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Group Cognitive Behavioral Analysis System of Psychotherapy (Group-CBASP): Adaptation to a Group Modality for the Treatment of Chronic Depression

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1. Introduction

Cognitive Behavioral Analysis System of Psychotherapy (CBASP) is a treatment model designed specifically, by McCullough (2000; 2006), to help individuals suffering from chronic depression. This model was developed initially as an individual treatment modality and will be discussed in this chapter solely in its adaptation to a group modality for the treatment of chronic depression with psychiatric outpatients.

The CBASP model is based on contemporary learning theory with its primary goal being: (1) to connect the patient perceptually to others (the environment) so that others can begin to inform / influence the behaviour of the patient in positive ways – CBASP is based on a Person X Environment Causal Determinant Model of Behavior; (2) to acquire stimulus learning (through the therapeutic and other more adaptive relationships) and response learning (acquire more adaptive coping behaviours to reduce interpersonal avoidance and increase positive reinforcements) (McCullough Jr, 2008). CBASP is a highly structured, skills-oriented and interpersonal approach, which teaches concrete skills to help patients overcome their interpersonal problems and is also a focused approach aimed at achieving tangible and attainable goals (Klein in McCullough, 2006). Keller et al., (2000) mounted a long-term, multi-site clinical trial showing the best-yet response rates for chronic depression when CBASP and pharmacotherapy are combined.

As stated by McCullough (2003), the success of CBASP is contingent upon the demonstration to patients that their behavior has consequences on others which in turn empowers the patient to overcome the despair over feelings of loss of control in one's life.

This person X environment causal determinant model of behavior is founded primarily on the reciprocal and bidirectional nature of human interaction, as elaborated by Bandura's Social Cognitive Theory (1999). In Social Cognitive Theory, the cognitive, affective and biological variables of each individual are thought to interact with their behavioral patterns, and with environmental events to influence one another within social systems (Albert Bandura, 1999). McCullough would agree with Bandura's statement that to better understand human behavior, it is best to conceive of an integrated causal system in which individuals create, organize and regulate social structures in order to manage their affairs according to some preset rules and sanctions which are also influenced by psychological mechanisms (Albert Bandura, 1999).

However, Bandura's bi-directional model of human interaction cannot be used when treating the chronically depressed patient, according to McCullough (2006), since the pre-operational structural functioning of the depressed patient precludes this "normal" social bi-directionality. CBASP therapists conduct treatment from a unidirectional perspective using strategies to inform patients of the consequences of their interpersonal behavior, in an attempt to help them move into a bi-directional involvement with the therapist and others. McCullough adds that this process involves the acquisition of formal operational functioning on the patient's part. Patients also learn alternative ways of behaving and responding with the therapist and learn to transfer these relational skills to their daily interactions with others and also learn to take increasing responsibility for the changes they are realizing in their lives.

McCullough (2000; 2006) describes a perceptual disconnection between the depressed patient and his or her interpersonal environment, such that the person's behavior with others results in consequences that have no informing influence on what the person subsequently does or does not do. McCullough has named this construct *perceived functionality* (J. P. McCullough, 2000; 2006; J. P. McCullough, Jr. & Penberthy, 2011) which he defines as being able to identify the consequences of one's interpersonal behavior (James P. McCullough, Lord, Conley, & Martin, 2010). The refractory or recurrent nature of this chronic illness is characterized by inflexible cognitive patterns and rigid interpersonal behavior which McCullough portrays as the "egocentric circular functioning" of these patients. The outcome of the depressed patient's inability to receive feedback from others, is an interminable circle of "sameness" and a "perceptual disengagement" when facing the therapist or even significant others, according to McCullough (2000).

There is increasing evidence of significant deficits in the mentalizing functions of depressed individuals. A concept used to understand the impaired social functioning of depressed patients is the "Theory of Mind" (ToM) (Baron-Cohen, 1989). Both ToM and mentalization are terms that denote the mental capability of a person to infer another's beliefs, affective states, or intentions (James P. McCullough, et al., 2010). Gotlib and Lee (1989) found that depressed patients report more social functioning difficulties, even after symptom remission, than non-depressed patients or non-psychiatric subjects in the community. Inoue et al. (2004) reported deficits in areas of the brain associated with social functioning and in

ToM abilities, even after symptom recovery from unipolar depression. In addition, depressed patients with ToM deficits have higher rates of relapse and a poorer social adjustment, after remission (Inoue, Yamada, & Kanba, 2006).

These findings are corroborated by further evidence that patients with major depression have impairments in affective and cognitive components of humour processing and have reduced mentalizing capabilities (Uekermann et al., 2008). Uekermann et al, 2008 postulate that these deficits may be a result of the working memory load involved in humour processing. Wolkenstein et al. (2011) did not find depressed patients to have impaired decoding abilities, contrary to other findings (Lee, Harkness, Sabbagh, & Jacobson, 2005; Wang, Wang, Chen, Zhu, & Wang, 2008) and suggest that only severely depressed patients appear to have a decoding impairment in theory of mind. They did however find these depressed patients to have a deficit in their reasoning ability. There appears to be some support for the hypothesis that chronically depressed patients with early onset depression, with characteristics described by McCullough (1990), may be among those who have more impairment in ToM abilities. These patients often report early experiences of trauma, physical or psychological abuse. Wolkenstein et al. (2011) found that depressed patients, in their study, show a higher accuracy rate in decoding negative mental states than healthy controls, while there is no difference between the two groups in their decoding accuracy of neutral and positive mental states. To explain these findings, Wolkenstein et al (2011) suggest that depressed patients may show a hypervigilance to negative emotional stimuli, although they add that it is not clear if this hypervigilance to negative social cues may be a risk factor for depression in these individuals. The authors conclude from their findings that depression may be associated with impairment in depressed patients' ability to draw valid conclusions about the mental states of others, reflecting, more specifically, difficulties in their capacities to integrate contextual information about another person (Wolkenstein, et al., 2011, pp.110). This may be understood as indicating deficits in higher order functions, as explained by ToM according to these authors.

2. Group-CBASP: Theoretical model

In light of the detailed descriptions provided by McCullough (2000, 2003; 2006) of the primitive thought structure, language patterns and the behavioral patterns of the chronically depressed adult patients, it becomes easy to understand how a group modality can provide an environment that is more enabling and empowering and that succeeds from the start at breaking the cycle of isolation and despair which these patients report on a continual basis at the start of therapy. In addition, the group setting helps to counter the individual therapist's temptation to want to rescue the depressed patient (J. P. McCullough, 2000) with group members instead making specific recommendations to each other on how to resolve certain difficulties. A group modality places individuals in an interactive mode in which they are repeatedly confronted with communication between group members from the start. The group is a social network in which members can influence each other intentionally, therefore exercising personal agency and enhancing self-efficacy (A. Bandura, 2012). Group

members' beliefs in their capabilities develop through their experience of mastery by working together on Situational Analyses that are challenging social problem-solving exercises. Through social modeling (A. Bandura, 2012), group members learn to persevere and observe how others in the group with similar depressive symptoms succeed at reaching their interpersonal goals. Finally, learning occurs through the effects of social persuasion (A. Bandura, 2012) with group members influencing and encouraging each other. The group also provides a naturally rewarding environment resembling the one patients left behind, being on disability from work or having withdrawn from family and friends. The group is a form of simulation or "social laboratory" replicating to some extent reality-based, expected levels of functioning for each individual. For example, group members are expected to attend each and every group session or to notify of their absence in case of an emergency. Group members are also asked to respect a limited set of rules covering issues of confidentiality and acceptance to work on individual objectives.

For this reason, depressed patients are often reluctant initially to participate in group therapy, which they perceive as an exposure experience to the much feared stimuli that they have successfully managed to avoid, which is interactions with others. Indeed, interactions between group members are very few and far between, at the start of group therapy. Their interpersonal behaviors are characterized by what is described in pre-operational children as "parallel play". Group members listen to others but rarely engage one another in a discussion on a particular topic and often avoid eye contact with others in the group, especially at the beginning of group therapy. Nevertheless, the presence of other group members whom patients see as having very similar difficulties as themselves including social avoidance comes as a great relief to them who quickly begin to feel inadequate and ashamed of their own interpersonal difficulties.

Depressed patients in a group openly acknowledge their difficulties identifying personal life regarding goals that govern their interpersonal interactions. They often report dissatisfaction and frustration about feeling misunderstood by others, which in turn appear to reinforce social avoidance and the vicious cycle of defeatist thinking and hopelessness that McCullough (2000) has clearly articulated in his description of the dynamics of chronic depression. In the group setting, members work together and in parallel to understand each other's interpersonal motives or lack thereof, which is framed in terms of a "Desired Outcome" obtained at the end of a specific interpersonal "slice of time", as is explained to them. They learn to solve "one problem at a time", as taught by McCullough (2000), to succeed at overcoming a chronic depression.

The Situational Analysis (SA) is the main skill acquisition exercise taught to depressed patients in Group-CBASP. The SA requires that patients attend to the various steps involved in the analysis of an interpersonal situation and calls on the very mentalizing executive functions that these patients are lacking and that CBASP aims to help them recover. They learn to attend to reality-based elements of an interpersonal situation such as characteristics of their non-verbal behavior within the situation outlined, the Actual *observable* Outcome of the situation and finally their Desired Outcome which needs to be under their control,

realistic and attainable in order for them to reach it. Participants are also made aware of their thoughts during the interpersonal situation described. In the revision of the SA, patients need executive cognitive functions to determine if their thoughts or “read” of the situation was relevant or not to the actual verbal exchange that took place and learn to identify an “Active Interpretation” which will lead them more directly to the “Desired Outcome”, being their interpersonal goal they previously identified. They also learn how intense emotions impede their ability to “read” an interpersonal situation accurately.

In Group-CBASP depressed patients learn early in therapy that their interpersonal motives or goals are anything but unambiguous. These patients acknowledge, early on in the group, their use of avoidance strategies in the face of interpersonal conflict. They find themselves however in a situation of cognitive dissonance within the group, being drawn into the cohesion that develops between group members on one hand and their withdrawing behaviors in the face of this social situation on the other. Group members appear to respond to this dissonance by being very reticent to contribute to their learning by bringing difficult interpersonal situations to be discussed in the group using the SA exercise, as they are instructed to do. Their feeling is that the group is already an exposure situation that is, in many cases, more intense than what they will have experienced in a long while considering their degree of social isolation and withdrawal. Even significant others in their community appear to have accommodated to these patients’ passive and helpless stance.

For the reasons previously described, the goals of Group-CBASP parallel those described by McCullough (2010) for individual therapy. The group therapist “choreographs and directs the interpersonal learning processes” (James P. McCullough, et al., 2010, p.321) in order to achieve two essential learning goals: (1) The group setting helps to counter-condition the patient’s pervasive interpersonal fear, replacing it with *felt interpersonal safety*. This goal is achieved when patients can perceptually discriminate group members from maltreating Significant Others (Sos) and come to feel safe with each other. (2) The second learning goal of Group CBASP is realized when patients’ interpersonal avoidance strategies are replaced with approach behaviors. Group members begin to assert themselves in the group and communicate with each other about what they want or don’t want and begin to think about how they will attain these interpersonal goals. The development of *perceived functionality*, previously described, becomes more perceptible with group members expressing their understanding of each other’s SAs.

3. The interpersonal circumplex as a psycho-educational tool

A useful approach to integrate in a Group-CBASP model is the use of the interpersonal circumplex as a psycho-educational tool to help depressed patients understand and improve their interpersonal functioning. The interpersonal circumplex (IPC) model conveys a more interpersonal explanation of psychopathology and places normality and abnormality on a continuum using the same dimensions and constructs of motivation, self-efficacy and behavior, to delineate them (Pincus & Wright, 2011). This model complements CBASP and helps to reposition the maladaptive functioning and possible personality psychopathology

of chronically depressed patients within their present interpersonal environment and to observe their manifestations in the group setting. This interpersonal approach helps to circumvent the avoidance behaviors of participants in the group by normalizing the process by which their maladaptive functioning is explored and addressed.

The interpersonal circumplex reflects the relationship between two categories of interpersonal behaviors, traits or motives. On the horizontal axis the dimension of *affiliation* represents the need for closeness with others and a sense of communion with others. On the vertical axis the dimension of *agency* portrays the sense of having control, dominance or power over one's life. These two dimensions represent the two challenges which we are faced with since childhood; that is the need to get along with others and the need to move forward in life with independence and autonomy (Bakan, 1966; Horowitz et al., 2006).

Group-CBASP helps participants gain a better understanding of their interpersonal difficulties and behaviors by focusing on their interpersonal goals. They are encouraged to see that some form of intention or goal motivates most of our interpersonal interactions, whether it is conscious or not (Horowitz, 2004; Horowitz, et al., 2006). The Revised Interpersonal Circumplex Model described by Horowitz et al. (2006) is presented to participants to help conceptualize their interpersonal relations and interpersonal conflicts with some distance from the negative emotions which these have come to evoke in them. We discuss the central role of one's intentions or goals within each interpersonal "slice of time", as described in the CBASP model, and we focus on how their ambiguity from one person to another and from one situation to another may in turn lead to miscommunication and to a frustrating or unsatisfying interpersonal outcome (Horowitz, 2004; Horowitz, et al., 2006).

The concept of interpersonal complementarity, according to Horowitz's revised model of the interpersonal circumplex, is introduced to group members to emphasize the importance of a bi-directional communication between two parties and to explain that "an interpersonal action *invites*, rather than *elicits*, the partner to react in a particular way, but an invitation does not guarantee the desired reaction" (Horowitz, 2004, p.68). As such, the complement of one particular interpersonal behavior would therefore be the reaction from person B that would satisfy person A's motive (Horowitz, et al., 2006). Person B may in turn choose not to respond according to A's desired motive or may also misunderstand this motive. Group members are shown how an unambiguous interpersonal behavior can have as its complement from the other a response that is similar with respect to the horizontal axis (connection invites connection, detachment invites detachment) and reciprocal with respect to the vertical axis (influence invites deference and deference invites influence) (Horowitz, et al., 2006). Therefore, a response which might frustrate A's motive may then be considered to be non-complementary. Interpersonal theory and empirical evidence suggest that complementary interactions that tend towards the fulfillment of motives within a dyad are more rewarding than non-complementary interactions resulting from miscommunication or the frustration of motives (Horowitz, 2004).

Horowitz et al. (2006) outlined the application of his revised model in the context of personality disorders by proposing that most personality disorders contain a single salient interpersonal motive that organizes the other features. Similarly, the Desired Outcome, within a Situational Analysis, can be presented as the interpersonal motive that reframes and organizes the depressed person's personal conflict in a person X environment context of the interpersonal circumplex. This allows us to transpose a personal or intrapsychic conflict into one that is more easily externalized and discussed in an interpersonal space that is more visual and that situates the Desired Outcome relative to the two higher order motives of agency and affiliation. Patients become more attentive and attuned to the consequences of theirs and others' behaviors and consequently develop the mentalizing skills needed to improve their social skills.

Through the use of Situational Analyses the group discusses the interface between their interpersonal motives (Desired Outcomes), their perceived interpersonal self-efficacy in being able to reach these goals, their behavioral strategies used to reach a Desired Outcome, and their coping strategy or emotional reaction when these efforts fail. This adaptation of Horowitz et al.'s (2006) model to Group-CBASP facilitates a group discussion that remains interactive and that involves all members in the discussion of one particular Situational Analysis. Group members gain a better understanding of why they often feel frustrated in their interpersonal relations when they become more sensitized to their miscommunications that result from an ambiguous or unattainable Desired Outcome.

To personalize the presentation of the interpersonal circumplex, group members receive the results of self-report questionnaires completed at the start of the group, which indicate their profile along the two dimensions of Agency and Affiliation with regards to their interpersonal values (Locke, 2000), their interpersonal self-efficacy (Locke & Sadler, 2007) and their self-reported interpersonal problems (Horowitz, Alden, Wiggins, & Pincus, 2000). Locke (2000) developed the Circumplex Scale of Interpersonal Values (CSIV), which measures the value or preferences that individuals place on certain interpersonal outcomes or modes of conduct associated with each octant of the Interpersonal Circumplex. Respondents rate (on a scale from 1 to 4) the importance of various interpersonal outcomes or modes of conduct that they anticipate to have in the group setting. The scale demonstrates very good internal consistency for the eight scales of the circumplex, with a Cronbach's alpha ranging from .76 to .86. Also, the intercorrelations of the eight CSIV scales reveal the expected positive correlations between adjacent octants and high negative correlations between polar opposite octants on the interpersonal circumplex. Overall, the pattern of correlations showed a circular ordering with no reversals. The CSIV shows good convergence with a measure of adaptive interpersonal traits, the Bem Sex Role Inventory (Ben, 1974), and with a measure of maladaptive interpersonal traits, the Inventory of Interpersonal Problems-Circumplex (IIP-C; Alden, Wiggins, & Pincus, 1990); as well as with a measure of implicit interpersonal motives, the Thematic Apperception Test (TAT; Atkinson, 1958) and explicit interpersonal motives, the Interpersonal Goals Inventory (IGI; Dryer & Horowitz, 1997).

The Circumplex Scales of Interpersonal Efficacy (CSIE), also developed by Locke and Sadler (2007), is also a self-report measure of individuals' confidence in their ability to perform interpersonal behaviours successfully associated with each of the 8 octants of the Interpersonal Circumplex (such as giving orders or following orders). Respondents rate (on a scale from 0 to 10) how confident or sure they are that they can do certain specific behaviors within the group setting. Higher scores indicate greater self-efficacy. The scales of the CSIE have been shown to have internal consistency (Cronbach alphas ranging from .66 to .83 for each of the 8 scales), they conform to a circumplex structure and show good convergent validity with the scales of the IIP and CSIV.

There is evidence supporting the findings that both self-efficacy and values, as described above, have shared variance regarding the prediction of interpersonal behaviour, although self-efficacy alone explains unique variance in interpersonal behaviour that is not explained by values (Locke & Sadler, 2007). Locke and Sadler (2007) explain that this follows Bandura's (1997) hypothesis that "people will not attempt a behaviour if they do not believe that they can complete it successfully".

The Inventory of Interpersonal Problems (IIP; Horowitz, et al., 2000) is a 64-item self-report instrument that identifies a person's most salient interpersonal difficulties. A brief version containing 32 items (IIP-32) is used instead as it preserves the scale structure of the 64-item version and retains the four items of each scale with the highest item-total correlations. The internal consistency for the IIP-32 scale is high with reliability coefficients ranging from .68 to .93. Good test-retest reliabilities which compare to the ones obtained for the longer 64-item scale. Correlations between the scale scores of the IIP-64 and IIP-32 range from .88 to .98 and are all significant, suggesting that the IIP-32 scales, particularly the total score, are a good estimate of the IIP-64 scores.

The Group-CBASP model set within the interpersonal circumplex framework lends itself well to the study of the interpersonal pathoplasticity of depression. Some recent studies are revealing very useful information regarding the relationship between the course and outcome of major depressive disorder (MDD), which can vary widely, and the interpersonal style of the individuals. Cain et al. (2012) were the first to use the IPC and a Latent Profile Analysis to examine interpersonal pathoplasticity in the course of MDD and identified six distinct, homogeneous interpersonal groups of depressed individuals that did not differ on baseline symptom severity. In addition, they found individuals endorsing a submissive interpersonal style reporting a more chronic depressive course and poorer functioning over the course of a ten-year follow-up period, having controlled for the effects of a personality diagnosis.

In a pilot study (Sayegh et al., 2012) of Group-CBASP with chronically depressed outpatients, conducted by the present authors, twelve sessions of group therapy showed significant decreases in self-reported symptoms of depression and in the use of Emotion-Oriented Coping (Endler & Parker, 1999), as well as increases in overall social adjustment (Weissman, 1999) and Interpersonal Self-Efficacy (Locke & Sadler, 2007) when compared to their pre-treatment levels. Moreover, the beneficial effects on overall depression and social

adjustment were quite strong. Group-CBASP appeared to facilitate the acquisition of interpersonal skills as seen in patients' improved Interpersonal Self-Efficacy in the area of agentic behaviors that include assertive, self-confident, and independent behaviors. The authors recommend extending the duration of Group-CBASP to 20 sessions in order for improvements to reach levels of remission for both depression and adaptive social functioning.

The ongoing research at the Depressive Disorders Program of the Douglas Mental Health University Institute also confirms previous findings (McCullough et al., 1994) that chronically depressed individuals tend to have interpersonal profiles on the Interpersonal Circumplex that are within the submissive/avoidant and submissive/dependent quadrants and more so with regards to their perceived Interpersonal Self-Efficacy (Locke & Sadler, 2007) at the start of group-CBASP. The group setting offers an opportunity for depressed patients to learn interpersonal skills that help them improve their self-efficacy and begin to reintegrate a more functional and active life-style. Further research is being carried out at the Douglas Institute to show how Group-CBASP differs from a Behavioral Activation group treatment in the acquisition of interpersonal self-efficacy and social functioning, while both groups may experience similar remission from depressive symptoms.

4. Group-CBASP methodology and procedure

The Group-CBASP manual was developed at the Depressive Disorders Program of the Douglas Mental Health University Institute, Montreal, Quebec and follows the basic learning paradigm of the model developed by McCullough (2000). The group manual, which was approved by Dr. McCullough, contains two modules: the first is a Behavioral Activation module addressing the life style of the depressed person and the compliance to medication and the second is the CBASP-proper module which adapts the CBASP approach to a group setting and includes the Interpersonal Circumplex as an educational tool.

4.1. Selection criteria and pre-group preparation

Patients with major depressive disorder are referred to Group-CBASP by the treating psychiatrist who will have begun pharmacological treatment. Each patient is met individually by one of two group therapists, prior to the beginning of the group, for at least two sessions. In these sessions current symptoms are reviewed and the usefulness of Group-CBASP as a possible therapeutic modality is discussed with each patient, provided there are no contra-indications.

4.1.1. Contra-indications to Group-CBASP

1. Group-CBASP is not recommended for patients who are at high risk for suicide, as these patients need individualized, crisis intervention tailored to their particular difficulties.

2. Group-CBASP is not recommended for patients who are so regressed that they do not make any eye contact with the therapist during the entire initial individual sessions. These patients often speak with few words and appear openly anxious. The group experience is premature for such individuals who also often have very little insight into their non-verbal behaviors. More individual sessions are needed to help build a therapeutic alliance and consequate these individuals' withdrawn and submissive behaviors in order to bring them to accept to work with an interpersonal approach such as CBASP.
3. Group-CBASP is not recommended for patients who become angry with the therapist during the initial individual clinical interviews while the Significant Other History exercise is carried out, as preparation for the group. These patients often present with a personality disorder, as demonstrated by the rapid development of a negative transference reaction within the first or second session. The presence of a personality disorder does not preclude the possibility of participating in Group-CBASP, it is rather the patient's capacity to contain anxiety and to control acting-out behaviors which determine his/her ability to tolerate the tension of being in a group setting and the need to share attention with others.
4. Group-CBASP is not recommended for patients actively abusing substances. These patients will need to initiate participation in a substance-abuse program concurrently as they attend Group-CBASP, in the least, and be abstinent during group sessions.
5. Although patients with psychotic symptoms may find the group setting very anxiety provoking, Group-CBASP may be adapted to help certain patients with a psychotic depression learn to ground themselves in the behavioral and reality-based anchors of an interpersonal situation. A discussion of how to accurately describe the Actual Outcome according to observable and behavioral indicators, for example, can help such a patient discriminate between ideas of reference or delusional thinking and the reality-based outcome of the interpersonal slice of time.

If there are no contra-indications for Group-CBASP and the patient accepts to work within a group setting, the patient and therapist carry out the Significant Other History exercise, which has been very well described elsewhere (J. P. McCullough, 2000; J. P. McCullough, Jr. & Penberthy, 2011). The purpose of this exercise is to establish a Transference Hypothesis identifying an interpersonal domain that represents a "core content of each patient's interpersonal fear" (James P. McCullough, et al., 2010, p. 324). The Transference Hypothesis is formulated in an "if this..., then the group members will respond that...." manner. The transference Hypothesis, comprising the interpersonal domain of difficulty (see below, CBASP interpersonal Domains) for each group member, will be integrated within the group work and serves as a measure of acquisition learning of felt-safety with others. This learning is the basis upon which participants begin to discriminate between the safety experienced within the group and the malevolent Significant Others who have hurt them or with whom there has been a deficit in early attachment (Shaver & Mikulincer, 2011). Each participant is made aware of his/her Transference Hypothesis as this is frequently referred to at intervals during Group-CBASP in the form of a *Personal Questionnaire* that uses a paired comparison-rating task (J. P. McCullough, 2006). This is discussed below in the section on "Measuring acquisition learning in Group-CBASP".

Following the individual sessions, participants are given self-report questionnaires to complete, some of which are used to provide information during sessions about each group member's interpersonal values, self-efficacy and interpersonal problems, previously described. Patients are given some basic information regarding the structure of the group, such as: (1) each group accepts a maximum of six patients, (2) group sessions are two-hours long, and (3) the group meets for 20 consecutive weeks. Participants undergo a semi-structured interview with another team member who administers the Hamilton Rating Scales for depression (HAM-D-21; Hamilton, 1967) and anxiety (HAM-A; Hamilton, 1959), the Inventory of Depressive Symptoms (IDS-C; Rush, Carmody, & Reimetz, 2000; Rush, Gullion, Basco, Jarrett, & Trivedi, 1996a) and the Life-RIFT (Leon et al., 1999), which is a brief semi-structured interview designed to assess functional impairment. The Life-RIFT is derived from the Longitudinal Interval Follow-up Evaluation (LIFE; Keller et al., 1987).

4.2. Group-CBASP sessions outlined

1. **Group session 1** - During the very first group session, group members begin with brief personal introductions followed by a presentation by the group therapist of the outline of all group sessions. Some basic group rules are agreed upon and questions about procedures are answered. Then, everyone receives their completed Inventory of Depressive Symptoms- self-report questionnaire regarding symptoms of depression experienced in the last month. This helps the new and often uncomfortable members talk about their depressive symptoms while maintaining some degree of privacy regarding other personal issues that they would rather not reveal at the present time. A discussion follows on the particular manifestation of depressive symptoms for each member.

Following this first group discussion, the group therapist reviews the diagnostic criteria for major depressive disorder and discusses how this differs from dysthymia and from chronic depression. With the help of some graphs, some definitions of what are a relapse and a recurrence and the importance of compliance and maintenance of long-term pharmacotherapy for recurrent depression are reviewed. Another group discussion is held around the particular course, early or late-onset, of each member's depressive illness. All members having received a diagnosis of the more severe or chronic form of major depression, hearing other members share their experiences often helps them feel reassured that they are not alone experiencing these symptoms. A discussion regarding their experiences with medication ensues.

This first group session ends with a suggestion to members that they chart their mood over the course of the next month using a distributed mood chart. Then a homework assignment is given asking the members to chart on an activity schedule their typical activities in the next week including times at which they wake-up and go to sleep, times at which they take their meals, go out for a walk and even carry out their personal hygiene. They are also instructed to include any social interactions they may have during the week even if these are telephone calls with a friend or acquaintance.

2. **Group session 2** - In the second group session, the activity charts are reviewed and a discussion is held on the current life style of each group member in their present state of health. We identify aspects of their daily routine that may be problematic particularly with regards to the frequently mentioned isolation which results from their avoidance of contacts with just about anyone. The therapists then present a behavioral activation module on healthy living which includes the importance of a balanced diet, physical activity, good sleeping habits, attention to personal hygiene, ways to stimulate one's cognitive functioning and attention to one's environment. The idea of reintroducing positive reinforcements and pleasure experiences, which have been dramatically reduced since the onset of the depression, is discussed.

Members are encouraged to choose one area of their personal life style that they need to make changes in and to choose one social activity that would represent a challenge for them but that is also a preferred activity. These activities may be in the area of physical exercise, eating or sleeping habits, or in improving personal hygiene. The concept of graded task assignments is explained and positive reinforcement from discussing these challenges with peers in the group who understand them is very supportive for patients. The members are asked to identify a time in the week when they will begin to put into practice these selected activities which come to represent their "challenge" for the week. Every week until the end of group therapy, members discuss at the beginning of each session how they were able to carry out the challenge of the past week and then identify a new level for this challenge for the following week or perhaps identify a new challenge. This summarizes the behavioral activation module that is integrated into a Group-CBASP model.

3. **Group sessions 3 & 4** - At the beginning of the third and at every other group session, activity charts are reviewed first and every member indicates the degree to which he/she was able to reach the behavioral goal they will have given themselves for the past week. Each member also sets a new level for this goal or decides on another goal to reach for the following week. This discussion often entails readjustments of members' expectations that are too high or too low and the possibility to validate this with other group members instead of having only the therapist's view, as is the case in individual therapy.

Following this discussion on behavioral activation, the third group session introduces the CBASP model with a discussion of the cycle of hopelessness and global thinking that generates helplessness and defeatism, which in turn result in feeling misunderstood by others and in avoidance of others. The long-standing social isolation brings about the perception described very well by McCullough (2000), on the part of chronically depressed individuals, that they have no effect on others in their environment and that others' feedback has little if any impact on them nor informs their own behavior. This results in the inability of these individuals to identify interpersonal motives for their behaviors that are intrinsic and self-determined. They do not understand nor identify the consequences of their own behaviors on others or vice versa. The interaction between the person and the environment is severed, as described by McCullough, as these individuals begin to feel that they have lost control over their

lives. Following a presentation by the group therapist on this vicious cycle, group members take a few moments to write down their own personal cycle of global thinking that leads to hopelessness and withdrawal from others. A discussion follows with each participant sharing his/her experience that has led to such a feeling of loss of control over his or her life.

5. The situational analysis within a group setting

The therapists introduce the exercise of the Situational Analysis (SA) in the third or fourth group session, presenting it as a strategy that helps break the vicious cycle of chronic depression and hopelessness. This exercise is described in great detail by McCullough (2000) who provides the rationale for each step of the exercise, explaining the do's and don'ts and the objectives to reach. The SA will only be described here in its adaptation to a group modality maintaining the same rationale and objectives described by McCullough, although the empowering effects of group learning and sharing enhance the experience. Participants are encouraged to learn to regain control over their lives by solving one interpersonal problem at a time (J. P. McCullough, 2000). An example of an interpersonal interaction that may have been stressful or frustrating is requested from any group member to demonstrate the exercise of the SA in this group session.

The group therapist first teaches members how to listen to an interpersonal interaction and to extract from it a specific "slice of time" with a clear beginning and an end marked each by a distinguishable behavior and then to describe the content of what was said within this slice of time. An example is given of a telephone call, which begins and ends with a specific marking point. We may at times go over several social interactions within the group before someone mentions a conflictual interpersonal issue. This SA exercise is difficult for group members to learn as it engages the mentalizing and executive functions that are found to be lacking or diminished in patients with chronic depression. For this reason two to three sessions are taken-up explaining the SA using an example provided by each group member in turn. The tendency is for group members to deny having interpersonal problems as they report feeling safe having withdrawn from almost all social interactions.

In order for all group members to participate in the exercise together, each member is asked to complete the five steps of the exercise on their own SA form while the whole group discusses the particular example of one individual's SA. Doing the exercise together contributes to the group's cohesion and helps each member learn to formulate a succinct sentence to explain what they mean, which in turn enhances their mentalizing functions. The five steps of the SA are carried out within the group in the following format:

5.1. Elicitation phase of the SA

- **The first step of the SA** involves a description of an interpersonal situation recounted by one of the group members (the protagonist) who is first instructed then asked to indicate the beginning and end of the "slice of time". The group therapist writes out on

a board the member's exact words while recounting the event with specific instructions given to "tell us who said what" without any editorializing.

- **In the second step of the SA**, the group therapist asks each group member to imagine himself or herself in a similar situation as the member recounting the event (the protagonist) and to think about how they would "interpret" or "read" this situation if they had been involved. The protagonist also performs this step reflecting on his/her own experience. This step elicits the thoughts or interpretations of the protagonist from the beginning to the end of the "slice of time" described, asking group members: "how did you read what happened?" A few minutes are spent writing out this second step and a discussion follows beginning with the protagonist describing his/her interpretations/thoughts about the event, as the group therapist writes this out on the board. The other group members take turns sharing their interpretations/thoughts, imagining that they had been in such a situation.
- **In the third step of the SA**, the group therapist asks the protagonist to describe his/her non-verbal behavior within the "slice of time" recounted in step one, including the tone of voice, eye contact, gesturing or any other adjective describing observable appearance only. Other group members, who witness how the protagonist recounted the event with non-verbal indicators that are often similar to the original situation, often corroborate this description. The group therapist writes this on the board and members complete their form in their own words.
- **In the fourth step of the SA**, all group members are asked to take a moment to think and to write down the "Actual Outcome" of the "slice of time" recounted by the protagonist. Group members are instructed to describe how the situation ended for the protagonist with a focus on the "observable" behaviors only and not on theirs or the protagonist's feelings about it. Participants often have difficulty understanding how to recount an Actual Outcome in behavioral terms and more time is spent early on in Group-CBASP to explain the need to "stick to the facts" and recount only "what happened". Later on as participants learn to do SAs, group therapists suggest that steps four and five are reflected upon together and that participants write them both down before discussing and sharing their responses within the group. This will give them more time to think of their own personal experience with a similar situation. When step four is discussed, the group therapist first asks the protagonist to describe how the situation ended for him/her ("Actual Outcome"), writes it on the board, and then each of the other members' answer is heard. The group therapist observes how difficult it is for members to provide an "Actual Outcome" that is observable and that uses behavioral indicators and this difficulty is discussed in the group. Some group members continue to have this difficulty for at least two months into Group-CBASP until they finally come to understand near the end of group treatment.
- **In the fifth step of the SA**, the group therapist asks the protagonist how he/she would have liked the situation to end; that is his/her "Desired Outcome". Instructions are given to all group members to specify a Desired Outcome that is given in behavioral terms, that is "realistic and attainable" by the protagonist within the "slice of time" that was previously described and that is within his/her control to reach. The other group

members are instructed to think of how they would have wanted such a situation to end, for themselves, if they had been in this or in a similar interpersonal situation in place of the protagonist; that is their own “Desired Outcome” for themselves. Many members misunderstand these instructions and instead suggest how they think the protagonist ought to have behaved or ended the situation, revealing their focus on the other and increased ability to help others but not themselves.

The fifth step of the SA is the most difficult for depressed patients as this is the step that raises the issue of their inability to identify an interpersonal motive or goal. Initially, the group therapist does not insist on giving too many instructions in order to avoid turning the session into a classroom where members become preoccupied with performance. A discussion ensues instead on the negative emotional arousal that such a frustrating interpersonal interaction, recounted in the “slice of time”, triggered in the protagonist and in others who identified with the situation. Group members often describe a Desired Outcome that is not under their control but that depends on the other person in the interaction to whom the protagonist was speaking. Members learn to use the method of Socratic questioning to ask themselves and each other whether it is possible to attain a Desired Outcome that is not under their control. An example of such a Desired Outcome is: “I want to make him understand what I am trying to say...” Often the protagonist will not be able to identify a Desired Outcome at all for the remaining of the group session. This is certainly accepted and normalized and the attention can be turned to how others in the group would have wanted to end such an interpersonal interaction recounted in the “slice of time”. The group therapist guides a discussion around the problematic interpersonal conflict and the feeling of powerlessness about not knowing what one wants. The group therapist can then return to the protagonist to ask if this discussion helps him/her identify a Desired Outcome.

Group members are very supportive of each other throughout this process. Nevertheless the protagonist may begin to experience an uncomfortable cognitive dissonance between experiencing on one hand a pull to avoidant others in the group and on the other the positive reinforcement from group members who similarly feel confused or discouraged about having ambiguous or ambivalent interpersonal motives. These discussions gradually move the group members towards a better understanding of what it means to formulate a Desired Outcome in behavioral terms that is under the control of the protagonist and that is attainable. The role of the group therapist is very critical at this step of group learning and needs to remain focused on highlighting the tense emotional experience of learned helplessness while beginning to consequence the members’ interpersonal behaviors during group discussions. The group therapist choreographs the group process to assure that the focus remains on learning goals of CBASP. As such, McCullough (2000) clearly outlines the need to follow the sequence of the 5-step SA exercise, indicating the rationale for each one. This procedure alone assures that the therapist does not “take over” the process and provide the answers that will inevitably undermine the group members’ efforts and struggles to find their own individual solutions.

- **Step six of the SA** is a question posed to the protagonist once the Desired Outcome has been formulated correctly. The group therapist asks the protagonist: “Did you reach your Desired Outcome?” McCullough (2000) explains and stresses the importance of this step as being one which allows the negative emotional reaction of the protagonist to rise and be expressed with regards to his/her lack of readiness to behave in the way he or she would have wanted, as outlined in their Desired Outcome. If the protagonist answers “no” to the question raised, the group therapist asks why and the protagonist usually describes the usual maladaptive pattern of behavior that results in the same unsatisfactory outcome he/she feels is not under his/her control. The protagonist only answers “yes” to the question if the Desired Outcome is the same as the Actual Outcome. This only occurs when the group is discussing an interpersonal event that was satisfying to the protagonist and did not engender any distress. Such an example may be useful in teaching the SA exercise or in cases where there is a great resistance or fear in the group to discuss any interpersonal conflict. At other times, the group therapist may observe that the protagonist answers “yes” to the question although he/she appears dissatisfied with the Desired Outcome. It is important to point out the non-verbal behavior that may be contrary to the verbal content of the Desired Outcome. The group therapist asks the protagonist if he/she is satisfied with this Desired Outcome given and the answer often changes to a “no”. The protagonist explains that he/she feels powerless to do anything else and this generates more discussion in the group about this inner conflict.

5.2. Remediation phase of the SA

Following these six steps of the “Elicitation Phase” of the SA in Group-CBASP, the group therapist introduces the “Remediation Phase” of the SA involving the following steps:

- Once the Desired Outcome is identified, described in behavioral terms and appears to be under the protagonists’ control, the discussion moves to the Remediation Phase following the answer given to question six above. Having expressed distress over maladaptive patterns of behavior that prevent the protagonist from reaching his/her Desired Outcome, the group therapist suggests that the protagonist and others in the group turn their attention to the interpretations in step two of the SA to see if these help the protagonist reach his/her Desired Outcome or not. McCullough (2000) describes the resolution of the Remediation Phase as being a negative reinforcement experience in the sense that the protagonist will feel relief from distress in the face of his/her maladaptive interpersonal behavior, if these steps are carried out properly. The group therapist asks the protagonist and others in the group, to review each interpretation and consider whether each one is *relevant* to the situation described in step one and whether it is *accurate or true*. Group members explore and discuss these questions and ask themselves if the interpretations provided by the protagonist, or by themselves,, are grounded in the event in that each interpretation ought to “reflect what actually

happened in the slice of time". If this is the case, then the interpretation is said to be *relevant*. "A *relevant* interpretation plants your feet solidly in the event", according to McCullough (2000). Also, the interpretation is accurate if it describes what actually happened between the protagonist and others within the given slice of time, rather than reflecting only the feelings, thoughts or perceptions of the protagonist.

- If the interpretation is *relevant* and *accurate* then the group therapist will suggest keeping it and asks how this interpretation helps the protagonist reach his/her Desired Outcome. If the interpretation doesn't help reach the Desired Outcome, it is not retained although it may have been relevant and accurate.
 - The Desired Outcome may be revised at this step if the protagonist acknowledges that it is not attainable or realistic. Otherwise, the same exercise is done to revise each of the remaining interpretations.
- b. The second step in the revision of the SA is to construct an *Active Interpretation* that prepares the protagonist to move towards the Desired Outcome. The group therapist asks the protagonist: "What do you need to say to yourself about what you need to do to reach your Desired Outcome, your goal?" Other group members may help the Protagonist find a self-statement that will help him/her reach the desired interpersonal goal.
 - c. The group therapist then asks the protagonist "If you had used this Active Interpretation, how would your behavior have changed (in that slice of time)?" The protagonist needs to answer this question and will always reveal an insightful statement, if he/she will have been able to do the SA from beginning to end. The group therapist then asks, "If you had behaved this way, would you have gotten what you wanted, that is, your desired outcome?" Finally, the group therapist asks the protagonist and other group members, "What did you learn doing this exercise?" McCullough (2000) underlines the importance of allowing the protagonist to think and identify the learning that took place and most of all the behavior that needs to change in order for a person to reach his/her interpersonal goals. It may take time for group members to name what they learned and more practice with the SA may help, however hearing other group members' learning experience is also very helpful. Often group members will point out an important aspect of the SA that the protagonist didn't give himself/herself credit for.
 - d. Once the Situational Analysis is completed, the group may practice social skills training and learn interpersonal skills through role-plays and in-vivo exposure with other group members, practicing the new behaviors they have identified in the previous step.

Once all these steps of the Elicitation and Remediation Phases of the SA have been discussed in the group setting, participants will have all had a first-hand experience with this problem-solving strategy to help them deal with interpersonal conflict. The group therapist collects at the end of each group session the members' SA forms that have been completed, having asked them not to change their first responses to each step of the SA. These forms will be used to monitor learning over the course of Group-CBASP and contribute to a clinical profile for each group member.

4. **Group sessions 5 to 8:** Sessions five to eight are spent practicing the SAs using participants' interpersonal experiences that are discussed during the first hour of the group or using examples of interpersonal interactions that have been conflictual for them in the recent past. Throughout group therapy, members are asked to bring each week a completed SA form describing an interpersonal interaction they had difficulty with. They are encouraged to do the exercise whether the five steps have been completed or not.

6. The interpersonal circumplex in Group-CBASP

The Situational Analysis is a challenging exercise that engages both cognitive and interpersonal skills of group participants. This is particularly demanding for chronically depressed patients who have developed an avoidant style of relating to their environment. Group therapists often find themselves facing a passive group of participants who have not done their homework and who maintain their levels of interpersonal conflicts or frustrations to a minimum. It becomes difficult to ask them to explore their "stressful interpersonal situations", as suggested by the Situational Analysis, in a group setting. Therefore, by introducing the Interpersonal Circumplex to participants and providing them with their own personal profiles on this circumplex, they soon come to realize that many of them share a common interpersonal style that situates them in the non-agentic and often non-affiliative quadrant of the interpersonal circle. The model is introduced in the following way:

6.1. Group sessions 9-10

The group therapist draws the Interpersonal Circumplex on the board and distributes to all participants their own results on the circumplex for each of the three assessment measures (discussed above), which they will have completed before the beginning of the group. The following discussion, initiated by the group therapist regarding the use of the interpersonal circle in Group-CBASP, has been adapted from Horowitz et al.'s (2006) Revised Interpersonal Circumplex Model explaining the following:

- The group therapist suggests to group members that we can conceive our interpersonal relations as consisting of exchanges between others and ourselves because we have a reason to interact. We may speak to another in an attempt to get closer to that person or in an attempt to distance ourselves from him or her. Similarly, some individuals may interact in an attempt to influence or control others, while other individuals may seek, on the contrary, to be led or helped by another. Therefore, if you do not know the motive behind a person's desire to interact with you, it can be difficult to understand what the person wants from you and to evaluate or anticipate the impact this may have on you.
- Generally, interpersonal behaviors are motivated and oriented towards a goal: each person usually wants something from another when he/she interacts. By speaking to you this way, my motive is to influence you in a positive way. I will feel satisfied about having fulfilled this motive if I receive from you what I expect, that is your

attention. I may also not be aware of my motives and these may also vary in importance for me. We all have different motives to which we attribute different degrees of importance. You can see this in your own Circumplex profile of interpersonal values.

- According to this model of the Interpersonal Circumplex, there are two large categories of motives that are at the top of the hierarchy of motives: that is motives concerning our *communion* with others and motives concerning our feeling that we are active *agents* in our lives. The Circumplex reflects the relationship between these two categories that drive our interpersonal interactions. *Communion* is on the horizontal axis and represents our need to get close to others, to feel loved, to belong, to establish friendships with others around us and other such affiliative behaviors. *Agency* is on the vertical axis and represents influence, dominance, competitiveness, or power over others and other such assertive behaviors. These two dimensions are in fact the two biggest challenges that we face from early childhood on; that is the need to get along with others and the need to move ahead and realize ourselves as autonomous individuals. These dimensions go from one extreme to another, such that at one end of the horizontal axis you may feel that you are too close in your relationships with others and that you tend to lose your boundaries, while at the other end you may want to distance yourself from others completely. At one end of the vertical axis, you may want to exercise ultimate control over others, while at the other end you may be too submissive to others and feel too dependent.
- Your own profiles will show whether you are at one or more extremes in terms of how confident you feel about being able to interact with others (on the efficacy scale) and about the importance you attribute to various interpersonal values that are in fact preferences for certain outcomes in interactions with others (on the values scale). You will also find a profile for the interpersonal problems that you reported in your responses to another questionnaire (on the Inventory of Interpersonal Problems – IIP). This last profile provides an indication of where on the circle you feel that you are experiencing distress in your interactions with others.
- Some of your behaviors may be driven by two motives that go together or that are in conflict. For example, you may want to influence a person and get close to this person as well. This may go over well or it may become a problem in certain situations. We may therefore place just about all your interpersonal behaviors on this Circumplex and define them along these two dimensions. We can then assume that when one person approaches another, his/her behavior is motivated, although the person may not necessarily be aware of their motive or objective at the time or of its importance to themselves. Also, the importance of interpersonal motives varies from one person to another and from one stage of life to another within the same person. Generally speaking, satisfying an important motive is associated with positive feelings, while frustrated motives are associated with negative feelings (Lazarus, 1991). We may also have conflicting motives that we are not aware of. This may generate such distress that in turn has a negative effect on mood and can place a person at risk for depression or an anxiety disorder.

- In summary, the meaning of our interpersonal behaviors largely depends upon the underlying motives that drive them. When these motives are not clear, behaviors can become ambiguous and lead to misunderstandings and even conflicts.

6.2. Interpersonal complementarity and the circumplex

Our interpersonal behaviors seek to evoke, invite or elicit a response or a reaction from another person. The response of this other person is called the “complement” of the behavior that we initiated.

According to Horowitz (2006), the complement of a behavior, is the response of the other that will **satisfy** your motive for your behavior. We generally feel satisfied when the person we are addressing responds to us in the way that we expect. These complements are usually found to be:

1. Similar with respect to the horizontal axis: Affiliative behaviors invite the same affiliative responses, while distancing behaviors invite another to also distance themselves.
 2. Reciprocal with respect to the vertical axis: Control/influence invites another to yield or cooperate and vice versa a call for help invites another person to take control.
- Serious interpersonal problems may arise when others regularly frustrate motives that are important to you. You might come to feel that you want to withdraw from others as a result and this often occurs with chronic depression. You might also learn to develop motives that protect you from feeling vulnerable or weak and these may be related to interpersonal patterns of behaviors or schemas (Young, Klosko, & Weishaar, 2003).
 - Having had some important motives frustrated for many years of your life, you may have developed **strategies** to use in order to avoid further rejection or negative judgments or to camouflage your true motives (Horowitz, et al., 2006). Many depressed individuals have come to avoid others and most of all avoid conflicts with others. Other individuals have learned to please others instead, as a way of avoiding criticism or rejection. Still others may have learned to be on the offensive or to be very guarded to avoid being victimized. Many depressed individuals with unrelenting standards for themselves and perfectionistic traits may hide their need for support and help from others by taking charge in all their interpersonal interactions. Some of these strategies may become too extreme and maladaptive causing stress and strain in your relationships with others particularly if they fail to obtain the desired response. This may lead in turn to increased destructive behaviors such as excessive drinking, hoarding, binge eating or purging, or sleep disturbances or to physical violence.

The Group-CBASP therapist uses the Interpersonal Circumplex to portray the importance of the Desired Outcome in Situational Analyses. The Desired Outcome can now be seen as the motive that clarifies and gives meaning to the interpersonal interaction described within the chosen slice of time. Group members can now visualize the Desired Outcome on the Circumplex and decide how to orient their behavior to agree with a most valued interpersonal outcome.

Group members can also better understand how ambiguous or unclear motives can lead to interpersonal conflicts. Each Situational Analysis that is done in the group can now bring forth the responsibility of the protagonist to determine a Desired Outcome that is under their own control if they want to increase their chances of obtaining a “complementary” response from the other person that will satisfy them and fulfill their Desired Outcome. Group members begin to visualize their behaviors on the Interpersonal Circumplex and begin to think about the impact that their behaviors have on others with whom they interact. They can take more responsibility for their own behaviors and develop more curiosity about how the other will respond, accepting that each member of a dyad has control over their own behavior. As an example, one group member who understood the principle of complementarity with regards to the horizontal axis of affiliation realized that if he began to smile to people he crossed in his neighborhood during his daily walks, they would smile back and say hello. This group member shared his experience with others in the group and felt empowered to find that he could have that effect on people around him that he wanted, as he described himself as being a friendly person who had been a leader in a dominant role both at work and at home prior to his major depressive episode. He shared with others in the group his desire to move out of the distant/yielding lower quadrant and move into the friendly/dominant quadrant.

Similarly, the Interpersonal Domain can also be used to bring forth the particular interpersonal theme that is problematic for each group member and reframe it as being the most salient motive that can be situated within one of the quadrants of the Interpersonal Circumplex. This is explained in the following section.

7. Interpersonal domains in Group-CBASP

Group sessions 11 & 12: We may now return to the interpersonal domain that was identified with each group member during the two individual sessions prior to the beginning of Group-CBASP (described earlier). These four “transference domains of interaction” (J. P. McCullough, 2000, p. 90) that are assessed at specific intervals during group therapy include the following:

1. Moments in which *interpersonal intimacy* are felt/verbalized by either the group member or by the therapist.
2. Situations in which the group member *discloses/expresses emotional needs* to others in the group either directly or indirectly.
3. Situations in which a group member *fails at something* or *makes an obvious mistake* during a group session (such as learning the SA).
4. Situations in which *negative affect* (fear, frustration, anger, etc.) is obviously felt or expressed, either directly or indirectly, by a group member towards others in the group.

McCullough (2000; 2006) explains that these themes were chosen to reflect the “maltreatment themes” that chronically depressed patients typically report, such as getting close to a significant other, experiencing emotional needs with a significant other, failing or

making mistakes around a significant other and having negative feelings toward a significant other. Each group member enters Group-CBASP having discussed the function of his/her interpersonal domain as being the central motive or objective that will be addressed within the group. Each group member has a Transference Hypothesis formulated in an *if (one of the 4 domains is manifested in the group)...then (group members may respond in an anticipated negative way)*. Some group members will have been able to identify, at the initial individual interview, the interpersonal domain as being the one they want to work on and improve during group therapy. These individuals are more aware of having learned maladaptive coping behaviors and strategies but do not yet see the impact of these on others nor do they assume the consequences of these behaviors. Other individuals who are less clear on what they want or need to change with regards to interpersonal motives or who have little insight, may learn from others during group therapy and gain a better understanding of how their interpersonal domain manifests itself within the group. Varying levels of awareness and insight within the group can stimulate learning and contribute to group cohesion.

It is often very difficult, however, for group members to discuss at the beginning of group therapy the way that these domains are problematic in their lives as these are at the heart of their avoidance behaviors. The outcomes, as formulated in the Transference Hypothesis, being negative, chronically depressed individuals have come to develop strategies to protect themselves from this negative outcome. For example, an individual avoids disclosing needs and feelings to others because he/she expects the hurtful humiliation experienced from malevolent significant others. Instead, this person may have learned to please others to avoid a reprimand or in the hope of gaining the long-awaited love and recognition. In time, this strategy, comes to replace the need for self-disclosure, albeit unconsciously, but it becomes so demanding that the individual may choose to avoid others altogether in order to minimize the increasing burden of trying to please everyone. Although an individual may agree that the Interpersonal Domain of disclosing needs or feelings to others is problematic for him/her, it may not be obvious to this person that he/she developed the strategy of pleasing others to protect the self from a perceived negative outcome associated with self-disclosure. The link between the Interpersonal Domain, which is the salient motive that individuals want to work through in therapy, and the maladaptive strategies developed to cope and attempt to arrive eventually at this most salient motive, can be made in group therapy. The group therapist points out the more adaptive function of the Desired Outcome in the Situational Analysis in helping group members reach their interpersonal motive within a particular social domain.

This is why most group members may not understand at the beginning of group therapy how their Interpersonal Domains will be worked through in the group in front of strangers as they are unaware of the strategies they have built to avoid disclosure, intimacy, expressing a negative emotion or admitting to a mistake. During group therapy members begin to see their strategies operate defensively even though they increasingly feel safe and engaged within the group. Gradually through discussions and the use of the Interpersonal Discrimination Exercise (described below), the therapist consequences the maladaptive behaviors used in these defensive strategies, placing the group member in a mismatching experience with in vivo

consequences of their behaviors on others in the group. This requires that the group member use a more formal operations perspective and mentalizing capacities to focus on the consequences of his/her behaviors on others and often chooses to change these maladaptive behaviors. Gradually, these maladaptive strategies are replaced with more risk-taking behaviors within the group involving the Interpersonal Domain that each had identified as the central motive important to work on in group therapy. The Interpersonal Discrimination Exercise (described below) can be used to help group members see the impact of their behavior on others in the group when they attempt, consciously or not, to manifest a behavior related to their Interpersonal Domain. More interactive exchanges take place in the group as the group therapist keeps the focus on working with Situational Analyses. Group members can now see the value of a Desired Outcome, in an interpersonal “slice of time”, as helping them gain control over the impact that they can have and want to have on others, just as they have learned of the impact that they have on members within the group. The concept of “solving one problem at a time” becomes clearer as group members see the gains they make with each new Situational Analysis.

8. The interpersonal discrimination exercise (IDE) in Group-CBASP

Group sessions 13-18: The IDE is a technique used in CBASP to help group members discriminate between their emotional responses and behaviors experienced within the group and the emotional responses and behaviors they developed using maladaptive strategies with malevolent significant others. The IDE provides an opportunity to use an operant conditioning paradigm (Neudeck, Schoepf, & Penberthy, 2010) to show group members how they can change their attitudes and behaviors following the negative reinforcement experienced from positive responses of others in the group, which are contrary to the expected responses of past malevolent Significant Others. Group members learn to improve their level of empathy with this exercise by feeling how others respond to them in ways that satisfy their motives and desired outcomes. Their risk-taking behavior is rewarded and its consequences are felt. This helps repair the person X environment rift that had been growing and alienating everyone including the depressed person herself or himself.

- **Example of an IDE** - A group member, usually agreeable and pleasing, comes in group one day and reports in a frustrated tone that she did not interact with anyone all week and did not do anything towards reaching her behavioral challenge for the week. Everyone in the group is silent awaiting the response of the group therapist who also decides to wait silently. Another member steps in and adds that he did not reach his goal either and expresses his understanding to the first member or perhaps directs this comment to the group therapist. The therapist nods in support, validates that this is difficult and asks the first member how she feels. This generates a discussion around the table about how others feel about her challenge and theirs and about the possibility that the member may have aimed too high or been too critical of a smaller step that was taken but was minimized. This often leads to a reformulation of the behavioral challenge by the member herself towards a goal that she feels is more attainable.

- Following this discussion, the group therapist returns to this member and identifies the Interpersonal Domain that she manifested, in this case *expressing negative emotions*. The therapist is aware of the importance of each Interpersonal Domain for each group member and decides to use this interpersonal experience (referred to by McCullough, (2000; 2006) as being a “hot spot”) to carry out the Interpersonal Discrimination Exercise (IDE) with her. The group therapist brings the member’s attention to the fact that she expressed a negative emotion to the group. The therapist then asks this member how a maltreating Significant Other would have responded to her if she had expressed herself this way. This group member may not recall this information with others watching and listening however the focus is kept on the current difficulty she has expressing negative emotions and what is at stake in doing so, in this case risking being rejected. This reminder raises the person’s level of tension as she recalls her behavior and its implications for her. She reflects on what she did and may feel uncomfortable. The group therapist brings the person’s attention away from herself and her discomfort and asks her how others in the group responded to her when she expressed these negative emotions. It is often difficult for depressed individuals to put themselves in the other’s shoes, as it would counter the preferred avoidant position. This “mismatching” interpersonal situation provides an opportunity for this group member to take notice of the support and acceptance of others in her time of need, thus enlisting her empathic skills and mentalizing functions. She and others engage in a spontaneous discussion of the importance of the supportive feedback of group members for them and this discussion contributes to building a strong sense of cohesion and belonging within the group. The group member, in this example, is astonished to realize that she has indeed expressed negative emotions quite openly without negative consequences. She gradually comes to understand that her strategy was to always try to appear perfect, wanting to be the “best patient” to please the therapist and impress others, out of fear of being rejected and unwanted if she expressed negative emotions.

The remaining group sessions are spent reviewing Situational Analyses that can now be seen as useful problem-solving tools that help group members regain control over their lives. The group therapist successfully choreographs the interactions between group members, as described above, to assure that a return is always made back to the Situational Analysis as the primary focus of learning in group therapy.

Group sessions 19 & 20: These last two sessions are used to review the group members’ group therapy experience and to discuss ways in which they handle losses, separations and farewells. The group therapist introduces these themes around session 18 to suggest that group members think about their group therapy experience and identify goals that they feel they’ve reached as well as goals that they have not reached or new ones they can now identify. These are discussed during group sessions 18 or 19. In addition, follow-up group sessions once per month are introduced as an opportunity to receive some feedback and share their experiences generalizing the skills learned in group therapy. Patients will also be meeting with their treating team, at the end of Group-CBASP, to go over the improvements made and determine the individual follow-up for each patient. The theme of farewells and

“Adieus” are kept for the last session or can be discussed earlier, depending on each group’s process and dynamics. Each group member has an opportunity to express themselves to specific individuals in the group or to the group as a whole.

9. Contingent personal responsivity in Group-CBASP

McCullough (2006) introduced CBASP as an interactive therapeutic modality in which the therapist uses his own personal responsivity during sessions to consequence the patient’s in-session maladaptive behaviors and help him/her change them. The therapist responds in a *disciplined manner* (J.P. McCullough, 2006) to help the patient with early or late-onset depression to connect perceptually with his/her environment, in this case group members. The interpersonal environment of the chronically depressed patient comes to have no “informing influence” on the individual’s behavior, which only serves to reinforce social isolation. McCullough (2006) provides numerous examples in which the patient’s maladaptive behaviors interfere with progress in therapy and demonstrates how the therapist consequences this behavior by showing the patient in a *disciplined manner* the effect he/she has on the therapist.

Similarly in Group-CBASP, the group therapist assumes a position that models this *disciplined involvement* for all group members. The group therapist choreographs, as described by McCullough, contingencies in each group session to keep the group members focused on the steps of the SA and brings forth the learning acquired. This focus also places emphasis on the discomfort and distress experienced when group members determine that they are not reaching their desired outcomes, followed by relief when this dilemma is resolved in remediation of the SA. The group therapist asks each member what he or she learned in each SA and points out behavior changes that are discussed. Each group member also consequences each other’s behaviors during group sessions following such behavior modeled by the group therapist. The best examples of this occur when group members give feedback to a protagonist during a Situational Analysis. By speaking from the point of view of their own experience in a similar interpersonal situation, group members say how they would have responded at each step of the SA (as described above). The protagonist learns to observe his/her own maladaptive behaviors and thinks about the impact these may have on others.

The Group-CBASP therapist has the difficult task of keeping the group members focused on the task at hand. He/she counters the pull to allow the group to avoid discussing interpersonal conflict while on the other hand not becoming too directive and rescuing the members during a difficult SA. The group therapist also reframes interpersonal avoidance as being a hostile reaction, whether apparent in missed group sessions (not due to an emergency as indicated by the group rules at the start of Group-CBASP), or whether manifested during group sessions by withdrawal and detached interpersonal behaviors. The group therapist again calls attention to the effect of this behavior on others in the group and focuses on the maladaptive nature of this strategy in being able to achieve a Desired Outcome.

10. Measuring skill-acquisition in Group-CBASP

McCullough (2010) outlines a new empirical method for measuring the change that occurs in CBASP for chronically depressed patients and suggests some new directions for future research into the active ingredients that contribute to the success of CBASP. In addition to the application of these same guidelines to Group-CBASP, the current authors have added further instruments that will also be discussed relative to their contribution to recovery from chronic depression.

In its adaptation to a group modality, the role of all group members as well as of the group therapist become instrumental in Group-CBASP, being essentially an interpersonal model of psychotherapy. Following McCullough's guidelines (2010), treatment is implemented in the therapist to group member interactions as well as in the group member to group member interactions. The vehicle of change is therefore shared among all participants in the group, however the group therapist retains the same responsibility, described in greater detail by McCullough (2000; 2006; 2010), of choreographing and directing the interpersonal learning processes by consequating group members' behaviors with each other. As such, the group therapist strives to achieve two essential learning goals specified by McCullough and adapted to Group-CBASP:

1. The group therapist counter-conditions the group members' pervasive interpersonal fear of being together in a group, replacing the fear with *felt interpersonal safety*. This first goal is achieved when the group members can perceptually discriminate the group members, including the therapist, from maltreating or malevolent Significant Others (Sos). The group members will come to experience safety and a sense of "belonging" within the group such that they take more ownership for the group process by the end of group therapy. Also, they come to perceive the group therapist as an equal member who will consequate their behaviors just as they have learned to expect from others in the community.
2. The second learning goal of Group-CBASP is realized when each group member's interpersonal avoidance is replaced with approach behaviors. Group members begin to assert themselves and communicate spontaneously together on the topic of what they want or don't want and on their current level of interpersonal difficulty, without the therapist's interventions or assistance. There is no doubt that in order for Group-CBASP to help depressed patients solve interpersonal problems and achieve *perceived functionality* (previously described), they will need to have learned to identify the consequences of their interpersonal behaviors.

10.1. Measuring goal one: Achieving *felt interpersonal safety*

The goal of measuring whether group members achieve interpersonal safety together is accomplished with the use of the Interpersonal Discrimination Exercise (IDE) (McCullough, 2006). McCullough (2009; 2010) operationalized the IDE exercise into a four-step-performance task that each group member can learn to self-administer. Using the Form for

Scoring the Self-Administered Interpersonal Discrimination Exercise (SAd-IDE; J. P. McCullough, 2009), the two co-therapists can rate the group members' performance using the SAd-IDE form which each scores independently to obtain a measure of inter-rater reliability. This measure is described in greater detail by McCullough (2010) for individual therapy and has been adapted by the current authors for Group-CBASP. In short, the IDE is administered with each group member whenever one of them encounters a "hot spot" (i.e., statements made by a group member that includes material specific to his/her Transference Hypothesis) in an interaction with others in the group. Criterion performance is defined as being able to self-administer the IDE without corrective assistance from the therapist and obtaining 4 performance "hits" for the IDE exercise in two successive trials. The group co-therapists can then independently rate the SAd-IDE scoring form at the end of the group therapy session.

In addition to this measure, the Personal Questionnaire is also given at regular intervals (approximately every third group session) throughout Group-CBASP to assess the group members' perceptual capacity to discriminate the group members (including therapists) from maltreating or malevolent Significant Others. The Personal Questionnaire is a *patient self-report methodology* comprised of paired comparisons using three cards that are each compared to one another by each group member separately (J. P. McCullough, 2000; 2006). These cards contain the same content of the Transference Hypothesis used for the IDE exercise but formulated with a (1) baseline illness-level indicating no perceptual difference observed between group members and malevolent Significant Others (e.g., *More often than not I feel that if I disclose my needs and feelings to others in the group, then they will humiliate and reject me.*); an (2) improvement-level indicating some perceptual change observed between group members and malevolent Significant Others (e.g., *Sometimes I feel that if I disclose my needs and feelings to others in the group, then they may not humiliate or reject me.*); and a (3) recovery-level indicating a clear perceptual change observed between group members and malevolent Significant Others (e.g., *More often than not I feel that if I disclose my needs and feelings to others in the group, then they will not humiliate or reject me.*). This exercise can be administered at the beginning of the group session by distributing to each group member a set of three cards containing the graded formulation of their own Transference Hypothesis and recording their responses to each of three comparisons. The scoring procedure is clearly outlined by McCullough (2006, pp. 163-167).

10.2. Measuring goal two: Achieving *perceived functionality*

Whether administered individually or in group therapy, Situational Analysis (SA) is the active ingredient of CBASP (J. P. McCullough, 2000) that is administered at almost every session of Group-CBASP and is the predominant focus of learning. Acquiring the ability to self-administer SA is directly related to the individual's awareness of the consequences of their behaviors and is therefore the technique used to measure the attainment of this second learning goal. SA is a "mismatching" exercise carefully choreographed by the group

therapist within a group setting, following guidelines provided by McCullough, without digressing into other areas of the patient's intrapsychic functioning. The group therapist keeps the focus instead on the problematic interpersonal behaviors that maintain feelings of helplessness and loss of control reported by depressed individuals. It is the correct application of the SA by the group therapist that successfully demonstrates to group members "that the interpersonal consequences they report are, for the most part, self-produced" (James P. McCullough, et al., 2010, p.326). Measuring this learning acquisition will then enable the clinician to monitor the patient's ability to generalize these skills to situations outside group therapy. As previously described (see The Situational Analysis within a group setting), the group therapist collects the SAs from each group member at the end of every group session for the SA that was done that day as a group and may collect SAs that group members have done on their own during the previous week. These SAs are dated and rated by independent raters using the operationalized steps outlined by McCullough (2000, p.201). Group members will need to show they can self-administer the SA to criterion level performance along the five-step SA exercise procedure described by McCullough (2000; 2010) twice in succession without assistance from the clinician. In addition, these two trials will need to receive a score of "5-step-hits" for this learning goal to be achieved.

10.3. Measuring the learning content of Group-CBASP and its impact on treatment-outcome

A patient profile can be constructed comprising the acquisition-learning data collected above in the achievement of the two essential learning goals of CBASP, plotted over the 20 Group-CBASP sessions. In addition, a 20-item questionnaire has been constructed by the current authors comprising items measuring change in Behavioral Activation, in Interpersonal Self-Efficacy (Locke & Sadler, 2007) and in symptoms of depression (IDS-SR; Rush, Gullion, Basco, Jarrett, & Trivedi, 1996b). Group members complete these items at the beginning of each group session. Together, these measures provide an evolving picture of each group member's personal learning and contribute to the compilation of group data that can be used towards more empirically-driven research questions that may seek to compare Group-CBASP to other group treatment models. Changes in behavioural activation and in depressive symptoms reduction are important indicators of the generalization of learning to other areas of the patient's functioning. Furthermore, acquired Interpersonal Self-Efficacy, particularly along the dimension of Agency as demonstrated in a pilot study (Sayegh, et al., 2012), may be a good indicator of the empowering experience of Group-CBASP in helping depressed individuals regain control over their lives. The current authors, in a randomized-control study comparing Group-CBASP with a group Behavioral Activation program, will verify this hypothesis empirically in the ongoing development of Group-CBASP research. As recommended by McCullough (2010) and similarly for Group-CBASP, further research is also needed to identify the "essential mechanism of change" (pp. 334) in this effective treatment modality.

11. Group-CBASP maintenance and follow-up

The reality of chronic depression is that follow-up in the form of continuation and maintenance sessions of Group-CBASP is as important as long-term pharmacotherapy. Group-CBASP helps chronically depressed patients resume interpersonal interactions and a more active life in more fulfilling ways, however their newly acquired learning will take time and practice to reach levels that are rewarding and that reinforce adaptive behavior. It is recommended that monthly Group-CBASP sessions be provided to group members who have completed the 20-week program. This monthly session provides an opportunity to review Situational Analyses and the generalization of adaptive behaviors to interpersonal situations outside of therapy. In the authors' experience, it has not been necessary to provide individual follow-up concurrently with Group-CBASP. It is useful however for the treatment team to meet with each patient a short time following the end of Group-CBASP to discuss maintenance and continuation and to continue assessing change with a follow-up evaluation. This provides an opportunity to set new goals and to evaluate the effectiveness of the psychotherapeutic treatment plan.

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