagnosis of depression. We

believe a symptom screening using the PHQ-9 is more feasible for many treatment settings, rather than requiring a diagnosis.

Because BRIGHT is not designed to directly address clients' alcohol and drug use problems, we recommend that they receive an alcohol or drug use intervention or be a client at an outpatient or residential drug use program.

We believe that the following types of clients *may not* benefit from BRIGHT:

- People with bipolar disorder who are not taking medication to treat their bipolar condition.
- People who suffer from psychosis. This means people who hallucinate, have delusions, or have extreme disorganization of thoughts or behavior. Some people who have psychosis may be diagnosed with schizophrenia or a related illness.
- People who are still using alcohol or drugs so frequently that they are unable to come to group without being under the influence. The supervisor may require that an individual be abstinent for a certain period of time before he or she is eligible to join the group.
- People who have cognitive impairment that significantly interferes with their ability to communicate or learn.
- People who are very hostile or have severe behavioral problems that would be difficult to manage in a group setting.

What is cognitive behavioral therapy?

Cognitive Behavioral Therapy (CBT for short) is an approach to treating depression. While CBT can be used with individuals or groups, BRIGHT is designed to be a group therapy.

As the name suggests, CBT focuses on cognition (thinking) and behavior (acting). People who suffer from depression can make remarkable progress if they change the way they think about their lives and how they act. "Acting" includes doing such activities as taking a shower or going to a movie, as well as interacting with other people.

Part of your job as a group leader will be to help people:

- Take a closer look at their thoughts and make changes in their thinking that will help them feel better.
- Understand that if they engage in activities they will begin to feel less depressed.
- Identify healthy ways to interact with other people.

Of course, people cannot change every negative aspect of the world around them. We can't all by ourselves control the traffic or the crime rate, for example. But there are many things we *can* change. As people who are depressed become aware of the way that thoughts and behaviors affect mood, they can feel happier and more hopeful even if certain unfortunate circumstances in their lives don't change. Instead of being something that is perceived as uncontrollable, depression becomes something that can be managed.

It's important to explain to your group members how BRIGHT will help them feel better. The treatment manual guides you to provide the following information to group members:

- This treatment focuses directly on your day-to-day life. It offers a practical approach to help you feel better.

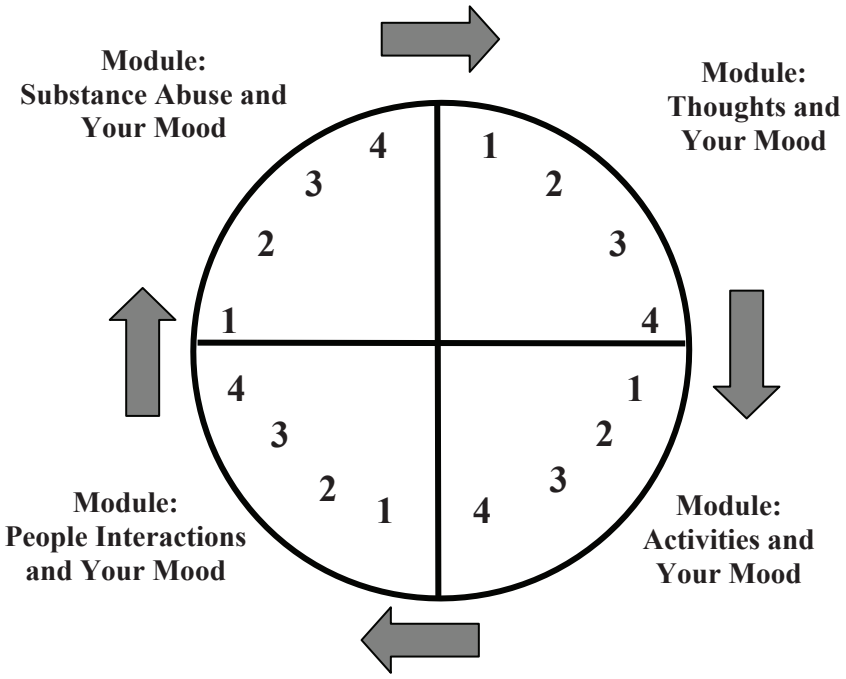
- CBT can benefit almost everyone. Even when we are not especially aware of it, we are having thoughts that influence how we feel. If you can think in ways that are helpful, you will begin to feel better.

- People who are depressed often aren't doing anything they enjoy. This treatment teaches ways to bring fun activities back into life.

- Staying sober is more difficult if you still feel down after getting sober. This treatment will help you stay away from drugs or alcohol by giving you ideas about how to improve your mood.

BRIGHT STRUCTURE:
FOUR MODULES WITH FOUR SESSIONS EACH

BRIGHT consists of four modules. A module consists of four sessions, each of which emphasizes a specific topic and its connection to mood. As shown in the figure below, the modules focus on thoughts, activities, people interactions, and substance abuse. Each module has its own workbook.



Outline for Each Session

In general, the outline for each session will look like the one below:

I. Welcome and Announcements
II. Review
III. New Topic
IV. Key Messages
V. Practice
VI. Feedback
VII. Looking Ahead

Co- Leading and Preparing for Group

There are some points that are helpful to keep in mind when you are working with another group leader in conducting the BRIGHT CBT group:

1. **Plan ahead:** One of the most important things you can do to help make a session run smoothly is to carefully review the session in your manual well before group and then meet with your co-leader to plan how you will divide up reviewing material, leading exercises, and so on. This not only makes it easier on the two leaders, but it also makes for a more polished and professional presentation to the group.

2. **Try to divide tasks evenly:** It's important for group members to see both of the counselors who are leading the group as active and invested in the group.

3. **Don't discuss conflicts or disagreements with one another in front of the group:** Another advantage of reviewing the session material with your co-leader before group is so that you can both be clear that you are on "the same page" (you have a similar understanding of what needs to be covered in each group, how the material might relate to specific members, etc.).

    a. However, it's possible that during a group session your co-leader will handle a situation differently than how you would handle it. You might disagree with how your co-leader said or did something.

    b. It's important to communicate with your co-leader about this, but the place to do this is after the group and/or in supervision, not in front of group members.

    c. In the group it's okay to do things like add on a comment to what your co-leader has said if you think he or she missed an important point, but you want to avoid openly disagreeing with your partner or criticizing what he or she did or said. This may be uncomfortable for group members to see, and they might not feel comfortable or safe in the group if they think the leaders aren't getting along.

4. **Communicate!** Remember that an effective partnership is one where people communicate. The points we've talked about so far all relate back to the central idea that open, clear lines of communication will help you and your co-leader run the group smoothly.

    a. Try to make time to talk about how the group is going with your co-leader.

    b. We've already discussed the importance of planning ahead before group, but it's also important to talk with your co-leader about how the group went after a session is over, to "de-brief" with one another, to plan what you want to discuss in supervision, etc.

    c. This kind of sharing will help you learn from each other and provides you with support!

Using the Time Wisely

Each session lasts for 1½ or 2 hours, depending on how your program is organized. It is very important to start and end the sessions on time.

It can be tricky to balance all of the demands on time. Each CBT session combines time for the presentation of new ideas and skills with time for group members to talk and learn from each other. Group members may feel rushed as they try to absorb a lot of new information. You can reassure them (and reassure yourself, too) by telling them that they are not expected to learn everything in every session. Because people learn differently and like different things, the program offers a variety of ideas and skills with the knowledge that some parts will work for some people and other parts will work for other people. Nobody is expected to learn it all the first time through!

In each session, it is important to allow time for group members to talk about their own experiences, ask questions, and hear from other group members. In fact, in the overall course of a module, each person should have a chance to talk about personal issues related to depression. It is important that group members learn to discuss their concerns with the group. If some group members are reluctant, talk with your supervisor. Your supervisor may have ideas for how to encourage the group member to participate, or may arrange for that person to have individual therapy.

However, it is also important to cover the intended material for each session and encourage group members to practice the skills you are describing. It is not helpful for the group members to only talk about how badly they feel and not have enough time to learn the techniques that will help them get over their depression.

The sessions are organized to allow some discussion time. As you become more experienced, you may be able to manage the sessions so that you spend more time on one topic when the group seems to need it, and a little less on others. For now, follow the time estimates we provide in the "Leader Tips" boxes.

You will probably have some group members who are not shy about talking and others who don't talk very much or ever. It may be easy to rely on the few talkers to keep up the energy of the group, but don't forget to draw out other people. To the talkers you can say gently:

> "Thank you for sharing your ideas. I wish we had time to hear more, but since our time is limited, let's hear from some other group members. [Say the name of the shy person], do you have any questions, or would you like to share your ideas?"

or

> "[Say the person's name], I'm going to interrupt you because you have brought up some interesting ideas. I bet the group would like to add to what you have said. [Say another group member's name], what was your experience?"

or

> "Thank you for sharing your ideas, but I'm going to interrupt you now so that I can tell the group about another important topic."

or

> "We are so glad you are sharing with the group. As you know, we have to balance our time. Are you ready to give up your turn?"

Make sure that in the 1½ or 2-hour session, everybody gets to talk at least once. But keep in mind that you don't have to hear from every group member every time you ask a question or present a new lesson. You could say, for example:

"We don't have time to hear from everybody in this lesson. Is there anybody who had a particularly difficult week who would like to share his or her experience?"

or

"We don't have time to hear from everybody. Who hasn't had a chance to share for awhile?"

or

"Who haven't we heard from for awhile? I know that the group would like to hear everybody's ideas."

Techniques for Talking with Group Members

CBT requires that the group members work. In each session, they are asked to learn specific strategies to help them think and act in new ways that will improve their mood. Then they are expected to practice these strategies. This is a lot to ask, especially of someone who is depressed.

When group members begin treatment, they may not see a better future. They may feel like failures. Let group members talk about their feelings so they know that you understand just how bad they feel. Let them know that you believe in their ability to help themselves feel better. If they feel heard and understood, they will be more open to the help you and CBT offer.

The best way to show warmth and concern is by asking careful questions and by listening carefully to what group members say. The following techniques encourage group members to open up and show warmth and concern.

Open- Ended Questions

Open-ended questions encourage the client to provide more information, while closed-ended questions invite brief responses such as "yes" or "no." By asking more open-ended questions, you invite the client to share more about his or her experiences. See the next page for some examples.

Examples of Open- Ended Questions

Checking- in with the client

- How is that working for you?
- How does that sound? Do I have that right?
- What gets in the way (of practice)?
- How might you practice that at home or keep that going?

Connecting the client's thoughts, behaviors, and interactions with their mood and recovery

- How did/does that impact your mood/recovery?
- How helpful is that [thought, activity, interaction] in improving/ supporting your mood/recovery?
- What do you notice about the connection between your [thoughts, activities, interactions with people] and your mood?
- What do you notice about the connection between your [thoughts, activities, interactions with people] and your recovery?

Identifying thoughts

- What was going through your mind as you were feeling [sad, angry, etc.]?
- What other thoughts did you have in this situation?
- If that thought were true, what would that say about you?
- What does that mean to you?

Emphasizing options

- What could you have done differently to improve your mood and support your recovery?
- What are some other options you might want to consider?
- What are the consequences of that behavior [or of that option]?
- How could you think about this situation differently?

Building client self- efficacy

- What does it mean to you that you were able to make that change?
- What helped you to be able to do that?
- What did you learn from doing that activity?
- What was it like to try that?
- What is the next step for you?

Restating

Restating means to repeat what the group member said in your own words to be sure that you understood correctly and to let the speaker know that you were paying attention and understood his or her message. Here are some examples.

1. Group member statement: I feel so tired all the time. I never want to do anything.

> *Group leader's restatement*: So, you just don't have any energy.

2. Group member statement: I've been feeling down, and I've missed several days of work. I'm afraid I'll lose my job.

> *Group leader's restatement*: You haven't felt well enough to get to work, and now you're worried that you might be fired.

3. Group member statement: Life without alcohol is just no fun. I haven't had a good time since I stopped drinking.

> *Group leader's restatement*: So, you're saying that you really haven't had any fun since you stopped drinking.

You can encourage group members to tell you whether your restatement captures what they were trying to say. Ask: "Did I get that right? Does that capture what you were trying to say?" If not, you can try another way of restating. Offering the group member the opportunity to correct you shows that you really want to understand how they are feeling.

Reflecting Feelings

Reflecting feelings means to make a statement that goes beyond what the speaker actually said and that describes his or her feelings. Here are some examples.

1. ***Group member statement***: I feel really alone.

   Group leader's statement of feelings: You are feeling alone and it sounds like that is really hard for you.

2. ***Group member statement***: I told my boss that I wasn't feeling well and needed to take a day off, but he said he couldn't give me any time off this week.

   Group leader's statement of reflected feelings: It sounds like you might be feeling that your boss only cares about work, and not about you.

3. ***Group member statement***: I figured that when I quit using drugs, I'd feel a lot better about myself, but I don't.

   Group leader's reflected feeling: It sounds like you are feeling discouraged.

Summing Up the Problem

Summing up means to package the last few moments of conversation and label them in a way that allows group members to understand their jumbled feelings and figure out how to solve a problem. Putting a label on that set of feelings also creates a way for both you and the group member to refer to the feelings in the future. Here is an example

Group Member's Statement: I just don't know how to face taking care of the kids and cooking dinner after putting in a long, hard day at the office. I mean I love my kids and I like being home, but it's just daunting. When I'm busy I don't think about how lousy I feel, but when I leave the office my mood drops. I don't know…driving home half of the time I just want to stop by a liquor store and get loaded and the other half of the time I just feel tired and numb and want to crawl into bed.

Group Leader's Statement: Most people are tired at the end of a work day, and the transition from work to home may be difficult. No matter how much you enjoy being home, it brings its own stresses, such as the need to cook dinner.

You won't be able to come up with a simple label for every situation, but it is perfectly fine to sum up a group member's feelings or problems by just describing them as well as you can.

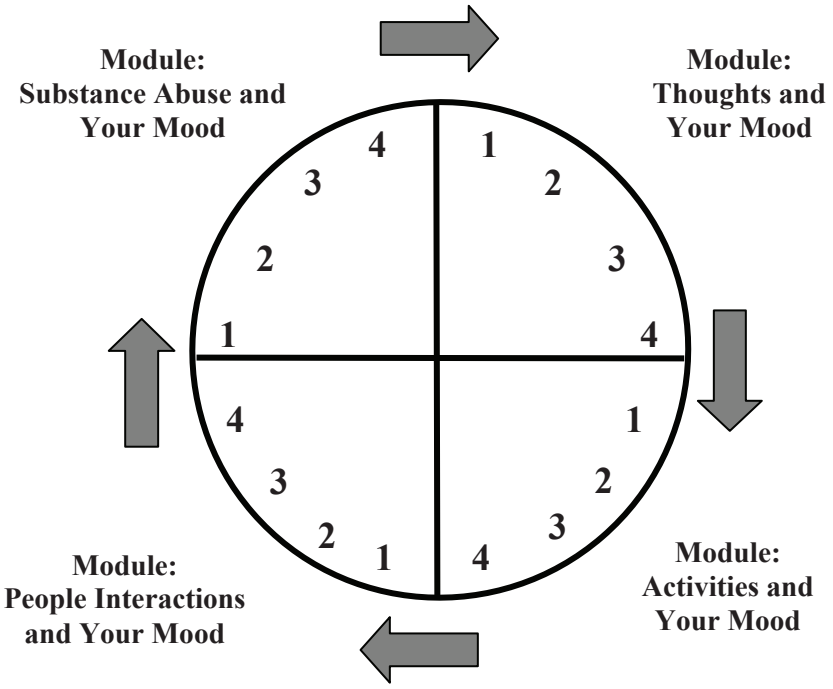
Don't Forget to Check In with Group Members

For most of us, our brains wander after about 20–30 minutes of listening. Make sure to periodically scan the group and check out group members' expressions and body language. Are they looking away, doodling in their workbooks, or in some other way showing that their attention is wandering? One strategy that can help keep group members with you is to stop often and ask group members questions. You could say: "*What have you found most helpful in the past 30 minutes? How does the information relate to your recent experiences?*" Remind group members that they are welcome to write notes to themselves in their workbooks.

Managing the group

Group Structure

Remember the diagram that illustrates the structure of the CBT program? The structure of the program affects the structure of the group, as well. Organizing the program in four continuous modules means that new members may join a group that is already in progress, and members who have completed all four modules may leave a group that will continue to exist after they have gone. Generally, we believe that groups work best when they have about eight to 10 members.



All group members will participate in all 16 sessions, but the four modules are independent of each other, so a group member can enter the group at Session 1 of any module. This means that people who are depressed and referred to group therapy don't have to wait until the whole 16-session treatment program ends before they can join a CBT group. Some group members will begin with the Thoughts module, and others will begin with the Activities, People, or Substance Abuse modules, depending on when they enter treatment.

Introductory material must be presented at the beginning of each module. That means that by the time the fourth module starts, members who joined the

group when it was first launched will be hearing that material for the fourth time. The repetition is probably helpful, but to keep veteran group members interested, you can ask a volunteer to explain certain parts of the standard group procedures.

Group members can play different roles in the group based on how long they have been with the group. New members benefit from having "veterans" in the group who can share firsthand information about how the group has helped them. Veterans also benefit; they seem to develop greater commitment to the group material and to making changes in their lives when they are asked to help new members learn the skills. Encouraging the veteran members to participate—explaining the introductory material, for example—will help them learn the material themselves, since teaching something often helps people learn it better. It will also allow them an opportunity to "shine," and you can praise them for contributing to the group.

Depressed people often need to talk openly about their relationships with work colleagues, family members, and friends. For people who have abused substances, in particular, their relationships with old friends may be troubling if the friends are still using. Open communication is easier in a group that begins as a group of strangers, so CBT works best if individuals in the group do not bring family members or other people they know to the same group. However, if you lead a group that includes people who know each other, be both welcoming and sensitive to the fact that those people may not talk as freely as others.

Contact Group Members Before Their First Session

We recommend that group leaders call or meet with new members before the members attend their first group meeting. In this initial contact, group leaders can explain:

- The purpose of the CBT group.
- Specifics of the group, such as where and when it meets, how many sessions there are, and how each session will be conducted.
- Who the group leaders are and what their experience is.
- Contact information for the group leaders—phone numbers and the best time to call.

If you wish, you can use the "Pre-Group Client Orientation Form" (on page 58) to help structure an initial individual orientation session with a group member. The form includes suggested questions to ask as well as specific points to make about the CBT group.

During your first contact with new group members, ask them whether they know other group members. Talk with your supervisor ahead of time about this possibility, find out whether another CBT group is running at the same time or in the near future, and be prepared to recommend that family members, work colleagues, and friends attend different CBT groups.

Group leaders might also ask the new group members questions in order to become acquainted, establish a comfortable relationship, and provide support that is specific to each person's needs. For group members who have experienced traumatic events in their past, contact with the group leader before CBT helps them feel a connection with the group leader and trust that the leader understands their specific history. Asking about prior treatment experiences may also help to get around barriers the group member may have about going to group. Questions to the new group members might include:

- Why do they think they were referred to treatment?
- What do they see as their main problem?

- Have they had any prior treatment? What did they like or dislike? What barriers might get in the way of attending all the group meetings?
- What do they hope to get out of CBT?
- What concerns or reservations do they have about treatment?
- Are there things about them that they would like the group leaders to know, but may be hard to share during the first few sessions of the group?
- What questions do they have?

Each group member may be at a different point in the recovery process. You may choose to talk openly with individual group members about how ready they are to change their alcohol or drug use habits. You could say:

> *"We understand that you may have a lot of feelings about what it means to stop drinking or using and to be sober. You may think that giving up alcohol or drugs is a good thing and will make your life better. But you may also worry about what life will be like when you are sober and what will change. It is important to explore both sides of this issue."*

What to Do If Group Members Miss the First Session

In the first session of each module, you will present background information that is not repeated in Sessions 2–4. That means that new group members who miss the first meeting will miss the background information. (If they have attended Session 1 of a previous module, then this is not a concern, since the background information is the same in each module.)

Make contact with any group members who missed the session and make a plan to go through with them the information they missed. For example, you can ask them to come 30 minutes early to the next session, or to stay after.

Confidentiality in the Group

During the first session of each module, group rules are reviewed. One particularly important rule is rule #3, "Maintaining the confidentiality of the group." This rule is repeated below. Notice that the rules include explicit permission for group leaders to regularly share information with each other and with their supervisor, and also to share information with the group member's doctor or others if they think that the client's health or safety is at risk. The group rules also outline the legal limits to confidentiality (e.g., danger to self or others, and cases of child/elder/dependent adult abuse).

The group rules regarding confidentiality listed in the first session of each module are meant to be a general guide. Talk with your supervisor regarding other confidentiality issues that may arise at your site and how they may be handled. For example, if a group member in the group reports using substances, is this information that the organization requires to be reported to all members of the group member's treatment team or is this something that can remain confidential? At some organizations, only the information that a client is attending a group for depression may be shared with treatment providers other than the group leaders and the supervisor. In other organizations, you may function as part of a treatment team and may share information with other providers in that team. Be sure to inform the members of the group of the specifics regarding how confidentiality issues will be handled at your site.

Here is the excerpt from the Group Leader's Manual and Group Member's Workbook regarding confidentiality.

"3. Maintain the confidentiality of the group. Please do not share what you hear in the group with anybody else. Likewise, group leaders will not repeat what you say. There are three exceptions.

First, your group leaders share information with each other and with the licensed mental health professional that is supervising the group.

Second, if group leaders hear something that makes them think your health or safety is in danger they will talk with your doctor or others.

Finally, by law, a group leader must report:

- If a child or dependent adult is being abused or neglected.
- If an older adult is being abused or neglected.
- If someone is in danger of hurting himself or herself or someone else."

Friendships Among Group Members

It is natural for group members to form friendships among themselves and to want to spend time together outside of the group. Some group members may already know each other. However, group therapy works best if group members maintain a therapy-only relationship and do not socialize outside of the group. (They may pursue friendships after the group is over—you cannot control that.) This policy:

- Helps ensure that what is said in the group remains confidential. It would be natural for group members who become friends to chat privately about the group and other group members.

- Encourages group members to share openly with the entire group, without having to worry about what a friend might think.

- Prevents cliques and the possibility that some group members would feel hurt and left out.

- Discourages a strong group member from influencing or taking advantage of another, weaker, group member.

(**Note:** If your group members live together in a residential treatment setting, they will know each other and likely will have formed friendships, so this guidance will not be practical. However, you can encourage group members to respect and protect the privacy of one another.)

Challenges of Adding New Members While the Group Is in Progress

Adding new members can disrupt relationships in the group, even when groups have been meeting for only a brief period. Group members have formed relationships with each other and will likely feel comfortable talking about their problems in front of each other. Bringing new members into the group may disrupt those relationships. At the same time, new members may feel like outsiders coming into an established community. Discuss these issues with the group as a whole. Ask continuing group members how it feels to *have* new members in the group and ask new members how it feels to *be* a new member.

You can tell group members who are continuing their therapy that change can feel upsetting, even when the change is good. One way to help all group members feel comfortable together is to encourage old members to share what it was like to join the group, as well as their struggles and what they have learned in the group that has been helpful. This discussion will help new members understand that they are encouraged to talk about their personal feelings and their depression in front of the group. Encourage (but don't force) new members to participate. You can help make everybody more comfortable by reminding the whole group that they are all fighting a common enemy—depression.

What to Do When Group Members Arrive Late

There may be members who are late to the sessions. Lateness can disturb you as the leader and other group members and reduce the benefits of treatment. One way of dealing with lateness is to talk to the person who was late after the session is over. Express concern and help the member identify the obstacles to getting to meetings on time and figure out ways of solving the problems. Some members may encounter a number of real obstacles, such as a bus that did not

come, a job that requires overtime, or the need to care for a sick child. Approach the problem with patience and understanding and praise the group member for making the effort to come to the group. Make sure that group members understand that you want them to come to the group, even if they are late, rather than skipping the group altogether if they see that they won't make it on time.

Reach Out to Group Members Who Have Missed Sessions

It is likely that some group members will miss one or more sessions in a module. When people are depressed, it can be difficult for them to take even the smallest actions. Getting dressed, leaving the house, and traveling to the group meetings require a substantial amount of energy. Even in residential or inpatient settings, where group members live in the same location where the group meets, someone who is depressed may not feel like walking down the hall to a group meeting.

Make contact with group members who have missed sessions. Call them on the telephone, meet with them in person (especially if they are in a hospital or other health care setting where you can meet with them easily), or mail them a card or letter. You might even pass around a card or a piece of paper during a group session and ask members to write a brief note to the absent member, letting the member know that he or she is thought of and missed. You should take responsibility for mailing the card (partly because group members' addresses are confidential information). Tell the group member that if he or she would like to come to the next session 15 minutes early, you will be happy to go over material from previous sessions.

Help group members solve any problems that prevent them from getting to the meetings. For example:

- If they didn't allow enough time to get there, they can set an alarm clock to remind them when to leave home.
- If they didn't have transportation, help the person figure out how to ride the bus or get a ride from a friend.
- If they are reluctant to come because they didn't do their practice activities, make it clear that they should come to the group anyway.

Reassure group members that, if their out-of-group practice becomes a problem, you will help figure out solutions.

- If group members doubt that the effort it takes to get to group meetings will be worthwhile, ask them:
  - What they have been doing to feel better, how long they have been using their own strategies, and if the strategies have been helpful. Most people will say that their attempts to feel better haven't been successful, or that their efforts have helped a little but not enough.
  - What they think the chances are that they will feel better if they keep doing what they have been doing. They may admit that they will probably keep feeling bad.
  - What they think the chances are that they will improve if they take part in the CBT treatment. Remind them that CBT has been helpful for people just like them with depression. They will probably agree that their chances of feeling better are improved if they come to the group.
  - If they will consider coming to more sessions before they decide that the group can't help.
  - What thoughts they have on the day of therapy that prevent them from coming to the meeting. Suggest that they replace a hopeless thought with a hopeful one; for example, "My depression won't go away after one session, but I can learn things that will help me begin to feel better."

What to Do If Group Members Don't Get Along

Sometimes group members don't like each other or can't get along and these problems get in the way of successful group therapy. Group members are encouraged to talk about problems openly with the group. However, some may find this difficult, especially if they are concerned about hurting the feelings of a group member, or feel nervous about their safety around a particular group member. Be alert for these kinds of problems. Once in a while, it is necessary to remove a person from a CBT group and find a different group or a different kind of therapy for that person. Don't try to handle these kinds of difficult situations on your own—discuss them with your supervisor.

What to Do If a Group Member Expresses Strong Emotions

It is likely in the course of leading the BRIGHT group that group members may express strong emotions such as despair or rage. The way you respond in these moments will of course depend on the emotion and the situation. However, some suggestions for responding to strong emotions are outlined here:

- Do not ignore the group member expressing the emotion (whether it is someone crying or someone fuming with anger). Instead empathetically acknowledge the group member's experience and ask if they would like to or share their experience with the group or talk outside the group with one of the co-leaders. For example, to someone crying, you may wish to say "[Group member's name], I noticed that you are crying. I'm sorry to see that you're so upset. Would you like to share what is going on with the group or would you prefer to come outside with me for a few minutes so we can check in?" There are special circumstances where it might be more appropriate to simply ask the group member to talk outside the group for a few minutes to check in. For example, if you notice that the group member is actively trying to hide their emotions (e.g., by burying their face in their workbook and pretending to read), this may be an indication that they may become embarrassed if their emotional state were immediately brought to the attention of the group. As a general rule, group members should be encouraged but not required to share their private experiences with the group.
- Do set appropriate limits so that the group experience can be beneficial for everyone. For example, if a group member is very angry and bangs fists on the table, acknowledge that you see that he or she is very angry, but that the banging is disturbing to other group members, so this behavior needs to stop. You may also want to invite him or her to take a break for a few minutes from group.
- Do encourage the group member expressing the strong emotion to use CBT skills to cope with his or her experience. When relevant, invite the group member to work with the emotion using the planned group exercises. You may also ask the person experiencing the emotion if they

can think of a CBT skill that has already been covered that might be helpful to them that day, or gently suggest one of these skills.

- Help the group member connect to their individual therapist (if he or she has one) or another provider in his or her treatment team for support.
- Check in with the group member regarding accessing other social support. Problem-solve with the group member regarding how to get the support they need during what appears to be a challenging time for them.
- Assess for suicidality if the person appears distraught or has a history of suicidal thoughts or actions.
- Continue to stick to the agenda for the group even if one of the individual members may be very upset and may need to leave the group for a while with you or your co-leader. Sadness and other strong emotions are common in depression and in a group therapy experience (as well of course in the human experience) and should not be taken as signals to significantly change the group format or content (e.g., do not turn the group into a crisis management session for an individual member).

What to Do If a Group Member Uses Substances

Organizations vary in whether group members may continue to attend the groups if they use drugs or alcohol (in the days leading up to the group). Check with your organization and ensure that your group members understand the policy within your setting. However, group members may never attend the BRIGHT sessions *while intoxicated*.

If a group member who had a recent relapse to substance abuse (but is not currently intoxicated) attends your CBT group, it is important to do the following:

- Be nonjudgmental and non-blaming, but do express concern regarding the client's health and well-being. Do not criticize the behavior of the group member or allow other group members to chastise the group member for using drugs.

- Do not allow this client (or any other client) at any time during the course of the group to romanticize the use of drugs or directly encourage others to use drugs. If this occurs, quickly respond and let the client know that this type of communication is not tolerated in the group, as it may be harmful for other group members who are working on their sobriety.
- Within the structure of the group that day, encourage the group member to use the CBT techniques to support their sobriety.
- Be particularly alert to any signs that the client may be suicidal, as current substance abuse heightens the risk of suicide for people who are depressed.

Cases where you find that a group member has in fact arrived to group intoxicated deserve special mention. If you see signs that a group member has arrived to group intoxicated, either you or your co-leader needs to step out of the room with the client for a private meeting. In this meeting, the group member should be informed that, while you are glad that they made the effort to come to the session, they will have to wait until next session to participate because they appear to be intoxicated. As above, be careful not to shame the client for using substances or for coming to group. We also recommend that you consider implementing the following suggestions to address an intoxicated group member:

- If the group member is an outpatient treatment setting, make sure that he or she has a safe way home (i.e., make sure they don't drive intoxicated).
- Assess whether the group member may be returning to a situation where they are at high risk for using more of the substance. For example, ask the client where they are going and, if this is a high-risk situation, encourage them to go somewhere else where they would be less likely to use. If the client reports having substances at their home, ask them if they have a friend or relative who would be willing to dispose of the alcohol or other drug they have at their home or whether they would be able to do it themselves.

- If the client is sober enough to talk with you, instill hope in the client by reminding them that for most people there are slips on the way to sobriety and that they can reestablish their sobriety by choosing to avoid substances for the rest of the day.
- If they have already been in BRIGHT for several sessions when this incident occurs, remind them of the relevant CBT skills to help them produce more helpful thoughts, activities, and people interactions to support their recovery.
- If possible, arrange support and help for the client in regaining sobriety. For example, encourage the client to talk to his or her drug counselor or individual therapist or AA sponsor, as applicable. Remind the client that you want the BRIGHT group to also be a source of support for their sobriety and that you hope that they will come to the next session.
- Your organization may also have other guidelines regarding how to help clients who have recently used substances to which you may need to refer in these situations.

What to Do When a Group Member Expresses Suicidal Thoughts or Plans

Clients with substance abuse problems and depression are a high-risk group for suicide. The science of predicting who may try to take his or her own life and the best intervention strategies for helping suicidal clients continue to evolve. If you are receiving supervision, consultation with your supervisor regarding how to handle suicidal clients at your site is essential before your first contact with any client who may be entering the BRIGHT group. Be sure that you are knowledgeable about the step-by-step guidelines for handling instances of suicidal ideation at your site, including after hours procedures. In general, if the suicidal ideation is expressed by a group member during the group time, at least one of the group leaders needs to meet privately with the group member either during the group (while the other group member leads the group) or immediately after. For some sites, the next step may include contacting the group member's primary individual counselor at a residential treatment center to coordinate care. In these cases, sometimes a hand-off is arranged where one group leader stays with the group member until the individual counselor is available to further assess the client. For other sites, the group leaders may be

in charge of conducting a more thorough suicide assessment prior to treatment planning or referral.

As part of the BRIGHT program, there is a regular assessment of depression symptoms, including suicidal thoughts, through the Patient Health Questionnaire-9 (PHQ-9). Item number 9 on the PHQ-9 directly assesses suicidal ideation by asking "How often in the past 2 weeks have you had the following problems… thoughts of harming yourself or that you would be better off dead?" Every time this questionnaire is administered in the group, it should be immediately reviewed to determine whether there may be need for further assessment of suicidality. Any group member's answer that indicates that he or she has been having suicidal thoughts deserves further timely assessment, either during group or immediately following group.

Low scores on the Quick Mood Scale that is completed weekly by group members should also trigger further assessment of suicidality. For example, if you notice that there are 1s, 2s, and 3s on a group member's completed mood scale, this might be a sign to further assess suicidality. In these cases, the typical procedure is for one group leader to set a time to talk with the with group member immediately after group. In this meeting, tell the group member that you are concerned about them because of the low mood they reported on the Quick Mood Scale and that you wanted to make sure that they are going to stay safe and have the support they need before the next group. Directly inquire in this meeting regarding suicidality. For example, you may wish to ask "Have things been so bad that you have been having thoughts about harming yourself or that you'd been better off dead?" Remember that asking about suicide **does not** increase the risk of suicide and that finding out about suicidality can give you an opportunity to help the client. If the client does report suicidal thoughts, immediately contact your supervisor and follow the procedures for handling suicidal clients that you and your supervisor have discussed prior to the group starting.

While different group leaders' scopes of clinical practice and different sites' institutional rules regarding handling suicidal behavior may vary, there are some common sense procedures for imminently suicidal clients (e.g., those who have expressed a specific immediate plan for self-harm) that generally apply at most sites. These include keeping the imminently suicidal client in direct observation while contacting your supervisor or seeking professional help

immediately for the client (or having a colleague seek help). In cases where an imminently suicidal client refuses to stay with a staff member and leaves the premises, you should immediately contact an emergency service, such as the police, 911, or, in some cases, a Psychiatric Emergency Team. All states in the United States acknowledge that cases of imminent self-harm limit patient confidentiality. The limits to confidentiality are discussed in the "Group Rules" section in the first session of every module in the BRIGHT CBT Program. In these cases, swift action to protect the client typically involves, at minimum, divulging to law enforcement or other essential emergency personnel details regarding the client's suicidal status and whereabouts.

What to Do When a Group Member Expresses Thoughts or Plans of Harming Others

If you are receiving consultation or supervision, talk with your supervisor about how to handle situations in which a group member is in danger of harming someone else. It is essential to have plan for handling these situations before starting the BRIGHT group. If this type of situation arises, contact your supervisor as soon as possible. As reviewed in the "Group Rules" section at the beginning of each BRIGHT module, communication regarding intention to harm others cannot be kept confidential. Health care practitioners have a duty to warn an intended victim and may have a duty to take other steps to prevent violence. Review and be knowledgeable about the relevant governmental and professional guidelines regarding working with homicidal and other potentially violent clients that pertain to your practice.

The Importance of Practice

Anyone learning a new skill has to practice. It is very important to follow up on CBT practice assignments. If you don't ask group members about their practice, they may think that it is not important. Each session includes a time to talk about practice, but you can also reinforce the importance of practice by asking group members informally, as they arrive at the group meeting, "How did your practice go?" Help them solve any problems they are having and answer questions. Problem-solving is an important part of CBT.

Give group members feedback—tell them that you are glad to see that they are practicing. Offer ideas about other ways they might think, do things, relate

with people, and deal with recovery from substance abuse that would help them feel better and enjoy life more.

Group Members Should Take Credit for Practicing CBT Skills

Help group members understand that it is because they are practicing the new skills that they are feeling better. If group members believe that they have improved only because of their relationship with you or their participation in the group sessions, they may not have the confidence to continue to practice when they are no longer in treatment.

What to Do If a Group Member Is Not Doing the Practice Activities

(**Note:** Practice is very important for CBT to be effective. This information is repeated in the Thoughts module so it will be handy for you to refer to.)

Most group members will do their practice activities; you should begin with the assumption that they will. Checking early in each session on the practice is the best way to let group members know how important their practice is. However, there may be individuals in the group who consistently do not practice. Identify this problem as early as possible.

Find out why the group member is not practicing. Is it an issue of time, reading ability, forgetfulness, or other responsibilities getting in the way? Once the obstacles are identified, you can help the group member figure out how to overcome them. You might say, "We want you to start feeling better, and we know how important practice is. Can we help you figure out what is getting in the way so that you can do the practice and start feeling better more quickly?"

Identify thoughts that contribute to not practicing, such as "It doesn't matter what I do, nothing will change," or "I don't feel like doing my practice." You might ask him/her: "Are you sure that what you do won't make a change in the way you feel? Do you think you have a better chance of improving your mood if you keep doing what you have done in the past, or if you try these practices that have helped others?" Help the individual to dispute these thoughts.

No one assignment is going to "cure" depression, but practicing outside of the group will help the group member learn to control his or her negative mood.

Get reinforcement from other group members. You can ask other group members to help problem-solve. It is likely that other members will volunteer information as to what has helped them to practice.

Complete the practice within the session. Be flexible about finding another way for the person to practice. Maybe he or she can complete the Quick Mood Scale for the whole week just as the session begins, for example. Or ask the individual to practice some of the skills before and after the session. The individual should be reminded that the Quick Mood Scale is best finished on a daily basis. Looking back at the past week's mood is less reliable than completing the Quick Mood Scale each day. But asking members to complete the incomplete scale in-session indicates that you take practice seriously.

Strike the right balance. It is important to give group members the message that practice is important. However, it is also important that they come to the CBT sessions whether they have completed their practice or not. In fact, the group member might tell you that he or she can't do anything right. Point out that he or she was successful in coming to the group, and coming to group is a first important step to feeling better. Be warm and supportive of the group member and let him or her know that you are glad he or she chose to come to the session whether or not he or she completed the practice.

Avoid Applying CBT Lessons Too Broadly

A number of problems can come up in leading group CBT. Several stem from over generalizing. That is, sometimes when group members learn new ways of thinking about things, they apply those lessons too broadly. You can help them avoid over generalizing or thinking that CBT will solve all their problems. CBT can help a person get over depression, but it will not, for example, turn somebody into a brand new person or cure homelessness.

Feeling Guilty for Letting Oneself Be Depressed

One of the symptoms of depression is excessive guilt. People who are depressed may use a CBT idea to blame themselves. It is important to point this out early so group members can catch themselves if they are doing it and stop.

- **Depression is not caused by negative thoughts.** One problem arises from telling individuals that they can manage their moods. Once they recognize this, they may then "logically" assume that they are to blame for being depressed in the first place because they didn't manage their mood effectively. This is a difficult concept—a depressed person can help get over depression by learning how to manage thoughts and behaviors, but they didn't *cause* their depression by not thinking or behaving "right." You can assign group members the task of noticing if this thought—"My depression is my fault because I didn't manage my moods"—enters their minds. Help them understand that the statement is not true. Tell them that they didn't steer themselves off the road. Rather, their mood may have been thrown off when they hit a rock. CBT is the steering wheel that will help them get back on track.

- **Depression is not caused by negative behaviors.** Similarly, if people understand that they can change the way they behave, they may feel that they should have changed their behavior a long time ago. For example, a woman who has been depressed may regret not taking better care of her children and blame herself for not managing her behavior.

  It is true that people might have caused real injury to their families. But you can help people recognize that the problems of the past stemmed partly from depression. By learning new ways of thinking and behaving, they can avoid creating more problems for themselves or others. They might be able to think of life as a precious gift. Even though they didn't "spend" the gift wisely in the past, they can do so now.

Trying to Be Perfect

Group members may come to a conclusion that seems logical to them: They can be perfect if they apply the lessons of CBT. Tell group members that if they use perfection as a standard by which to judge themselves, they will always be disappointed because people cannot be perfect. The ideal is worth pursuing as long as it serves as a guide rather than a goal. Tell group members that they won't succeed at everything every time and that this is okay.

Thinking "Happy Thoughts"

If people have limited income and education, few job skills, and few relationships with other people, they are right in thinking that they face many challenges. If they feel that you do not understand these challenges or that CBT ignores the real world, they may resist your efforts to help. CBT does not teach that positive thinking is the way out of depression; CBT does teach that some ways of thinking help improve mood and day-to-day life. Tell group members that you understand that the problems they face are real. But encourage them and tell them that CBT will help them identify ways to make things better for themselves.

What to Do If a Group Member Is Not Making Progress with CBT

Depression is very treatable and CBT has helped many people who are depressed, but it may not work for everybody. If any individual in your group does not appear to be feeling better after about four sessions, talk with your supervisor about the individual. By "not feeling better," we mean that the person:

- Has a consistently low mood;
- Has low scores on the Quick Mood Scale and they don't get better;
- Reports that his or her mood is getting worse;

  and/or

- Reports other symptoms of depression or increased risk for use alcohol or drugs.

If a person has been depressed for a long time, he or she may continue to report low mood and not recognize that there has been improvement. Your judgment of the person's progress is important. However, do not try to handle a situation of this kind by yourself. A supervisor can get the group member the help he or she needs.

If you think that a group member is having suicidal thoughts, is being hurt, or is having thoughts about harming another person, contact your supervisor immediately and get help for that person before the end of that group session.

Again, do not handle these serious situations on your own—your supervisor is there to help and to look out for the safety of every person in the group.

Meet Individually with Each Graduating Group Member

(**Note:** If you have time, and if the graduates have time, meet with each graduating group member. If you do not have time, go over some of the points described below in the discussions the group has with the graduates at the end of Session 4 in each module.)

About two weeks before the last session of each module, make an appointment with each group member who is graduating from BRIGHT (he or she will have completed all four BRIGHT modules) to meet one-on-one and talk about future plans. These meetings will probably take about 30 minutes. You could meet with some individuals before the sessions and some after, but contact them ahead of time to make an appointment that is convenient for both of you. Go over the following points.

- **Look at the progress the individual has made in improving his or her mood.** Ask the group member to look back at his or her scores on the Quick Mood Scale. Mood scores will fluctuate during the group, but if the group has been effective, the person's scores should go down from beginning to end, showing less depression.
- **Give the credit to the individual.** Make sure the group member understands that it is his or her own effort and use of the CBT skills that has caused the depression to get better. Tell the group member that he or she can continue to manage mood and depression by using the skills learned.
- **Identify the most helpful aspects of the group.** Group leaders can ask graduating members to name the specific tools and skills that have helped them the most to relieve their depression. It is important to tell the individuals that they have unique strengths independent of the skills they learned in the group. Name some of these skills specifically for each graduate.

- **Inspire hope.** Congratulate group members on the progress they have made, and remind them that in the future they can turn back to the CBT tools in their workbooks (which they keep).
- **Help graduates prevent a relapse.** Remind graduating group members that if they find the symptoms of depression returning despite using all of the tools that they learned in the group, they can see their own doctor or counselor to request a referral to further treatment without waiting until the depression becomes disabling. If you believe that a group member who is ready to graduate is still suffering from depression, talk with your supervisor.
- **Discuss future plans.** Ask graduates what their next steps will be. For example, what will they do if they feel themselves becoming depressed again? If they feel like using drugs or alcohol? Possible next steps include:
  - Using the CBT skills on their own.
  - Getting a medication evaluation or referral for other services.
  - Attending a support group.
  - Attending another group focusing on a different problem.
  - Getting individual therapy.

Allow the Group to Say Goodbye to Graduating Group Members

When members enter and leave the group at different modules, some will graduate at the end of one module, and others will be left behind to complete the other CBT modules.

In the first session of a module, name the members who will be graduating at the end of the module and focus some attention on those members during each session. As graduating group members begin their last session, group leaders should remind the group of who will be graduating from the program at the end of that session. Congratulate the graduates for learning new skills to manage their depression. Remind all group members that mood management is a continuing process and that one of the goals of the program is for them to learn skills they can continue to use after the program is over.

It will be natural for group members who are not be graduating to feel happiness for the graduates but sadness for themselves. They might even compare themselves with the graduating group members and feel that they are not making good progress. Encourage them to talk about what they have learned from the graduating members. Ask them to consider some of the goals that they would like to achieve in the remaining time. Remind all group members that CBT is usually effective in helping people feel better, that it takes both time and practice to work, and that you will continue to be there to make sure they get the help and support they need.

Allow time for friendly conversation. You might ask the graduates to talk about some of the same topics that you addressed individually with the graduating members in one-on-one meetings. For example:

- One graduate might share his scores on the Quick Mood Scale and discuss how his mood fluctuated or improved as the therapy progressed.

- Another graduate might talk about her future plans, or how she will prevent a relapse into depression or substance abuse or deal with a relapse if it happens.

Supplies you will need

At the beginning of each session, there is a list of materials that you will need to conduct that day's session. The list is generally short and uncomplicated. However, if you want to order the audiotape described below, you will need to do that in advance of when group begins. In total, the materials you will need for the CBT modules are as follows.

If you are reading this, you already have the **Group Leader's Introduction**. Each leader should have a copy of this book.

Group Leader's Manual—one for each of the group leaders.

Group Member's Workbook—at least one for everyone in the group, plus a few extra. Since your groups will consist of about 8–10 people, have about 12–15 workbooks on hand. Group members will take their workbooks home after each session and should bring them back to each session. But have a few extras on hand at each session so that you can loan them to group members who forget to bring their own copies back. You may want to ask the group member to not write in the loaned copy of the workbook. Another way to handle this problem would be to ask the group member who forgot his or her workbook to share with another group member.

Pens—enough for everyone in the group.

The PHQ-9 depression measure—enough copies for everyone in the group to fill out the survey during Sessions 1 and 3 of each module—or eight times altogether. So, for example, if you have five people in your group, you would need 40 copies (5 x 8 = 40) of the measure, plus a few extra. (Photocopy the PHQ-9 from page 52 in this Introduction.)

Small index cards—to use in the Thoughts module, Sessions 1–4; enough so that each group member can have seven.

Binder clips—small sized, one for each group member, so group members can attach their index cards to their workbooks.

Laminating paper—enough for each group member to laminate three index cards.

Scissors—3–4 pairs—enough for group members to share.

Dry erase board, chalkboard, or large sheets of paper to present material to group. Depending on where your group meets, you may have a chalkboard you can use to explain the material to the group. If not, make arrangements to have a big tablet of paper, or some other means to work with the group.

Kleenex or other facial tissue to offer to group members as needed.

Certificate of Achievement for graduating group members. On page 59 in this Introduction is a sample achievement award that you can copy to give to group members when they complete all four CBT modules and graduate from the program. Fill out each certificate, and present the certificates to graduating group members at the end of their last session.

THE PHQ- 9 DEPRESSION MEASURE

Sessions 1 and 3 of all modules call for you to pass out the PHQ-9 to group members. Pass out the first page only. The second page provides information on scoring and interpretation.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:			+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	_____
Somewhat difficult	_____
Very difficult	_____
Extremely difficult	_____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

ZT242043

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Certificate of Achievement

Complete the Certificate of Achievement for each group member and give it to them when they graduate from the group.

Achievement Award

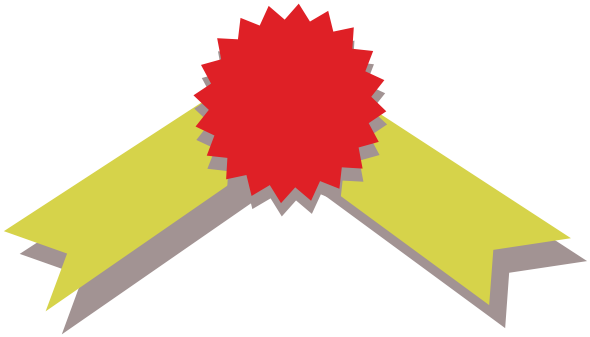
Congratulations!

_____
[name]

You have successfully completed

Group Cognitive Behavioral Therapy for Depression (CBT)

_____
[date]



_____
[Group Leader signature]

_____
[Group Leader signature]

Additional thanks

At the San Francisco General Hospital Depression Clinic, many individuals helped shape the treatment approaches used. Among them are Jacqueline Persons and Charles Garrigues. A special thanks to the co-authors of the 1986 version of the CBT manual, Sergio Aguilar-Gaxiola, and John Guzmán.

We also wish to thank David Burns. The categories of thoughts in the "Thoughts" module are adapted from his book *Feeling Good: The New Mood Therapy* (1980).

The idea of doing an experiment in the "Examine the Evidence," exercise in the "Thoughts" module was adapted from the manual *Cognitive Behavioral Therapy of Depression* by the Kaiser Medical Center Department of Psychiatry (1999).

The "Yes, But" exercise in the "Thoughts" module was developed by Kurt Organista at the San Francisco General Hospital Depression Clinic.

The goal-setting activity in the "Activities" module is adapted from the "Going for the Goal" program leader manual (Danish et al., 1992).

The "My Rights" statements in the "People" module are adapted from *Treating Alcohol Dependence* (Monti et al., 2002).

The exercise called "How Do the People in Your Life Support You?" in the "People Interactions" module was adapted from Wheatley, Brugha, and Shapiro's *Preparing for Parenthood* manual (1998).

Appendix: Pre- group orientation form

We recommend that group leaders call new group members or meet with them one-on-one before they attend their first CBT meeting. This form can be helpful in organizing that first conversation.

PRE-GROUP INDIVIDUAL CLIENT INTERVIEW
Orientation Form

PURPOSES OF MEETING:

1. To understand how alcohol/substance use and depression impacts the client's life.
2. To troubleshoot barriers to attending group CBT regularly.
3. To give information and answer any questions about the CBT group.

REVIEW CLIENT'S CHART

This section is designed for the counselor to collect information ahead of the interview. Start the interview on page 2.

Client Name: _____ Male / Female

Age: _____ Ethnic Background: _____

Alcohol/Substance Use:
Drug of Choice: _____ Problem Alcohol Use? ☐YES ☐NO ☐Don't Know
Drugs used: _____
Previous Alcohol/Substance Abuse Treatment? ☐YES ☐NO ☐Don't Know # times?_____
Reason for seeking treatment this time? ☐ Criminal Justice mandate ☐ Friends/Family
☐ Self referral ☐ Child and Family services requirement (i.e., get my kids back) ☐ Other:
_____

Mental Health:
Mental Health History: Prior Treatment? ☐YES ☐NO ☐Don't Know
Diagnosis: ☐YES ☐NO ☐Don't Know Diagnosis: _____
Previous suicide attempt/ideation? ☐YES ☐NO ☐Don't Know Details: _____
_____

Other:
Medical problems? _____
Medications? _____
Interpersonal problems? _____
Abuse history: ☐Physical ☐Sexual ☐Verbal Describe: _____
Legal Problems? _____
Education Level: ☐ 8th grade or lower ☐ some High School ☐ HS School Grad ☐ Don't Know
Issues/Notes:

Note to Counselor: Use this information as a guide. Spend more time on sections that are more relevant to the client and less time on areas that are less important. Each section is meant to be brief and if the client wants to talk more than the time allowed, you can encourage the client to bring his or her concerns to the group or ask the client to talk with their individual counselor. For example, you can say *"I'm glad you brought that up and I think CBT can help with those concerns. In the interest of finishing this session on time, would you be willing to bring those ideas up during our group?"*

1. Welcome and introductions (2 min)

Hi and welcome to the CBT group. My name is ____ and I am one of the counselors that will lead this group. The purpose of today is for us to get to know each other, to give you information about the CBT group, and to give you the opportunity to ask any questions you may have about the group. I'll be asking you some questions and taking notes today, but I want to keep this informal, so feel free to ask any questions you have as we go along today. How does that sound?

2. Current reason for treatment (5 min)

I've had a chance to review your chart, so I have some idea about what led you here. (**Briefly** and specifically summarize your understanding so the client can correct or elaborate on what you say.)
I understand that you came to treatment because _____and that your goals are to_____. Is that correct?

3. Alcohol/Substance use (5 min)

I understand that your drug of choice is _____? Is that correct?

I'd like to understand more about what you like and dislike about using (drug of choice). *That will help me understand your alcohol/ substance use more.*

What do you like about (drug)? *How about what you don't like?*

Likes	Dislikes

How many days has it been since you last used (drug)*?* _____ *Days*

What has helped you to stay clean/sober? (reinforce healthy behaviors)

4. Depression (5 min)

Tell me more about when you're sad or depressed. What are you like? How do you act, think, and feel differently? (assess severity and impact on functioning)

Were things ever so bad that you thought about hurting yourself? ☐YES ☐NO ☐Don't Know

If YES, assess severity and write down details about past attempts (e.g., where, how, etc.).

5. Past treatment history (5 min)

Have you ever been in alcohol/ substance use or depression treatment before?

Alcohol/substance use treatment ☐YES ☐NO

Depression treatment ☐YES ☐NO

In general, what were some of the things you liked or found ***most helpful*** *about past treatment?*

What did you dislike or find ***least helpful*** (troubleshoot any misperceptions they may have about the group)*?*

6. Orientation to Group (5 min)

We will talk in more detail about the CBT group during the first session, but let me highlight a few things and see if you have any questions. **(Review handout)**

This group will be a commitment. What might get in the way of you attending the group? [Generate ideas and solutions to address these barriers.]

Barriers	*Solutions discussed*

7. Summarize (3 minutes)

(say summary here about what was discussed such as treatment goals, likes/dislikes about substance use, depression symptoms, things the client would like to change, motivators and barriers to treatment, etc.) *Do I have that right? Did I miss something?*

8. End the meeting

Thank you for sharing your experiences with me today. It helps me understand your situation better. I am glad that you have joined the group and I think it will be helpful to you. **(Build hope for the client)**

Do you have any questions before we end today? Remember that you can call me if you have any questions before the group starts. You will join the group on [date]. The group will be on [day, time, and location].

Notes to group leader:

- Dealing with clients who report no/little depression
  - Prevention: *Have you ever been more depressed than you are now? The same skills that you will learn in group have been used in depression prevention program. It is possible that learning new tools will help you to avoid getting more depressed in the future.*
- Dealing with clients who don't know what they will get out of the group or don't think it will help
  - *What might your mood be like if you don't go to the group? What might your mood be like if you go to the group? This kind of treatment has helped others in the past, is it possible that it will help you? Would you be willing to give it a try?*
- Dealing with clients with strong cravings
  - *What has helped you in the past? For example, you're not using right now even though you have cravings, what are you doing now to accomplish that?* (Ask about client's social support, schedule, and focus on going a day at a time – e.g., *What will get you through your cravings until your next appointment at the clinic?*)

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